Intermon Oxfam PHP Best Practice for Emergencies and Post Emergencies 2010

Photo taken from WSSCC

Mariona Miret WaSH Coordinator AH DCI
Myra Foster Humanitarian Technical Advisor-Public Health Promotion AH DCI
Marta Valdes Monitoring Evaluation and Learning Coordinator UDTM DCI

Table of Contents:

Acronyms:

AIDS	Acquired Immune Deficiency Syndrome
BCC	Behavior Change Communication
CHAST	Child Hygiene and Sanitation Transformation
CLTS	Community Led Total Sanitation
FGD	Focus Group Discussion
HH	House Hold
HIV	Human Immunodeficiency Virus
HIF	Hygiene Improvement Framework
HP	Hygiene Promotion
INGO	International Non-governmental Organisation
IO	Intermon Oxfam
LLIN	Long Lasting Treated Net
MEL	Monitoring Evaluation and Learning
MEAL	Monitoring Evaluation Accountability and Learning
MOU	Memorandum of Understanding
NFI	Non Food Item
OGB	Oxfam Great Britain

ORS	Oral Rehydration Salts
PDM	Post Distribution Monitoring
PHAST	Participatory Hygiene and Sanitation Transformation
PHP	Public Health Promotion
PLWHA	People Leaving with HIV/AIDS
POU	Point of Use (refers to water treatment at HH level)
RTE	Real Time Evaluation
SSHE	School Sanitation Hygiene Education
WaSH	Water Hygiene Sanitation
WatSan	Water Sanitation
WHHT	Water House Hold Treatment
WHO	World Health Organization

Introduction: What is PHP and Why is it important?

Introduction and antecedents:

This document is for Public Health/WaSH field staff and managers. It describes the process and standards for all Intermon Oxfam Public Health Promotion programmes. This document is taken heavily from the **Humanitarian Reform PHP project**[1] , **Oxfam Great Britain PHP guidelines 2003** as well as various technical briefs and guidelines. It is based on best practice and evidence. It should be taken as a basis for PHP programming and will be used for technical evaluations.

These are the mandatory requirements that all PHP staff and partners are expected to follow. However, there will always be situations in which these requirements are not appropriate; in these cases (as with SPHERE) the staff member responsible must be able to justify why he/she did things differently. These requirements are to support and give clarity about what we do, NOT to limit our actions.

What is PHP?

Public Health Promotion is a term to refer to a strategy which aims to mobilise communities to promote health and mitigate or prevent the outbreak of disease especially in humanitarian emergencies. Oxfam's present scope of intervention aims to ensure maximum impact through an integrated response with the provision of water and sanitation and a co-ordinated response with other sectors such as health care provision. Other Public Health issues not directly within Oxfam's current remit could also be targeted using similar techniques. Public Health Promotion stresses the need for a planned and systematic approach to the provision of clean water, improved sanitation, vector control, the provision of essential items such as soap, water containers or bednets and the provision of information and learning opportunities. It depends on a detailed knowledge of what people know, do and think as well as knowledge of environmental health, engineering, epidemiology, communication and learning strategies[2].

Hygiene Promotion: IO´s Hygiene Promotion is a term used in a variety of different ways but can be understood as the systematic attempt to enable people to take action to prevent water and sanitation related disease and to maximise the benefits of improved water and sanitation facilities. Sphere notes that there are three important factors in Hygiene Promotion: 1) mutual sharing of information and knowledge, 2) the mobilisation of communities, and 3) the provision and maintenance of essential materials and facilities.

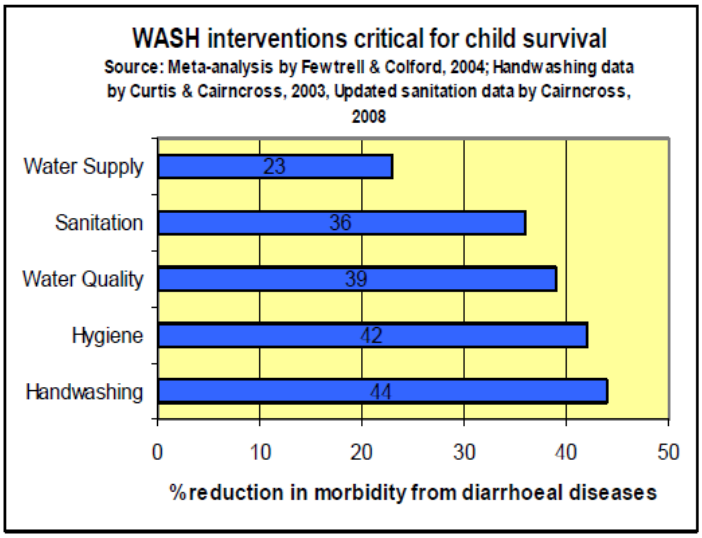
Hygiene Promotion includes the use of communication, learning and social marketing strategies and combines 'insider' knowledge/resources (what people know, want, and do) with 'outsider' knowledge/resources (e.g. the causes of disease, including social, economic, and political determinants, engineering, community development, and advocacy skills).

[1] Humanitarian Reform project 2009
[2] Oxfam PHP guidelines 2003

Why is it important?

Public Health promotion is not a new concept in public health and development however, the inclusion of PHP in the WaSH sector and the humanitarian context is a relatively new innovation that has only really begun to be prioritized over the last decade. Public health promotion is the most cost effective health intervention and can have huge impact on morbidity and mortality reduction of water related diseases. Years of experience, research and evidence have shown that Watsan programmes that include a PHP approach lead to a more optimal use and maintenance of infrastructures. When beneficiaries and stakeholders are consulted and actively participate on the identification of their own hygiene needs and the subsequent action planning to solve these problems we see a greater impact on people´s lives and a more equitable intervention with lasting impact.

The diagram below shows the relative importance of different WASH interventions and the need for Hygiene Promotion.

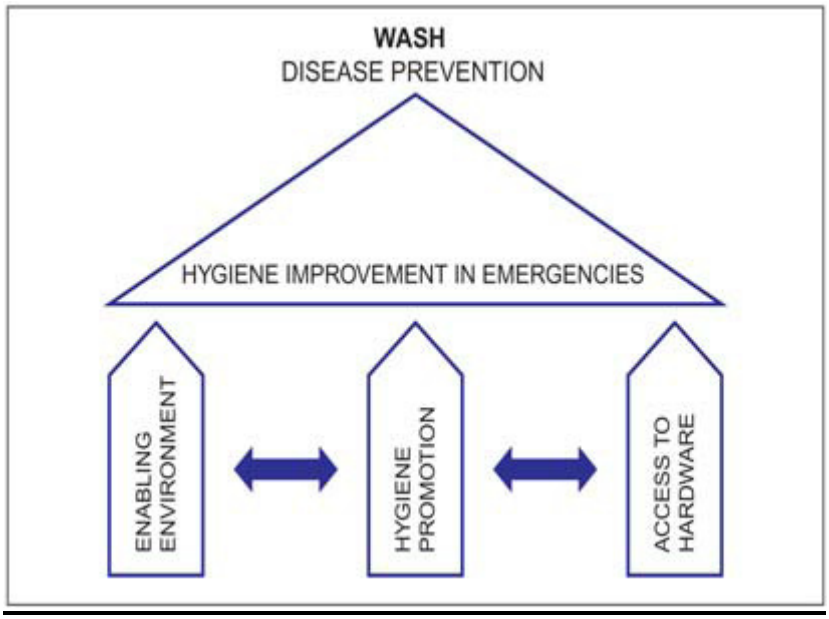


The priority focus of Hygiene Promotion in an emergency is the prevention of diarrhoeal infection and outbreaks through:

- Effective handwashing with soap at key times
- Safe disposal of excreta
- Reducing the contamination of household drinking water

Interactive Theatre Promotion of latrine use and handwashing with soap in Chupanga, Mozambique 2009

Hygiene Improvement Framework in Emergencies[3]



Hygiene Promotion also involves ensuring that **optimal use** is made **of the water, sanitation and hygiene enabling facilities that are provided**. Previous experience has shown **that facilities are frequently not used in an effective and sustainable manner** unless Hygiene Promotion is carried out. Access to hardware combined with an enabling environment AND Hygiene Promotion make for hygiene improvement as shown in the model of the Hygiene Improvement Framework HIF for Emergencies (see above). The overall aim of hygiene improvement is to prevent or mitigate WASH related diseases.

Description of the three pillars of the HIF

Enabling environment

- Policy improvement-security and human rights framework, government leadership and support
- Institutional strengthening-capacity building and helping groups define their mission, roles, and responsibilities
- Community organization-local structures take responsibility for operating and maintaining local systems
- Financing cost-recovery systems
- Cross sectorial coordination & public/private partnerships- bring government, MOH, Rural Water, NGO´s together when appropriate to form task forces, interagency committees, WaSH cluster coordination, access to healthcare & food, address cross cutting issues (HIV/AIDS and Gender)

Hygiene Promotion

- Communication
- Social mobilization
- Community Participation

[3] Taken from Hygiene Promotion Project 3 Humanitarian Reform 2007

- Social Marketing
- Advocacy

Access to hardware

- Water supply systems-access, quality, quantity
- Improved sanitation
- Household Technologies and materials
  Soap
  Safe water containers
  Chlorine solution
  LLITNs

*See **PHP Briefing Paper***

Integration of PHP and Watsan[4]

Reviews and evaluations clearly show that the most 'successful' Public Health/WaSH programmes (in terms of health impact, beneficiary perception and satisfaction) are those in which Public Health Engineers (Watsan) and Public Health Promoters (PHPs) work closely and harmoniously together.

For Watsans and PHPs to work together effectively, there must always be joint planning between the two teams, and individual work plans should always cover both sectors. Both teams also need to attend regularly scheduled (weekly) meetings to encourage effective collaboration and communication.

Roles and responsibilities

Joint responsibility between Watsan and PHP but lead by PHP:

- **Mobilising** people and communities to carry out 'clean–ups' and help construct watsan facilities where required
- Carrying out community **consultations**, including feedback, around sitting and design of facilities
- Setting up water and sanitation **maintenance systems** (including committees, training, provision of tools, equipment and/or spare parts, revenue collection systems).
- Make people and communities aware that they have the right to give feedback (and complain) and we have the obligation to respond, staff can differentiate between feedback and complaints
- All team members have a basic understanding of both Intermon Oxfam and the context in which they are responding.

Responsibility of PHPs:

- Building **awareness** of health issues around watsan within communities
- Managing Public Health **information** collection and dissemination (monitoring, community feedback, baseline data).

Responsibility of Watsan:

- Assessing **technical options** for the provision of water, sanitation and emergency shelter

[4] Oxfam Mandatory Public Health Engineers Minimum Requirements 2007

- Creating **designs** based on technical feasibility and community feedback
- **Organising** (with support from PHP where relevant) construction
- **Supervising** and monitoring construction
- Ensuring that facilities constructed are of good **quality** and are maintained at that standard for the duration of their or the project's lifespan.

Ch 1. Community/Individual Mobilization- *What should be my Community Approach?*

1.1 What is Community/Individual Mobilization in first phase of emergencies?[5]

Strategies for involving communities in **TAKING ACTION** to achieve a particular goal should be opted for. At the height of an emergency what matters is that people engage in risk reduction such as using the defecation fields or temporary latrines and using the handwashing facilities provided for as long as the heightened risk lasts. As the situation settles people may be less willing to do this but the short term action has prevented unnecessary deaths. Some degree of enforcement may thus be necessary but it is important that people are given information and a rationale for why this is being required of them.

-The **emphasis of mobilisation is on the action taken** rather than the longer-term concept of behavior change and it thus provides a more useful model for the emergency context. Whilst various techniques may be used, Oxfam supports any approach which aims to allow men, women and marginalised groups increasing control over implementation and decision making in order that such action may have lasting benefits. Problem solving by communities themselves should be encouraged rather than presenting people with ready-made solutions

Who do I involve in PHP?

1.2 Community Participation:

-Effective mobilization is closely linked to community ownership and participation. Participation does NOT simply involve people contributing labour, equipment or money to a project, but aims to promote the active involvement of all sections of a community in project planning and decision making. It aims to encourage people to take responsibility for the process and outcomes, both short and long term, of a project. Encouraging participation in an emergency can help to restore people's self esteem and dignity, but achieving participation within a short time-frame can present significant challenges. It should be remembered that at different stages of the emergency different levels of participation are possible and therefore a flexible response is required. ***(See link Sphere minimum standard for Hygiene Promotion).***

[5] Guidelines for Public Health Promotion in Emergencies OGB 2003

1.2.1 Community Participation and Gender Mainstreaming

-In situations of displacement as much as 80% of the population may be women and children. **Gender mainstreaming**, or considering gender issues in every aspect of our work, is one of IO´s corporate priorities. This means IO will continue to ensure that both women and men are consulted, and their different needs considered in the design and implementation of programmes, to be sure that they benefit equally. Best practice will strive to have programmes that ensure that they promote a fairer balance of power between women and men, at household, local, national level. Women will be included in decision-making processes, and civil society organisations will be supported to challenge community policies which make life harder for women and inhibit change. ***(See links OI Policy Compendium Note on Gender Issues in Conflict and Humanitarian Crises & IO Manual de Enfoque de Género en AH)***.

-Ensure men's assent and support in gender focus by carrying out activities emphasizing the rationale for women's participation and the benefits of gender justice to family and community with participation by both men and women.

-At all stages of the programme cycle, when appropriate, community participation is encouraged. Women's traditional gender role as carers and providers for families means they are best-placed to advise on appropriate planning of sanitation, water, feeding, and health-care services[6]. This leads to a higher quality intervention where beneficiaries have the right to decision making resulting in more community ownership. Three pile sorting, community mapping[7], NFI identification and distribution, input on hardware design, monitoring and evaluation should be done alongside community members, especially women and vulnerable groups. Participation should be seen as a fundamental way of working with the community. When at all possible appropriate and feasible programming should be informed and readjusted reflecting feedback from the community.

Who is really calling the shots?

-Efforts must be made to identify and empower vulnerable groups to participate (elderly, chronically ill, marginalized peoples due to ethnicity, religion, or political affiliation, women headed households, orphans, and disabled individuals) to ensure there is representation from all segments of the population. All efforts to ensure we do no harm, do not increase stigma and or security should be made when facilitating these people to participate.

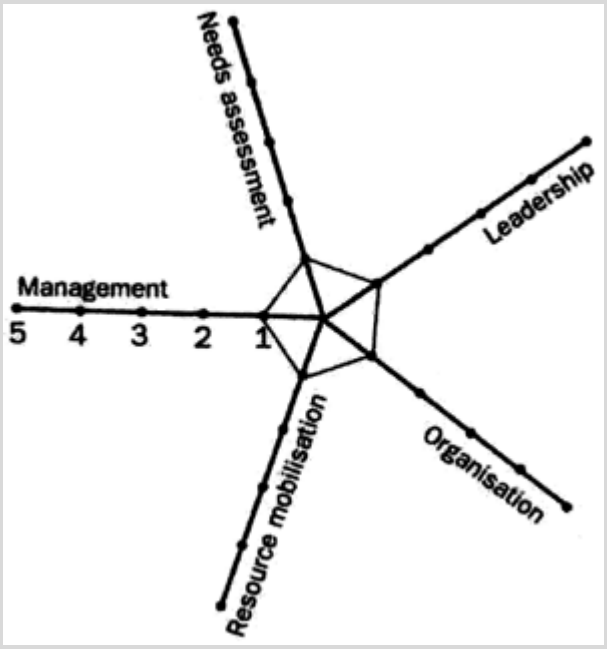
*These groups are not always directly participating in the community leadership structures and all efforts must be made to ensure that community participation is not merely perpetuating the exclusion of vulnerable and marginalized populations.

[6] OI Policy Compendium Note on Gender Issues in Conflict and Humanitarian Crises 2007
[7] PHAST tools step one and two

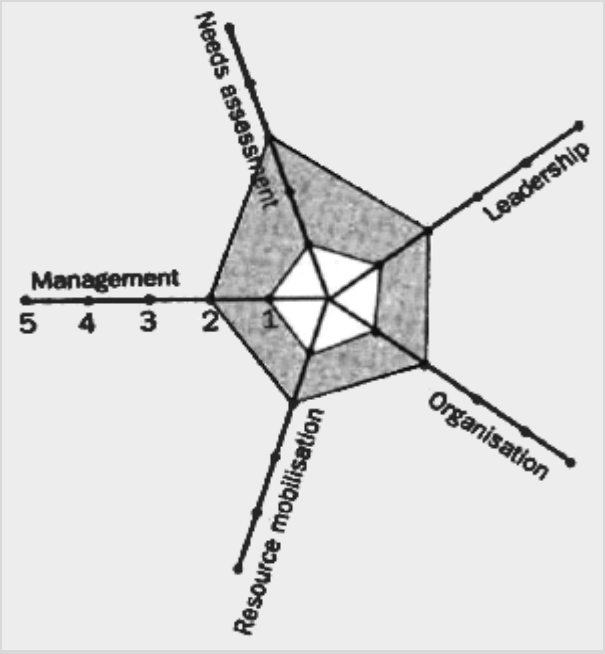
How do I ensure Community Participation in my programme?: Measure it, plan for it, implement it, monitor it, and evaluate it!

Depending on the phase and severity of the emergency we tend to measure community participation by process indicators such as how many women were part of the health committee or whether men and women were consulted about latrines. This is actually consultation which is a kind of participation. However, for IO participation and gender are transversal and essential in our ways of working. This means for true participation we need to know where we are and where we want to get to by the end of the intervention. It is possible to measure an abstract idea like participation by using spider gram analysis with sub groups of beneficiaries and IO staff and partners.

A spider gram at beginning of an intervention can look like this…



…but we can plan for it to look like this in six months…depending on the context and what level of participation we envisage.



:

Practical tip for measuring and planning for participation:

You chose five indicators such as leadership, organisation, management of resources, needs assessment, Involvement of women. Then you make a matrix with a score of 1-5.

Indicator	1 (bad)	2 (poor)	3 (fair)	4 (good)	5 (excellent)
Leadership	No committee after six months	Committee but has never held a meeting	Committee but holds meetings once every two months	Committee formed and holding monthly meetings	Committee formed without Oxfam influence and holding

					weekly meetings
Organisation	Community only works on projects if paid by Oxfam	Community works but only when told to do so by Oxfam	Community volunteers for work but needs supervision	Community organised work groups after meeting with Oxfam	Community already had organised working groups before Oxfam arrived
Management of resources	Community lost equipment given by Oxfam	Community took equipment but only leaders use it	Community has equipment but often argue about using it	Community shares all equipment as needed	Community requested equipment and manages it
Needs assessment	Assessed by Oxfam	Assessed by Oxfam but with community involvement	Leaders and Oxfam assessed needs	Leaders assessed needs but without consulting the community	Leaders in consultation with community assessed needs and informed Oxfam
Involvement of women	No women involved in decision making	Women on committees but in a minority and do not talk	Women represented equally but talk occasionally	Women talk as much as men	Decisions taken equally by men and women

When you have decided on the score, write it on the arm of the spidergram for that indicator. When all indicators have been scored, join up the lines. You can do this before and after a project and then compare lines. If there is good community participation, the lines will all be further out on the arms.

1.3. Identifying key participants: Key stake holders/Informants

-Best practice is to identify pre existing networks and social coping mechanisms through which to mobilize the community. For example formal and informal women's cooperatives and collectives sometimes exist in the community and are a good place to start to mobilize. These groups generally have a vested interest in hygiene as caregivers and mothers. Local cultural norms will have to be taken into consideration but elderly women, midwives, local healers, and adolescents are good individuals for community mobilization.

- Children in school are a 'captive audience' and learning about hygiene can be integrated into the curriculum or incorporated in the form of specific projects reaching out to the community and forming an effective link between the school and home-learning environments. Where schools are not functioning or when many children do not attend school, they may be reached in other settings, e.g. church or youth groups or perhaps simply in the places where they gather daily to play. Adolescents in particular are often

very influenced by their peers and can be helped to become effective peer group educators[8].

-Traditional leaders and women´s leaders exist in some cultures but might not be evident immediately. Seek them out and understand their roles in the community as decision makers and actors. (Examples of Femme Sorcier in Chad and Traditional Tribal Queens in Mozambique)

-Traditional, key influence people (religious leaders, etc.) and administrative leaders must be consulted and the proper cultural gatekeepers should be participating. These figures might not necessarily directly participate in activities (i.e. serve as members of a WaSH committee due to the work load and political position they hold) however they should advise and maintain a dialogue about the project. This gives legitimacy to PHP activities and ensures security as well. It´s best practice to keep them informed of our activities and work in the most transparent way possible without undermining our independence using the community accountability best practice in chapter 8.

-Best practice will analyze and understand the micro context and understand the power map at a micro scale (camp and or/and village level). Understanding how power is distributed throughout the zone of work is imperative to our work especially when creating new systems and or structures. (Example of WaSH committees from Chad made up of participants from vulnerable populations working alongside figures that are decision makers and linked to the women´s power structure femme sorcier to guarantee legitimacy and coherence to the local culture and the newly formed committees)

1.4 Safe Programming Minimum Standards

Protection is defined as all of the activities that have an objective to assure respect of the rights of the individual in accordance with the content and sprit of the applicable legislation such as human rights, International Human rights and the rights of the refugee. We use the word protection in the humanitarian response to refer to our work at IO as a humanitarian organization that does not specialize in protection but has as a primary aim to contribute to the improved security of civilians exposed to the generalized risk of violence, coercion, and or deliberate deprivation of our humanitarian programming.

Protection approach is based on the risk approach as in management of natural disasters.

Risk= (Threat + Vulnerability) X Time

IO will not for the time being do vertical protection programming however our actions for protection will be seen in all phases of the project cycle by analyzing the protections environment and taking protection issues into consideration in our programming. We will also monitoring protection issues and adjust programming accordingly. All tools for analysis are streamlined to assess the protection.

[8] Adapted from Hygiene Promotion: a practical manual for relief and development Humanitarian Reform 2007

All staff and partners will continue to guarantee the quality of WaSH projects by considering the safety of our teams as well as the beneficiaries in all stages of the programme cycle. Safe programming is considered a minimum standard for project implementation and helps to ensure the most optimal use/access to infrastructures and PHP activities. ***(See links Safe Programming Best Practice tips, Socio Culture_Technical Brief_Oxfam & IO Manual Enfoque de Protección AH).***

Ch. 2 PHP Methods and tools: *How do I do PHP?*

2.1 How and when to do PHP

Although there are many variations in hygiene approaches, many can be grouped somewhere on a continuum as depicted in the table below. In practice, few programmes will be at either extreme of the continuum, but use elements from both strategies, depending on what they want to achieve, with what means and over what period.

Table 2: Continuum of approaches to hygiene promotion [9]

Short term intensive (rapid onset less than 6 months intervention)	**Long term broad more than 6 months (DRR, post emergency and or rehabilitation phases)**
Few and identical objectives for large populations	Number and type of objectives more diverse and may be set locally
Programme has carried out assessment and in-depth assessment- community participates via **consultation** as a minimum standard. Ensure Gender analysis and disaggregated data.	Formative research carried out with the community members- **partnership** model of participation is sought Requires research for design and baseline and periodic access and impact studies and periodic adjustment of longer-term project
Emphasises mass implementation using mass media and personal contacts by promoters. Programme agency or agencies are in charge with participation from the community. (best practice seeks to go beyond consultation and into active participation and decision making but this will depend on the type and character of the emergency)- **Fast PHAST** & **BCC campaigns and strong reliance on health promoters** are common.	Emphasises community capacity building for self-implementation.("autonomisation", self-management) Communities are in charge, 'own' their local programme under outside programme **– PHAST** and community identified management systems for Watsan infrastructures. Less reliance on heavy structure made up of health promoters.

[9] Adapted from IRC Hygiene Promotion Thematic Overview Paper 1 2005

Targets specific improvements in **high risk practice** of all groups- segmentation of the population and message positioning drawing on **social marketing techniques**: (common examples of areas of focus) • Handwashing with soap or ash at key times (after using the toilet, before handling food and after handling/disposing of child's faeces • Safe water at household level – household water storage and treatment. Maintain the water chain. • Sanitation- use and maintenance of sanitation infrastructure. **Child to Child, Health promoters, house to house visits, theatre, posters, radio songs and messages**	Targets **specific improvements of specific groups- segmentation of the population via social marketing** techniques community identified needs and priorities for promotion with technical support from IO. Programmes to improve income, sanitation provision, situation of women, housing, skill training. LRRD- Looks for **synergies with livelihoods** (micro credits and small production for WaSH committee participants for example) **WaSH Committees, Social Marketing, Community Led Total Sanitation (CLTS), CHAST, School WaSH Committees**
Costs are covered by external (donor and private) funds- incentives for health promoters, repairs for water systems, spare parts replacement, new infrastructure construction etc	Cost recovery schemes for water system maintenance and motivation for WaSH committees can in part be generated from the community and or links with livelihoods. Health promoters become integrated into wash committees.
Specific skills requirements are communication and marketing & dialogue	Specific skills requirements are community organisation and gender and poverty sensitive approaches.
Monitoring and Evaluation conducted by IO staff and health promoters	Community participation in monitoring and evaluation of programming using adapted tools

2. 2 How to "DO" PHP: Methods & Tools

In order to guarantee efficiency and quality to our intervention best practice will employ evidence based methodologies to target our intervention and improve our standard operational procedures while being flexible to the community participatory process. Many of our standard methods are based on Participatory Rural Approach or PRA.

Participatory Rural Approach (PRA)- A growing family of approaches, methods and behaviors to enable people to share, enhance and analyze their knowledge of life and conditions, and to plan, act, and monitor and evaluate. It is the approach that IO takes using the following recommended methods and tools.

Hundreds of participatory techniques and tools have been described in a variety of books and newsletters, or taught at training courses around the world. These techniques can be divided into four categories:

- Group dynamics, e.g. learning contracts, role reversals, feedback sessions
- Sampling, e.g. transect walks, wealth ranking, social mapping
- Interviewing, e.g. focus group discussions, semi-structured interviews, triangulation
- Visualization e.g. venn diagrams, matrix scoring, timelines

To ensure that people are not excluded from participation, these techniques avoid writing wherever possible, relying instead on the tools of oral communication like pictures, symbols, physical objects and group memory. ***(See link PRA Chambers summary paper).***

- **Participatory Hygiene and Sanitation Transformation PHAST**[10]- When possible PHAST for emergencies should be used and it's transformative value should be capitalized upon whenever possible. PHAST for emergencies has only three steps, but should still be used to facilitate the community process to mobilize themselves and not merely for spreading messages or data collection. When there is a longer time scale and a stable community (min 6 months) it is strongly recommended to implement the whole 7 step PHAST process. ***(See links PHAST and PHAST for Emergency guidelines & PHAST Monitoring Guidelines IRC)***

- PHAST tools should be adapted to the local context reflecting the infrastructures and habits of the target population. ***(See link- PHAST tools examples)***

- **Community Led Total Sanitation (CLTS)**- Poor access to adequate sanitation, resulting in the practice of widespread open defecation, has negative health and social impacts on communities, particularly in terms of diseases such as diarrhoea and cholera. CLTS involves facilitating a process to inspire and empower rural communities to stop open defecation and to build and use latrines, without offering external subsidies to purchase hardware such as pans or pipes. Through the use of PRA methods community members analyse their own sanitation profile including the extent of open defecation and the spread of faecal oral contamination that detrimentally affects every one of them. **This method requires state support and is a long term solution for scale up and is not appropriate for a first phase emergency.** This method uses disgust and social desirability drivers for behavior change and mobilization[11]. ***(See link Community Led Total Sanitation 2005)***

- **School Sanitation, Hygiene and Health Education: SSHHE** A schoolchild educated to the benefits of sanitation and good hygiene behavior is a conduit for carrying hygiene messages far beyond the school walls, bringing lasting improvement not only to his or her health and wellbeing, but also to that of the family and the wider community. It is difficult therefore to over-emphasise the importance of school health and hygiene education (SSHE). Perhaps the most

[10] PHAST: Participatory Hygiene And Sanitation Transformation, WHO, 1998

[11] Practical Guide to Triggering Community Led Total Sanitation 2005 Kamal Kar

important lesson from past experience is that SSHE is an 'approach to life' rather than an academic subject that can be taught with a focus on theory and written examinations. With that in mind classroom teaching has to go hand in hand with practice and that in turn demands that schools have adequate, clean and well maintained water and sanitation facilities. – ***(See School Sanitation and hygiene Education Thematic Overview Paper IRC & Getting Children to Handwash with Soap: A Guide for Conducting School-Based Handwashing Programmes)***

- **CHAST** is PHAST for children and should be used in schools to promote change and mobilize students to action. ***(See link- CHAST "Children´s Hygiene and Sanitation Training in Somalia" & School Sanitation and Hygiene Education Symposium The Way Forward: Construction is not Enough!)***

- **Child to Child** methodologies (CHAST draws heavily on such methods) recognise that children in many countries may be responsible for looking after younger brothers and sisters, and that in their role as caretakers they are in a position to educate and support their siblings to ensure better health**.** ***(See link Child to Child technical brief - Child to Child Games &-Tools for Schools Kit- Getting Kids to Handwash with Soap: A Guide to conducting School-Based Handwashing Programme).***
  Best practice shows that programmes where children are allowed to investigate hygiene behaviors both in their school, home and community environment have more impact. ***(See link- Tools for Schools Kit- Handy Little Book of School Research)***

- **Social Marketing**[12]- Social marketing requires significant amount of time to research and understand the problem and identify an appropriate strategy. However, the emphasis on understanding the 'consumer's' viewpoint, creating a demand for water, sanitation, and hygiene, and emphasising the positive benefits of engaging in improved hygiene rather than the negative consequences (i.e. death or disease) as in traditional hygiene education, are important principles that can be applied even in an emergency as it enters into a stabilization phase and the scope of the intervention allows sufficient funds, human resources, and time for appropriate evaluation and planning. Best practice has shown that such internal drivers (motivation) as social acceptance, nurturance, and disgust are effective drivers for mobilization and behavior change. ***(See links Social Marketing in Emergencies Technical Brief IO & Social Marketing Technical Brief Humanitarian Reform & The Hand washing Handbook: A guide for developing a hygiene promotion program to increase hand washing with soap).***

2.3 Community Health Workers/ Health Promoters:

-The most commonly used approach to access the population in the first phase of an emergency is that of identifying and training community outreach workers (volunteer

[12] Social Marketing Technical Brief Humanitarian Reform

community mobilisers/animators, health promoters). ***(See link HR for Generic ToR´s for community volunteers & technical tests)***

-A cascade system, where outreach workers (at least 1:500 per population or **more if intensive work is required** or if populations are spread out)[13], are supervised by trained IO PHP staff who are supported/managed by skilled professionals (PHP officers, Wash Managers etc.) is the most common model used, but others are possible.

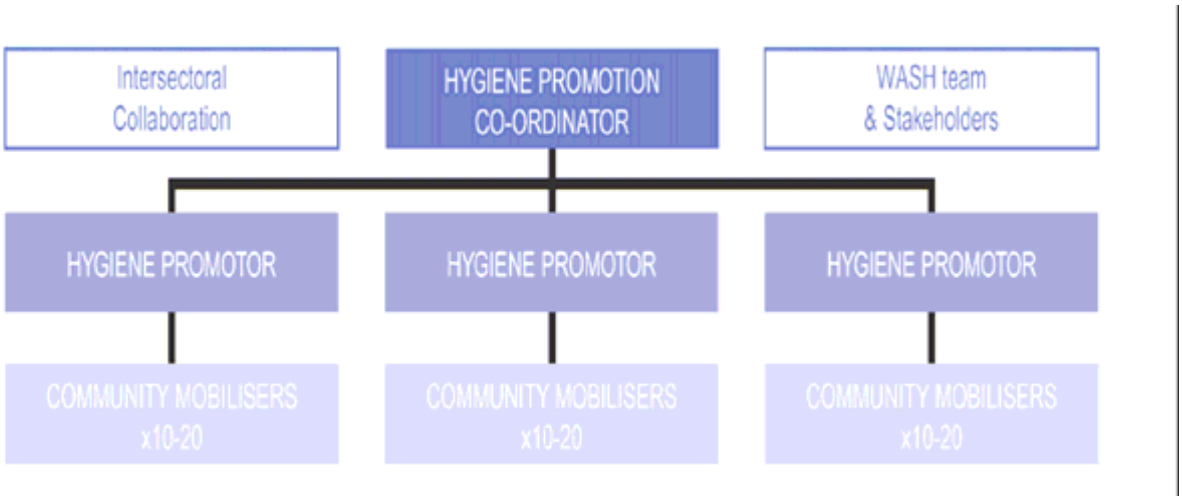


Diagram taken from Humanitarian Reform 2007. Sample cascade system for hygiene promoters and community immobilizers

-A network of peer educators might also be established e.g. teenagers or young mothers. Hygiene clubs could also be established in each affected area. A key aspect of the initial Hygiene Promotion assessment should be to identify existing local capacity and skills. ***(See Humanitarian Reform Modules for Hygiene Promotion for Hygiene Promoters (IO staff and partners) and Hygiene Promotion for Hygiene Promoters for Community Mobilizers- volunteers)***

-When possible it's best practice to identify individuals that may have already been working as health promoters for the MOH or other actors. All efforts to not create a parallel system lead to a more integrated and sustainable health promoter network and are more connected.

-A gender balance team should be ensured, women provided with equal opportunity for training, paid work and high level positions both institutionally and at beneficiary level.

-Best practice will attempt to work **directly with the community and not merely working through health promoters.** At times communities may see these individuals as responsible for maintenance and community hygiene, especially if these individuals receive some kind of incentive. Working through health promoters is one method for accessing a population and best practice is working directly with communities in forming action plans and hygiene committees or systems for community management to find solutions and take action as soon as the situation has stabilized and the quality of the intervention will not be compromised by working directly with the community.

[13] The ratio of 1:500 people is suggested as the minimum level of intervention by Sphere

2.3.1 Incentives:

-If the health risks are very acute e.g. high risk of a cholera outbreak, it may be unrealistic to ask people to work for long hours for little remuneration. Payment in vouchers, food or in kind e.g. bicycle, tee shirts, soap, hygiene items etc. may be an option.

-Creation of promoters´ kits made up of lanterns for night patrolling, rain gear, bicycles for monitoring and mobilization, materials for training and community sensitization, t-shirts or traditional clothing printed for visibility are all good ideas for in-kind incentives. A clear contract will need to be signed for maintain of any material belonging to IO (cycles for example). These materials should have official visibility of the mission as well as donor and partners logos. Ensure proper permission has been received to use and replicate logos, and ensure compliance with the Code of Conduct.

-Some agencies may not have the resources to provide financial or other incentives and unilateral decisions by incoming agencies may undermine efforts to ensure future sustainability. The issue is complex and needs to be addressed through the co-ordination mechanism. Payment also depends on how many hours of work are required for community health workers.

2.4 Community Hygiene and Water point management groups:

Priority is given to facilitating the process whereby the community will identify and organize themselves for water point management. *(See **Modelos de intervención**)*

- Identify key actors in the community that may have an interest and be appropriate candidates to mobilize the community. Midwives, young people, teachers, active community members, & religious/spiritual leaders are good human recourse pools for both health promoters and community groups.

-Water point management can take many forms. Depending on the community process IO gives priority to support the community to identify and manage ways of organizing and managing its water points and sanitation infrastructures. Water and WaSH committees are one of many management models and will not always be appropriate. In the case that a WaSH committee is deemed appropriate, they must be involved in the identification of needs, design, implementation, monitor and evaluation of the water point. *(See Link **Community Management and Briefing Document OGB** & **Example Roles and Responsibilities Water Committee Members OGB**)*

WaSH Committee in East Chad Displaced Camp

Health Promoters in Haiti Flood Response

-If a system to manage water works, governmental water department or non formal committees or management groups exists, best practice will be to strengthen this network and work through it as much as possible.

-For management of a school hygiene committees, teachers, parents groups and students should participate and feed back their needs and opinions as well as participating in the actual implementation and mobilization of school hygiene.

2.5 Formalizing our activities:

-Traditional and administrative leaders must be consulted and the proper community gatekeepers should participate at a minimum standard of consultation. See chapter 1.3 for details.

-Research and experience have shown that unless a community management system is in some way linked to the local authorities and, therefore, accountable to them, it is unlikely to be sustainable. All the information about who is responsible (training and equipment provided, details of any revenue system initiated, the MoU, etc.) should be supplied to the relevant person in the local authorities[14]. ***(See Link Example MOU OGB)***

2.6 Use and maintenance of facilities:

- In order to ensure use and maintenance it is imperative to have community participation and that feedback from women and young girls especially on the sitting of latrines, shower facilities, and community laundry facilities is used for planning and design.

- Where appropriate, it is good practice to form water and/or sanitation committees made up of representatives from the various user groups, and with equal numbers of men and women. The functions of these committees are to manage the communal facilities such as water points, public toilets, and washing areas, to be involved in Hygiene Promotion activities, and also to act as a mechanism for ensuring representation and promoting sustainability. The coordination between PHP and Watsan on this activity is vital. Best practice will have the teams working together in terms of planning and community liaising.

- Making sure that both men and women gain the benefit of the water, sanitation and hygiene interventions by understanding and 'rules' that apply to their particular gender in relation to these services. For example, some communities have specific cultural related rules such as daughter-in-laws cannot use the same toilets as mother-in laws and in others women hygiene promoters may not be able to speak with men. In this second case, it would be important to ensure that both men and women hygiene promoters and community facilitators are trained.

[14] Oxfam Mandatory Public Health Minimum Requirements 2007

- Make sure that meetings, discussions etc. tie in with the availability of both women and men and do not clash for example with the times when women are care taking.

- Where appropriate PHAST tools (***See link PHAST guidelines step 4 and 5***) can be used to ensure that the members are aware of their responsibility for activities via participatory action planning and definition of roles and responsibilities.

- If a cost recovery system is opted for, ensure to conduct a stakeholder analysis looking into beneficiaries´ willingness to pay, prevalence of community corruption, and prevalence of vulnerable populations ensuring they are not excluded due to inability to pay. Best practice allows the community to regulate these issues whilst IO facilitates the process.

- A system of spare parts for maintenance will need to be identified and set up in close coordination with Watsan team. Link this system to local authorities (i.e. Rural Water Department, Ministry of Public Works*). (See Link **ACF How to make WaSH Sustainable in Vulnerable Contexts** & **Safe Programming Best Practice tips**)*.

Ch. 3: Behaviour Change Communication

3.1 Behaviour Change Communication[15]:

Behavior change communication (BCC) is an interactive process for developing messages and approaches using a mix of communication channels in order to encourage and sustain positive and appropriate behaviors. BCC has evolved from information, education, and communication (IEC) programmes to promote more tailored messages, greater dialogue, and fuller ownership. Participation of the workplace stakeholders is vital at every step of planning and implementation of the behavior change programmes to ensure sustainable change in attitudes and behavior.

What PHP message do I use?

-It is recommended that both the **available mass media (e.g. radio, poster, leaflets, stickers) AND other more interactive methods** are employed. Even in an acute emergency some initial discussions with individuals and community groups can take place and as the emergency evolves more widespread use of methods that foster discussion should be encouraged. (***See link IEC Technical Briefs & Social Marketing in Emergencies Technical Brief***).

-Themed and targeted health campaigns that reinforce and complement watsan hardware activities tend to be more efficient to bring communities to action and should be attempted.

-Analysis of modes of communication should be done to identify how people communicate and where and in what form they get their information from. PHAST tool for analysis of

[15] Behavior Change Communication Toolkit for the Workplace, ILO-FHI HIV/AIDS

communication channels can be used to facilitate this process. Campaign messages should then be tailored and targeted in turn.

* If a large scale print campaign is appropriate ensure that materials are piloted first checking that they are clear and understood and if they are to be presented in local language ensure the materials are tested before mass production to ensure proper translation and understanding. Many people do not learn to read in their native language if a lingua franca exists and is taught in formal education. Consult with local community and educators to ensure proper language for translation.

-Hygiene Promotion programmes need to be carried out with all groups of the population by facilitators who can access, and have the skills to work with, different groups (for example, in some cultures it is not acceptable for women to speak to unknown men). Materials should be designed so that messages reach members of the population who are illiterate. Participatory materials and methods that are culturally appropriate offer useful opportunities for groups to plan and monitor their own hygiene improvements.

-Household visits are a good way of guaranteeing accountability to the beneficiaries and is a service that is appreciated by most people. However, it is important to not over use this strategy as it can have limited impact if over-used causing burn out of health promoters and boredom of the beneficiaries if not complemented by other activities. Always introduce yourself, wear visibility, and ask permission before beginning any sensitization activity at household level.

Household visits Djbal Refugee Camp East Chad 2009

-Campaigns that entail an element of fun and competition work well to motivate communities to action depending on culture and context. Such activities as **cleanest households/latrines, student of the month, community hygiene celebrities** along with prizes that reinforce hygiene habits can be used. (Soap, trowels for cleaning up children faeces, brooms, etc). Winners of such competitions are then seen as examples of positive hygiene behaviour and help to create a demand based on social status drivers.

-**Campaigns** are normally short (2 weeks to 1 month) and bring a lot of attention to a hygiene topic. Message should address key behaviours and misconceptions and are targeted for all user groups. Campaigns should focus on a minimum of information and replicate it in through as many communication channels to reach saturation. (Radio, word of mouth, house hold visits, poster, banners, T-shirts, community dialogue, competitions, dance, interactive theatre).

Interactive Theatre Chupanga Mozambique

Health Promoter using PHAST method for identification of high risk hygiene behaviour Dolo Odo Refugee Camp Somali Region, Ethiopia 2009

3.2 Targeting Hygiene Behaviours:

-**Avoid promoting too many health messages.** Focus programmes on key risky behaviour being practiced in the community. Normally this will revolve around hand washing at key times, appropriate disposal of children's faeces, uptake of safe water, and use and maintenance of sanitation facilities.

-Prior assessment and formative research on actual practices and internal drivers for hygiene habits will ensure proper targeting of practices and messages. Messages should be targeted to all segments of the population ensuring messaging for vulnerable populations, children, youth, men, women, elderly, ethnic minorities etc.

Global Handwashing Day Chad 2009

In developing countries the biggest killers of young children are respiratory infections and health importance for which the evidence for the impact of handwashing is less strong are helminth and eye infections, especially trachoma[16].

a. Diarrhoeal disease (which can include shigellosis, typhoid and cholera)
b. Acute respiratory infections
c. Helminth infections (especially ascariasis)
d. Eye infections

*Hand washing with soap has been proven to reduce diarrheal disease by up to 42%[17] and is also the most cost effective intervention against diarrhoea and can also reduce acute respiratory infections (ARI) by up to 23%[18]. Handwashing with soap thus represents a cornerstone of public health. It can be considered an affordable, accessible **"do-it-yourself" vaccine**. Best practice will promote this behaviour using drivers like disgust, nurturance, social acceptability, and attractiveness to bring communities to action.

Ch 4. Hygiene Kits:[19]

4.1 Hygiene Kit

An Oxfam 'hygiene kit' is designed to promote hygiene within the family, and may also include certain items considered to restore dignity such as shampoo for women. A hygiene kit should ensure beneficiaries have the ability to practice basic hygienic practices[20].

IO will consider that there are 4 scenarios for distribution of hygiene kits

1. **General Blanketed distribution**- All beneficiaries receive the same standard kit
2. **No distribution** is appropriate based on evaluation- some scenarios to consider
   - In some contexts beneficiaries are not displaced
   - Individuals were displaced but were able to transport their basic necessities.
   - The population is chronically without these items and not displaced. A distribution could compromise the do no harm mandate and create/exacerbate a cycle of dependency. With the exception that there is not a high risk of epidemic outbreak.

[16] WELL FACTSHEET Author: Jeroen Ensink Quality assurance: Val Curtis
[17] The Lancet Infectious Diseases , Volume 3 , Issue 5 , Pages 275 – 281, V. Curtis , S. Cairncross
[18] Risk of respiratory infection and handwashing with soap - Rabie and Curtis 2005 review, updates with Luby et al., 2005 and Sandora et al., 2005.
[19] Best practice materials produced through the WASH Cluster HP project, c/o UNICEF 2007
[20] Oxfam GB Public Health Promotion Hygiene Kits Jan 2008

3. **Targeted distribution:** Only a certain subpopulation of the total beneficiary population is identified as vulnerable and will benefit directly from a distribution. (Chronically ill populations, pregnant mothers, vulnerable populations, female headed households, child headed households, orphans, disabled individuals are usual groups for targeting) These distributions must be done in the most transparent manner working with the community to identify and make clear why distribution is not taking place for the entirety of the population. See NFI section below for details on beneficiary selection. In case of chronically ill beneficiaries see HIV/AIDS section for strategies to not create stigma.
4. **Behaviour trials:** In some cases for formative research purposes, behaviour trials will be carried out. This is the case where a hygiene kit or certain NFI´s is distributed to any or all of the populations in point 3 and used for formative research purposes, supportive monitoring/follow up as a strategy for behaviour change. ***(See link- The Handwashing Handbook A guide for developing a hygiene promotion program to increase handwashing with soap & Handy Little School Book)***.

4.1. 2 Specifications of Hygiene Kits

The following hygiene items might be included in a hygiene kit for affected populations but the exact contents of any hygiene kit will depend on specific circumstances.

- storage of safe drinking water at household level
- good practice around drinking water use
- all family members able to practice hand washing at key times
- the washing of self and clothing
- management of babies and young children's faeces
- dedicated water containers for anal cleansing (if used)
- management of menstruation
- practice of reasonable food hygiene

Example Basic IO Hygiene Kit:

-Soap for laundry (200gms laundry soap per person per month as per SPHERE)

-Soap for personal hygiene (Sphere recommends 250grams bathing soap per person)

-Water collection AND storage containers made of food grade sealable recipients with (lids or caps) (Sphere specifies at least 2 water collecting containers of 10-20 litres plus 'enough water storage containers to ensure there is always water in the house')
* best practice will provide for the storage container to have a faucet

-Household water treatment for one month (Certeza, Waterguard, PUR, HTC mother solution etc.)

-ORS+Zinc sachets

*(See Link **House hold water treatment- IFRC HWTS Manual** & **OXFAM TBN 4 Household Water Treatment and Storage**).*

Additional hygiene items may be identified based on needs assessment and cultural context. Such items may include:

- Washable/disposable sanitary towels for women
- Underwear for women and men (and children where appropriate)
- Washable nappies for babies
- Potties for young children
- Bedpans/urinals for those with disabilities
- Anal cleansing containers
- Razor blades, nail clippers, combs, shampoo, toothbrush and toothpaste (only if appropriate contextually and after ensuring other actors are not providing such items)

4.2 Phasing of NFI distribution

*The following is a recommendation always taking into consideration the context and needs to feed the overall phasing strategy.

1st PHASE
2 water containers (1 collection & 1 storage)
Soap for laundry and personal hygiene for 2 weeks (225gms)
Depending on the specific situation other items may also be distributed in the first phase e.g. anal cleansing containers, LLITN´s or Water treatment agents (where people have some familiarity with these).

2nd PHASE
Additional water container i.e. a water basin for washing or kettle for anal cleansing
Soap for one month (250 grams per person per month)
Cloth (ideally for menstrual hygiene but could be used for other purposes, 1x3m either dark or light cotton cloth per woman)
Water treatment agent for household usage for 15-30 days minimum – including instructions on use and water treatment and storage container (can be provided in 1st Phase if people are already familiar with this)
Potties for young children

3rd PHASE
Locally defined and purchased hygiene items

*(See Link **NFI´s Technical Briefs**)*

Ch 5. Other Non food items NFI´s:

5.1 Vector Control- Long Lasting Insecticide Treated Nets (LLITNS)

-Insecticide Treated Nets should be distributed only after proper assessment and context analysis in keeping with the IO LLITN policy and with appropriate sensitization ***(See Link NFIs- IO LLITN´s Policy)***.

-Mosquito nets should only be distributed in accordance with the national or regional IO policy. (Community sensitization for use of nets previous to distribution and targeting of pregnant mothers and <5´s is best practice when a blanket distribution is not possible)

5.2 Community Kits:

5.2.1 Community Watsan Construction kits:

-Tools and equipment for constructing watsan hardware or digging drainage may be distributed (e.g. shovels, picks, wheelbarrows, buckets, boots etc.)

-Each situation must be judged according to accepted norms and considerations of health and safety. Discussion with the engineers will also be important in deciding what items to provide for these activities. Tools should be culturally appropriate and selected with the community. PHP takes lead on this activity and should work with community to define a system for managing the tool kits with a clear user policy that is agreed upon before distribution of tools.

*Women and men may have different preferences for construction tools, for example head pans versus wheelbarrows for earth moving[21].

5.2.2 Cleaning Kits:

-At times a village clean up for solid waste and or latrine cleanup may be necessary (especially in the case of Cholera or extreme solid waste contamination provoking the public health situation i.e. trash or defecation fields)

-Safety equipment should be ensured for community members/volunteers/and or staff involved in the cleaning. Ensure people have access to protective gear for hygiene and cleanup committees like gloves, masks, boots, detergent for cleaning, scrub brushes, buckets for water transport, chlorinated lime for latrines and soap.

*for general latrine hygiene pouring ash and or lime in latrines helps to control strong smells and flies.

[21] Oxfam_Technical_Brief_Sociocultural

5.3 Health promoter kits:

-Backpacks, water bottles, materials for health promotion (notebooks, pencils, pens, erasers etc) cycles, t-shirts, and caps can be used as incentives. If the response will take place during the rainy season take into consideration providing boots and protective rain gear for promoters.

-If cycles are to be used for community health workers, best practice will draw on a document ensuring clear responsibilities for maintenance, ownership and theft. Ensure permission from local authorities for health promoters to ride a cycle (ensure staff have the proper documents and licences appropriate for the context) and ensure appropriate visibility on cycles.

*Ensure cycles have had their first maintenance and are in working condition before distribution.

5.4 Shelter and House Hold Kits:

IO may distribute shelter and household items when appropriate (no other actors are covering the gap, cultural context/KAP of the population in regards to shelter and house hold item use and market supply must be analyzed previous to implementation. This will be conducted in close coordination with logistics and ideally as part of the contingency planning process.

Best practice will have, as part of the contingency planning, a predefined set of NFI kits taking into consideration a prevision of scenarios the various contexts in country might require. Best practice will be to have made decisions/definition of kits prior to emergency about what will and will not be distributed and ideally have in contingency stock if appropriate. This information will feed decision making during the assessment planning phase of the actual emergency and final decision of definition of kits for distribution in the response phase.

For the purpose of a coherent coordination consider Shelter NFI´s as follows

- Plastic sheeting and construction kits with lead taken by logistics and cultural preferences identified lead by PHP
- House hold kits which are oriented towards items to be used inside the household with lead taken by PHP (cooking kits, blankets, LLITNs etc)

(See link NFI´s - Household Kits and Shelter IO Briefing Paper)

Ch 6. Selection and distribution of hygiene items NFI´s:[22]

Pre-distribution

6.1 Identification of NFI´s

-Participatory identification and prioritisation of appropriate hygiene items should be done with the community if possible during the rapid assessment. The emphasis is on providing items that people are familiar with, especially where these may be important for cultural or religious reasons e.g. containers for anal cleansing.

***Issues to consider when supporting women and girls with dealing with their menstruation needs:**

1. What do women and girls usually use for dealing with their menstruation – cloths, sanitary pads etc? Make sure the required materials are provided with or alongside hygiene kits (if cloth is provided this should be of a dark colour and never white).

2. If disposable sanitary pads are to be provided then facilities for effective collection and disposal are essential. Where waste disposal is not effective there will always be the risk that used sanitary pads will end up on piles of refuse thrown into the road or public areas. This is unhygienic, unsightly, and could pose a risk to health.

-Where possible provide people with samples of items so that they can choose according to preference e.g. materials for women's menstrual protection or items available on the local market.

-A clear, detailed description of the item is required when ordering, along with an indication of the item's priority.

-NFIs should be packaged for ease of handling and transportation by beneficiaries, and securely enough to prevent leakage of liquids.

6.2 Identification of beneficiaries

- A registration list of beneficiaries' households is required (indicating male, female, anyone with a disability or special needs, children, elderly people, and any other vulnerable group

[22] Best practice materials produced through the WASH Cluster HP project, c/o UNICEF 2007

(e.g. female or child headed household) and the total number of household population/occupants). ***(See Link NFI´s- example Beneficiary Registration Form)***

- Ideally, use existing registrations lists e.g. those for food distribution, or identify respectable leaders or volunteers within each area to do the registration. This can be cross-checked by random visits to some of the registered households to verify information given by leaders.

-This is the first step to identification of vulnerable population. An analysis of vulnerability will need to be done to determine this aggregates ability to cope. By default this population is not to be considered vulnerable without cross checking and analysis. Look for other NGO´s that are working on identification of vulnerable populations.

- All attempt to align PHP beneficiaries with the Food Security/Livelihoods strategy (if it exists in your zone of work) for beneficiary definition and selection criteria should be attempted. An assessment of vulnerability should be done in order to target beneficiaries and reach the most vulnerable population.

-In case of high prevalence of corruption or abuse of power by leaders to exclude or maintain families/individuals in a state a marginalization, IO will adhere to a system of at least one week of highly visible sensitization and advising the population about a distribution before the actual day of distribution. The will allow the population time to make a complaint if they have not been registered BEFORE the day of the distribution and allow for proper follow up of complaints.

(See PHP Minimum Standards for Public Health Promotion during the first three months)

6.3 Planning

-An NFI distribution team should be identified for each location and should include a distribution officer, beneficiary leader(s), and volunteers. Don´t forget to include: ink for thumb prints, pens for signatures, and tables and chairs for distribution committee members.

-A plan for distribution management, task allocation to various teams, flow management, recording, and security will also need to be drawn up with the Logistics team and PHP coordination.

-A distribution venue must be identified ensuring that the location is prepared before the distribution and selected with the community. Times and locations should be agreed and decided upon with the community and specifically with the women to ensure safety, and availability of the target population for distribution. (Best practice will work around community schedules and avoid scheduling overlap during community activities (Church or Mosque attendance) *Take into consideration probable high times for agitation of the population (Sunday afternoons, after sporting events, etc)

-A distribution schedule detailing dates/times, distribution sites, targeted beneficiaries, items needed, and the responsible persons for every site must be prepared. The list should be shared with the logistics team/warehouse to enable them to prepare transport and support if required.

- Information about the time, place, and nature of the distribution must also be communicated to the affected population via their leaders, notices, community health workers etc. If the distribution is targeted, the beneficiary selection criteria should also be made known.

-If necessary, organise and train separate teams to carry out demonstrations or provide information on assembly and use of items distributed e.g. water filters, chlorine solution and ORS

6.3.1 Assuring Privacy

-It´s best practice to arrange a safe and private place for women to receive items for menstruation and or underwear separately from the general distribution.

Mainstreaming Gender for NFI Distributions:

-Women should be involved through their own chosen representatives, at all stages of any distribution. Directive action may be needed.

-All information regarding distributions should be accessible by women. High levels of illiteracy amongst women may limit the effectiveness of written or even pictorial notices.

-Ensure that women and girls (and young boys) are not exposed to sexual coercion because of distribution. All measure to prevent this must be taken.

6.4 Distribution of NFI´s

-Capitalize on the concentration of people to explain how the distribution will work, the time frame and ensure that beneficiaries understand the criteria for beneficiary selection, NFI content and use, in order to encourage transparency. They will also need to made aware of their rights in regard to distribution (specifically that the distribution is free) and the complaints procedure, should the need arise.

-Representation from either traditional or administrative bodies should be present at distributions for transparency and coordination purposes keeping in mind prevalent levels of corruption, representation of women, social bias and inequality and how much responsibility community members will accept.

-Where possible, ensure that the materials distributed are intact and functioning e.g. that buckets have lids and taps, and that water filters have all the component parts.

6.5 Assuring Security during the distribution: [23]

-Assure that the site is accessible, and sufficient staffs are allocated to deal with problems and questions, crowd controllers in place with megaphones if needed, a separate queue for vulnerable people e.g. elderly/ pregnant women may be needed but ensure that proper sensitization is done to guarantee their security and no to create stigma.

-Always assure there is a vehicle on standby for evacuation if needed, functioning and reliable communications, radios, and/or mobile phones.

-If necessary and appropriate arrange for demonstration of how to assemble or use certain items such as water filters or remind re hygiene issues.

-Ensure as much as possible that disruptions to the distribution e.g. people who may be making false claims, are dealt with quickly, effectively and away from the crowd. Designate the above task to a reliable person. (Local leaders, a complaints committee etc)

-Make sure beneficiaries know what to do if items are broken or faulty e.g. buckets missing lids or taps.

*(See **Manual Enfoque de Protection AH de IO**)*

A crucial role of the PHP team is to actually promote the use of certain items, e.g. demonstrating the use of water purification tablets or water filters. Whether this is done at point of distribution or later will need to be decided on a case-by-case basis. People may be receptive to reinforcement of healthy practices and new ideas at the same time they are receiving new items but this needs to be balanced against considerations such as the time people may be asked to stand in line in the hot sun or security issues around large crowds of people.

*(See **technical brief IFRC Household Water Treatment Systems HWTS Manual**)*

6.6 Provision and Supply:

-It may be possible to organise a mass distribution of some pre-stocked priority items, such as soap or water containers, in the very early stages of a large emergency but with other items there must be an assessment of what people need and what is culturally appropriate.

-It is recommended that only items that are not culturally sensitive, such as soap (for laundry and personal hygiene), household water treatment and water containers, be stockpiled for mass distribution in the first few days of an emergency. Check expirary dates on items like soap, and water treatment before stocking.

-For other more culturally sensitive items (e.g. sanitary pads and underwear) pre-assessment is critical.

[23] Oxfam GB Public Health Promotion How to guide and Briefing Paper:NFI 2008

-It is beneficial to procure some items locally, where possible, to ensure that they are acceptable. Ensure quality of items procured locally.

-It may also be possible to organise the provision of cash or vouchers to enable people to make their own decisions about the purchase of hygiene items especially for items such as underwear or sanitary material, thus enhancing people's dignity and ensuring appropriateness.

-Some of the above items e.g. soap and disposable sanitary towels may need a repeat distribution every few months to replenish supplies, depending on people's capacity to meet their own needs.

-Best practice will entail stocking of IEC materials such as posters, pamphlets, banners, megaphones and counselling cards for NFI´s and ensure they are not damaged by rain or mildew.

6.7 Communication/Coordination with WASH stakeholders:

-Maintain open communication with other actors and attend Cluster WaSH coordination meetings regularly and feedback to the team. Identify gaps in coverage and avoid overlap of distribution.

-Coordinate PHP activities with other actors when possible and all attempts to avoid gaps, overlap and replication of activities should be made. Integration of PHP activities across sectors (hygiene promotion and or integrated soap distribution with WFP food distributions are best practice but ensure that activities are not overburdening the beneficiaries with too many activities/information)

Ch 7. Mainstreaming: HIV/AIDS in WaSH

7.1 Mainstreaming HIV/AIDS

What is mainstreaming HIV/AIDS

The term **mainstreaming HIV and AIDS** refers to 'adapting development and humanitarian programmes to ensure they address the underlying causes of vulnerability to HIV infection and the consequences of HIV/AIDS' (Holden 2004: 40). The focus of such programmes, however, remains the original goal (in the case of Oxfam providing water, sanitation, and hygiene promotion as well as livelihoods, for example).[24]

[24] Humanitarian Programmes and HIV/AIDS_Oxfam 2007

7.2 Vulnerable Populations:

> By "vulnerability" we mean the characteristics of a person or group in terms of their capacity to anticipate, cope with, resist, and recover from the impact of a natural hazard *or conflict*.. It involves a combination of factors that determine the degree to which someone's life and livelihood is put at risk by a discrete and identifiable event in nature or in society" At Risk [25] (***See link- Theoretical Framework HA IO***)

-The HIV pandemic has left millions of people with additional vulnerabilities on-top of existing ones which they already may have due to their previous position in society. People living with HIV/AIDS (PLWHA) and their carers may also have additional water and sanitation needs to the general population. This population is considered as vulnerable and considered a priority in terms of identifying PLWHA who may be house or bed-bound and unable to move very far to use the toilet. As they become increasingly sick, their carers will have to increasingly help them with their hygiene care and support their water and sanitation needs.

7.3 Minimum Standards for HIV/AIDS PLWHA

Based on needs and context analysis the following should be considered as a minimum best practice standard of activities for chronically ill populations and their care givers.

-Vulnerable populations including but not limited to people living with HIV/AIDS (PLWHA) and chronically ill persons may be bed-ridden and unable to attend distributions. House-hold delivery of items or pre-arranged persons to accept NFI´s for them should be made available.

-Ensure that NFI´s for chronically ill populations are light enough to carry or provide services to help individuals carry items back to their dwelling. Provision of 10L recipients for water collection is best practice for this population. Give out five-litre collapsible jerricans for children, as they are easier to carry. Extra blankets may be necessary as well.

-Extra quantities of soap and point of use water treatment may be necessary for chronically ill individuals. When appropriate water filters or house hold water treatment should be provided to ensure immuno-compromised individuals can guarantee water quality at house hold level.

-Ensure IO staffs are given sufficient briefing and training on the HIV/AIDS prevalence and threat in the zone of work. Ensure condoms are available to staff in IO provided housing and office spaces.

-IO does not enter into general condom distribution or community sensitization of causes and prevention for HIV/AIDS as the impact of such vertical approaches may be minimal. Secondly, IO recognized that these activities are more appropriate for actors with speciality in this sector. Rather, IO takes a more punctual approach of mainstreaming our activities by consistently taking into consideration how the HIV/AIDS epidemic will affect our work both

[25] Theoretical Framework for Humanitarian Action IO 2008

institutionally and in terms of the needs of beneficiaries. Each activity should be analyzed considering:

- the context
- prevalence of HIV/AIDS
- the risks posed by the epidemic in the zone of intervention
- Current capacity of IO to provide promotional activities

An assessment of HIV/AIDS should take place at the beginning of the mission[26]. ***(See Link- HIV/AIDS- Humanitarian Programmes and HIV/AIDS Oxfam pg 24-26.) and Chapter 8 Assessment for tools).***

Two key questions to answer in programming

1) How will HIV and AIDS affect the programme?

2) How will the programme affect HIV and AIDS prevalence?

Analysis should attempt to answer these two key questions above when planning activities and the result should be used to design activities and guide our decision making in conjunction with the results of the HIV/AIDS assessment.

7.4 Avoiding Stigma:

-UNAIDS estimates that more than 90 per cent of HIV-positive people do not know their status. Even those that do know may not necessarily disclose this information to others, as they may be afraid of being marginalised or even discriminated against both socially and in the workplace. Stigmatisation in its many forms isolates people and denies them their basic human rights.

-Families or individuals can be seen as privileging from a distribution or service due to their HIV/AIDS status and this in itself can cause stigma.

-Families can reject a family member who discloses their status, leaving the person alone and without family support. Disclosure of status should never be compromised and confidentiality of beneficiaries must be assured.

-Certain groups such as commercial sex workers and homosexuals are blamed for the spread of HIV and their targeting for services may cause more stigma if not managed in a confidential way.

[26] Humanitarian Programmes and HIV/AIDS Oxfam

7.5 Best Practice for identifying vulnerable chronically ill population:

-Use the term vulnerable populations or chronically ill as an umbrella term to identify PLWHA (generally the definition of elderly, orphans, and single mother headed household, chronically ill will cover this population.)

-Identify local structure that may already be serving this population (i.e. confidential counselling and screening clinics, hospitals providing ARV´s and treatment, governmental or NGO´s that provide services to vulnerable populations (i.e. elderly, orphans, single mothers, child headed households, chronically ill populations, etc.)

-Targeted distribution can be done through the entities so as not to create stigma and remain a level of confidentiality and professionalism for our beneficiaries.

-Identifying vulnerable populations for sanitation interventions should take stigma into consideration and ensure that beneficiaries are not stigmatized.

-Vulnerability of a particular household can be worked out using the ratio of well carers to unwell family members. The higher the ratio of dependants to carer, the harder it will be for carers to cope, especially if they are elderly, or children, or are themselves unwell. You may want to work out this ratio during nutritional surveys or when you are registering for hygiene kit distribution.

Ch 8. Community Accountability:

8.1 What is Community Accountability?[27]

Our current working definition of accountability to those affected by crisis is the following: People and communities with whom we work systematically inform programme choices and implementation, throughout the lifetime of the project, and are the most important judges of programme impact.

All Oxfam work starts with the premise that participation is the essential and default way to approach programming. In order to achieve anything like this in our humanitarian programmes Oxfam GB, needs to build on its participative approach and:

[27] OGB ACCT Framework

1. Ensuring our staff and implementing partners do their work honestly and openly, involving communities in decision-making that affects them and their lives and promoting appropriate participation

2. Providing clear, appropriate and accessible information relevant to the men and women directly affected, whether about their rights and entitlements, or our capacity to respond to their needs

3. Opening ourselves up to both positive and negative feedback particularly by those affected by our programmes, committing to responding to complaints in a systematic and respectful way, and making changes to our programme or approach when necessary

8.2 Best Practice Community Accountability:

- Ensure that communities are made aware of why we are working in their community, what our mandate is, where our funding comes from, what we are and are not able to provide in terms of services. Information in terms of limited budgeting/programming should be shared to ensure transparency.
- Proposed timelines for activities should be made public and the community should offer feedback and actively participate in the scheduling of such activities.
- Make communities aware of the complaints procedure and that they have the right to complain and that action will be taken to follow up complaints in a timely and professional manner. Best practice will ensure that the complaints process is available to all members of the community and its reporting mechanisms defined with the community.
- Accountability mechanisms should be established with the affected populations to promote transparency and participation
- As a minimum a feedback system should be set up – a common system may be considered to reduce confusion among communities supported by more than one affiliate (OI) [28]

Community Consultations in East Chad

[28] Minimum standards for MEL in OI humanitarian programs 2009

8.3 Some helpful issues to be shared with the community to ensure transparency and Accountability [29]

1. What is the project area for each project?
2. Who decided on the project?
3. Which specific members of the community were involved in deciding on the project activities?
4. What is the plan for the whole project?
5. How long will the project last?
6. Who are the beneficiaries?
7. Why are some people chosen and not others?
8. Which members of the community were involved in deciding the criteria for choosing the beneficiaries?
9. How does the project work? How is the community involved?
10. What will the community contribute?
11. What will Oxfam contribute?
12. What do the materials cost Oxfam?
13. What is the plan for this month?
14. What is the progress this month?
15. What are the main challenges for the technical staff this month?
16. What are the technical staff doing to address these challenges?
17. What exactly will the beneficiaries receive?
18. When will they receive it?

*(See link- **Accountability Tools**)*

Ch 9. Assessment and Start up- *When do I do assessment and when do I do a baseline?*

Baselines are different to assessments as baselines are designed to provide data that are comparable with end of program data in order to measure impact. An in-depth assessment may or may not use calculated sample sizes and quantitative data analysis. The following two scenarios A (rapid assessment and indepth assessment) and B (baseline) will make clear when we do baseline and when we do rapid assessment and or in-depth assessment.

9.1 Scenario A. Rapid onset emergency and/or exploratory mission –

[29] OGB Accountability Need To Know List - FINAL - Pocket Humant Hdbk

Assessment
Project and funding cycles in emergencies are often short and there is little time to conduct comprehensive formative research on which to base programme design. (Traditionally a KAP survey -**K**nowledge **A**ttitudes and **P**ractice-has been used to define the basis for PHP programming) In such situations carrying out large scale surveys to define a baseline has been shown to be fraught with problems – not least the likelihood of data being invalid. The execution and analysis of surveys may also divert resources away from the most important task of mobilising people to take action to address what are often very obvious problems that do not require in depth research. However, it is important to be able to define the impact of programmes and whether Oxfam is making a positive difference. We do this by taking the **following minimum standards for assessment** into account.

For a **rapid onset emergency** and as part of an **exploratory mission** more punctual data will be collected using the WaSH Rapid Assessment tool ***(See Link IO WaSH Rapid Assessment Tool)***

-The WaSH rapid assessment tool is for **any** IO staff and partners conducting rapid assessment and or exploratory missions. It should be used as a guide to gather both primary and secondary information. It uses key questions and checklists to gather secondary information and a mixture of quantitative and qualitative methods to gather primary data. Some information will be collected from various sources and methods and may seem repetitive; however, it is necessary to verify information and include representation of all stakeholders in the assessment. This means speaking to varied groups of stakeholders unless security or access precludes this.

9.2 Scenario A. Rapid Assessment timelines:

WaSH Rapid Assessment Tool should be used in the first 72 hours of the emergency in order to collect information in a standardized way that can be used for decision making, project proposal & planning. **A situational analysis report should be generated as early as possible based on the initial findings to be used in programme planning and project proposal.**

-Collecting data for proposal writing and providing initial information for monitoring is an activity that must be planned and carried out by the whole team and managed by the project manager. All too often it is an activity that is thought to be the sole remit of the public health promoters. Assessment team should be gender balanced with clear terms of reference.

-As a general rule of thumb the below table can be used to help make decisions about when and how to go about data collection in a rapid onset emergency.

9.2.1. Minimum Rapid Assessment Standards

Stage I rapid assessment[30]

[30] IO WaSH Rapid Assessment Tool 2009

Method	Who	Time Frame	What	Outcome
WaSH rapid Assessment tool **Secondary information analysis and primary data collection via Exploratory walks, FGD and discussions with key informants**	Key Informants : MoH, Water and sanitation dept, other agencies, community leaders and community members	2 – 3 days (up to one week of the emerg ency)	Overview of public health and key risk factors for water and sanitation related disease including malaria e.g. drinking water source, excreta disposal, hand washing with cleansing agent, basic gender assessment especially of issues affecting women e.g. protection, initial information on appropriate design of latrines	Initial assessm ent report & recs, problem statement and concept paper

Stage II Further Analysis- In depth assessment must take place within a month of rapid assessment- ***It must produce or provide data to verify or expound upon desegregated data from the rapid assessment***

Method	Who	Time Frame	What	Outcome
Gender Analysis and social analysis- power mapping and evaluation of vulnerabilit y	Oxfam national staff and then male and female community groups- PHAST gender analysis tools and ***Gender Cards*** **&** ***Gender Analysis***	Over one week by the 3rd week of the operati on	Understanding of issues that affect both men and women and how intervention can support long term goal of gender equity. Understaning the social and political environment at micro level	To feed into final data report and feed activity planning

	People Oriented Planning Framework			
HIV/AIDS risk analysis	Ministry of health officials, health data, women and men focus groups. Tools pg 21-26 Humanitarian Programmes and HIV/AIDS	Over one week by the end of the first month of the operation	Understand the context of HIV/AIDS and how it will affect programming and impact.	To feed into data report and feed activity planning
Participation Analysis	***Spider gram***	By the end of the first month	Define a baseline for participation and set goals indicators for the timeframe of the project	Data report and indicator setting

9.3 Best Practice for Information management during the fist phase of the emergency: Suggested Methodology[31]

- Rapid assessment carried out by an integrated team using the WaSH rapid assessment tool
- Use a white board or matrix in Excel to track changes and to plot in data from assessed sites
- Choose minimum indicators from the list or adjust to fit the cultural and socio-economic context
- Set up the minimum monitoring – the what, when, how and by whom?
- Adapt formats for current use
- Set up database and files for qualitative data
- When time allows, carry out a baseline survey – using survey format (adapted to context)
- Ensure ongoing consultation with beneficiaries – check on needs, involve in distribution, give information
- Set up mechanism for feedback from the affected population
- Carry out satisfaction survey for NFI distribution

[31] Minimum Standards for PHP monitoring during the first tree months of a rapid onset emergency OGB 2007

- Prepare for a Real Time Evaluation
- Prepare for a technical review if appropriate
- Review indicators and monitoring system after three months and adjust accordingly
- Train national staff on monitoring and evaluation when time allows

*(See link **Minimum standards for public health promotion monitoring during the first three months of a rapid-onset emergency A Guide for field staff OGB 2007**)*

9.4 Cholera and outbreak Assessment:

Objective of the case control study: During a cholera outbreak IO will do a case control study in addition to cholera outbreak assessment *(See Link **IO WaSH Cholera Guideline vs draft**)* in order to identity the main mode of transmission of the vibrio and gather information on the main risk factors propagating the outbreak in order to control the spread of an epidemic*. (See Link **Cholera & outbreak assessment –Case control) Technical Brief**)*

9. 5 Scenario B. Baselines in DRR, Slow onset chronic contexts and/or transition into rehabilitation phase

Baseline

9.5.1 Baseline for PHP- KAP study

After exploratory mission using WaSH rapid Assessment tool (see above for rapid assessment) if it is determined the project will have a time frame **of more than six months** the minimum standard is to implement a baseline. At present IO´s approach for PHP baselines will be to implement a **KAP Study**[32] by implementing a quantitative/qualitative baseline in the first 2 month months of the project (considering that rapid assessment and possibly in-depth assessment has now been conducted a baseline will expound on that information, produce data disaggregated by sex as well as sufficient information to define coverage and set a baseline of the project indicators using a representative sample).

Beyond the KAP Study- If programmes have often been top-down, it is at least in part because we have not had good techniques for finding out what people know, do and want, on which to base our programmes. The limits of the KAP(Knowledge, Attitudes, Practices) study are well known. Respondents in KAP surveys often tell the interviewer what they think she wants to hear, or what they think will bring the greatest benefits (Kroger). Interviewing about hygiene is of little use because of the sensitivity of the subject. However, over the last decades, there has been an explosion of interest in methods which can dig deeper and produce more insight into health problems. Innovative techniques such as focus groups, transect walk and participant observation are now used as best practice in the WaSH rapid

[32] KAP study for chronic and slow onset emergencies include a KAP survey and qualitative methods. The sample selection methodology for the survey is LQAS. To complement the quantitative survey, qualitative PRA methods like focus group discussion, in-depth interview, community mapping and three pile voting, matrix rating are recommended. These tools are described in step one and two of the PHAST manual. Gender analysis and HIV/AIDS analysis can be integrated into the baseline.

assessment tool. What has been lacking in baseline definition is a systematic approach which links key questions to appropriate methods to inform programme design. This systematic approach is called **formative research**[33] We are committed to establishing a set methodology for conducting formative research in order to better design and measure impact of our PHP programmes in the next two years. (2010-2011) ***(See link How much can a KAP survey tell us about people's knowledge, attitudes and practices? Some observations from medical anthropology research on malaria in pregnancy in Malawi)***

9.5.2 Minimum Standards Baselines in Chronic contexts or transition from a rapid onset into rehabilitation phase

Note priority is placed on participatory Monitoring and Evaluation and needs assessment when possible and appropriate. ***(See Link Participatory Monitoring and Evaluation)***

Phase I Rapid Assessment

Method	Who	Time Frame	What	Outcome	Tools/Links
Rapid Assessment Phase I activities primary and secondary data collection and analysis	See above Rapid Assessment Phase I	Idem	Idem	Idem	***WaSH Rapid Assessment tool-***

PHASE II KAP Study Design

Method	Who	Time Frame	What	Outcome	Tools/Links
KAP Study Design-Protocol definition	PHP team send to BCN for validation	First Month of project	Define the study and validate the methods	Validated protocol for cohesive and technically correct study	***Protocol Example & Baseline Checklist***
KAP Study sample	PHP team with	Week 1	LQAS sample selection	Systematic Sample for implementati	***Participants manual & Procedimientos_Met***

[33] Towards Better Programming- A Manual on Hygiene Promotion UNICEF LSHTM 1999

	technical support HQ	One day		on	***odo LQAS*** *&* ***Excel Hoja de Calculo***
Questionnaire and structured observation Design	PHP team	Week 1	Design a questionnaire coded and validated by PHP team, community and HQ.	Rough Draft Questionnaire ready for piloting and validating	***Towards Better Programming: A Manual for Hygiene Promotion*** *&* ***MiniSurvey*** *&* ***Validating a questionnaire technical Brief*** *&* ***Baseline Checklist*** *&* ***OGB Survey guidelines*** *&* ***Structured Observation Tech Brief***
Design FGD guides, Participation measurement, Gender analysis plan, HIV/AIDS checklist, structured interview guides	PHP team using standard tools adjusted to context	Week 2 & 3	Ensure a consistent tool is used by surveyors and reliable information is collected	Rough Draft guides ready for piloting and validating	***How to conduct a focus group discussion*** *&* ***Key Informant Interviews Technical Briefs*** *&* ***Tools pg 21-26 Humanitarian Programmes and HIV/AIDS*** *&* ***Gender Checklist Cards*** *&* ***Gender Analysis*** *&* ***Spider gram***

Phase III Validating and piloting

Method	Who	Time Frame	What	Outcome	Tools/Links
Select and Train Surveyors	PHP team plus survey team made up of community members when possible	Second half of the first month-1 week	Train members on data collection**, participatory methods for data collection**, and reduce information bias	Trained team ready to implement based on best practice	***PRA Monitoring Tools for Matrix Ranking, Pocket Voting.*** ***Use design tools phase II above for training***

Pilot questionnaire	PHP teams plus surveyors 10 sample households	1-2 days	Ensure the tool is reliable and valid	Trained team ready for implementation	***Generic tool: Under Construction 2010***

Phase IV Data Collection and Analysis

Method	Who	Time Frame	What	Outcome	Tools/Links
Implement the questionnaire and qualitative package (matrix ranking, mapping, pocket voting, FGD, interviews, analysis of secondary information.	Survey team, followed up by PHP team. Qualitative component implemented by PHP team	Can take up to three weeks if the service area is large- logistics are difficult	Collect quantitative and qualitative data to inform the project and give a baseline	Primary data collected from project area ready for analysis	
Data Results compiled and analyzed	PHP Officer with follow up WaSH manager and HQ validation	Two weeks after launch of the study- two weeks	Questionnaire data imputed into standard format	Quantitative data imputed into standard format for analysis plus qualitative data collected and organized	***LQAS Excel Hoja de calculo & Qualitative data vs Quantitative & Analyzing Qualitative Data Technical Brief***
Results compiled and Final report Submitted for revision	PHP officer with follow up WaSH manger and validation HQ	Rough draft ready one week after analysis	Quantitative data imputed into standard format for analysis plus qualitative data collected and	Final KAP study report ready for dissemination and comments. Final version used for	***Example Baseline report***

	organized	baseline planning and activity definition.

Pocket chart voting in El Chaco Paraguay Drought Emergency Response 2008

9.5.3 PHAST as the qualitative component of the KAP Study

Note: In some contexts where PHAST is being implemented as a methodology the **qualitative** baseline can be implemented in conjunction with the initial implementation if PHAST (steps 1,2 &3)assuming that an exploratory mission has already been done using rapid assessment tools and a quantitative survey using LQAS is being implemented. *(See Link **PHAST monitoring IRC** & **PHAST step 1,2 &3 Problem Identification**)*

Ch 10. How do I do Monitoring Evaluation and Learning MEL?:

10.1 What is Monitoring?[34]

Monitoring is the systematic and continuous process of collecting and using information, throughout the programme cycle for the purpose of management and decision-making[35]

There are two types of monitoring:

10.1.2 Process monitoring

Process monitoring looks at how the project is being developed by

[34] Oxfam MEL Guidelines PHP portion
[35] Oxfam Emergency Response Manual

- Regular reviews of the work being carried out
- Assessing whether the work adheres to standards such as Sphere
- Identifying and solving problems
- Taking advantage of new opportunities
- Monitoring the emergency situation ***(See Link Technical Brief Process Monitoring & WaSH Monthly Reports)***

10.1.3 Impact monitoring

Impact monitoring looks at whether the project is having the intended impact by:

- Assessing whether the project purpose is being achieved and whether the project is making a difference
- Reviewing the appropriateness of the project's approach vis a vis the objectives *during* the project, enabling adaptation if necessary
- Looking at outcomes as well as outputs by comparing progress against results in the LogFrame
- Assess the impact and lead to improvements in the effectiveness of the programme.

In order to carry out monitoring there need to be both process and impact indicators as well as a system that is adequately resourced both in terms of staff, planning, follow up, & finances. This should be defined within the first month of the operation for a project of more than six months ***(See link- Monitoring Matrix)***

See below for process monitoring and PDM section for more details on Impact monitoring

10.2 Why monitor?

Especially in emergencies, evaluations to assess impact are not always carried out. Monitoring is a way of showing what impact has been made but more important, how this was achieved. **On the other hand, it is not possible to do an evaluation if there has been no monitoring.**

10.2.1 Function of Monitoring

Monitoring will ensure that we are:

- On track
- Achieving our objectives

- Looking at strengths and weaknesses
- Identifying spin-offs[36]
- Making changes if we have to before it is too late
- Making sure we are not wasting money or our limited resources

[36] Negative or positive effects of the project that were not intentional. An example of this is a net distribution programme to pregnant women that took place at the local clinic. An unexpected spin-off of this was that antenatal attendance increased significantly due to the programme.

- Making sure the community is involved and the process is documented
- Making sure Sphere standards are being maintained
- Identifying areas for staff training
- Picking up other areas where we may need to look for funding or gaps for possible public health promotion intervention

10.2.2 Who monitors what?

-Best Practice In public health promotion Monitoring:

Who	What	Why	How
Coordinator and also supervisors	Performance of staff Project implementation according to the timeframe Budget Progress of project Achievement of objectives	To ensure quality of work To assess capabilities To identify areas for further training To make sure the project is on track To make sure resources are used in a responsible manner	Performance reviews Weekly meetings Field visits Financial statements Monthly budget monitoring
Public health promoter volunteers	Use and maintenance of facilities Appropriateness of facilities Appropriateness of non-food items Involvement of the beneficiaries Involvement of women, children and vulnerable groups Level of knowledge Behavior change Accountability	To ensure quality To insure appropriateness and consultation of beneficiaries To measure impact	Monitoring forms Focus group discussions Pocket charts Transect walks Spidergrams
Health committees	All the above Participation of representatives of all members of the community	As part of community empowerment To keep communities informed of progress	Community meetings Community voting Monitoring formats

Best Practice has shown that monitoring should start as soon as possible after the event or the beginning of a response. An assessment is usually the first step to information gathering followed by baseline collection**. Even if there is no baseline (rapid response), a basic monitoring system should be put in place. Usually in the beginning this is purely quantitative – how many latrines, how many tap-stands? It is important that indicators are kept to the minimum and are easy to understand and to measure.**

Methods for Monitoring

Almost all methods used in baseline data collection can be used in monitoring. Monitoring tools should be **SEE** - simple, effective and easy to use.

Indicator	Method	Recording data	Constraints
Morbidity and mortality data	Set up a system whereby weekly clinic data are collected	Only collect data on waterborne diseases or malaria	Data are often unreliable and may not be complete Useful to also collect self-reported

			incidences in the community – use a standard definition for diarrhoea or malaria
Improved sanitation according to Sphere	Latrine inspection by community and public health promoters Focus groups with men, women and children Transect walks to look for signs of outside defecation Pocket voting with children Picture drawing for children (see box below) Faecal mapping[37] Photographs	Picture forms for community members Check-lists Results from focus groups recorded	Definitions such as "clean" need to be defined Taking photographs may not be culturally acceptable Be careful of taking pictures of people defecating as this could be a violation of their privacy rights
Access to clean drinking water	Water testing at source Water point inspection Jerry can inspection at water points Household visits to look at water storage containers Testing of water containers Mapping of water points for equity	Water point monitoring forms Household visit forms Maps of water points	Some communities object to someone sitting at the water point with a form – it is seen as "spying"
Increased knowledge of hygiene and improved hygiene practices	Inspection of handwashing facilities at the latrines Focus group discussion Household visits Handwashing demonstrations by children Pocket voting with children Three pile sorting of habits that have changed Quizzes and competitions for children Demonstrations of ORS Observation walks around the camp or community Timelines and	Household visit forms Focus group discussion results written up Pocket voting results recorded	Handwashing is hard to monitor as people tend to tell you what you want to know use proxy indicators such as presence of soap Children are good at observing their own family behaviors and tend to be more honest

[37] Children drew a map of the community showing areas where there was indiscriminate defecation. They then placed red flags in these areas for the whole community to see. Naming and shaming quickly brought changes to the area!

	seasonal calendars for disease prevalence		
Gender and increased community participation	Focus group discussion Exit interviews after committee meetings Observation at committee meetings	Focus group results written up Spidergrams	Having women on committees is not enough, there must be evidence of their actual participation in decision making

10.2.3 When to readjust monitoring methods?

There are no hard and fast rules but we know our programmes take place in highly dynamic situation where the context can evolve and our systems for monitoring must adapt to them. The following are best Practice:

- Only monitor as long as the information is useful to the programme – an example being still collecting morbidity data in a programme that has moved from emergency to recovery with an emphasis on livelihoods. The type of information monitored needs to be adjusted to the changed context.
- Handing over monitoring to the community leads to empowerment and reduces the feeling of being a helpless victim. New monitoring tools (possibly designed for populations with low literacy or capacity) and redefinition of roles and responsibilities for monitoring will need to be addressed.
- If facilities are handed over to families or individuals, then the responsibility to maintain and report problems lies with the owner rather than with programme staff. This is linked to the exit strategy and should be considered at the design phase of the project. Possible links to the community management structures for repairs, the complaints system or a link with local water authority needs to be defined.
- Once an emergency situation is stable, reduce the frequency of monitoring - consider random checks rather than routine monitoring

10.2.4 Capitalization of monitoring

What do you do with the information?

Best Practice -If you are not going to use the information don't collect it!

Monitoring data should feed into the planning and management of the project. You can do this by:

- Holding weekly or biweekly meetings with all the WaSH team to discuss the data, what it means and what changes should be made.
- Deciding if the formats are giving you the information you need or whether you need to use other methods such as more qualitative methods
- Passing on information to the project manager to add to the reports
- **You also need to feedback to the community through committees or leaders**

10.3 Minimum standard for Monitoring: Formats for process and impact monitoring

We have included several monitoring formats as well as a format for reporting against the objectives on a monthly basis using a mixture of structured observations ***(See link Monthly Monitoring Technical Brief & Structured Observations Technical Brief & Monthly Monitoring Forms & Monitoring Matrix)***

10.4 Post Distribution and monitoring of NFI´s- Impact & process monitoring

Monitor beneficiary satisfaction (See also Community Accountability Ch. 7) with the distribution process and the hygiene items, and observe the use of the items provided is done via post distribution monitoring PDM is best practice in impact/process monitoring of the NFI activity. A PDM should be carried out no less than 3 weeks after each distribution.

Other points about PDM

• Compile distribution reports of items distributed, the number of people receiving items and their level of satisfaction with the items received.

• Reconcile stock levels with broken or defective items etc. Document emerging issues and lessons learnt.

10.4.1 PDM Methods

The context is known, the beneficiaries are identifiable (registry of beneficiaries in a camp is available per neighbourhood, block, village etc), geography for follow up is manageable. PDM is done by randomly selecting a percentage of households for interviews using **LQAS sampling methodology**[38] & should be used.

Monitoring may also highlight where items have been sold in order to purchase items that are considered more important e.g. food or medicines, and may thus highlight other unmet needs. It should look at selection criteria, distribution methods and satisfaction with items distributed.

10.4.2 NFI monitoring tool

NFI post distribution monitoring form		
Did you receive a hygiene kit from Oxfam in the last (insert time frame under investigation)?	Yes	No

[38] LQAS- Is a methodology of data collection and analysis that allows us, with limited resources to measure indicators of quality, and coverage of services practices, knowledge etc. It helps us to optimize resources allowing us to rapidly assess, using a small sampling, and detect problems, solutions, and risks in order to take decisions and feed back into programing

What did you get in the kit?		
When did you get it?		
Did you receive any of the items from other NGO's? (List)		
Was it what you needed?	Yes	No
Structured observation-Is the (insert NFI to be investigated) being used?	Yes	No
Was there anything you would have liked to receive in addition?		
Was it timely?	Yes	No
Are you planning to share it with other people?	Yes	No
What was the most useful item you received?		
What was the least useful item you received?		
What did you do with the cash/ NFI you received?		
What did you think of the way the distribution was carried out?		
Do you consider the NFI´s you received to be of good quality? (durable, clean, no holes, in good functioning order, having all the parts and pieces needed to function etc)		

-The PDM can be used to identify some progress on the impact monitoring in a chronic context with longer timelines. Varied questions checking the proxy indicators can be collected and analyzed in order to follow up the use/coverage of NFI´s as well as progress of proxy indicators.

10.5 Time of Distribution Monitoring- Good enough scenario

Scenario 1 - At times the context is not well known, the beneficiaries cannot be followed up for geographical, timeline or budgetary complications. In this case a **Time of Distribution Monitoring TDM will be used.** This method is **implemented at the time of distribution** and cannot tell whether or not the beneficiaries have used the NFI´s, however it can inform us on satisfaction and item quality as perceived by our beneficiaries.

This method entails systematically selecting beneficiaries from the distribution and conducting the monitoring at the time of the distribution using a series of simple questions adapted from the tool above.

10.6 Indicators

10.6.1 What are indicators?

-In order to monitor and evaluate, you must have identified indicators**. Indicators are how you measure what is happening in the project in order to see if (and how) you have achieved your objective.** They can be either qualitative or quantitative but both must be measurable. This is done at the project proposal writing stage. Community indicators should also be included.

-Indicators are either process or impact. Process indicators are found at Activity and Result level of the Logical Framework whilst impact indicators are found at Purpose or Specific objective level.

The IO WaSH indicator tool should be used to make decisions about project indicators. ***(See Link PHP Indicators Humanitarian Reform & IO WaSH Indicator Tool Under construction).***

10.6.2 Proxy Indicators:

Although IO, as WaSH professionals, is sensitive to the need for patience in assessing the benefits of hygiene promotion, some donor and agency rules may sometimes demand early results from impact analyses. It can be difficult to plausibly try and measure impacts. Even if reliable health statistics are available, impacts will only begin to show up after a critical mass of behavior change has been achieved. Research by Esrey, has shown that 75% adoption of key hygiene conditions and practices has worked as such a critical mass for diarrhoeal diseases. Work is therefore done on monitoring techniques that measure impacts on hygiene behavior prior to attempts to detect impacts on health.[39]

The use of the concept of plausible inference means that programmes can be evaluated in terms of proxy indicators such as use of facilities rather than relying on mortality and morbidity data alone which is difficult to obtain and often cannot be used to assess the success of one particular intervention. Plausible inference accepts that certain interventions will have known outcomes. (proxy measures directly relating to WaSH could be but are not limited to use and maintenance of watsan infrastructures, hand wash with soap and use of household water treatment.)

[39] Hygiene Promotion IRC 2005

10.6.3 Using Community Indicators (Community Accountability)

These are indicators that have been initiated by the community and developed through a participatory method of consultation. Community indicators are the **means used by the community to measure process or impact of the project.**

-Best practice will be analyzing the context and working with communities to identify how our beneficiaries will define impact and in turn how they would like to measure that.

*Best practice will be to assure indicators are appropriate and measure the project objectives and impact. ***(See link Community Indicators)***

Note for all project indicators: If an indicator is identified as not working or is measuring inappropriately, best practice will liaise through the proper channels (admin/Fin, TDP´s, AROO) checking on adapting, changing, or modifying PHP indicators. Some donors are specific about the time frame that the indicators can be changed thus it is necessary to inform the proper channels with as much notice as possible before changing indicators

10.7 Evaluation

10.7.1 What is Evaluation?

There are many definitions of evaluation. A very comprehensive one is:

"An examination as systematic and objective as possible of an on-going or completed project or programme, its design, implementation and results, with the aim of determining its efficiency, effectiveness, impact, sustainability and the relevance of its objectives. The purpose of an evaluation is to guide decision-makers" (UN)

10.7.2 Components of Evaluation

10.7.2 .a Reviews[40]

A review is often carried out during the life of the project. You will also hear the term Real-time evaluation. Reviews can be external (outside evaluator) **or internal (self-evaluation by the team itself).** Mid-term review (for interventions of at least one year)

- At least once during the first year, the indicators should be reviewed and adjusted. If the indicators are the same for all affiliates/partners, the review should be joint

[40] Minimum standards for MEL in OI humanitarian programs11-12-09

- A learning event such as a monitoring review (OGB) or a review day should be held to assess progress and to discuss changes. These events should be held on a six-monthly basis and could be a joint affiliate/partner or per affiliate
- If per affiliate, the results should be shared – preferably at a common learning day if access and resources allow
- In a longer-term program (two years or over) a mid-term review would take the form of a mid-term evaluation (at the end of the first year) with a more in-depth assessment of process and impact
- Best practices:
    - If the indicators are the same for all affiliates/partners, the review should be joint
    - The mid term review events should be held on a six-monthly basis and could be a joint affiliate/partner or per affiliate
    - If mid-term review is done per affiliate, the results should be shared preferably at a common learning day if access and resources allow

Questions to ask in a monitoring review:
How are we doing?
What should we change?
What do beneficiaries think of our programme?
What has changed because of beneficiary input?
Is it meeting needs?
Are there gaps and who will fill them?
Lessons learnt

10.7.2.b SWOT analysis

A SWOT analysis is a useful way of looking critically at what is happening in the project. This process can be carried out by the public health team itself and even by the beneficiaries with facilitation support. The following matrix is the usual tool.

Strengths – what was good about the programme?	**O**pportunities – what can we do to change things? What helps the programme to be a success?
Weaknesses – what was weak about the programme?	**T**hreats – what could affect the programme and prevent it from succeeding

10.7.2.c Impact evaluation

Evaluations are developed around specific criteria to help to meet learning and accountability needs. Within those broad overarching objectives, programme teams will need to make decisions about the specific purpose that their programme evaluation will serve. The purpose of an evaluation will be affected by: stakeholder needs, timing, type of programme, timeline for the evaluation, available resources, and what information is already available.

Another useful framework for developing evaluation questions is the DAC criteria: Relevance, Effectiveness, Efficiency, Impact, and Sustainability - provide a good framework. Oxfam GB's seven key questions about performance and impact of our programmes also provide a useful starting point:[41]

10.9 Oxfam PHP Impact Assessment

Oxfam sometimes looks at the following areas during an impact assessment:

- Impact on people's lives- (discussed below in depth 10.9.1.)
- Beneficiary participation
- Sustainability
- Impact on gender equity
- Impact on policy and practice ideas and beliefs
- To what degree have we **learned** from this experience and shared the learning?
- How cost-effective has the intervention been?

The last two areas are covered in other Oxfam documents. See Oxfam Evaluation Guidelines and publications so only the first five technical PHP criteria will be covered in depth here.

IMPACT refers to significant or lasting change in the lives of people as perceived by the people themselves. This change can be positive or negative. The most significant question to ask when assessing impact **is what has changed and what is different as a result of this intervention.**

Behavior change is seldom the main objective of the humanitarian project: it is more to protect people from the negative impact that the emergency may have on their lives and to restore normality as quickly as possible. In a longer term programme (more than six months) you may well be able to start to measure behavior change.

10.8 Measuring impact on indicators (a continuation of Impact Monitoring)

You need to develop impact indicators at the purpose level on the LogFrame. **These are often proxy indicators.** (see above for explanation of proxy indicators)

Morbidity and mortality indicators are mostly used at the goal level as they are influenced by other factors such as the presence of medical facilities, other NGOs, government programmes, the weather and the environment.

It is possible to measure the impact of specific Watsan and hygiene promotion interventions on disease by looking at major outbreaks of diseases such as cholera or asking the community for their perceptions of disease patterns.

[41] Oxfam GB Evaluation Guidelines

10.8.1 Final Evaluation of the baseline KAP Study-

In order to evaluate the indicators and technical impact we will repeat the steps from Scenario B. Baselines in Chronic contexts or transition into rehabilitation phase Step II-IV will be reimplemented and progress against objectives compared to the initial baseline.

10.9.1 Impact on people's lives

One important way to measure the impact of an intervention on people's lives is to ask them!
We can assume that some change has taken place by using morbidity and mortality data or proxy indicators but this will only show quantity not quality.

Key Questions:

Water

Is the water that people are drinking less contaminated than previously? Household water sources are the most useful to test but you probably need to check on the quality of water from the source also.
Are more people using the protected water source for their drinking water now or do people still use the unprotected source (there are possibly long queues at the protected water source)? Are people using more water than previously?

Excreta disposal Hygiene

Do more people have and use latrines than previously?
Are more people using latrines than previously and disposing of excreta in latrine (e.g. infant's excreta)?
Knowledge of prevention and treatment and action taken has increased?
Do more people say they wash their hands more often than previously? Are there hand washing facilities by the latrines?
Do more people know how to prevent diarrhoea?
Do more people know how to make up ORS and when to give it?
Do more people use an impregnated mosquito net?
Are there less breeding sites for mosquitoes?

10.9.2 Beneficiary participation-measuring it

A definition for participation in emergencies has been drawn up:

"Participation in humanitarian action is understood as the engagement of affected populations in one or more phases of the project cycle: assessment; design; implementation; monitoring; and evaluation. This engagement can take a variety of forms.
Far more than a set of tools, participation is first and foremost a state of mind, according to which members of affected populations are at the heart of humanitarian action, as social actors, with insights on their situation, and with competencies, energy and ideas of their own[42]."

However, often in emergencies, beneficiaries only participate in decisions that have already been determined by the NGOs – where latrines will be sited or what kind of hygiene kits they require.

Key Questions: Have people been allowed to make decisions about the project – have they been in control or has OXFAM made all the decisions for them? E.g. siting of wells or tapstands, design of latrines, formation of committees etc.

In order to measure participation, the programme should have **realistically** decided what level of participation was envisaged for the programme. A matrix should have been drawn up using the same format as the one for community committees and an indicator added to the LogFrame. The following typology along with the spider gram for participation can be used for this purpose:

10.9.2.a A typology of participation in humanitarian action[43]

Type of participation	Description
Passive participation	The affected population is informed of what is going to happen or what has occurred. While this is a fundamental right of the people concerned, it is not one that is always respected.
Participation through the supply of information	The affected population provides information in response to questions, but it has no influence over the process, since survey results are not shared and their accuracy is not verified.
Participation by **consultation**	The affected population is asked for its perspective on a given subject, but it has no decision-making powers, and no guarantee that its views will be taken into consideration.
Participation through material incentives	The affected population supplies some of the materials and/or labour needed to operationalise an intervention, in exchange for a payment in cash or kind from the aid organization.
Participation through the supply of materials,	The affected population supplies some of the

[42] Participation by crisis-affected populations in humanitarian action: a Handbook for Practitioners. ALNAP 2003
[43] Adapted from Pretty J. 'Alternative systems of enquiry for a sustainable agriculture' in the Institute of Development Studies Bulletin, vol.25 Brighton: Institute of Development Studies,1994, pp.37-48

cash or labour	material, cash and/or labour needed to operationalise an intervention. This includes cost-recovery mechanisms.
Interactive participation- **Partnership**	The affected population participates in the analysis of needs and in programme conception, and has decision-making powers.
Local initiatives- **Empowerment**	The affected population takes the initiative, acting independently of external organizations or institutions. Although it may call on external bodies to support its initiatives, the project is conceived and run by the community; it is the aid organization that participates in the population's projects.

See link Spider Gram for participation

10.9.3 Sustainability

Sustainability is the measure by which community projects can be continued and managed by the community themselves within their own limited human and material resources without relying on funding from external sources. It is closely linked to the concepts of **capacity building and empowerment.** ***(See Link Sustainability Planning and Monitoring WSS)***

Key Questions: Will this project last? Is is connected to local initiatives? Is it coherent? What will happen when the pump breaks down or when maintenance is needed? Where will the money come from? Where will the spare parts come from? Has the training for pump attendants or technicians and outreach workers been adequate? Are committees financially able and will they be accountable for funds they collect? Do they still meet regularly? Will volunteer outreach workers continue their work or have some given up already – why?

There is often an erroneous assumption that if volunteers are trained, (be it in health, livelihoods or as a water committee) that these people will continue to work as such even after the project has ended or refugees/IDPs have returned to their villages. There is little written evidence to support this assumption. There often has to be some sort of support mechanism in order for this to happen.

However, sustainability is one of the areas often selected for impact assessment. Although sustainability is difficult to achieve in an emergency programme, there are some proxy indicators that can be used. A useful tool for this is the Spidergram so called because when filled in, it looks like a spider's web. The sustainability indicator could be:

At least 80% of community management groups score 4 on Sustainability Spidergram after a year[44]

(See Link Spidergramme for measuring sustainability and Sustainability Matrix)

[44] See spidergram handout on the accompanying CD

See Link IRC Sustainability of Hygiene Promotion and measuring impact

10.9.4 Impact on gender equity

An assessment would look at any changes that have occurred in the equal opportunities for men and women. It is good to look at how many women are employed as pump attendants, latrine attendants or public health promoters but it is equally important to look at any negative aspects of this change – did the woman pump attendant experience any harassment from male colleagues, did the female public health promoter have to fit her household chores in around her Oxfam work and how did this affect her family life?

Key Questions- What difference has this project made to gender equity?
Has information been collected from men and women? Is mortality and morbidity data collated for men and women? Have we listened to the voices of men and women? Did men and women make decisions or just men? Are the committees representative of women and men? What do people think of the female committee members? What do they think of the female pump attendants or technicians?

10.9.5 Impact on policy and practice

Key Questions: Have there been any changes in approach? Have people started to work in a different way because of this project? Is there greater beneficiary participation or more attention to gender equity? ***(See Link Gender Checklist)***

Some questions to ask here are:

- Were Sphere standards adhered to, not just by Oxfam but also other agencies? Did Oxfam influence other agencies decision to use Sphere standards?
- Was Oxfam able to lobby other agencies, **communities** and or Ministries to make changes to procedures or protocols?
- Was there a new approach to the way Oxfam worked taking into account cultural or societal differences?

10.10 Best Practice in planning an evaluation

In planning, you need to consider the following:

What is the purpose of the evaluation?
What type of information should be collected?
Who will be involved?
What methodology will be used?
What resources are required?

*Best practice ensures women and men directly participate in the evaluation of the intervention they have received as both a best practice for social science research as well as accountability to beneficiaries.

-Involving the beneficiaries in the evaluation by using a more participatory style and sharing the

results of the evaluation with the community. If done with care and respect for existing community structures and culture, beneficiary involvement can assist in building up good project-community relationships.

The Hawthorne Effect
If people are being monitored and observed, they may act differently and may do what is expected of them (use latrines or wash their hands) simply because they are being observed. **Best practice will use random household visits** rather than keep going back to the same households all the time.

10.11 Summary of Impact Monitoring Final Evaluation Minimum Standards[45]

Method	Who	Time Frame	What	Tool/Links
Technical Impact Monitoring Final Evaluation- KAP study After Action Evaluation	PHP field team with follow up WaSH mgr. and validation HQ Self Evaluated WaSH team- WaSH mgr take lead	For programmes over six months where a baseline was done- Conduct in the last 2 Months of project Midterm review for programmes under a year long	Final KAP study impact report showing the advance or non advance of the indicators. Short report with results and recommendations of approach if needs reorientation. Learning event for all affiliates	KAP study tool used for baseline
Final Impact Evaluation	External evaluator or WaSH internal evaluation of impact – PHP takes lead	For programmes over a year-The timing for this will depend on the program – it could be after moving from a recovery to rehabilitation stage orr at the end of 18-24 months ❖ Impact on people's lives ❖ Beneficiary	Overall idea of the impact the project has had in order to evaluate future projects, approach and current impact.	-Impact on People´s lives – ***FGD*** & survey ***Participation-spider gramme*** FGD Gender and equity- ***Gender Checklist*** Policy and Practice- FGD- ***In-***

[45] Minimum Requirement 11-12-09 OI

	participation ❖ Sustainability ❖ Impact on gender equity ❖ Impact on policy and practice ❖ Other criteria can be identified and added with the first four as a minimum standard	***depth interview*** (key informants)

- Best practice:
  - If the evaluation is per affiliate, a learning day for all affiliates/partners should be held in country.

For more details on Monitoring and Evaluation ***see Minimum Standards draft M&E and M&E portion of PHP OGB***

10.12 PHP Learning – Under construction 2010

Ch 11. Exit Strategy

-An exit strategy should be defined before activities begin. Handover of the programme to local authorities, other organizations, or the community will need to be defined as a strategy early on and the programme beneficiaries should be made well aware of our intentions and plans from the start.

Recovery or phase-out[46]

All emergency programs either move to a recovery phase (usually after two to three months), rehabilitation (longer term) or a phase-out, which will vary depending on the funding agreements and the context. All program plans need to have a clear strategy for either phase.

A clear exit strategy (for all affiliates/partners) for phase-out with Lessons learnt being documented and disseminated (for example posted on the dashboard).
If recovery, the monitoring framework/s should be adjusted to this phase. Lessons learnt from the first phase should be factored into the program plan for the next phase.

[46] MEL Minimum Standards 12-11- 2009

How to say goodbye[47]

-Ensure that the teams' departure at the end of the project is smooth and transparent. The people who have been involved in your project, including beneficiaries, staff, and local partner agencies and authorities, should know what is happening and why. Define in detail communication needs and activities. These may include:

1. Writing a letter to staff, followed by group and individual meetings.
2. Writing an official letter about project closure for regional, district, and village leaders, including elders and informal leaders. Follow letters with face-to-face briefings. Put a copy of the letter to village leaders on information boards.
3. Using a question and answer sheet to guide staff when communicating with beneficiaries about the end of the project.
4. Planning for the conduct of exit meetings with communities.
5. Reporting on project achievements and learning.
6. Writing a letter to other NGOs and partners. Follow this with face-to-face briefings and meetings.
7. Holding focus groups and/or house-to-house visits to reach women and vulnerable groups who may be unable to attend formal meetings.
8. Using posters and leaflets, including formats appropriate for less literate people.
9. Inviting feedback/comments on project activities.
10. Collecting stories about successful work and positive community interaction. Give these back to the community, e.g. have a photo exhibition during handover.
11. Supporting appropriate cultural activities or celebrations when projects are handed over to the community.
12. Evaluating exit communication activities and recording lessons learnt.

.

Health Is in your hands!

[47] HAP standards 2007 tool kit