

# Acknowledgements

Many people from Oxfam and elsewhere contributed to the production of these guidelines and offered helpful advice and suggestions in the rewriting. In particular I would like to thank the following:

Judith Appleton, Sabita Banerji, Andy Bastable, Simon Bibby, Sue Chowdhury, Carmel Dolan, Dave Gillespie, Mohammed Hassan Qazilbash, Lansana Kamara, Annie Lloyd, Richard Luff, Jean McClusky, Momodou Mboge, Shimeles Mekonnen, Mark Myatt, Marion O' Reilly, Linda Stanton,

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# Section 1

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Introduction



# Oxfam's Approach to Humanitarian Emergencies

Oxfam Handbook on Development And Relief 1996:

*'It is Oxfam's experience that relief programmes are significantly enhanced if the people affected are actively involved in all aspects of planning, implementation and evaluation of those programmes. This is especially the case where aid workers are unfamiliar with the customs and culture of those they are assisting. It should always be remembered that the beneficiaries in any programme are the most valuable resource and that agencies must utilise their knowledge and learn from them. While it may not be easy to institute effective consultative and participative mechanisms in the initial stages of an emergency, an attempt should be made to establish the principle of consultative planning and then build on imperfect beginnings.... Oxfam also recommends that wherever possible relief programmes work with the existing local structures in order to support and enhance their longer term capacity to respond to emergencies.... Programmes should be made to reflect the diverse concerns of women as well as men, of older as well as younger people and of those who risk becoming marginalised because they belong to a minority group.'*

A 'Rights Based Approach' challenges the concept of agencies delivering aid to the victims of disaster. It asserts that people have **Rights** and that there is therefore a corresponding **Duty** to ensure those rights are maintained. The Humanitarian Charter, which Oxfam subscribes to, affirms the fundamental importance of **The Right To Life With Dignity**. The Sphere Project details minimum standards for the delivery of water, sanitation and hygiene promotion, which are 'a practical expression of the principles and rights embodied in the Humanitarian Charter.'

Communicable diseases such as diarrhoea and malaria are a major cause of mortality and morbidity in humanitarian emergencies. Some studies have shown that diarrhoeal diseases alone contribute to between 25-50% of all deaths (Toole and Waldman 1990).

Studies conducted by Esrey et al (1985, 1991) have shown that whilst improvements in water quality alone produced limited reductions in childhood diarrhoea by 15-20%, the greatest reduction was attributable to safer excreta disposal (36%) and hand washing, food protection and improvements in domestic hygiene (33%).

However, the simple provision of clean water, toilets, mosquito nets or insecticides does not necessarily ensure that people will use these resources effectively or even at all as complex factors will influence how people behave. In order to prevent diseases such as diarrhoea and malaria it is vital to learn from and involve the people affected.

Public Health Promotion is the planned and systematic attempt to enable people to take action to prevent or mitigate disease. It combines insider knowledge (what do people know, do and want) with outsider knowledge (e.g. the causes of disease, epidemiology, vector control and communications and learning strategies). Public Health Promotion can be used to target a wide variety of Public Health problems but **Oxfam's distinctive competence at present focuses on the control of diarrhoeal diseases and malaria.**

These guidelines stress an innovative approach to health promotion that emphasises the importance of people being mobilised to take action to reduce public health risks. Such a model is more appropriate to the emergencies context where individual recognition of responsibility and collective action can enable both lives to be saved and enhance people's self confidence to address the problems that face them. Using such a model acknowledges that even short-term actions, sustainable or not may be appropriate.

These guidelines are meant for anyone who believes that community involvement is important for the effective promotion of health in emergencies. More specifically they are for field workers – engineers, vector control officers and health workers - initiating public health promotion projects either as part of a water and sanitation or a vector control project. They will also be of use to managers who have the responsibility for ensuring an integrated and gender focussed approach to Oxfam's work.

The guidelines are meant to be used in conjunction with the Emergency Response Manual (ERM), which includes the Public Health Assessment Tool (PHAT) and the Malaria Control Guidelines. They provide a practical guide to designing Public Health Promotion projects by outlining the different stages involved in carrying out such interventions. They do not provide details on the provision of water and sanitation hardware but they do provide details on how to assess, plan and monitor water and sanitation programmes.

### Action Versus Behaviour Change

At the height of an emergency what matters is that people engage in risk reduction such as using the defaecation 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.

In Sierra Leone one agency suggested asking the army in to ensure people used the latrines but this would have undermined the possibility of sustained change or improvements in the long term as people often react negatively to coercion. The right balance must therefore be found which is based on respect for the people we are working with.

The emphasis on action rather than behaviour change can also provide a more empowering approach to working with those affected by disasters by recognising that they are not just victims but that through collective and individual action they are also able to help themselves to mitigate the effects of a disaster.





**Public Health** is often defined as the ‘promotion of health and prevention of disease through the organised efforts of society’. A public health intervention aims to ensure co-ordination between sectors (e.g. in Humanitarian programmes with those involved in food and nutrition, water and sanitation, shelter, health care etc.) and to base its actions on sound public health information which is aimed at the maximum impact for the greatest number of people.

**Public Health Promotion** is a term coined by Oxfam 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.

**Hygiene Promotion** is the term that Oxfam previously used to describe the educational activities carried out alongside water and sanitation programmes. It is still a term which is used in the literature on water and sanitation and by other organisations involved in this sector. The broader term Public Health Promotion is now the terminology of choice within Oxfam.

**Community Mobilisation** is a strategy for involving communities in TAKING ACTION to achieve a particular goal. The emphasis of mobilisation is on the action taken rather than the longer-term concept of behaviour 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

**Community Participation** is the foundation for all Oxfam programmes whether in relief or development. It does NOT simply involve people contributing labour, equipment or money to the 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 the 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 will be possible and therefore a flexible response is required.

Sustainability refers to the potential for lasting improvements that a project offers. In the emergencies context sustainability may not always be possible or necessary to prevent significant mortality but where possible work should be carried out in such a way that opportunities for lasting benefits are actively sought and resourced as required.

## Whose Responsibility?

All the members of the Public Health team are responsible for ensuring that Public Health principles are adhered to, that minimum standards are met, that those affected are involved in the response and that every opportunity is taken to ensure that, where possible, improvements are lasting. Project managers, engineers, public health promoters, vector control officers all have a role to play in achieving the project goal of improving health and minimising risk. Each task however may be the predominant responsibility of either the public health promoter or the engineer. The allocation of tasks and activities will depend upon the individual team make up and the skills and resources available.

Oxfam's interventions in Public Nutrition are not directly managed by Public Health Promoters but the education component of Food and Nutrition programmes should apply a Public Health Promotion philosophy to enable people to take action to reduce health risks and to maximise the benefits of any nutrition intervention.



# How Do You Go About It?

It is not possible to provide a blueprint for setting up a public health promotion programme in emergencies as situations will vary greatly. Work may be undertaken in a camp situation, or an urban or rural environment as a response to a mass exodus of people, flooding, drought or other calamity and each situation will present specific challenges. In addition work in areas of ongoing conflict may also require taking novel approaches to service provision where contact time with beneficiaries may be significantly reduced. Oxfam may also find themselves intervening in situations which present different levels of risk and this must be assessed and interventions planned accordingly.

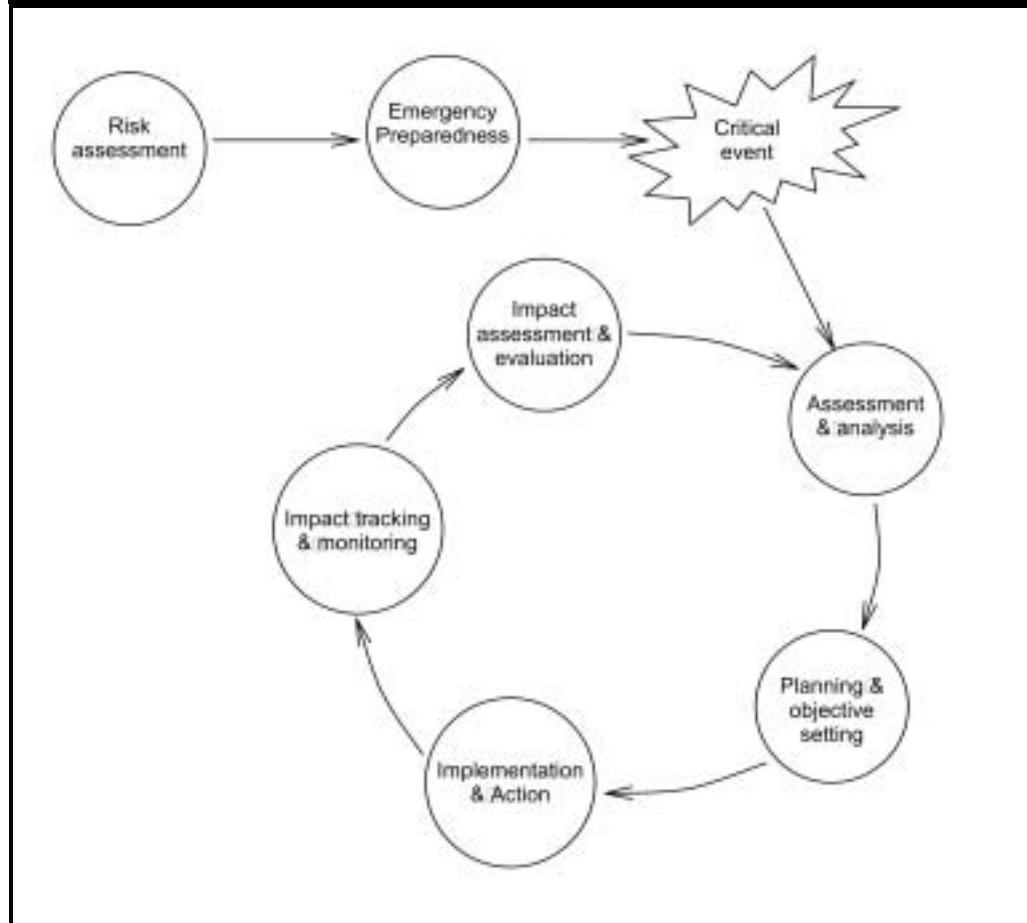
Decisions will need to be made about which aspect of public health is prioritised as trying to do too much can compromise effectiveness especially if you are trying to achieve results in only three to six months. The resources section includes a logarithm which should help you to prioritise work.

Liaison with other agencies is crucial – it is the combined impact of all the interventions, which will make a significant difference to people's lives rather than the single focus of one agency.

Despite a sometimes rapidly changing situation and often a very short project timespan, it remains important to include all the stages of the project cycle as far as possible. It should be remembered that the project cycle is also a dynamic process and the stages of the process will need to be revisited as a deeper understanding of the situation is gained and as the situation itself evolves. The **Emergency Response Manual** provides more useful information.

The guidelines provide details on how to implement each stage of the project cycle as shown below (except emergency preparedness, which requires separate examination). Implicit in this model is the assumption that there is a continual process of assessment and analysis leading to action which generates further assessment and analysis. All the stages of the project cycle must be followed. The appendices provide more detailed background information on how to carry out particular activities.

## Planning Model



Different Situations - Different Interventions:

### ***High Risk Situations***

High risk situations may last for days or weeks and are usually characterised by people in transition or newly arrived at a camp or settlement. High-risk situations may follow severe flooding, earthquakes or conflict or may arise because people's vulnerability is increased due to malnutrition or the outbreak of disease. People's main concern is to maintain or acquire the basic necessities: food, water and shelter. Their physical safety may be uncertain. Depending on the conditions which prevailed before their flight, there may be high levels of illness, malnutrition and physical injury. High rates of mortality may be evident (over 2 per 10,000 per day in poorer countries). Families may also have become separated and communities fragmented. At this stage full participation may not be possible but consultation and discussions should be employed as part of any assessment. More didactic forms of health education may be necessary such as campaigns - ensuring that people have the key information necessary for preventing disease. People may be more receptive to information from mass information campaigns at this time but wherever possible discussion and dialogue should form the basis of mobilisation campaigns.

### ***Medium Risk Situations***

Such situations may continue for weeks or months and in the wake of an emergency are characterised by increasing stability in the camp or settlement. Basic provision of food, water, sanitation and medical care is in place though it may be inadequate. Mortality and morbidity rates should be decreasing (crude death rate 1.0 to 2.0 per

10,000 per day) but there is a continued risk of the outbreak of disease. If communities have managed to stay together, social structures and hierarchies may have been re-established or new ones built. It is a time when greater beneficiary participation should be possible and when more participatory forms of public health promotion should be employed. Adults generally do not learn from being fed information and discussion and dialogue is necessary for people to incorporate any necessary changes into their lives.

### ***Maintaining Health***

If and when it becomes apparent that a prolonged stay in the camp or settlement is likely, it remains important to be aware that the situation may deteriorate again. People may have returned to their homes following flooding or conflict but they may still remain vulnerable. Morbidity and mortality rates may not be higher than the normal rates expected for the population (0.5 per 10,000 per day in 'developing countries'). People may be able to engage in routine daily activities such as cultivation and attending the market. The infrastructure for long term habitation will be either established or developing, and new or previous systems of community organisation will be operating. Schools may be functioning, religious groups mobilised and government structures may be involved in the delivery of services. It should be possible to work with some or all of these structures. Other environmental risk factors may be seen as important such as the threat of landmines or snakes but ongoing support to ensure adequate excreta disposal may still be necessary.

Conceptualising emergencies in this way is over-simplistic and it should be remembered that the stages of an emergency do not usually follow a linear progression. Such a framework, however, helps to highlight how different interventions are required at different times. As a humanitarian worker you may be intervening at different stages. The decisions made about the choice of interventions may have consequences for months, perhaps years following their implementation and every effort must be made to allow adequate time for assessment dependent on an analysis of risk.



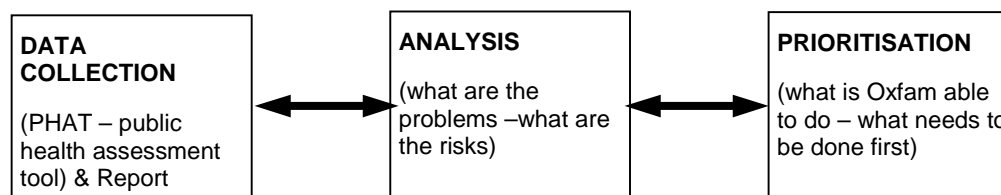
## Section 2

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# Assessment and Analysis



# Overview



The process of assessment and analysis, planning, monitoring and evaluation are essential in relief as in development work and many interventions have failed for want of adequate assessment and planning. However, you will not be able to find out all the relevant information straight away and in an acute emergency some assumptions will need to be made within a few days to provide the framework for a proposal until more detailed information can be gathered. Not all projects will commence in an acute emergency, however, and the time available for data collection should thus be adjusted accordingly. Use the **Public Health Assessment Tool** to guide your assessment

The process of assessment has been broken down into three stages (see page 21)

**Stage 1:** initial rapid assessment using exploratory walks and discussions with key informants in order to provide concept paper and/or proposal - should be undertaken in the first week

**Stage 11:** initial baseline data collection which is concurrent with discussion groups to mobilise communities using mapping, focus group discussions and household observation - should be undertaken between weeks 2 - 4

**Stage 111:** obtaining a deeper understanding of what people know, do and think, using tools such as matrix ranking, seasonal calendars and gender analysis - should be undertaken once the initial baseline data has been obtained although some initial data on gender issues should be gathered as early as possible.

- Gather information on government structures with which you should be working, prevalence and trends of the most common diseases and what data other agencies or Government bodies have or will gather in their assessments before embarking on the field assessment
- If available, invite a representative from the Ministry of Health or Water and Sanitation on the assessment
- Use rapid assessment methods initially: exploratory walks, discussions with key informants and opinion leaders (e.g. leaders: religious and secular, elders, teachers, TBAs etc.) and observation. Mapping, focus groups (men, women and children) and other participatory tools can be used to supplement the baseline data collection
- Mapping represents a very useful way to gain an overview of the water and sanitation situation from the perspective of the beneficiaries and to initiate community discussion on possible solutions. Separate maps should be drawn with women and men and other distinct and often vulnerable groups such as children or older people (See Resources Section for further information)



- In the initial assessment period try to identify the camp or community organisation and leaders, if any. Community structures may have become severely disrupted during an emergency or may be non-existent. Mobilising the community to regroup and elect new leaders or representatives if necessary will facilitate any future work with them
- Briefly assess the key areas of possible intervention which epidemiological common sense tells us are major risk factors in many emergency situations e.g. 1) excreta disposal (including that of young children and babies), 2) hand washing practices, 3) water supply, 4) food hygiene in markets and communal areas and 5) malaria risk factors and other potential vectors of serious disease e.g. lassa fever or typhus
- If water sources are to be rehabilitated try to assess existing or possible mechanisms for future maintenance such as water committees or user groups.
- Outreach workers may already exist and their initial training may simply need to be supplemented - try to identify them. There may also be people available locally with expertise in public health or community development.
- It is also useful to try and find out what communication media are most common in the community and whether there are existing tools and visual aids that might be used by the outreach workers.
- Large questionnaire surveys are time-consuming, expensive and require specialised knowledge of survey design to provide valid information. When discussing hygiene or health, people may also often give the answers they think you want to hear making the results unreliable. Only use a survey if you are confident of your design and sampling methods and the relevance and validity of the data you hope to obtain.
- Continue with a more detailed assessment as you design and implement your campaign or the first phase of your project. Other participatory methods of assessment such as pocket charts and matrix ranking may be used once the facilitators have received appropriate follow-up training in how to use these techniques (see IT Hygiene Promotion manual)

### To Survey Or Not To Survey?

In the emergency intervention in East Timor, a week was spent carrying out a water and sanitation survey of 180 households in Dili. It took another week to compile and analyse the results. However it was discovered that the survey forms had not been adequately filled in despite a three-day training and piloting exercise. Valuable time was wasted carrying out the survey which yielded very limited results and called into question the very reliability and validity of the study. It was also evident that the situation was changing so rapidly that a survey did not provide useful information to measure the effect of an intervention. More participatory forms of assessment may often yield more useful results faster. In Burundi a combination of exploratory walks, mapping and the random selection of 10 houses per settlement to estimate the quantity of water used were employed as assessment methods. In Mozambique however, it was felt that there was sufficient time to carry out a 'Knowledge, Attitudes and Practice' survey, which provided useful baseline information prior to the distribution of bed nets. The survey was carried out in conjunction with focus group discussions and mapping.

## First Steps: What Sort Of Data Is Useful?

The list below is an example of some of the initial key information for Public Health Promotion that should be gathered as early as possible. The Public Health Assessment Tool (PHAT) should be consulted for further details of what assessment data is required.

- government structures (health services(including public health)/water supply/education)
- population (numbers and profile), average household size
- mortality and morbidity (including malnutrition)
- basic epidemiology of common diseases which pose a risk to the population (e.g. diarrhoea/malaria) disaggregated by sex if possible
- key informants, opinion leaders (male and female)
- community organisation & structures (women's groups, water committees, religious institutions, social societies, youth groups, schools, markets, health service etc.), gender roles
- existing outreach workers (Community Health Workers, Social Development extension agents etc.)
- vulnerable groups (disabled, older people, female headed households, ethnic minorities etc.)
- literacy rates for men and women

- A general Public Health assessment is necessary in order to set any response within the broader context of the promotion of health. Other agencies – governmental and non-governmental will also be present and the prioritisation of work will need to make reference to what they are prepared to do as well as to Oxfam's key competencies and experience. Water and Sanitation, including Vector Control and Public Nutrition currently provide the major focus for Oxfam's Humanitarian work.

## Planning And Liaison

The incidence of diarrhoea and malaria will be affected by many factors. It is important to be aware of the availability of health services, nutritional status of the population, food security and shelter as well as the more obvious water and sanitation issues and for agencies to plan their response in collaboration with each other. The success of any emergency intervention is dependent on the coordination of all those involved and no one intervention can address the problems on its own.

- Assessment data is meaningless without subsequent analysis of the information and the setting of priorities. Compiling a problem tree may allow a closer examination of the causes of problems and possible solutions and help to focus on the most significant risk factors. A problem tree is formed by outlining problems and for each problem asking the question 'why'. By continually asking 'why', the root causes of problems may be discovered and priorities for intervention thus become clearer.
- If diarrhoea is a major problem with evidence or risk of high morbidity or mortality (and it often is) the focus of the Oxfam response should be excreta disposal, handwashing, protection of water from contamination and the provision of clean water in adequate quantities. The necessary software or promotional interventions should similarly focus intensively on these aspects until the risks have been mitigated. If malaria is also a significant problem it may be necessary to provide additional and separate resources to help address this problem.
- Ongoing epidemiological disease surveillance will be necessary to monitor outbreaks of disease especially those related to water and sanitation. In most large-scale emergencies other agencies or government bodies will be best placed to gather such data from their records of clinic consultations or from isolated reports and investigations. However, in many other situations there is very little data available and ways need to be found to ascertain disease prevalence through discussions with those affected or by encouraging community leaders or community mobilisers to keep records.
- Analyse the raw data from focus group discussions by highlighting key themes and ideas. This data can only be examined in general terms rather than attempting to convert the responses into percentages, which is often done. Therefore the report would state e.g. 'many people said that young children under eight years old did not use the latrines because they were dark' or 'Some people claimed that the smell in the latrines attracted evil spirits and therefore they did not want to dig one'. Focus group discussions allow you to explore people's

perceptions in more detail and to be aware of some of the constraints or opportunities that the programme may face. From such discussions you should be able to identify the key areas where action is required and encourage beneficiaries to identify such problems for themselves. The current 'problem situation' will then provide your baseline data.

### **A Word on Water**

Estimating the quantity of water used may present particular problems. In the camp situation it is often easier to keep track on the amount of water distributed and to assume that this will provide an indication of the amount of water actually used. However, in other situations people may collect water from a variety of different sources. Estimating the amount used by finding out the number of containers filled and how many people in the household may also be difficult and frequently there is a lack of precision about the size of the containers. A detailed household observation may be necessary to get a more precise impression of how much water people tend to use. However, this is only indicated where there are specific concerns about whether people are using enough water. If people are observed going to the river to wash themselves and their clothes, it can probably be assumed that people are using an adequate amount of water. In this instance the distance to water points may be a more significant indicator to focus on. Once again impressionistic data obtained by 'pacing' or timing the distance to the furthest and nearest water points should be sought.

# Rapid Assessment & Baseline data

Collecting data for proposal writing and to provide a baseline for monitoring is a team 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.

The initial information gained from the assessment will provide some useful baseline data but it cannot be assumed that this will be sufficient to measure the success of the programme. It will be necessary to continue to collect baseline data and to try to do this in a structured way. In an emergency situation where time is limited it may only be possible to get data that is representative of the situation rather than data that is statistically valid. Evaluation will have to rely heavily on people's perception of impact and on evaluation of the combined agency response.

The following data collection plan gives a framework for collecting this. In the acute stages of an emergency it may not be possible to collect such information straight away and the information gained from the rapid assessment will have to serve as the baseline. However the nature of public health promotion is such that more data is collected with every interaction with groups or individuals and this should all feed into a separate **Assessment and Baseline Data Report** to facilitate subsequent monitoring and evaluation.

## Stage I: Rapid Assessment

Method	Who	Time Frame	What	Outcome
<b>Rapid Assessment Exploratory walks and discussions with key informants</b>	Key Informants: MoH, Water and sanitation dept, other agencies, community leaders and community members	2 – 3 days (up to one week)	Overview of public health and key risk factors for water and sanitation related disease including malaria e.g.drinking water source, excreta disposal, handwashing with cleansing agent, basic gender assessment especially of issues affecting women e.g. protection	Initial assessment report, problem statement and concept paper

## Stage II: Baseline Data

Method	Who	Time Frame	What	Outcome
<b>Mapping</b>	Mixed group of leaders and community members then male and female community groups	Over one week in each location with at least three	Existence of water and sanitation facilities, current practices and breeding sites or environmental health problems	To feed into initial baseline data report

		groups initially		
<b>Focus group discussions using pictures (e.g. three pile sorting)</b>	Male and female community groups	Over one week in each location (at least three groups)	Usual hygiene practices and current problems, Knowledge of diarrhoea and/or malaria and treatment seeking behaviour	To feed into initial baseline data report
<b>Household Observation</b>	Random selection of households in each location	Over one week (time may also be available to start stage III activities)	Risk practices for water and sanitation related disease, amount of water used	To feed into initial baseline data report

### Stage III: Further Analysis

Method	Who	Time Frame	What	Outcome
<b>Matrix ranking of environmental health problems seasonal calendars and pocket charts</b>	Male and female community groups	Over one week concurrent with household observation	Ranking of most significant problems, understanding of links between seasonal changes and incidence of disease, understanding of water sources and water use and sanitation practices	To feed into final baseline data report
<b>Gender Analysis</b>	Oxfam national staff and then male and female community groups	Over one week	Understanding of issues that affect both men and women and how intervention can support long term goal of gender equity	To feed into final baseline data report

These methods have been chosen because they allow for a detailed but rapid assessment of the situation. Sample sizes and selection methods are not believed to be as important in this kind of assessment. Instead **triangulation of methods** is used to ensure as valid a representation as possible. In acute situations where time is of the essence, the involvement of beneficiaries in critically analysing the situation is a more useful approach to stimulating action and ensuring people's right to influence the provision of aid than the knowledge that such information is scientifically accurate.

### Case Study: Mozambique

In Mozambique following severe flooding in Chokwe district an emergency team of public health promoters and engineers began working in the camps of displaced people. An initial emergency assessment was conducted over three days. Teams of two to three people and an interpreter were assigned either different areas of the larger camps or different camps. They talked to the affected population (both men and women) to define the most significant problems and to assess what resources were available and what Oxfam might be able to provide. In addition discussions were held with elders, TBA's and some of the medical staff from the nearby clinic to determine needs and priorities. Regular meetings of other agencies involved in the response were also attended as well as meetings with the Water Department and Ministry of Health. Daily team meetings were also held in which information about data gathered was shared. From this initial assessment and analysis a concept paper was drafted and circulated to the major funding agencies.

Following discussions with those affected, temporary water supplies and emergency latrines were constructed. Volunteer outreach workers were identified and trained and visited families in their shelters informing them of what they could do to prevent diarrhoea. A distribution of soap and buckets was also carried out.

Unfortunately although the team was constantly collecting 'baseline information' through everyday contact with beneficiaries, this was not carried out in a structured way and it was never collated and rarely shared. The team identified the need for monitoring and evaluation but did not feel they had time to put in place the necessary baseline data collection. The situation was also rapidly changing as people made their way back to their villages once the floodwaters had receded sufficiently. The team decided to recruit someone who would be assigned to monitoring and evaluation but there were delays with recruitment and it was only two months before the end of the project that a monitoring and evaluation consultant visited the project.

An attempt had been made to design a more structured baseline data collection by one of the team members which involved focus group discussions, interviews with key informants, structured observations, observations at water points and exploratory walks. Feedback from the M & E consultant revealed that whilst such a structured format seemed appropriate, in fact the team were attempting to collect too much information and a lot of the data was already known within the team. At the same time another engineer team member had decided to initiate latrine monitoring which was a part of the structured household observation, therefore duplicating efforts. **A more useful approach would have been to design the data collection in conjunction with the whole team and to scale down the amount of information collected to focus on critical risk factors.**

# Information Collection: Use of Different Methodologies

Rapid Assessment	Baseline Data Collection	Monitoring
<p><b>Exploratory Walk</b></p> <p>Use to collect initial data on what facilities are available at present and what main problems/risks are: provides rapid impression of situation</p>	<p>A checklist (see appendix) can be used to record information from different areas or zones to define indicators for monitoring. Information will be impressionistic and cannot be presented as 'survey' data</p>	<p>Using 'crude' indicators such as a rating of how much indiscriminate defaecation observed, or evidence of handwashing facilities, change should become obvious by comparing checklists used for baseline data collection</p>
<p><b>Key Informant Interviews</b></p> <p>Use to collect initial data on main problems/risks and people's perception and understanding of risk</p>	<p>Record information and identify themes and trends to help define indicators. Do not present as percentages or statistical information but as narrative, qualitative information cross checked by using other methods.</p>	<p>Repeat interviews and ask people to identify changes they perceive to have taken place using previously identified indicators. Previous and new key informants should be interviewed.</p>
<p><b>Mapping</b></p> <p>May be possible to do one or two maps at the same time as interviewing group of key informants but may take time to do well</p>	<p>Structure mapping activities to include different areas and groups, ensure data is recorded both in form of map itself and accompanying commentary and observations. It may provide numbers of facilities or breeding sites.</p>	<p>Repeat mapping to use as visualisation of community perceived changes at three monthly intervals. It may be possible to obtain numerical data for each map and this can then be collated for the whole area.</p>
<p><b>Focus Group Discussion</b></p> <p>May be possible to organise one or two FGDs as part of initial assessment</p>	<p>Information needs to be summarised and cross checked with other information collected and presented in narrative format. This data cannot be interpreted in terms of percentages.</p>	<p>Subsequent focus groups should <b>not</b> identify the same groups. Organising focus groups should be an ongoing activity as this is an opportunity for community discussion and learning.</p>
<p><b>Three Pile Sorting</b></p> <p>Time not usually available for preparation of materials or in depth discussions but pictures may be used to make FGD more interesting</p>	<p>Can provide detailed information on how people perceive problems if careful recording is made. Cannot present this data in percentages – narrative required</p>	<p>Such activities should form part of ongoing training and key information should be recorded</p>



Rapid Assessment	Baseline Data Collection	Monitoring
<p><b>Household Observation/Interview</b></p> <p>May be useful to visit one or two homes during exploratory walk if there is time.</p>	<p>Random selection of small sample of households in different areas to provide <b>impressionistic</b> data only. This is not intended to be used as a survey so do not try to collect too much data. Data can be presented in form of percentages with qualification that this is not necessarily statistically valid: ensure you provide 'sample' size. If used and cross checked with other methods, greater reliability of the data can be assumed.</p> <p>This method can be used to investigate situations such as quantity of water used in more depth – use up to ten households and look at one or two indicators only.</p>	<p>Repeat household observations making selection of households as random as possible. Conduct at 3-6 month intervals. You do not need to use the same households. Only useful if cross checked with other methods.</p>
<p><b>Spot Check observations</b></p> <p>Not applicable at this stage</p>	<p>This method can be used to produce a large number of observations on specific issues such as number of school children washing hands after using latrines.</p> <p>Data can be presented statistically and percentages extrapolated with the qualification that the data is not necessarily statistically valid although the larger the number of observations, the more reliable the data. May be best used as a monitoring tool.</p>	<p>This tool can be used in various ways for monitoring:</p> <ol style="list-style-type: none"> <li>1. A large number of observations may be repeated on particular indicators as with the number of school children washing hands after using latrine.</li> <li>2. Spot checks should also be conducted on an ad hoc basis to verify if toilets are clean.</li> <li>3. Checking if people coming to clinic or distribution know how to make up ORS etc.</li> </ol> <p>These activities should be carried out as part of regular programme activities.</p>
<p><b>Pocket Charts</b></p> <p>Not appropriate at this stage</p>	<p>Can provide some quantitative data on what people do but cannot be presented as percentages – provide actual outcome of session and backup narrative of key information</p>	<p>Such activities should form part of ongoing training and key information should be recorded</p>
<p><b>Matrix Ranking</b></p> <p>Basic ranking of problems may be possible if situation not high risk</p>	<p>Should only be used if situation stable – pocket charts may be more useful in providing indicators. May provide deeper understanding of people's preferences for facilities such as latrines</p>	<p>Should only be used if situation stable – pocket charts may be more useful in providing indicators</p>

Assessment and Analysis

Information Collection: Use of Different Methodologies

Rapid Assessment	Baseline Data Collection	Monitoring
<p><b>Seasonal Calendar</b></p> <p>Time not usually available in high risk situation</p>	<p>May provide useful information on peak seasons for sickness and useful to make link between e.g. rainfall, sickness and food availability. More useful as a training tool than a monitoring tool</p>	<p>More useful as a training tool than a monitoring tool in emergency situations</p>
<p><b>Gender Analysis</b></p> <p>Some information should be sought from key informants on gender roles and relations etc. but time not usually available for comprehensive gender analysis</p>	<p>Baseline information on gender: may help to determine appropriate gender indicators for situation</p>	<p>May not be possible to view significant change in short time available but individual gender indicators should be monitored</p>

Drawing on significant experience from the field, Oxfam is proposing a more radical approach to data collection in emergency situations. 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. In such situations carrying out large scale surveys 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. The perception of those we are working with is vital. The emphasis on participatory monitoring allows a community defined perspective on impact assessment and is also a way of motivating action. Cross checking and triangulation of data gives greater validity and reliability to the data. Such an approach is thus thought to be ‘good enough’ given the constraints and will do more to encourage participation in the short time frame available. The humanitarian department is committed to researching the use of participatory approaches in emergencies.

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 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.

# What about Gender and Representation?

Whilst many people accept the importance of taking a gender perspective in the provision of humanitarian assistance, there is much work to be done on incorporating gender into the design of programmes. The table below provides a checklist to assess the extent to which gender and the consideration of different groups is being used to inform programmes. It should be incorporated into the monthly reporting format and other gender and representation dimensions added as necessary.

Do you have information from male and female groups? How many of each?	Male:	Female:
Were <b>Key informants</b> drawn from different sections of the community? (rich, poor, leaders, women, disabled, older people)		
Which vulnerable groups have you consulted? E.g. Female headed households, pregnant women, elderly, poorer women, disabled		
What special provision has been made to include women and vulnerable groups? E.g. facilities for the disabled or pregnant women		
Did women interview women?		
Were the different results compared and discussed with men and women separately?		
How have you ensured women's safety? (latrines far from the camp or without adequate lighting may make women more open to sexual violence)		
How have you ensured women's privacy? (latrines should be separate from men and have simple locks on the door)		
Do women have sanitary protection?		
What efforts are being made to ensure that women have information on refugee rights and benefits available?		
How many male and female project staff do you have?	Male:	Female:
What efforts are being made to employ women?		
What training on gender has been offered? Are people aware of what to do if there are reports of violence against women (e.g. rape)		
Are efforts being made to train women in non traditional roles? (such as pump attendants or technicians)		
Did you conduct a gender analysis?		

# Gender Analysis

Gender refers to the socially derived attributes, roles and responsibilities that are associated with being male or female in a particular culture. Gender relations are concerned with how power is distributed between the sexes and how that power, influences the differences between men and women.

Gender relations are context specific and vary according to the situation. In any community gender roles and relations will change naturally over time and they are not fixed in the way that many people assume. Specific events such as conflict and crisis may bring about this change and both women and men may be forced to take on roles that up until that point have been unfamiliar. A gender analysis must recognise this fact and continually reassess how this change is taking place and the effect it is having on the project and vice versa.

A gender analysis needs to focus on both the different roles and the different relations between the sexes i.e. the different tasks and responsibilities and the way that men and women relate to each other. So for example in a water and sanitation project women may take on particular tasks in relation to water such as collecting it and cooking with it and men may be responsible for protecting water sources or repairing handpumps. This basic analysis looks at gender roles but a deeper analysis would also look at what influence women have over the repair of the pumps and how men influence the collection and use of water and how the sexes might interact to compromise or enhance access to this resource. An understanding of power relations in the family is critical in order to design the most appropriate response. For example, targeting an intervention at encouraging mothers to take children to the clinic early may miss the fact that this cannot be done without permission and or financial resources from the father.

## Why gender is important – an example from Kosovo.

Since the war of 1999, many rural women in Kosovo are confined to the home. The information they receive is filtered through men. There are far more men, than women in evidence on the roads, in the shops and cafes but in many rural villages the majority of adults are women. The implications are serious. Men are determining the future of villages in Kosovo, although women are the majority but one which is unseen and unheard.

Two things seem to hide the gender imbalance in villages. A count of the total population will include people who have perhaps lived abroad for many years but still send money home. Families may have ten women members and only two men although the men will still be seen as the head of the household. Also, outside organisations consulting villages first seek the village head, who is invariably a man. If women are included in a meeting to make it more 'representative', they will generally let the men lead. When women are consulted separately, their priorities become more visible and Oxfam is in a better position to press for their voices to be heard by the multilateral organisations working in Kosovo to set up a new society.

*Adapted from Unseen and Unheard – village women in Kosovo by Serena Ann*

In emergency situations protection of refugees or displaced people is also important and women may be particularly vulnerable. Their physical, emotional and social security are all greatly increased. They may be the victims of rape or torture or they may be forced to prostitute themselves in order to gain access to needed resources.

Basic information may be denied to them which could help to allay their concerns or allow them to make decisions about their safety. All programmes must attempt to become aware of such issues and ensure that both women and men are assured of their dignity.



# People Oriented Planning Framework

Gender analysis frameworks come in many shapes and sizes. The 'People Oriented Planning Framework' has been developed especially for emergency situations. It is recognised that at the height of an emergency it may be difficult to obtain all the information necessary but with a clear framework in mind it may be possible to gather data as the programme proceeds ensuring that information is fed back into programme design. Although this framework may look complicated much of the information is gathered by teams as they carry out their usual work. When time allows it is useful to try to involve people themselves in the process of analysing these dimensions of their situation through the creative use of PRA tools.

Change, participation and the importance of analysis are three key factors, which the POP emphasises. The framework has three components:

- Tool 1: The Determinants Analysis (Also Called The Refugee Population Profile And Context Analysis)
- Tool 2: The Activities Analysis
- Tool 3: The Use And Control Of Resources Analysis

**Tool 1** examines who the refugees are and their context and includes an assessment of community norms and social hierarchy. It also looks at institutional structures, economic conditions and internal and external political events in order to identify the extent to which these factors will affect the findings of tools 2 and 3.

**Tool 2** examines who does what, when they do it and where and whether there have been changes brought about by the crisis. Protection is a crucial concern in emergencies especially for girls and women and examining the activity of protection is important as the social networks that previously offered protection may have been undermined.

Activities Analysis				
Activities	Who?	Where?	When/How long?	Resources Used?
<b>Production of goods</b> e.g. carpentry and metal work <b>and services</b> e.g. teaching, domestic labour				
<b>Agriculture</b> e.g. land clearance, planting, care of livestock, irrigation				
<b>Household production</b> e.g. childcare home garden, water collection, sanitation				
<b>Protection activities</b> e.g. of unaccompanied children, single women, elderly people				
<b>Social, political, religious activities</b> e.g. community meetings, ceremonies				

**Tool 3** helps to determine how resources are distributed and who has a say over their use both before the crisis and at the present time.

<b>Use of Resources Analysis</b>		
<b>Resource lost due to flight</b>	Who used this (gender/age)	Who controlled this (gender/age)
Land Livestock Shelter Tools Education System Health Care Income		
<b>Resource brought by refugees</b>	Who has this (gender/age)	Who uses this (gender/age)
Skills e.g. political, manufacturing, carpentry, sewing, cleaning, agricultural, animal husbandry Knowledge e.g. literacy, teaching, medicine/health		
<b>Resource provided to refugees</b>	To whom is this provided (gender/age)	How/where/when is it provided (through males or females)
Food Water and sanitation Shelter Clothing Education Legal Services Health Services Etc.		

More information on this and other tools can be found in 'A Guide to Gender Analysis Frameworks' by Candida March, Ines Smyth, and Maitrayee Mukhopadhyay





## Section 3

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# Planning and Objective Setting

# Overview

- The rapid change which is characteristic of many emergencies often makes planning and objective setting very difficult but it remains very important to define your objectives and the means by which you will assess your intervention before you begin implementation
- Initially it will be the Public Health team which sets the objectives but as the project progresses there will be the opportunity to allow different community groups to set their own objectives e.g. the digging of a specified number of latrines by a certain date
- Set short and long term objectives if possible (see page 36) to ensure that a longer term perspective for the project is considered

The following priorities for water and sanitation are recommended in an acute emergency (Adams, J. 1999):

## Water And Sanitation Priorities

- provide a minimum amount of water for drinking, cooking and washing
- ensure people have enough water containers to collect and store water cleanly
- provide facilities for people to dispose of excreta safely especially young children and babies
- protect water supplies from contamination
- ensure that people have key information to prevent water and sanitation related diseases: focus on those that pose the most serious threat only (include knowledge of ORT if this is not being done by other agencies)
- ensure that people have soap or alternatives for handwashing
- ensure adequate drainage around water points

It is vital to consider other Public Health risks also. Malaria, typhus, lassa fever and dengue are all public health problems which Oxfam has attempted to address in its programmes. It is important to consider each in the existing context. Some problems may be widespread but not necessarily as serious such as scabies or headlice. On the other hand dengue fever and lassa fever may give rise to epidemics of haemorrhagic fever which can often be fatal. Attempts to address such problems however, will be limited in the absence of adequate health care facilities. Malaria is endemic in many of the countries that Oxfam works in but levels of endemicity and people's immunity to the disease will vary. Once again if adequate health care is not available attempts to reduce the incidence of malaria will be limited and the decision to intervene must be based not only on an assessment of the risks but also on an assessment of the resources available and the likelihood of the response having an effect. This may also be influenced by the actual nature of the emergency. For example distributing bednets where access to the population is limited may mean that people do not use them appropriately.

# Logical Framework Analysis

The logical framework attempts to show the different levels of objectives that project workers will be working towards and how these logically relate to one another i.e. in order to achieve the aim or goal the following 'purpose objectives' must be defined. In order to achieve those 'purpose objectives' certain outputs are necessary and in order to achieve those outputs certain activities are necessary.

Logical frameworks are now being used more frequently and it is a useful exercise to draw up a large framework and fill in the specific details of the project in conjunction with other team members (see resources section for example logical frameworks). This framework will need to be reviewed in line with different phases of the response and if necessary updated at each planning meeting. Similar principles and approaches will apply when planning a vector control, bednet or other community mobilisation project.

On the following pages a set of objectives for a water and sanitation project is provided. In order to provide a concrete context, a camp situation of 50, 000 refugees has been envisaged. The Sphere Minimum standards have been used in part as the OUTPUT objectives to help to familiarise people with them. However, it is preferable when drawing up a logical framework to present to a donor that these standards are converted into outputs that are specific to the situation e.g. use '**Establish temporary and longer term excreta disposal systems for men, women and children within three months**' instead of '**People have sufficient numbers of toilets, sufficiently close to their dwellings to allow them rapid, safe and comfortable access at all times of the day and night**'.

In setting objectives it is useful to look at the five key areas of impact that Oxfam programmes in other areas are asked to report against:

- Impact on people's lives
- Impact on gender equity
- Participation
- Sustainability
- Impact on policy and practice

**The impact on people's lives is the most important change objective in an emergency** and the other areas of desired impact may not be possible initially.

However they must be considered and the opportunity to incorporate these aspects into all of Oxfam's work should be taken wherever possible. It must be remembered that in many areas of the world crisis has become a way of life and enhancing people's capacity to cope with subsequent crises should be one of the objectives of any intervention.

# Possible Objectives for a Water and Sanitation Programme

## Impact Objectives

### **Aim**

To contribute to improving the health of the refugee population and to Prevent The Outbreak Of Major Epidemics

### **Purpose 1: Short Term Objective**

to limit the spread of water and sanitation related diseases within 3 months

### **Purpose 2: Long Term Objective**

to begin the process of capacity building and enhancing problem solving skills in the affected population.

## Outputs

### **Output 1: Sphere Standards 1 & 2**

People have sufficient numbers of toilets, sufficiently close to their dwellings to allow them rapid, safe and comfortable access at all times of the day and night (Sphere excreta disposal standard 1)

### **Output 2: Sphere Standards 1, 2 & 3**

All people (women and men) have access to a sufficient quantity of water for drinking, cooking and personal and domestic hygiene (Sphere water supply standard 1)

### **Output 3: Sphere Hygiene Promotion Standard 1**

All sections (women, men, children, vulnerable groups) of the affected population are aware of priority hygiene practices that create the greatest risk to health and are able to change them. They have adequate information and resources for the use of water and sanitation facilities to protect their health and dignity

### **Output 4: Sphere Hygiene Promotion Standard 2**

All facilities and resources provided reflect the vulnerabilities, needs and preferences of the affected population. Users are involved in the management of hygiene facilities where appropriate

## Activities

### **Activity 1**

Continue more in depth water and sanitation assessment activities (baseline data and further analysis) and ensure triangulation and disaggregation of data

### **Activity 2**

Demarcate areas for excreta disposal

Facilitate community members to decide on longer term sanitation options within 3 weeks aiming for maximum of 20 people per toilet

### **Activity 3**

Identify and train defaecation area/latrine attendants and water point attendants within the first week

### **Activity 4**

Provide facilities for hand washing at every defaecation area/public latrine

**Activity 5**

Identify and train campaign workers (2 day training) within 2-3 weeks  
Implement a 2 week information campaign providing key messages identified from initial assessment only (e.g. disposal of excreta especially children's excreta, hand washing using soap or ash and the need to dig more latrines)

**Activity 6**

Distribute or enlist the help of other agencies to distribute family hygiene kits if required (if not available ensure distribution of soap and water containers at least - 250g soap per person per month, each family should have 2 water collecting vessels of 10-20 litres and 1 storage vessel of 20 l)

**Activity 7**

Identify and commence training 10 children's facilitators to promote hygiene to young children using play and other participatory methods within 3 weeks

**Activity 8**

Identify and commence training of additional 80 volunteers (2 per 1,000 population) to promote hygiene within the community through group discussions, home visits, use of songs, plays, puppets and demonstrations etc. within six weeks

**Activity 9**

provide minimum of 15 litres of water per person per day (maximum distance from shelter to water point is 500 metres, faecal contamination 0-10 faecal coliforms / 100ml)

**Activity 10**

ensure adequate and appropriate shower and laundry facilities (one bathing cubicle per 50 people with separate facilities for men and women, one washing basin per 250 people). Design following consultation with community

**Activity 11**

Ongoing liaison with other agencies working in the camp

**Activity 12**

ensure ongoing assessment, planning and monitoring of the project (update log frame as necessary)



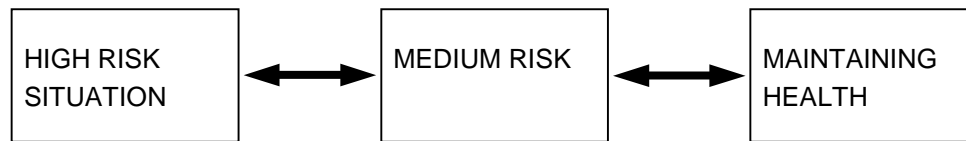
# Section 4

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## Action & Implementation



# Overview



**Work may begin in any of the above phases and will not necessarily follow a linear progression. Continual assessment of the most appropriate action required will be necessary. The initiation of a project does not automatically imply that acute phase activities are applicable.**

## High Risk

- Identify male and female outreach workers as quickly as possible – payment may be necessary at this time as volunteering may not be an option for most. It must be clearly explained to people that payment will only be given on a limited basis. Discuss with leaders about identification of workers ensuring that men and women are involved and that community work skills are required.
- Government employees skilled in community development or health education may also be available and should be identified in your initial assessment. It may be possible to have some of these staff seconded temporarily to Oxfam for the duration of the emergency. They are usually provide with an extra stipend for this work but this needs to be verified in country
- A campaign to disseminate key information about health risks (e.g. excreta disposal, use of certain waterpoints and the importance of handwashing) is often the most appropriate response in an acute emergency. At this time people may be more receptive to message dissemination. A few key messages should be identified and promoted through whatever channel is possible: outreach workers, loudhailers, community leaders etc. The campaign should not last longer than two weeks. There may be a need for further campaigns if there is a sudden deterioration in the situation and/or an outbreak of disease.

### Focus Efforts

Effective excreta disposal and improvements in handwashing are likely to yield the greatest benefits if the assessment shows these to be high risk practices. Raising awareness about ORT may also be extremely effective to mitigate an outbreak of diarrhoeal disease. Concentrate on these issues initially but remain aware that some activities may take place concurrently such as the distribution of Oxfam buckets or jerry cans.

In Sierra Leone Blue Flag Volunteers (one BFV for every ten households) were trained to teach people how to make up ORT and to refer cases of dehydration to the nearest clinic. In the camps in Rwanda latrine, water point attendants and outreach workers were identified immediately to ensure people were aware of the new risks they faced.





- You will need to provide a short 1 to 2 day training course for the campaign outreach workers / facilitators and ensure that their activities are supervised closely. It will be of benefit if short meetings are organised in the course of the campaign to assess any major problems. The numbers of facilitators will depend on the area to be covered, its accessibility and the urgency of the situation. WHO recommends 1:1000 outreach workers but more will often be needed especially if they are to be voluntary. The numbers of workers should also correlate with the capacity of the engineering team in order that the work of one keeps pace with the other.
- If leaders and key informants are available, ensure their co-operation with the campaign, Consider providing information at registration areas, distribution points, water sources, markets and any other public areas. Consider using a tannoy system, radio if available, short dramas, songs and/or puppet shows. In areas where literacy rates are high written information in the form of leaflets or posters may be useful if these can be developed quickly. Where possible always give the public the opportunity to ask questions.
- Target all sections of the population: women, men and children. It may be useful to recruit people who have a specific responsibility to work with children. Where schools are functioning or there are opportunities for non formal education it may be possible to support or introduce a public health promotion component
- Active case finding of people with diarrhoeal disease or malaria may also form part of the workload of outreach workers and this should be planned in conjunction with those involved in the provision of health services
- Continue assessing the situation to find out as much as possible about people's beliefs and practices and what the main risk factors are. Mapping and focus group discussions can be used as a basis for training sessions
- Consider distribution of essential items such as soap, drinking water storage and jerry cans
- It can take time to ensure that leaflets or messages conveyed are exactly right. The importance of enabling people to take ACTION cannot be overstressed so ensure that most of your resources are put into dialogue to stimulate action rather than simply one way message development.
- Defaecation fields or public latrines are often the most appropriate initial option in the absence of an adequate excreta disposal system but together with the sanitation engineer you will need to design a longer term system taking account of what the community feels is appropriate and catering to the needs of adults and children and those with special requirements such as older people, the sick or disabled

### Transit Camps

In East Timor emergency public latrine blocks were constructed by the UN forces in transit camps along the border with West Timor. Plastic slabs and sheeting were provided by Oxfam and MSF. The Public Health Promotion team had decided against working in these camps as populations would only stay for twenty four hours. However, their input on the design and siting of the latrines would have been invaluable. The latrines were rarely used because they were too far from the shelters, water was not provided for anal cleansing and the plastic sheeting did not afford adequate privacy. Long grass surrounded the entrance to the female latrine block showing they had never been used. However they were very clean!

If Malaria is seen to be a major problem it is important to get as much information as possible about the vectors involved (breeding, resting and biting habits) in order to plan an appropriate response. If a mosquito bites predominantly before 8pm then bednets may not be the most effective response. If mosquitoes rest outdoors rather than in, residual spraying will not work. If people refuse to sleep under nets because they are too hot then treated curtains or clothing may be a more effective solution than bednets.

### Medium Risk Situations

- Work may often begin in a situation which resembles the intermediate rather than acute phase as people in different circumstances will have different coping mechanisms. If this is the case then every attempt should be made to support such coping strategies and people should be mobilised to take collective action on a voluntary basis

### Incentives For Volunteers Or Outreach Workers

As far as possible monetary incentives should not be paid to volunteers as such a system cannot be sustained once the programme has finished. If a larger number of volunteers are trained (e.g. one for every ten to twenty households) their workload will be less and the system stands a greater chance of having a continued impact in the longer term. Incentives in kind (e.g. soap or ORS kits) however, may be used to motivate volunteers initially. The exception to this is in the event of a serious outbreak of disease when it may be expected that volunteers will give up a significant part of their time for home visiting and group activities to help stem the spread of disease. At such a time, it must be carefully explained why monetary incentives are being offered and that payment is for a finite period and dependent on impact. Volunteers should not be seen as the only strategy for public health promotion and work should be carried out concomitantly with opinion leaders and others who may influence the situation.

- As the situation stabilises there will be more time for participatory activities and ongoing assessment. At this time there are still significant risks to public health and care should be taken not to try to tackle too many issues at once. The technical and educational components of the programme should work together to achieve the maximum effect possible and team work and efforts to promote integration of both aspects are vital.
- Recruit additional facilitators as soon as possible and plan or adapt the training courses. One facilitator per thousand population is recommended by WHO but it may be necessary to review this number depending on workload, population density and accessibility. In recent years it has been suggested that if Community Health Workers cover a smaller number of households, they are more likely to be

able to sustain their work. In some countries one CHW per 10 households is recommended.

- It may now be possible to look in more detail at water collection, storage and use, food hygiene, vector control, disposal of solid waste and drainage and to continue to prioritise which are causing the most significant risks.
- Outreach workers and other facilitators should continue to address priority risk areas such as excreta disposal, hand washing practice, collective food hygiene and ORT. If, however, other diseases are more likely to cause a risk to health e.g. malaria, then improving drainage, eradicating breeding sites or the use of bednets will become the key issues for discussion and action. It is also possible that both excreta disposal and averting a malaria epidemic are equally important in which case adequate personnel and resources need to be deployed to tackle both issues
- We know from development programmes that message based health education has only a limited impact on changing behaviour. It is a common fallacy that people are empty vessels into which knowledge, leading to behaviour change, can be poured. The dissemination of messages especially if repeated frequently, and reinforced by the use of visual aids such as posters and leaflets however, can help to raise awareness about a particular issue or may simply provide information. They should not however, be used as a substitute for interaction and discussion in the emergency context where rapid results are necessary
- Discussion groups, puppet shows, plays and songs followed by questions and discussion are probably more cost effective than home visiting to individual homes or shelters but people may not always want to join in with group discussions or may only be available at certain times. Women especially may be too busy to attend discussion groups. A combination of approaches can be used.

#### **Children Under Five Make Up 20% Of The Population In Many Countries**

In the Burundi refugee camps in Rwanda, community members were asked what sort of latrines they would prefer to have. Discussions with the sanitation engineer eventually gave rise to a shared family latrine for four families with separate cubicles for men, women and children. The children's latrine was left open and provided a smaller squat hole with a surrounding bar for the children to hold onto. In the camps in Freetown, Sierra Leone potties were distributed to each family with children under five years old – one potty for every two children.

- In the event of a serious threat of epidemics other than cholera, dysentery or malaria (e.g. measles or polio) it may be necessary to divert resources to address these problems in the short term in conjunction with other agencies. Taking on other initiatives for too long may dilute the effectiveness of the ongoing programme.

### Suspected Polio In East Timor

In Dili in East Timor there were two cases of acute infantile paralysis and polio was suspected. A campaign was planned to immunise all children in the vicinity of the two index cases. OXFAM employed ten more public health workers for two weeks to ensure there was adequate capacity to inform and mobilise the communities.

In Liberia a yellow fever outbreak required that all agencies divert some of their resources into organising a mass vaccination campaign.

## Maintaining Health

- As the situation stabilises schools will start to function, religious groups may become mobilised and government structures may be involved once again in the delivery of services. It should be possible to work with some or all of these structures if you are not already doing so.
- Other environmental risk factors may be seen as important such as the threat of landmines or the spread of HIV but ongoing support to ensure adequate excreta disposal may still be necessary. Work with water and sanitation committees may be ongoing and groups should be encouraged to set their own objectives and deadlines.
- In this stage staff can rapidly lose motivation and become entrenched in routine ways of working. Follow up training and performance appraisal sessions should be conducted to continue to motivate staff

## Other Considerations

- Liaison with other medical agencies is important to ensure an overview of the health situation and to obtain data from any epidemiological surveillance that may be in operation. In this way it may be possible to identify any outbreaks of water and sanitation disease before they get out of control.
- Programmes or interventions run by other agencies or by the host government will often contain some component of public health promotion whether this involves plans to distribute soap or the development of a cholera preparedness strategy and liaison with them is vital. Other health agencies may also want to set up a system of outreach workers who will be involved in case finding and basic health education. However, there is a tendency for hygiene and health education to become marginalised when outreach staff are also engaged in case finding and basic treatment and it is preferable that the public health promoters devote their time to water and sanitation or vector control issues especially in the early stages.
- If remuneration for outreach workers is to be offered (this may depend on the host country or camp policy) the issue must be discussed and it must be understood that this can only be provided on a short term basis. At the height of an emergency when such workers will be expected to work full time to achieve maximum benefits, remuneration is usually necessary. Incentives such as soap, bowls etc. may be more appropriate depending on the situation. Ensure that a standard rate is agreed upon by all agencies concerned.
- Some projects may focus on short term improvement of water supplies only. If this is the case it is still important to align implementation with the technical intervention. The identification of water sources and prioritising those to be protected/rehabilitated should be a joint activity. The mobilisation of the

community to provide labour for digging wells or trenches may also be a key activity of the team. Problem solving with community members is also an important aspect of the work of the public health promotion team.

**“Our practices have been laid bare for all to see – now we must talk”**

In DRC community members met to review the results of a water and sanitation assessment. The data was presented in a visual format so that people could understand it more easily. Following the presentation people were asked to think of ways in which some of the problems could be tackled. One of the leaders was said to remark “our practices have been laid bare for all to see – now we must talk” and this initiated discussion which led to the community defining a list of actions that was very similar to that prepared earlier by the Oxfam team.

- Where water installations are being repaired the issue of maintenance will also need to be discussed, preferably before work begins if this is possible. It may help to draw up contracts with the community (see resources section). Explanations about system design and operation will also need to be given.

**Community Management**

A shallow well programme in Sierra Leone supported communities in setting up Area Development Committees to oversee the construction and future maintenance of the wells and handpumps. Pump attendants were given training to repair the handpumps and women were actively encouraged to become attendants. Discussions were held on how the pumps were to be maintained and how the money would be raised to pay for maintenance. More work was required with the committee and community members to ensure accountability for funds collected.

- If the spraying of insecticides is being considered then the following issues period as it will take three weeks before it begins to affect the overall mosquito numbers, the type of shelter need to be taken into account: spraying must take place as a pro-active control measure before the transmission material will affect the absorption rate of the insecticide and therefore effectiveness, imported chemicals will need a licence for retail in country, the lead time necessary for the procurement of chemicals may be several weeks, health and safety regulations of those handling insecticides must be strictly adhered to, community members may refuse to have their homes sprayed if they are not involved in the decision to initiate a spraying campaign and the longer term acceptability of spraying may be compromised if it is carried out badly.
- Finally, Public Health Promoters should endeavour to teach by example. Ensuring that their own living quarters or compound adheres to adequate standards of hygiene is important as is insisting on handwashing before eating etc.

### **Insecticide Treated Nets**

ITNs are not a magic bullet to reduce the incidence of malaria and should be used as part of a broader malaria control strategy which involves adequate and accessible treatment, environmental management in addition to an information and education strategy.

Bednets are also expensive (although if successful, cost effective) and their distribution may need to be targeted to those most at risk. Some authorities claim that the distribution of bednets during an emergency may compromise long term programmes which try to encourage people to buy nets. It is important to understand what a community already knows about the prevention and treatment of malaria and how willing they are to accept the use of bednets.

# Public Health Actions

Public Health Priorities	Possible Public Health Actions
<ul style="list-style-type: none"> <li>• Provide a minimum amount of water for drinking, cooking and washing</li> </ul>	<ul style="list-style-type: none"> <li>• Work with engineer and population to assess water needs and to identify water sources for protection or rehabilitation</li> <li>• Identify appropriate siting of tap stands through discussions with engineers and female and male community members</li> </ul>
<ul style="list-style-type: none"> <li>• Ensure people have enough water containers to collect and store water cleanly</li> </ul>	<ul style="list-style-type: none"> <li>• Organise distribution of jerry cans and Oxfam buckets</li> </ul>
<ul style="list-style-type: none"> <li>• Provide facilities for people to dispose of excreta safely especially young children and babies</li> </ul>	<ul style="list-style-type: none"> <li>• Recruit and train public latrine attendants to ensure cleaning and maintenance of public latrines and to encourage hand washing following use of latrines (people won't use dirty, smelly latrines)</li> <li>• Identify baby and infant defaecation practices and organise distribution of potties and/or nappies if appropriate</li> <li>• Recruit and train outreach workers to mobilise the community to dig family latrines</li> <li>• Organise a system for the distribution or lending of tools and/or slabs for constructing family latrines</li> </ul>
<ul style="list-style-type: none"> <li>• Protect water supplies from contamination</li> </ul>	<ul style="list-style-type: none"> <li>• Train water source attendants to encourage people not to defaecate near to water sources</li> <li>• Train support workers to chlorinate all wells and to test for residual chlorine levels</li> <li>•</li> </ul>
<ul style="list-style-type: none"> <li>• Ensure that people have key information to prevent water and sanitation related diseases: focus on those that pose the most serious threat only (include knowledge of ORT if this is not being done by other agencies)</li> </ul>	<ul style="list-style-type: none"> <li>• Recruit and train campaign workers to provide key information to people over a one to two week period as part of a cholera or malaria control campaign</li> <li>• Ensure the design of latrines is based on feedback from people who will be using them or at the very least on 'common sense best practice' (privacy, security, accessibility for disabled especially – 'would you use them principle')</li> <li>• During an outbreak of diarrhoeal disease or malaria keep the community informed of the extent and severity of the outbreak and the benefits of reporting cases promptly.</li> <li>• Organise training sessions for community leaders and opinion leaders on risk reduction for malaria or cholera</li> </ul>
<ul style="list-style-type: none"> <li>• Ensure that people have soap or alternatives for handwashing</li> </ul>	<ul style="list-style-type: none"> <li>• Organise distribution of soap</li> <li>• Provide handwashing facilities at all communal latrines</li> </ul>
<ul style="list-style-type: none"> <li>• Ensure that public spaces such as markets have adequate water and sanitation</li> </ul>	<ul style="list-style-type: none"> <li>• Provide public toilets with handwashing facilities and latrine attendants</li> <li>• Provide waterpoints in markets</li> <li>• Provide incinerators for all market waste</li> </ul>

# Time scale: Gantt Chart

This activity plan is given as an example only and situations on the ground will vary considerably. Recruitment is sometimes notoriously difficult and may take longer than expected

Example project plan													
ACTIVITY (see p.23)	Week numbers												
	1	2	3	4	4	6	7	8	9	10	11	12	
1. Rapid data collection	█												
2. Baseline data collection	█	█											
3. Demarcate defaecation areas & consult on longer term options	█	█											
4. Recruit & train latrine and water point attendants 2 per installation	█	█											
5. Provide hand washing facilities 2 per installation	█	█											
6. Recruit & train campaign workers x 20	█	█											
7. Campaign			█	█									
8. Distribute hygiene kits (See page 40)			█	█	█								
9. Distribute tools and slabs for family latrine construction			█	█									
10. Recruit & train children's facilitators x 10		█	█										
11. Recruit and train further 80 facilitators		█	█	█									
12. Participatory hygiene promotion		█	█	█	█	█	█	█	█	█	█	█	█
13. Aim to provide 15 litres of water per person per day		█	█	█	█	█	█	█	█	█	█	█	█
14. Ensure adequate shower and laundry facilities													
15. Liaise with other agencies in the camp	█	█											
16. Ongoing assessment, planning & monitoring	█	█	█	█	█	█	█	█	█	█	█	█	█

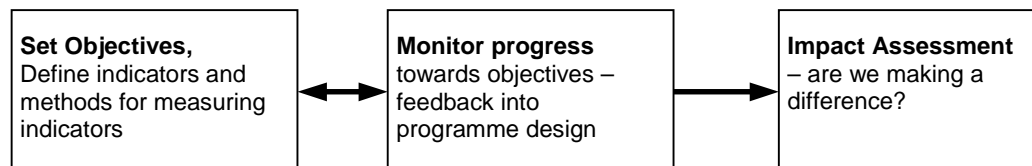


## Section 5

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# Monitoring, Impact Assessment & Evaluation

# Overview



## What is Monitoring?

- Monitoring is the ongoing, systematic collection and analysis of information relating to the progress of work. In an unstable and rapidly evolving environment a formal evaluation may not always be possible and the interdependency of the interventions of multiple agencies may make the attribution of impact very difficult. Monitoring may thus be the most useful tool for assessing effectiveness and efficiency and this will provide important information for any subsequent 'impact assessment' as well as for future planning for the project.
- When objectives are set, indicators of achievement and how those indicators will be measured should also be defined along with an attempt to make explicit the assumptions which underpin the project rationale: use the logframe as an active tool to guide your monitoring and evaluation. In this way you should be monitoring impact (significant change), outputs (facilities provided or systems set in place) and activities (trainings carried out, toilets or water points constructed)
- The Sphere Minimum standards provide indicators of achievement but these may need to be varied according to the situation and made as specific as possible. It is important to bear these in mind when monitoring programme activities.
- Don't forget to monitor participation and representation either through beneficiaries self ratings or using the indicators on the next page. The gender and representation form on page 27 may also be helpful.
- A significant part of public health promotion is encouraging community groups to solve problems and issues to enable project objectives to be met within the limited time frame. It is vital to record such problem solving activities and to monitor their outcome.
- Whilst it is important to identify both positive and negative benefits of the project when monitoring, collecting too much data may present problems when trying to interpret this data. Monitoring data should be fed back to the rest of the team at team meetings. An example monitoring form is provided in the resources section.

### Why monitor and evaluate?

In one programme an impact assessment which took place two years after the inception of the project found that many mothers still didn't know how to make up Salt and Sugar solution (SSS) to combat dehydration from diarrhoea. Further discussion revealed that too much reliance had been placed on training outreach workers to train other community members. Frequent monitoring of this indicator could have identified this problem earlier and attempts could then have been made to address the problem.

## What is Impact Assessment?

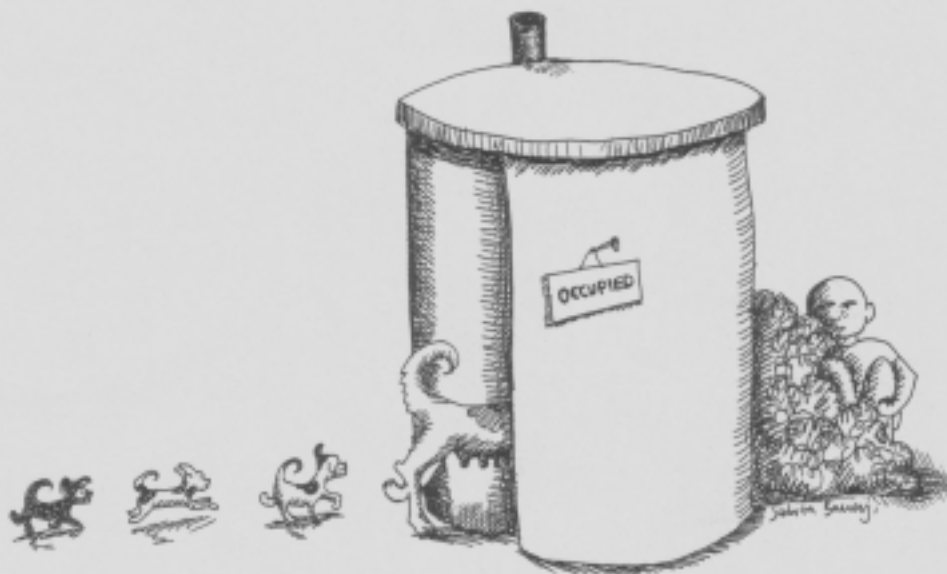
- Impact assessment attempts to determine whether significant or lasting changes in the lives of poor people have occurred as a result of project activities. Such changes may be positive or negative and intended or not intended. In emergency interventions lasting change may not be possible in a short space of time and significant change and avoidance of risks are often the key objectives of the programme. However the opportunity to achieve lasting change should be seized wherever possible
- The attribution of impact cannot always be inferred from indicators of mortality and morbidity as the incidence of disease is affected by many factors. The use of intermediate or proxy indicators to monitor the effect of a project is an acceptable alternative (see the monitoring table on page 85 for examples of proxy indicators)
- The views of beneficiaries must be sought to ascertain their perception of project impact.
- Some data on mortality and morbidity should be available from health centres or disease surveillance systems but this may not always accurately reflect the situation or provide a measure of previous mortality and morbidity or seasonal patterns of disease. However, clinic data may well provide some representation of what diseases are present in the community and should therefore be monitored.
- If nutrition surveys are being carried out it may be possible to ask some questions about morbidity and mortality at the same time or to follow up on whether distributions have been carried out appropriately.
- It is also useful to consult community members when trying to ascertain morbidity and mortality. Timelines, seasonal calendars or matrices (see Participatory Learning and Action: a trainer's guide) may be useful ways to initiate discussions about mortality and morbidity. In some instances community volunteers or leaders may be able to collate data on health and can be provided with books and pens to enable them to do this. Do not however, devote so much time to assessment of morbidity and mortality that other assessment activities are compromised.
- Most of the methods used for gathering baseline data can be used for monitoring and evaluation. Exploratory walks, household observations and spot checks should all be used. PLA tools such as mapping, pocket charts and three pile sorting can be used for both assessment and monitoring and are effective ways to involve people in the process.
- If hygiene kits or bednets have been distributed, it is a good idea to follow this up with a rapid household assessment of ten to twenty houses chosen at random in each area to see if the nets or kits are being used, who by and whether people felt that the distribution was carried out fairly. Other questions can also be asked but it is important to make the questionnaire as concise and rapid as possible.
- People may act differently from normal if they know they are being observed – this is known as the Hawthorn Effect. It is important to be aware of this and to ensure that this is mentioned in any report especially if such a phenomenon is suspected. If households are being monitored where there has been intensive work by outreach workers this may also bias the results and prevent extrapolation to the broader context.

## What is Evaluation?

- Evaluation can cover a very broad area and may be considered as a kind of research into a programme, its achievements and its limitations. It usually tries to assess impact as well as examining whether a project has been cost effective and efficient. It should provide recommendations for future interventions.
- It may not be possible to carry out a formal evaluation of a project in the short time frame afforded by most emergencies but monitoring of key indicators and an assessment of impact should always be carried out even if time does not permit a full assessment of all of the aspects of impact which Oxfam considers relevant.
- The evaluation of emergency interventions usually try to examine the whole intervention rather than one isolated sector as many factors will critically affect people's health in times of crisis.

### Toilets as Kennels?

In Sierra Leone an international NGO failed to consult with families on the design of latrines and the new VIP latrines, built at considerable cost, were never used - except as shelter by the family's dogs and their puppies. The family preferred a design with a door to ensure privacy.



# Sample monitoring checklist

## Health

- Crude Mortality and Morbidity Rates
- Mortality and Morbidity rates from Water and Sanitation Related Diseases (e.g. malaria, diarrhoea, dysentery) disaggregated by sex (if there is concern ) and age
- Nutritional status
- Proportion of mothers who know how to make up ORT and how to use it

## Sanitation

- number of families registering with latrine digging programme
- ratio of latrine access
- proportion of latrines kept clean
- proportion of latrines with handwashing facilities
- absence of open defaecation
- proportion of young children reported to use appropriate sanitation facilities
- proportion of mothers reported disposing of excreta of young children in the latrine or by burying it
- proportion of people reported using soap for handwashing after defaecating or handling infant's excreta
- absence of accumulated rubbish
- number of hygiene kits distributed and beneficiary satisfaction with distribution

## Malaria public health promotion

- number of ITNs distributed and used effectively (may be targeted at pregnant women and under fives)
- beneficiary satisfaction with distribution
- reported increase in timely consultations for fever of children under five
- reduction in number of breeding sites

## Water

- proportion of families reported using water container with lid for storage of drinking water
- proportion of families reported using protected water sources
- adequate amount of water used (15 litres per person per day)
- distance to nearest water point no more than 500m

## Participation & representation

- number of community groups setting objectives for action
- community rating of satisfaction with the project or reports of progress from community meetings
- number of meetings and discussion groups held with women and men
- number of groups where group problem solving was facilitated
- number and type of groups consulted on design of new latrines or siting of water points
- number of female and male personnel trained by the project

# Methods for Monitoring and Evaluating

Similar methods can be used for gathering information for monitoring and evaluation as were used for gathering baseline data. The important thing is to remember to collate this and to use it as a tool to feedback into programme design. An example matrix for programme monitoring is given below:

Objectives	Indicators	Tools/Methods/ means of verification	Progress against objectives
Improved Health of Population or reduction in risk of epidemics	Mortality and morbidity data	Clinic data Mortality record from leaders/outreach workers Discussion groups	Diarrhoeal and malaria rates remain stable (or reduced)
Sanitation provided to Sphere Minimum standards	Number of toilets constructed, proportion of population reported using toilets, proportion of clean toilets	Latrine monitoring forms, discussions with men and women	Ratio of toilets increased to 1: 50 Spot checks show approx. 80% of those observed kept clean Discussions reveal that children under 8 afraid to use toilets and toilets not used when people go to work on farms
Increased awareness of priority health risks such as children's excreta disposal, lack of handwashing and late referral to health centre for fever, withdrawing food and fluids from a child with diarrhoea	Proportion of people reported disposing of children's faeces safely, Proportion of people reported washing hands after defaecation and handling children's stools, increased timely referral rates to clinic, increased awareness and good practice in dealing with children's diarrhoeal episodes	group discussions, household assessments, faecal mapping with children	Mapping showed that many children not using toilets. Household assessments show increase in people providing handwashing facilities by latrines, group discussions reveal that more people practising handwashing at home but not when working in fields, increased knowledge about ORT, clinic data reveals increase in timely referral for fever
Increased participation and representation from the population	Water and sanitation committees functioning, Number of community groups setting objectives for action, Users take responsibility for the management and maintenance of water supply and sanitation facilities	Project records, group discussions	Gender analysis conducted Siting of tapstands conducted with active participation of men and women from communities Communities have agreed to elect representatives for development committees and to ensure that women are equally represented 20 communities have elected community workers to teach people about ORT and importance of seeking treatment early

- Participatory methods are probably the most useful ways of involving people in monitoring and evaluating the project and have the advantage of acting as part of a training or awareness raising programme. They can be backed up by the use of observation. Photographs or pictures of situations can be used to stimulate discussion and an approximation of percentages can be obtained by asking people to construct simple pie charts or to use stones or leaves to estimate numbers or proportions e.g. adult women or children under 10 using newly constructed toilets. If people are not using facilities effectively then further discussion can encourage people to identify what can be done about this.
- Mini 'surveys' or household assessments can be used to supplement information especially where materials such as bednets or buckets have been given out. The opportunity should still be taken to discuss findings and observations with households at the time of the household assessment.
- It is often difficult to obtain data on mortality and morbidity that is accurate, comprehensive and current. Data collection systems may be in place but if not clinics and health centres could be encouraged to collect this on a standard reporting format from the MoH. If the clinic staff are also involved and consulted on the project they may be more enthusiastic to collate data but may need to be supported with stationary etc.

### Monitoring Sickness

In Angola small teams of children were given a tin and visited households in a particular area. They asked the main caretaker in the house to put a stone into the tin for each young child (children not attending the school) who had diarrhoea in the last week. The stones were then counted and a discussion was had on where the most cases of diarrhoea were and why this was so.

In Sierra Leone disease monitoring forms were used by the volunteer outreach workers. However, those who were not used to reading and writing found this exercise difficult and might have been better off using the tin and stones method from Angola.

- If nutrition surveys are being conducted some questions regarding general public health may be included in the questionnaire. However, discussions and observation may be the only way of monitoring in the initial stages of an acute emergency as there may be little time or resources to organise surveys etc.
- Ensure that all information is collated in a separate monitoring and evaluation report which should be a continuation of the baseline data collection report
- A selection of monitoring forms is given in the appendix. A completed excerpt of the '**suggested monthly reporting form**' is shown on the following page as an example of how the situation could be monitored:

Section 5

Monitoring, Impact Assessment & Evaluation

Methods for Monitoring and Evaluating

Indicator	Some change	Major change	No change	Negative change	current situation	action required
Families are disposing of young children's faeces safely	✓				Children's excreta less visible Mothers say that progress is being made 5,000 potties distributed	Continue discussing with parents Start child to child activities
Toilets are both safe and private for women especially				✓	Oxfam constructed public toilets do not have lighting. Verbal reports of women being assaulted at night in the toilets	Discuss with community groups and leaders on ways to manage this problem
Families have handwashing facilities next to the latrine	✓				More facilities observed Soap not available	Encourage use of ash as alternative to soap, organise soap distribution Start child to child activities
Mothers know how to make and use salt/sugar solution or ORS		✓			Training in progress, random interviews at clinics indicate increase in knowledge	Continue programme activities
Families collect water from the protected source		✓			80% tapstands now functioning for 4 hours per day - queues force some people to go to the river.	Continue work on remaining tapstands
More mothers are taking their children to the clinic for treatment as soon as they suspect fever	✓				Clinic records show increase in timely consultations Mothers report prompt treatment seeking	Continue malaria education and discussion groups Include malaria in child to child activities
Families store drinking water in a covered container			✓		Distribution of Oxfam buckets held up due to logistic problems	Arrange distribution as soon as possible

- Information for monitoring can be collected by school children as part of the learning activities. Teams of children can be assigned to collect information on sickness or they can do mini observation surveys outside the school latrines to see if people are washing their hands. They can then do a presentation of the results to others in the school along with some discussion or a short play showing why it is important to wash hands after using the latrine. Some programmes have endeavoured to collect information of this sort on adults who may well find this



very patronising. School children however, are probably much more open to this sort of assessment as long as individuals are not named or punished.

- The child to child activity sheets detail other methods for getting children involved in monitoring water and sanitation. In one project children made a 'faecal map' which identified areas of indiscriminate defaecation and placed red flags over these areas in the school compound. Improvements were thus very visible!

## Section 5

Monitoring,  
Impact  
Assessment &  
Evaluation

Methods for  
Monitoring and  
Evaluating

# Sphere sanitation standards, measurable indicators and means of verification

The work of the project should also be measured against Sphere Standards. An example is provided below of how the Sphere Sanitation Standards might be monitored. Ideally the standards and should correlate with the objectives and indicators chosen for the project.

Sphere Standards	Measurable indicators	Means of verification
People have access to toilets which are designed, constructed and maintained in such a way as to be comfortable, hygienic and safe to use	<p>Consultation on design of latrines with community groups</p> <p>Toilets have the following features:</p> <p>Easy to keep clean,</p> <p>Private</p> <p>Accessible and easy to use for all groups</p> <p>They are lit at night</p> <p>Hand washing facilities are nearby</p> <p>They minimise fly and mosquito breeding</p>	<p>Project records, observation,</p> <p>Latrine monitoring forms,</p> <p>Focus group discussions with men and women</p>
All sections of the affected population are aware of priority hygiene practices that create the greatest risk to health and are able to change them. They have adequate information and resources for the use of water and sanitation facilities to protect their health and dignity	<p>Increase in awareness of risk factors and action taken e.g. Increase in proportion of people disposing of children's faeces safely</p> <p>Increase in proportion of people reported washing hands after defaecation and handling children's stools</p> <p>Number of hygiene kits distributed and used</p>	<p>Observation, mapping, focus group discussions, household assessments</p>
All facilities and resources provided reflect the vulnerabilities, needs and preferences of all sections of the affected population. Users are involved in the management and maintenance of hygiene facilities where appropriate	<p>Water and sanitation committees functioning</p> <p>Number of community groups setting objectives for action</p> <p>Users take responsibility for the management and maintenance of water supply and sanitation facilities</p>	<p>Project records, group discussions</p>

IMPACT refers to significant or lasting change in the lives of people. This change can be positive or negative. The most significant question to ask is what has changed and what is different as a result of this intervention. The following aspects of change are considered in longer term work and this may be a useful framework to assess the impact of emergency work also. It should be remembered that sustainability may not necessarily be the primary objective of emergency work and the impact on people's lives provides the most important indicator of impact. In considering the impact of Oxfam's response it would also be important to examine the role of advocacy and efforts to maintain beneficiaries protection.

- **Impact on people's lives**
- **Beneficiary Participation**
- **Sustainability**
- **Impact on Gender Equity**
- **Impact on Policy and Practice**

Some suggestions on how to determine impact are given below. The questions asked are not comprehensive but try to limit the amount of data gathered so that the emphasis is on the change that has occurred as a result of the project or combined intervention.

## 1. Impact on people's lives

One of the main indicators for determining impact on people's lives in an emergency is the mortality or morbidity rates. However, proxy indicators should also be used as it is difficult to determine the effect of a single intervention using mortality and morbidity alone. Impact must also encompass the difference that people perceive to have taken place.

### ***Are less people sick or have outbreaks of disease been averted?***

Such an outcome will be dependent on not only Oxfam's intervention but the combined intervention of all agencies. Examine the rates of morbidity and mortality from diarrhoeal related diseases and malaria but also at the crude mortality rates and trends. These can then be compared with seasonal trends in disease if available. It is also possible to ask people about their perception of the incidence of disease and death. Have less people died than this time last year or do people think that sickness has been averted by the work that has been done?

### ***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***

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

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?

## 2. Beneficiary Participation

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.

## 3. Sustainability

Will this project last? 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?

## 4. Impact on Gender Equity

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?

## 5. Impact On Policy And Practice

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? Have we had any influence on other Oxfam projects or the water supply department or the Ministry of Health? Have Sphere standards been adhered to?

# Section 6

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Important  
Considerations

# Training & Support for Public Health Promotion

- Sample training timetables are provided with this pack (See Resources Section) but are meant to stimulate ideas rather than suggest a fixed model. Other training activities and methodologies can be included to meet project objectives including training on gender and monitoring and evaluation. Training modules are currently being developed in the Humanitarian Department in Oxfam.
- Previous public health promotion training sessions have focused on process (e.g. community mobilisation, communication skills and how adults learn) as well as topic-based issues related to water and sanitation e.g. ORT, prevention of malaria and worms, maintenance of wells and chlorination. It is important to ensure that training is directed at realistic actions that people can take and does not overemphasise either message giving or signs and symptoms of disease.
- The training may need to be phased and initially should only address priority risk areas such as excreta disposal, handwashing, simple treatment of diarrhoea and how to work with communities.
- It should be remembered that training can also be conducted in the field and this may be the best way to introduce people to assessment techniques such as mapping and focus group discussions
- Training sessions will need to take account of how many people are to be trained, length of training, who will do the training, where it will be held, what methods will be used, how it will be evaluated and the arrangements for follow up training and support.
- The number of people to be trained will depend on the methodologies used. Training sessions which rely on the active participation of trainees become difficult if the group size exceeds 20-25 people and work best with 8-10 people. When working with larger groups ensure that there is ample opportunity for small group work.
- If you are expecting people to attend promptly for the whole course and they are not on the Oxfam payroll, you may need to remunerate them for their attendance. You will need to explain the reasons for this and that future courses which fit more conveniently into people's other responsibilities will not be reimbursed. Certificates might be provided instead for longer courses.
- Ideally training should be conducted in the participants' mother tongue. This may necessitate a short training of trainers focusing on how people learn best, participatory methods and role playing of teaching sessions.
- If conducting a campaign ensure that a meeting is arranged following the first day to allow outreach workers to voice any concern or problems they faced. Further follow up meetings should also be arranged on a regular basis with all outreach workers. These meetings are an opportunity for further training and support.

- Supervisory visits to field workers should also be time tabled and extra supervisors may have to be identified either as separate workers or chosen/elected from the existing outreach workers. Never undertake training unless you can guarantee supportive supervision.
- If household observation surveys are being carried out, the observers will require careful supervision and follow up to ensure that forms are filled out accurately to avoid observer bias and inconsistency.
- If promotional materials are being developed remember that this may be a good opportunity to depict women in non-traditional roles

# Teamwork and Integration

- Teamwork and integration are the responsibility of all team members and must be supported by all levels of management
- It is vital that all those involved attempt to understand what public health promotion is and how it can contribute to the programme and project outcomes
- It is important that one person co-ordinates the public health promotion aspect of the programme but this person can be either an engineer or a public health promoter – if the assessment indicates that there is a need for both a malaria control and diarrhoeal control component it may be necessary to recruit separate people to manage these components
- Assessments should be seen as a joint activity to provide crucial information for project planning and design e.g. the identification of water sources and priority sources to be protected
- Meetings with community members which involve discussions regarding the design and provision of facilities should initially be attended by both engineers and public health promoters
- Planning the project should be a joint activity and initial objectives should be discussed and defined together
- It may be helpful to write joint reports regarding work progress but if this is not possible team members should at least read and discuss each others reports
- Regular meetings must be held between all team members involved in the project including outside staff or project partners
- Visits to other team members' project sites will help to promote integration
- Public Health Promoters, outreach workers and community members can also be involved, when time permits, in such activities as water testing or visits to other projects or engineering sites



Experience has shown that the long term maintenance of water and sanitation installations should always be considered even in emergency situations. This is especially important where permanent water supplies are being constructed or renovated. People will not automatically assume the responsibility for keeping the system functional in the longer term and may think that this will be taken care of by the agency concerned. The community may well have 'participated' in construction work but this does not automatically mean that they feel a sense of ownership for the completed project. It is important to consider the following points:

- Do people in the community consider that the project responds to a priority felt need?
- Have women been involved as far as possible in the initial discussions on the proposed project?
- Does the project have the support of local government and community leaders? If respected community leaders are available they should lead the discussions rather than the agency involved.
- Ensure that the issue of long term maintenance is raised as soon as possible with community groups. Ask them how they intend to repair the system if it breaks down or what provision they have made for this in the past. Ensure that issues of financial accountability are also discussed. The availability of spare parts for pumps or other systems will also need to be investigated and viable systems identified
- Be aware that training for handpump technicians cannot be carried out successfully in a few days. Community members with minimal technical knowledge will need ongoing support where possible.
- If people do not attend meetings try to find out why and if alternative arrangements can be made.
- Try to ensure open and ongoing dialogue about the project. It is important to remain flexible and to encourage suggestions from community members on how the project should proceed.
- Formal agreements and contracts should be drafted when discussions have been finalised. An example contract is given in the resources section.
- Large scale piped water supply projects are fraught with problems when carried out in unstable environments and should be treated with caution. Many have failed to live up to expectations and it is vital to seek advice before embarking on such projects. Guidelines are available from the Humanitarian Department

### **Water And Sanitation Committees**

In Eritrea water and sanitation committees were selected by people in the camps. They were trained in water management and were also shown how to maintain the camp water distribution systems and the latrines.

Water teams in each of the camps were recruited during implementation. The teams worked on the systems throughout this period and therefore got to know how the systems work and could carry out simple maintenance.

Water point attendants were trained in the maintenance of water points, water transportation and water storage and families took it in turns to clean the latrines.



# Section 7

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## Resources



# Public Health Assessment Tool: Example Assessment Checklists

## Water & Sanitation

### Checklist For Rapid Assessments In Emergencies

#### **General**

- How many people are affected (by what) and why? Where are they? Settled or mobile?
- What are the current or likely water and sanitation-related diseases?

#### **Hygiene**

1. What are the accepted **beliefs and practices** among the affected population? Are there cultural sensitivities or taboo subjects?
2. Is there an understanding of the relationship between water/sanitation/shelter /vectors and disease?
3. What are the **common hygiene practices** among the affected population. ? (Washing hands after defaecation, disposal of children's faeces, use of soap, storage and covering of water, cooked food)
4. What are the **breast feeding practices**?
5. Does the community have **access to facilities important for maintaining hygiene** covered water containers /cooking utensils/ mosquito nets/soap/sanitary protection etc?
6. Are there any hygiene promotion activities?
7. Are they linked with water and sanitation and or health services?
8. Are the latrines or toilets cleaned and maintained so that they are hygienic and safe for all users?
9. Are the users involved in the management and maintenance of water sources and latrines?
10. Are there **existing outreach workers?** -community health workers, social development extension agents etc.

#### **Water**

##### **Water supply**

1. What is the current water source?
2. How much water is available per person per day, and do all groups (e.g. men, women, caste's, etc.) have equitable access to it?
3. Is the water available at the source enough for short term and longer term needs?
4. Are water collection points close enough to where people live?
5. Is the current water supply reliable? How long will it last?
6. Do people have enough water containers of the right size and type?

7. Is the water source contaminated or at risk of contamination (microbiological and chemical/radiological)?
8. Is treatment necessary? Is treatment possible? What treatment is necessary?
9. Is dis-infection necessary, even if supply is not contaminated?
10. Are there alternative sources nearby?
11. Are there any legal obstacles to using available supplies?
12. Is it possible to move the population if water sources are inadequate?
13. Is it possible to tanker water if water sources are inadequate?
14. What are the key hygiene issues related to water supply?
15. Do people have the means to use water hygienically in this situation?

## **Sanitation**

### **Excreta disposal**

1. What is the current defecation practice? If it is open defecation, is there a designated area?
2. Are there any existing facilities? If so are they used, are they sufficient and are they operating successfully? Can they be extended or adapted?
3. Is the current defecation practice a threat to water supplies or living areas?
4. Is the current defecation practice a health threat to users and do all groups have equitable access to facilities?
5. Are people familiar with the construction and use of toilets?
6. Are people prepared to use latrines, defecation fields, trenches etc? (e.g. is it safe for women after dark, and are they safe/user friendly for children)
7. What are current beliefs and practices concerning excreta disposal? ( Do men and women or different family members use the same latrine? Is children's excreta thought to be harmless?)
8. Is there sufficient space for defecation fields, pit latrines etc?
9. What is the slope of the terrain?
10. What is the level of the groundwater table?
11. Are soil conditions suitable for on-site excreta disposal?
12. What local materials are available for constructing toilets?
13. Do current excreta disposal arrangements encourage vectors?
14. Do people have access to water and soap for washing hands after defecation?
15. Are there materials or water available for anal cleansing?
16. How do women deal with menstruation? Are there materials or facilities they need for this?

### **Vector-borne disease**

1. What are the vector borne disease risks and how serious are they? (i.e. Any obvious problem of flies, mosquitoes, rodents, cockroaches, fleas, lice or bedbugs?)
2. If vector borne risks are high do people have access to individual protection?
3. Is the affected population used to dealing with these risks – how do they normally protect themselves?
4. Has the affected population travelled through an area infected with certain insect vectors?

5. Which groups of the population are most affected-children/men/women/new arrivals/old residents
6. Any evidence of overcrowding. - Do people have previous experience of communal living?
7. Do people have any livestock – where are they/ types/ where do the livestock defecate etc?
8. Is there any evidence of vector breeding sites – stagnant water/ uncovered pit latrines/water containers etc.
9. What is known about the characteristics of the vector? (e.g. mosquito species, breeding, biting, resting habits etc.)
10. Is it possible to make changes to the local environment (by drainage/ scrub clearance/excreta disposal/refuse disposal) to discourage vector breeding?
11. Is it necessary to control vectors by chemical means? What programmes, regulations and resources for vector control and use of chemicals are there?
12. Is there a National Public Health/Roll Back Malaria/Vector Control Programme?
13. Are people familiar with using ITN's or bednets – what are their sleeping practices?

### **Solid waste disposal**

1. Is solid waste a problem?
2. How do people dispose of their waste?
3. What type and quantity of solid waste is produced?
4. Can solid waste be disposed of on site, or does it need to be collected and disposed of off site?
5. Are there medical facilities and activities producing waste? How is this being disposed of? Who is responsible?

### **Drainage**

1. Is there a drainage problem? (flooding shelters and latrines, vector breeding sites, polluted water contaminating living areas or water supplies)
2. Do people have the means to protect their shelters and latrines from local flooding?

#### **Information Sources**

Observation, Mapping, Matrices, Interviews with women and community representatives. Local authorities, Ministries responsible for sanitation, water and the environment. Local and International NGO's and agencies. Hospitals, clinics and health outposts.

## Health

### Checklist For Rapid Assessments In Emergencies

#### General

- How many people are affected (by what) and why? Where are they? Settled or mobile?
- What are the current or likely water and sanitation and vector borne diseases (Please refer to Water & Sanitation section)

#### Mortality

1. What is the overall mortality rate (**crude mortality rate - CMR**) - expressed as deaths per 10,000 population per day. (Any evidence of **under- or over-reporting**?)
2. What is the **under 5 mortality rate** (age specific mortality rate for children under five years old. (Deaths/10,000/population/day)
3. What are the **cause- specific** mortality rates
4. What is the **main cause** of death?
5. Which **age group** is most affected?
6. Is there a designated burial area?

#### Morbidity

1. What are the primary health problems in the disaster affected area?
2. What are the **most frequent communicable diseases** e.g. measles, skin diseases, diarrhoea, acute respiratory disease etc
3. What are the primary health problems in the country of origin (if displaced involved)?
4. Determine **age and sex specific incidence rates** of major health problems and diseases that have public health importance.
5. Is there a standardised **health information system** for collecting data?
6. How is data collected and analysed?
7. Any evidence of **acute malnutrition**? How is this monitored? (Please refer to the Food and Nutrition Section)
8. Are there **specific health problems for women** (e.g. high birth rate, anaemia, sexually transmitted diseases, sexual violence/rape, and abortion)?
9. What is the **immunisation coverage**? Which vaccines given, (measles, polio, etc) when, where, date last immunisation occurred.
10. Are there victims of trauma, injury, or shot wounds.

#### Health Care Provision

1. What **health care provision** is available to the population and who is providing it ?
2. What services are available (curative, MCH, private, immunisation ETC)
3. Are the services accessible to and sufficient for the target population?
4. What is the situation in terms of health care personnel- level of training, ratio to health facility, outreach or volunteer workers?

## Section 7

### Resources

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5. Are the health structures adequately equipped - is there water available, refrigeration for vaccines, appropriate provision of drugs adequate toilets?
6. Is **malaria prophylaxis** offered to pregnant women?
7. What information is available about the **number and type of patients seen** - average numbers, types of diseases by sex and age?
8. Are there **important practices or beliefs** which affect peoples health?

#### Information Sources

Observation. Interviews with women and community representatives. Mortality and morbidity data collected from health facilities, nutrition centres/feeding programmes community health workers community - including cemetery staff, shroud distributors. Local Government Offices, Ministry of Health, NGO's and other agencies. Maps/ aerial photographs.



# Hygiene Practice Checklist

(adapted from Almedon et al 1997)

This checklist provides a comprehensive list of possible risk factors for water and sanitation related disease. DO NOT attempt to gather all this information initially as in the height of an emergency it is better to concentrate on those factors that pose the greatest risk and which are marked with an asterix. In some contexts it is possible that other factors take on greater importance e.g. if people are used to storing food in fridges and suddenly find themselves without, this may cause an increased risk and public health promotion would focus on ensuring people were aware of this increased risk.

HYGIENE PRACTICE	KEY VARIABLE
EXCRETA DISPOSAL	<ul style="list-style-type: none"> <li>* location of defaecation site</li> <li>* latrine structure and cleanliness</li> <li>* disposal of children's faeces</li> <li>* disposal of babies' faeces</li> <li>* use of cleansing materials</li> <li>* excreta disposal preferences for different groups</li> <li>* Latrine provision in market place or communal centres (e.g. feeding centre)</li> </ul>
WATER	<ul style="list-style-type: none"> <li>siting of latrines in relation to water sources</li> <li>* source of drinking water                             <ul style="list-style-type: none"> <li>different water sources used and use</li> <li>pattern of daily and seasonal use</li> </ul> </li> <li>* average distance to water</li> <li>* amount of water used per person                             <ul style="list-style-type: none"> <li>water quality at source and home</li> </ul> </li> <li>* water storage practices</li> <li>* methods of water treatment                             <ul style="list-style-type: none"> <li>water handling in the home</li> <li>water use and reuse</li> </ul> </li> <li>* hand washing (including religious rituals)                             <ul style="list-style-type: none"> <li>bathing (children and adults)</li> <li>clothes washing</li> <li>previous experience of water management</li> </ul> </li> </ul>
FOOD	<ul style="list-style-type: none"> <li>* food handling and preparation – household and communal (markets, communal kitchens, funerals etc.)                             <ul style="list-style-type: none"> <li>food storage practices</li> <li>food reuse practices</li> <li>breast feeding/weaning practices and beliefs</li> <li>washing and drying of utensils</li> </ul> </li> <li>* Knowledge of ORS</li> </ul>
ENVIRONMENT	<ul style="list-style-type: none"> <li>household and communal refuse disposal</li> <li>management of domestic animals</li> <li>* evidence of stagnant water around the house or water point                             <ul style="list-style-type: none"> <li>drainage systems</li> </ul> </li> <li>* vector control problems                             <ul style="list-style-type: none"> <li>slaughtering facilities</li> </ul> </li> </ul>

# How to Conduct a Mapping Exercise

Mapping is a useful exercise which can be used to gain an overview of the situation and to identify water and sanitation problems and hygiene practices which may be causing a risk to people's health. A mapping exercise should also allow people themselves to appreciate possible risks and it can often be a catalyst for community planned action. It can be initiated simply by approaching a small group of people or by organising groups of people in advance. It is useful to conduct separate mapping exercises with women and men to ascertain their different points of view.

- Have a clear idea in your mind of the possible things that might be identified on a map such as church, market place, water points, sanitation problems, breeding sites for mosquitoes etc.
- Identify possible resources that might be used for the map such as stones, leaves etc. but allow people to make their suggestions as you go along.
- Explain who you are and that you would like their help in conducting the exercise.
- Explain what you hope to find out and how the participants might go about making a map.
- Allow plenty of time for discussion of the idea of making a map - many people may be sceptical that they cannot do this because they have never been to school.
- If necessary begin the process yourself with a central landmark using a stick to draw on the ground. Try to "hand over the stick" as much as possible to other participants and allow them to control the making of the map. With some groups you could allow them to construct the map on their own and then walk around it with them asking questions about what they have depicted.
- Listen carefully to what people say and allow free discussion and debate amongst participants.
- Keep a record of who took part and when and where.
- When the map is finished, offer to transcribe it or get one of the participants to transcribe it onto paper. Ask the participants to decide where they would like the map to be kept, or who will keep it.

It might also be useful to compile quantifiable data from the mapping exercise. A table showing the quantities of each fixture that has been drawn on the map (i.e. numbers of latrines, protected and unprotected water sources etc.) can then provide a baseline for subsequent quantifiable evaluation or for the triangulation of results from questionnaire surveys. This can also be displayed with the map for those who can read.

## Example Observation Form

The form should be used in households with children under five years only. Start from the centre of the settlement or camp and choose every other house along a transect. If there are obvious differences in caste or religion, ethnic group or wealth, try to identify such groups prior to carrying out the observation and carry out separate observations within these groups or areas. Observe the situation if possible but you will have to rely on verbal reports for some questions. The numbers make compilation of the data easier. Remember that this is not a valid survey but a representation of the situation so conclusions cannot be drawn from these results alone. Keep the sample size small – 6 to 10 households in each area where particular characteristics might be expected to make a difference to the results e.g. different main occupation, ethnic group, wealth or availability of facilities such as schools or piped water supply.

<p><b>Water storage</b></p> <p>1. <b>What does the family use to store drinking water in?</b>            Jerry can = 1            Traditional pot = 2            Saucepan = 3            Other = 4</p> <p>2. <b>Is this water covered?</b>            yes=1            no=2</p> <p>3. <b>Is the water container clean?</b>            yes=1            no=2</p> <p><b>Sanitation</b></p> <p>4. <b>Does the family have a latrine?</b>            yes=1            no=2</p> <p>5. <b>Are there:</b></p> <table style="width: 100%; border: none;"> <tr> <td>Flies</td> <td style="text-align: center;">+</td> <td style="text-align: center;">++</td> <td style="text-align: center;">+++</td> </tr> <tr> <td>Faeces</td> <td style="text-align: center;">+</td> <td style="text-align: center;">++</td> <td style="text-align: center;">+++</td> </tr> <tr> <td>Smell</td> <td style="text-align: center;">+</td> <td style="text-align: center;">++</td> <td style="text-align: center;">+++</td> </tr> </table> <p>6. <b>Are there handwashing facilities?</b>            yes=1            no=2</p> <p>7. <b>Do all members of the family including children use the latrine?</b>            yes=1            no=2</p> <p>8. <b>Is there a problem with:</b>            Rats = 1            Flies = 2            Mosquitoes = 3</p>	Flies	+	++	+++	Faeces	+	++	+++	Smell	+	++	+++	<p><b>Child Defaecation</b></p> <p>9. <b>Did you see the child 0-8yrs (give age _____) defaecate during the observation period?</b>            yes = 1            no = 2</p> <p>If yes answer the following questions – if no leave blank</p> <p>10. <b>Where did the child defaecate?</b>            on a potty = 1            on the ground in the house = 2            on the ground outside the house = 3            in nappies = 4            in pants/trousers = 5            in the latrine = 6            other = 7</p> <p>11. <b>What happened to the Stools?</b>            Thrown in the latrine = 1            Left lying on the ground = 2            Thrown outside = 3            Taken to the rubbish heap = 4            Buried=5            Washed off = 6            Not seen = 7            Other=8</p> <p>12. <b>After cleaning the child's bottom did the person,</b>            Wash both hands with soap = 1            Rinse both hands with water only = 2            Rinse one hand = 3            Not wash hands = 4            Not Seen = 5</p>
Flies	+	++	+++										
Faeces	+	++	+++										
Smell	+	++	+++										

# Example of an observation guide used during an exploratory walk

(adapted from Almedom 1997)

The purpose of an exploratory walk is to give a general impression of risk factors for water and sanitation related disease. Used together with household observation and focus group discussions it can give adequate baseline data for the purpose of emergency interventions. If you find any intriguing information from the exploratory walk or household observation make sure that you investigate it further.

<p><b>Water</b></p> <ol style="list-style-type: none"> <li>1. <b>What are the available water sources and are they protected?</b> <ol style="list-style-type: none"> <li>a) Well</li> <li>b) Spring</li> <li>c) Rain water tank</li> <li>d) Seasonal Pond</li> <li>e) Public Stand Post</li> <li>f) Hand dug well</li> <li>g) River</li> </ol> </li> <li>2. <b>Who collects water?</b> <ol style="list-style-type: none"> <li>a) women</li> <li>b) children</li> <li>c) men</li> </ol> </li> <li>3. <b>What utensils are used for fetching water?</b></li> </ol>	<ol style="list-style-type: none"> <li>4. <b>What activities take place at or near the water source?</b> <ol style="list-style-type: none"> <li>a) washing water containers</li> <li>b) washing clothes</li> <li>c) bathing/washing</li> <li>d) watering animals</li> <li>e) other</li> </ol> </li> <li>5. <b>How long do people have to queue for water?</b></li> <li>6. <b>How long does it take to fetch water?</b> (round trip) – try to accompany a few people back to their houses and time how long it takes or pace the distance</li> <li>7. <b>Is water available continuously or at specific times only – give details.</b></li> <li>8. <b>Is there adequate drainage at water points?</b></li> </ol>
<p><b>Sanitation</b></p> <ol style="list-style-type: none"> <li>1. <b>Is there evidence of faecal contamination?</b> <ol style="list-style-type: none"> <li>a) along the roads?</li> <li>b) along the foot paths?</li> <li>c) near the water source?</li> <li>d) in/near the fields?</li> <li>e) outside the houses / shelters?</li> </ol> </li> <li>2. <b>What is the contamination observed?</b> <ol style="list-style-type: none"> <li>a) infants/young children's faeces</li> <li>b) adults' faeces</li> <li>c) cow dung and/or other animal faeces</li> <li>d) other</li> </ol> </li> <li>3. <b>Where is it observed</b> <ol style="list-style-type: none"> <li>a) compounds</li> <li>b) water points</li> <li>c) defaecation areas</li> <li>d) indiscriminate</li> </ol> </li> <li>4. <b>How many houses / shelters have latrines?</b> <ol style="list-style-type: none"> <li>a) none</li> <li>b) few</li> <li>c) many</li> </ol> </li> </ol>	<ol style="list-style-type: none"> <li>5. <b>Are the latrines clean? If not are there:</b> <ol style="list-style-type: none"> <li>a) flies</li> <li>b) faeces</li> <li>c) smell</li> <li>d) lid</li> </ol> </li> <li>6. <b>If clean is there evidence of use e.g. path leading to it used, recent faeces</b></li> <li>7. <b>Are there any hand washing facilities near to the latrine?</b> <ol style="list-style-type: none"> <li>a) water</li> <li>b) water and soap/ash</li> </ol> </li> <li>8. <b>Are there public toilets in public places?</b> <ol style="list-style-type: none"> <li>a) markets</li> <li>b) schools</li> <li>c) other</li> </ol> </li> <li>9. <b>How do people dispose of rubbish?</b> <ol style="list-style-type: none"> <li>a) burn it</li> <li>b) bury it</li> <li>c) communal rubbish tip</li> <li>d) indiscriminate disposal</li> </ol> </li> <li>10. <b>Is there evidence of rubbish attracting flies?</b></li> <li>11. <b>Is there adequate rubbish disposal in the market?</b></li> <li>12. <b>Is there adequate water supply in the market?</b></li> </ol>

# How to conduct a focus group discussion

(adapted from IT manual)

- Initially the facilitator will probably decide on the topic to be studied but later on as people become aware of how the process works they may also decide on issues they would like to explore.
- Prepare a framework of questions that might be asked to probe a particular issue. The questions should be as open ended as possible. Sometimes it may be easier to refer to someone in the third person rather than say 'what do you use for protection during menstruation' e.g. what do women use to protect themselves during menstruation?
- Invite suitable participants to attend the meeting at a venue and time identified by them. Six to twelve participants are often cited as an ideal but do not turn people away. In a camp situation there may not always be venues available that afford privacy. Ad hoc focus group discussions may be held under a tree or outside someone's shelter. Try to hold separate groups with men and women however to ensure that you have both perspectives.
- Introduce yourselves to the group and explain very clearly the object of the exercise and that you hope that everyone will learn from the session
- Explain that there are no wrong or right answers to the questions. Stress that people should try not to interrupt others when they are talking and that everyone's point of view will be valued.
- Try to make the discussions as interesting as possible for the participants by providing photographs or pictures of key problems or designs of toilets etc. Reassure participants that they can also discuss amongst themselves and ask questions of each other if they do not agree with what has been said.
- Do not interfere too much in the discussion or put your viewpoints across. As the session proceeds you will need to formulate new questions in response to what has already been said. If people ask for your opinion say that you will participate more once you have heard their views.
- The recorder should try to take as many notes as possible or if a tape recorder is available and with the permission of the participants you might tape the proceedings but care should be taken that this does not inhibit the participants.
- Bring the session to a close when you feel that the subject has been exhausted. If problems have been identified try also to get people to consider any possible solutions and how they intend to implement them.
- Thank the participants for their time and ask them if they would like to be involved in any further discussion groups or if you could meet up with them again to discuss any further conclusions you have come to or anything that was not clear.
- If a very large group turns up carry on with the discussion explaining the reasons why a smaller group was invited. At the end of the session ask whether people thought that enough people participated or only the confident ones.

# Focus Group Discussion

## Sample Questions

<p><b>Water Use</b></p> <p>Where do you collect your water? (drinking, washing, cooking, watering gardens)</p> <p>What do you think of the water? (taste, quality, distance, colour)</p> <p>Who collects the water?</p> <p>What do they collect it in?</p> <p>How long does it take to collect water?</p> <p>Do you transfer water to another container for storage?</p>	<p>What do you store your drinking water in?</p> <p>Where do you do your clothes washing?</p> <p>What do you wash your clothes with?</p> <p>What do you wash yourself with?</p> <p>If soap - where does the soap come from?</p> <p>What do you do with the water after washing?</p> <p>What is the most important use for water?</p> <p>Where does the water for beer making come from?</p>
<p><b>Latrine Use</b></p> <p>What type of latrines do you have?</p> <p>What made you decide to have a latrine?</p> <p>How do you find the latrines? (structure, cleanliness, privacy, smell etc.)</p> <p>Are there times when you don't use a latrine?</p> <p>Do you use a latrine at night?</p> <p>If not - what do you do?</p> <p>Do young children use the latrines?</p> <p>From what age do children start to use the latrine?</p>	<p>What happens to the stools of young babies?</p> <p>Does everybody do this?</p> <p>Who made the latrines?</p> <p>Who cleans, repairs, empties the latrines?</p> <p>Do young children wash their hands after using the latrine?</p> <p>Do adults wash their hands after using the latrine?</p> <p>How can we persuade other people to build a latrine?</p>
<p><b>Malaria</b></p> <p>What are the most common diseases at present and which are the most serious?</p> <p>Who gets these diseases? Men, Women, Young children older children?</p> <p>What do you do when someone has Malaria/Fever/Fits? (find out if people classify these separately)</p> <p>Who do you go to?</p> <p>When do you go?</p> <p>What do they do?</p> <p>What do you do if this treatment doesn't work?</p> <p>Do you give any home treatments? What are they – who do you get them from?</p> <p>Is this what happens to all members of the family?</p> <p>Is this what everybody does?</p>	<p>What causes malaria? – (probe for other answers)</p> <p>How can it be prevented?</p> <p>At what time do mosquitoes bite most?</p> <p>Do people use bednets here?</p> <p>How much did they cost – how much do they cost now / are they available?</p> <p>Do they dip them in anything?</p> <p>Who uses them (how many in a family)– why do they use them – who do they use them for? Are there people or family members who don't use them – if not do they take any other precaution?</p> <p>How long do they last – what happens when they get torn?</p> <p>How often do you wash them?</p> <p>Where and how do people sleep?</p> <p>What time do young children go to sleep?</p>

# Pocket or Voting Charts

Pocket charts can be used to explore people's different water source or defaecation preferences or simply to examine hygiene practices more closely. A cloth pocket chart can be made from cotton by a local tailor. Tins or pots can also be used. Pictures or photographs can be used to depict each activity or location on the two axes. Each participant is asked to vote accordingly and if possible in private. The votes are then collated and discussed with the group. If people are not used to using pocket charts then it is better to simplify the process and to vote on each activity in turn until people have got used to it.

The following formats can be used:

## Water use\*

	River/stream	Pond	handpump	Unprotected well	Protected well	Standpost	Protected spring	Unprotected spring
Drinking								
Cooking								
Washing								
Washing utensils								
Washing clothes								
Making beer								

\*It may be useful to have two voting rounds or two different voting slips for the wet and dry season or for pre and post displacement

## Defaecation Practices

	Latrine	Fields	Compound	River
Women/girls				
Men/boys				
Girl Children < 8yrs				
Boy Children < 8yrs				
Old Women				
Old Men				
Babies' faeces				

## Public health practices

	Using bednet	Covering drinking water	Handwashing after using toilet	Handwashing after cleaning baby	Handwashing before eating	Disposing of children's faeces in latrine
Sometimes						
Always						
Never						

It may be useful to summarise the results and subsequent discussion in the following format:

Purpose	Most widely used source		Reasons
	1 <sup>st</sup>	2 <sup>nd</sup>	
Drinking			
Cooking			
Washing			
Washing utensils			
Making beer			



# Example Baseline Data Report

**Below is an extract from an initial baseline data report – key areas for intervention have been highlighted:**

Data has been gathered using exploratory walks, focus group discussions, mapping and voting charts. Discussions with key informants have also been held. Separate discussion groups and interviews were held with male and female groups in order to gain their different perspectives. It was also thought necessary to collect separate data from the Twa group – a group known to be marginalised and excluded from many aspects of day to day life - to try and understand if they had particular needs or preferences with regard to the provision of water and sanitation. The key areas of significant public health risk were explored rather than trying to obtain all the information possible on 'hygiene practices'. A total of 12 focus group discussions were held. Mapping was carried out in six communities and exploratory walks conducted in three of the mapping communities and three additional communities. Voting charts on hygiene practices were used with a total of six groups – three men and three women.

Men and women do not use the same toilets and it is forbidden for a man to see his mother in law going to the toilet. Consequently many women wait until after dark before going to the toilet using a potty indoors if they want to pass urine. **Women are in need of cloth for sanitary protection. Men and women often go to the toilet by the river or in the bush** and only a few families have latrines – usually the better educated and better off families. **There is a significant amount of children's excreta** observed throughout the villages and children were also observed defaecating in the compounds. Unless this is very close to the house **mothers do not clean this up and do not perceive it to be dangerous**. Even amongst the families who have a latrine, **young children under eight years old are not expected to use it**. The reasons usually given for having a latrine, although this is uncommon, were privacy and preventing sickness. The former was especially important for women who felt that it was shameful to be seen by other people when defaecating. One old woman claimed that the reason she had a latrine was that 'a home is not a home without a kitchen and a toilet'

Water is used for anal cleansing and people consider that hands washed with water following this procedure is sufficient to clean them of dirt. Those who have attended primary school seem to be more aware of the connection between germs/dirt and sickness but only about 20% of children attend primary school. **Handwashing is not common prior to eating** with less than a quarter of those taking part in the pocket chart voting claiming to always wash their hands at this time. Water and soap are never offered to guests before they eat but will be provided after eating. Handwashing after cleaning the baby is also not practised as a rule. **Soap is no longer available** although people used to purchase locally produced 'black soap' made from coconut oil. People are not aware of ash as an alternative to soap.

**Very few mothers are aware of how to make up ORS or home made salt and sugar solution and rarely take their children to the clinic for diarrhoea alone. Most men were also not aware of how to make up ORS.** The clinic is at some distance and can take up to an hour and a half to walk there. There is no public transport. Mothers do

not like to go to the clinic because they feel the staff are too bossy and always tell them off. They must also **seek permission from the child's father** before they can go to the clinic and payment will be provided by him if he feels the child's sickness warrants it. **A child with fever will be taken to the traditional healer first and then, if there is no improvement, to the clinic.** A child with diarrhoea will be given breastmilk or water but **food is withheld. A child with fever is often wrapped up** to provide protection from the spirits. It is a common belief amongst men and women that diarrhoea and fever are caused by malicious ancestors who call on the spirits to harm the family.

**Only a few of those who have attended school seemed to be aware that mosquitoes caused malaria** and even they seemed sceptical as it is a common belief amongst men and women that malaria is caused by eating over ripe watermelons as malaria is more serious following the end of the rains which coincides with the end of the watermelon season. People are aware that larvae turn into mosquitoes and complain of getting bitten severely late at night. **Pools of water and puddles were a common observation.** Sleeping patterns vary enormously but it is common for young children to sleep just after sunset. Adults will often sleep by 9pm but women usually rise before men to do their chores such as collecting water and firewood. Only the most wealthy people use bednets and these are not treated. Nets cost approximately 2,000 francs (equivalent of \$10 )in the market but are not available at present.

Water is collected by women and children and drinking water is usually collected from the handpump although many have presently fallen into disrepair. In some areas a charge was levied for the use of the handpump but this money was not thought to have been used for maintenance. If handpump water is not available then people usually use the water from unprotected wells providing it is not too salty. Only a few of these wells were observed to be covered. Many had mosquito larvae in them and the water was often quite turbid. People prefer not to drink this turbid water but if necessary they will allow the dirt to settle overnight and then strain the water through a muslin cloth. Drinking water is usually stored in a separate container but is not often covered. **There is a shortage of water collecting and storage containers.....**

# Suggested Monthly Reporting Format

## 1.0 Overview of Public Health

### 1.1 Shelter

### 1.2 Food and Nutrition

### 1.3 Health indicators and provision of health care

### 1.4 Water and Sanitation

## 2.0 Programme Objectives or Logframe

## 3.0 Monitoring indicators and status form (see appendix 11)

Indicator	Some change	Major change	No change	Negative change	Current Situation	Action Required
Mortality and morbidity rates for all diseases under control						
No major epidemics from water and sanitation related disease						

## 4.0 Gender and Representation

Indicators	Status
Information is sought from different members of the community (rich, poor, leaders, women, disabled, older people)	
Vulnerable groups are identified and consulted and included in programme	
Baseline data has been collected from women by women	
Different views of men and women have been discussed with different groups	
Women have been provided with sanitary protection if needed	
Women's safety in using waterpoints and latrines is ensured	
Women's privacy is ensured	

Ratio of female to male staff reflects progress towards equality	
Efforts are made to employ and train women	
Gender Training has been offered to all PHP staff	
Efforts are made to train women in non traditional roles? (such as pump attendants or technicians)	

## 5.0 PHP process indicators and status

Indicator	Status (ongoing/ done/to do)	Comments
Rapid assessment and report		
Initial baseline data and report		
Further analysis		
Gender analysis		
Logframe		
Weekly/monthly reporting		
Final report		
Debriefing Checklist (prior to return only)		

6.0 Training and promotional activities carried out and planned (including distributions)

7.0 Materials developed

8.0 Request for support or advice from OH

9.0 Issues & recommendations (final report)

# Monthly Monitoring Format (to be inserted into Monthly Report)

A selection of the most relevant indicators should be made.

Indicator	Change				Current Situation	Action Required
	Some	Major	No	Negative		
Mortality and morbidity rates for all diseases within normal limits						
No major epidemics from water and sanitation related disease						
Increase in families disposing of young children's faeces safely						
Toilets are clean following spot checks						
Increase in number of families digging their own latrines						
Handwashing facilities next to the latrine						
More people are washing hands with soap or ash at key times						
Mothers know how to make and use salt/sugar solution or ORS						
People collect water from the protected source						
More parents are taking their children to the clinic for treatment as soon as they suspect fever						
Families store drinking water in a covered container						

Section 7

Resources

Monthly Monitoring  
Format (to be  
inserted into  
Monthly Report)

Increase in number of risk reduction initiatives taken by community groups						
Increase in number of trained personnel – both men and women						
Increase in confidence and knowledge amongst beneficiary groups						
Design of toilets reflects views of women and men						
Maximum of 20 people per toilet						
Public toilets are available in public places						
Toilets are both safe and private for women especially						
At least one water point is provided per 250 people						
15 litres of water per person per day is collected						
Maximum distance from any shelter to water point is 500 metres						
Public health promoters have been identified, trained and their performance is monitored						
Water point and latrine attendants have been selected, trained and are operating						
Outreach workers have been trained, supervised and their performance is being monitored						
Shower /laundry areas are constructed and men and women are satisfied with these						

# Water and Sanitation Programme Logframe

This project framework (logical framework analysis) envisages a scenario of 50,000 displaced people or refugees in a camp or camp like situation. It represents an example of what actions might be possible in the first few months and views the water, sanitation and hygiene promotion project as a whole. It is only a guide for action rather than a blueprint and should be adapted or modified as necessary (adapted from IT manual)

<b>NARRATIVE SUMMARY</b>	<b>MEASURABLE INDICATORS</b>	<b>MEANS OF VERIFICATION</b>	<b>IMPORTANT ASSUMPTIONS</b>
<p><b>AIM</b></p> <p>To contribute to improving the health of the refugee population and to prevent the outbreak of major epidemics</p>	mortality and morbidity rates from all causes	health centre records, mortality records from 'gravewatchers', information from community members	assumes that stability is maintained in host country and that further migration of refugees is not initiated, assumes easy access to refugee population
<p><b>PURPOSE 1</b></p> <p>to reduce the incidence of water and sanitation related diseases</p>	mortality and morbidity rates from water and sanitation related diseases	health centre records, gravewatching, family monitoring forms	assumes that major cause of mortality and morbidity is associated with water and sanitation related diseases and that beneficiaries see the project as a priority need for them
<p><b>PURPOSE 2</b></p> <p>To begin the process of capacity building and enhancing problem solving skills in the affected population</p>	Increase in trained personnel, number and type of new initiatives taken or led by refugees, increase in confidence and knowledge amongst refugees	Focus group discussions, self assessments and monitoring forms, project record	Assumes that felt needs and priorities of the refugees are considered important, translated into action and facilitated by the project management teams
<p><b>OUTPUT 1*</b></p> <p>To ensure people have sufficient numbers of toilets, sufficiently close to their dwellings to allow them rapid, safe and comfortable access at all times of the day and night (Sphere excreta disposal standard 1)</p>	maximum of 20 people per toilet, percentage of refugees using appropriate sanitation facilities, public toilets available in public places	focus group discussions, latrine monitoring forms observation of camp and latrines	assumes availability of suitable soil and water table conditions for latrine construction. Permission from host government to construct semi permanent latrine facilities

NARRATIVE SUMMARY	MEASURABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><b>OUTPUT 2*</b></p> <p>To ensure that all people have access to a sufficient quantity of water for drinking, cooking and personal and domestic hygiene. Public water points are sufficiently close to shelters to allow use of the minimum water requirement (Sphere water supply standard 1)</p>	<p>at least one water point per 250 people</p> <p>15 litres per person per day is collected</p> <p>maximum distance from any shelter to water point is 500 metres</p>	<p>project records, focus group discussions,</p>	<p>assumes availability of suitable water sources within reasonable distance from population</p>
<p><b>OUTPUT 3</b></p> <p>All sections of the community are aware of priority hygiene practices that create the greatest risk to health and are able to change them. They have adequate information and resources for the use of water and sanitation facilities to protect their health and dignity (Sphere Hygiene Promotion Standard 1)</p>	<p>People use the toilets available and children's faeces are disposed of immediately and hygienically, household toilets are cleaned and maintained, people wash their hands with soap or ash after defaecation and handling children's stools and before handling food etc (see Sphere indicators)</p>	<p>focus group discussions, pocket charts, observation</p>	<p>assumes availability of soap, water containers, water, chlorine or ash within the camp or adequate distribution mechanisms are in operation</p>
<p><b>OUTPUT 4</b></p> <p>All facilities and resources provided reflect the vulnerabilities, needs and preferences of all sections of the affected population. Users are involved in the management and maintenance of facilities where appropriate (Sphere Hygiene Promotion Standard 2)</p>	<p>Key hygiene risks are identified in assessments, a system for representative input for design and implementation is in operation, users take responsibility for the management and maintenance of facilities as appropriate (see Sphere indicators)</p>	<p>health records, project records, focus group discussions,</p>	<p>assumes that felt needs and priorities of the various refugee groups are considered important by the team and facilitated by the management structures</p>
<p><b>ACTIVITY 1</b></p> <p>Continue more detailed assessment of water and sanitation availability and usual defaecation and hand washing practices. Also assess the availability of soap and water storage containers. Continue gender analysis</p>	<p>number of meetings, discussions and interviews held, quality and quantity of data gathered</p>	<p>exploratory walk and observation, interview key informants, focus group discussions, pocket charts, (information may be collected at distribution and registration areas, water points and through ad hoc discussions)</p>	<p>assumes ability to communicate with target population</p>



<b>NARRATIVE SUMMARY</b>	<b>MEASURABLE INDICATORS</b>	<b>MEANS OF VERIFICATION</b>	<b>IMPORTANT ASSUMPTIONS</b>
<p><b>ACTIVITY 2</b></p> <p>If required demarcate areas for excreta disposal</p> <p>Facilitate community to decide on longer term sanitation options within 4 weeks (aim for 20 people per toilet)</p>	<p>number of latrines constructed or areas demarcated</p> <p>proportion of men and women consulted on design of new latrines</p>	<p>project records, observation</p> <p>focus group discussions and community meetings</p>	<p>assumes agreement and support from local administration and community representatives for acceptability of defaecation fields or public latrines</p>
<p><b>ACTIVITY 3</b></p> <p>Identify and train defaecation area/latrine attendants and water point attendants commencing within the first week and continuing as construction of trench latrines continues)</p>	<p>number of water point and latrine attendants selected, trained and operating</p>	<p>project records, training evaluation, supervision forms</p>	<p>assumes agreement from local leaders and selected attendants on remuneration and terms and conditions of work</p>
<p><b>ACTIVITY 4</b></p> <p>Provide facilities for hand washing at every defaecation area</p>	<p>number of hand washing facilities with cleansing agent</p>	<p>project records, observation, latrine monitoring forms</p>	<p>assumes availability of materials to construct hand washing unit</p>
<p><b>ACTIVITY 5</b></p> <p>Identify and train campaign workers (2 day training) within 2-3 weeks</p> <p>Implement a 2 week information campaign providing key messages identified from initial assessment only(e.g. disposal of excreta especially children's excreta, hand washing using soap or ash and the need to dig more latrines)</p>	<p>number of campaign workers trained</p> <p>number of refugees aware of messages, number of refugees disposing of excreta adequately and washing hands with cleaning agent at key times, number of requests for tools for digging latrines</p>	<p>project records</p> <p>focus group discussions, pocket charts, project records</p>	<p>assumes requirement for campaign (high mortality rates, imminent crisis predicted)</p> <p>Permission from local authorities to use campaign method</p>
<p><b>ACTIVITY 6</b></p> <p>Distribute or enlist the help of other agencies to distribute family hygiene kits if required (if not available ensure distribution of soap 250g per person per month and water containers)</p>	<p>number of kits distributed,</p>	<p>project records</p>	<p>assumes availability of hygiene kits</p>

NARRATIVE SUMMARY	MEASURABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<b>ACTIVITY 7</b> Identify and commence training 80 additional facilitators (1 per 1,000 population) to promote hygiene within the community through group discussions, home visits, use of songs, plays, puppets and demonstrations etc. within six weeks	number of facilitators trained	project records, evaluation of training	assumes that there is no shortage of suitable community members who can act as facilitators
<b>ACTIVITY 8</b> Identify and commence training 10 children's facilitators to promote hygiene to young children using play and above methods within three weeks	number of facilitators trained	project records, evaluation of training	assumes easy recruitment of staff
<b>ACTIVITY 9</b> provide 15 litres per person per day by end of 3 month period	amount of water pumped/supplied to camp	project records	assumes availability of suitable water sources
<b>ACTIVITY 10</b> ensure adequate and appropriate shower and laundry facilities (see sphere standards)	number of shower /laundry areas  community satisfaction with these	project records, focus group discussions	assumes felt need for public facilities
<b>ACTIVITY 11</b> liaise with other agencies working in the camp	number of meetings attended or discussions held	project records	assumes other agencies appreciate the need for regular liaison
<b>ACTIVITY 12</b> ensure ongoing assessment, planning and monitoring of the project (update log frame as necessary)	quality and quantity of data obtained,	project records	assumes situation remains stable and access to refugees remains possible

### ***Note on the logical framework***

The logical framework attempts to show the different levels of objectives that project workers will be working towards and how these logically relate to one another i.e. in order to achieve the aim or goal the following 'purpose objectives' must be defined. In order to achieve those 'purpose objectives' certain outputs are necessary and in order to achieve those outputs certain activities are necessary.

**\*For simplicity not all the relevant sphere water supply and excreta disposal standards have been given in this example. The Sphere Standards have been used to promote familiarity with them but if designing a framework for submission to donors more concrete outputs will need to be given – see p. 18)**

# Malaria Control Programme

## Logframe

This second logical framework envisages a target population of 50,000 displaced and flood affected people living in a variety of accommodation: with family and friends and in collective centres in a central town and surrounding villages. Once again it represents an example of what actions might be possible in the first few months.

<b>NARRATIVE SUMMARY</b>	<b>MEASURABLE INDICATORS</b>	<b>MEANS OF VERIFICATION</b>	<b>IMPORTANT ASSUMPTIONS</b>
<p><b>AIM</b></p> <p>To contribute to improving the health of the at risk population</p>	<p>mortality and morbidity rates from all causes</p>	<p>health centre records, mortality records from</p>	<p>assumes that stability is maintained and that further migration or flooding does not take place, assumes easy access to population</p>
<p><b>PURPOSE 1</b></p> <p>To contribute to reducing the incidence and severity of malaria and dengue fever within high risk groups</p>	<p>mortality and morbidity rates from suspected malaria or dengue</p>	<p>health centre records, volunteer and public health team 's monitoring forms</p>	<p>Assumes that the major cause or risk of mortality and morbidity is associated with mosquito borne disease and that beneficiaries see the project as a priority need for them</p>
<p><b>PURPOSE 2</b></p> <p>Begin the process of capacity building within community to ensure heightened capacity to respond to future emergencies</p>	<p>Ability to mobilise community members and define and carry out relevant actions, increase in knowledge about prevention, organisation of health committees</p>	<p>Project records, community discussions</p>	<p>Assumes that some community structures remain and can be reactivated</p>
<p><b>OUTPUT 1</b></p> <p>People have the means to protect themselves from malaria and dengue vectors and the number of vectors is kept to an acceptable level (Sphere Vector Control Standards 1 and 2 )</p>	<p>Distribution of 10,000 insecticide treated bednets to families with pregnant women and children under five, Malaria and Dengue awareness campaign targeting whole population and schools, reduction in breeding sites</p>	<p>Household assessment forms, group discussions, mapping of breeding sites and leaking pipes</p>	<p>Assumes government support for project continues, flood waters subside and there is no new flooding</p>

<b>NARRATIVE SUMMARY</b>	<b>MEASURABLE INDICATORS</b>	<b>MEANS OF VERIFICATION</b>	<b>IMPORTANT ASSUMPTIONS</b>
<p><b>OUTPUT 2</b></p> <p>All sections of the community are aware of what they can do to prevent malaria and dengue fever and are mobilised to take action to control these diseases. (Sphere Hygiene Promotion Standard 1)</p>	<p>Increase in timely under five consultations for malaria, reduction in breeding sites around dwellings, use of bednets by pregnant women and children under five</p>	<p>Health centre records, focus group discussions, pocket charts, observation</p>	<p>Assumes accessibility of health facilities,</p>
<p><b>OUTPUT 3</b></p> <p>The disaster affected population has the opportunity to participate in the design and implementation of the assistance programme (Sphere Analysis Standard 3)</p>	<p>Representation from all sections of community in detailed assessment and community defined objectives for action</p>	<p>project records, focus group discussions and interviews with key informants</p>	<p>Assumes that defined priorities of the various groups are considered important by the team and facilitated by the management structures</p>
<p><b>ACTIVITY 1</b></p> <p>Identify Public Health counterparts and provide three day orientation</p>	<p>Numbers of staff identified and training completed</p>	<p>Project records, training evaluation</p>	<p>Assumes willingness of Ministry of Health to second counterparts</p>
<p><b>ACTIVITY 2</b></p> <p>Conduct baseline survey to ascertain knowledge of malaria and dengue, bednet use and treatment seeking behaviour</p>	<p>number of focus groups and research sessions held with different groups, quality and quantity of data gathered</p>	<p>Project records and reports</p>	<p>Assumes ability to communicate with target population</p>
<p><b>ACTIVITY 3</b></p> <p>Carry out mapping exercise within all of the target communities to identify leaks in water supply network</p>	<p>Identification of major leaks</p>	<p>Project maps</p>	<p>Assumes community knowledge of location of major problem areas and willingness to divulge this information</p>
<p><b>ACTIVITY 4</b></p> <p>Repair leaks in the water supply systems which enhance vector breeding</p>	<p>Number of leaks repaired</p>	<p>project records, maps and observation</p>	<p>Assumes community willingness to have leaks repaired</p>
<p><b>ACTIVITY 5</b></p> <p>Identify and train community volunteers to promote use of nets and other vector control measures</p>	<p>Number of volunteers identified and trained</p>	<p>project records, training evaluations, community action plans</p>	<p>Assumes willingness of community to volunteer for these activities</p>
<p><b>ACTIVITY 6</b></p> <p>Distribute insecticide nets to pregnant women and families with children five years old</p>	<p>Number of nets distributed</p>	<p>Project records, household assessment forms</p>	<p>Assumes prompt purchase and delivery of nets</p>

<b>NARRATIVE SUMMARY</b>	<b>MEASURABLE INDICATORS</b>	<b>MEANS OF VERIFICATION</b>	<b>IMPORTANT ASSUMPTIONS</b>
<b>ACTIVITY 7</b> Design malaria and dengue leaflets to provide key information	Number and quality of leaflets designed	project records	Assumes availability of printing facilities
<b>ACTIVITY 8</b> Organise 10 teacher's workshops to promote control of mosquito vectors	Number of workshops held	project records, training evaluation	Assumes willingness of Ministry of Education and teachers to take part in activities
<b>ACTIVITY 9</b> Ensure close liaison with government and other agencies	Number of meetings attended	project records	Assumes adequate co-ordination maintained
<b>ACTIVITY 10</b> Ensure ongoing assessment, planning and monitoring of the project (update log frame as necessary)	quality and quantity of data obtained,	project records	Assumes situation remains stable and access remains possible

# Key activities for job descriptions

## Public Health Promoters

- To enable the community to find solutions to water and sanitation related problems through the use of discussion groups and visits to individual homes
- To mobilise people to dig family latrines and clean and maintain them
- To plan and implement other communication activities when appropriate e.g. campaigns or drama
- To ensure that prompt information on the progress of the water and sanitation project is provided to community members
- To liaise with community leaders and other agencies working locally in order to promote the project
- To provide information for assessment, monitoring and evaluation purposes in the form of verbal feedback or written documentation

## Public Health Promoters (Vector Control/Malaria Control)

- To enable the community to find solutions to water and sanitation related vector control problems through the use of discussion groups and visits to individual homes
- To mobilise people to take action to eliminate breeding sites
- To encourage the appropriate use of insecticide treated bednets
- To raise awareness about the importance of reimpregnating bednets
- To plan and implement other communication activities when appropriate e.g. campaigns or drama
- To liaise with community leaders and other agencies working locally in order to promote the project
- To provide information for assessment, monitoring and evaluation purposes in the form of verbal feedback or written documentation

## Campaign Workers

- To provide information to the population on ways of preventing the most significant water and sanitation diseases
- To be deployed as necessary in a public place e.g. registration point, market, distribution areas
- To visit families at home to discuss the importance of using and constructing latrines, disposing of children's faeces and hand washing and any other issues as determined by the project co-ordinator
- To provide feedback from information sessions through regular meetings with other team members and project co-ordinator

## Children's Health Promoters

- To identify groups of children in the community to work with
- To implement interactive education activities with children focusing on key hygiene behaviours
- To provide regular verbal or written reports on work undertaken
- To meet regularly with the other hygiene facilitators to discuss their work and to plan future activities
- To monitor and evaluate project activities as required

## Water Point Attendants

- To ensure that water points are kept clean and free from contamination
- To prevent people from washing in or too close to the water source
- To prevent children and adults from defaecating near to the water point
- To provide information to people on the problems associated with contaminated water

## Latrine Attendants

- To ensure that public latrines are kept clean following use (cleaning must be done frequently during the day)
- To encourage people to use the facilities provided to wash their hands following use of the latrine
- To provide information to latrine users on the importance of disposing of all excreta in the camp in the latrine (including that of young children and babies), and on the necessity to dig family latrines
- To maintain a simple monitoring form on the condition and use of the latrines

# Sample training timetables

## Campaign worker's course: sample timetable

TIME	DAY 1	DAY 2
9.00-9.45	Introduction: who's who, purpose of course, housekeeping (timetable, 'rules', remuneration, questions)	Review and Questions Allocation of responsibilities
9.45-10.45	EXERCISE 1 Health Problems in camp and suggested solutions	EXERCISE 6 Group work to design and plan work
Morning Break		
11.00-12.00	EXERCISE 2 Communication exercises: Working Together Good and Bad Teaching Role Play (e.g. nurse lecturing at community)	Exercise 6 continued  Feedback to group (demonstration)
Lunch Break		
2.00-3.00	EXERCISE 3 Use of Messages and their limitations  Key Messages	Trial Fieldwork
3.00-4.00	EXERCISE 4 Public Health Promotion techniques for message dissemination: where, how and when	Feedback and troubleshooting
4.00-5.00	EXERCISE 5 Use of songs and drama  Review and evaluation	Organise timetable and responsibilities for campaign  Review and evaluation



## Children's Facilitator's Course: Sample Timetable

TIME	DAY 1	DAY 2
9.00-9.45	Introduction: who's who purpose of course housekeeping (timetable, 'rules' remuneration, questions)	Dehydration and ORS Ways to discuss this with children
9.45-10.45	Health Problems in camp and suggested solutions	Using Pictures and available resources
Morning Break		
11.00-12.00	How children learn and teaching methods including child to child methodology	Clean Water
Lunch Break		
2.00-3.00	Causes and prevention of diarrhoea: serialised pictures (see IT manual)	Preparing Activity sessions in pairs
3.00-4.00	Exploring the use of songs, stories, role play and puppets to learn about diarrhoea and its prevention	Preparing activity sessions continued
4.00-5.00	Key Messages Review and evaluation	Feedback Review and evaluation Follow up

## Public Health Promoter's Course: Sample Timetable

TIME	DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
<b>9.00-9.45</b>	Introduction who's who purpose of course housekeeping (timetable, 'rules' remuneration, questions) Role of Facilitator	Communication Skills 1: Listening and Observation	Communication skills 2: Problem Solving	Existing Folk Media	Review role of facilitator
<b>9.45-10.45</b>	Exploring Health:Health Continuum and Three Pile Sorting (see Srinivasan)	Working with groups and group dynamics	Traditional beliefs and Practices	Monitoring & evaluation	Sick Baby, Healthy Baby (see IT manual)
	Morning Break				
<b>11.00-12.00</b>	How Adults Learn Role Play of lecture Limitations of message dissemination	Hygiene behaviours pocket chart (see IT manual)	Fieldwork preparation and review of techniques	Using Drama and Puppets	Food Hygiene
	Lunch Break				
<b>2.00-3.00</b>	Health problems in camp: use of pocket chart and matrix ranking (see IT manual)	Causes and Prevention of diarrhoea: serialised pictures (see IT manual)	Fieldwork	Preparing drama/songs/puppet show	Fieldwork: market survey
<b>3.00-4.00</b>	Focus Group Discussion on Water Use	Dehydration and ORT Monitoring	Feedback and Discussion	Preparing drama/songs, puppet show	Feedback and discussion
<b>4.00-5.00</b>	Review and Evaluation	Review and Evaluation	Review and Evaluation	Vector Control (see Thompson)	Review and Evaluation

## Latrine And Water Source Attendants Course: Sample Timetable

<b>TIME</b>	<b>DAY 1</b>
<b>9.00-9.45</b>	Introduction: Who's Who Purpose Of Course Housekeeping (Timetable, 'Rules' remuneration, Questions)  Role of Attendant
<b>9.45-10.45</b>	Communication Skills
Morning Break	
<b>11.00-12.00</b>	Three Pile Sorting exercise  Causes and Prevention of Diarrhoea:
Lunch Break	
<b>2.00-3.00</b>	Water and Sanitation Problems in camp and possible solutions
<b>3.00-4.00</b>	Disposing of excreta safely  Keeping water clean
<b>4.00-5.00</b>	Review and evaluation  Role of latrine and water source attendants  How can information help them and their families?

## Assessment Course: Sample Timetable

TIME	DAY 1	DAY 2
9.00-9.45	Introduction: who's who purpose of course housekeeping (timetable, 'rules' remuneration, questions)	8.00 - 10.45 Fieldwork with supervision
9.45-10.45	Observation Skills: Watch/Shoe exercise & Observation Forms	Fieldwork
Morning Break		
11.00-12.00	Focus Group Discussions	Discussion and Feedback
Lunch Break		
2.00-3.00	Communication Skills & Problem Solving	Communication Skills Role-play
3.00-4.00	Exploratory Walks	Presentation of role-plays
4.00-5.00	Observation forms exercise	Preparation for fieldwork

# Example Community Contract

**AGREEMENT BETWEEN: OXFAM AND -----**

**\_\_\_\_\_ TOWN, \_\_\_\_\_ DISTRICT REGARDING THE PROVISION OF A HAND DUG WELL AND THE REPAIR OF KARDIA HANDPUMPS.**

Oxfam intends to work in partnership with the above community in order to facilitate the provision of a well at the health centre and the repair of five Kardia handpumps. However, Oxfam can only facilitate the provision of the new well and the repair of existing pumps and will NOT be responsible for providing manual labour, locally available materials, payment for community members or for long term maintenance of wells and hand pumps. Oxfam's involvement in this project will depend on the commitment of the community and both parties will be bound by the terms of the agreement.

**UNDER THE TERMS OF THE AGREEMENT THE COMMUNITY WILL HAVE THE FOLLOWING OBLIGATIONS:**

Before Oxfam can commence any work all ownership and rights of way issues must have been settled.

**LABOUR:**

The community will provide the necessary labour for the digging of the wells including the extraction and removal of soil and any other assistance that may be required. Seven labourers per day will be required.

**MATERIALS:**

The community will provide the necessary locally available materials i.e. sand, gravel, sticks and clean water for the construction work.

The community will be responsible for project materials and will secure them as necessary. The materials must only be used for the purpose intended.

**ACCOMMODATION AND FOOD**

The community will provide accommodation and at least one meal per day for the technicians working on the well and will also provide food for community labourers.

**SAFETY**

The community must make every effort to observe the safety regulations laid down by Oxfam with regard to the digging of the well. First aid kits will be provided at every well site for minor injuries but if other medicines and medicaments are required these must be provided by the community.

**MAINTENANCE:**

On completion of the work the community will immediately become responsible for the long term maintenance of the wells and pumps. In order to minimise damage to the facilities and to minimise the risk of disease all community members will be responsible for day to day care and maintenance. The community will be required to finance the payment of spare parts where these become necessary.

continued..

The community is advised to set up a water or community development committee where one does not exist by electing representatives - 50% women and 50% men - which will include a chair person, secretary and treasurer.

The community will identify two suitable people (one man and one woman) to be trained in basic maintenance of the hand pumps and the well.

**UNDER THE TERMS OF THE AGREEMENT OXFAM WILL HAVE THE FOLLOWING OBLIGATIONS:**

**LABOUR:**

Oxfam will be responsible for the execution of construction works and supervision of this work.

Oxfam will provide training in basic maintenance of the hand pump for two caretakers chosen by the community. In addition Oxfam will work with members of the community to ensure that people are aware of how they can best prevent contamination of water supplies.

**MATERIALS:**

Oxfam will be responsible for providing all materials that are not available locally as specified in the community obligations above.

Oxfam will notify the community that they are ready to start construction work at least two days in advance.

In case of a deterioration in the security situation or during the period of heaviest rains, Oxfam reserves the right to cease all work. This work will be resumed as soon as conditions allow.

Both Parties reserve the right to sever relations if either side does not comply with the terms of the agreement or if materials supplied by either party are misappropriated.

**SIGNATORIES OF THE AGREEMENT**

Paramount Chief / Regent Chief:

Town Chief:

Elders:

Women's Leader:

Oxfam Representative:

DATE:

# Notes for teaching about Oral Rehydration

- Make sure you emphasise that ORS and SSS is NOT a cure but a way to prevent dehydration and death due to dehydration. Therefore do not expect the diarrhoea to stop immediately –it will run its course. Many people give up after trying ORS because it does not seem to cure the diarrhoea
- Emphasise the importance of continuing:
  1. BREASTFEEDING
  2. FEEDING OTHER SOLID FOODS
  3. DRINKING OTHER FLUIDS (except those with a high sugar content e.g. soft drinks and sweetened tea – these drinks do not help to rehydrate)
- Ensure that people are aware that they should give an adequate amount of SSS/ORS - many people only give a few tablespoons believing that it should work like medicine – give roughly 1 cup per stool for a child and 2 cups for an adult
- Discuss any problems that people have experienced in the past – Mothers often find that it is difficult to give ORS to a baby who is vomiting – they should persevere but give the solution more slowly – the child will probably keep down at least some of the solution even if vomiting and this will help to prevent dehydration
- Mashed banana is a good food to give to a child who is taking solid foods as it contains potassium which can become depleted because of the diarrhoea

# Training And Visual Aids Kit

- A4 Paper
- A4/A3 Card
- Pencils
- Felt Pens
- Paints And Brushes
- Balloons
- Felt
- Wool
- Glue
- Scissors
- Craft Knife
- Assorted Materials: Approx. 2-3 Metres
- Sewing Kit: Scissors, Needles, Thread
- Plastic Backing
- Blue Tack
- 'Wipeboard' Plastic
- Large Felt Pens X 5
- Exercise Books Or Notepads
- Biro
- Plastic/Card Folders
- Evaluation Sheets
- Megaphones and batteries may also be useful if conducting a campaign

A small number of pilot kits are available at Oxfam House but kits should be assembled locally if possible.



The following is a list of items that might be included in a family hygiene kit but kit contents will depend on the particular situation and the availability of items locally. Prepackaged kits have been used by various other agencies e.g. MSF, UNICEF and UNHCR. It may also be preferable to provide household kits which contain cooking pots and other utensils if these are not being provided by other agencies.

The specifications of this kit are for an average family of five people for one month.

- Soap (250gm Per Person Per Month – for laundry and personal hygiene)
- All Purpose Toweling Cloth X 2(For Sanitary Protection, Nappies Etc.)
- Sanitary Towels (both disposable and reusable are possible but disposal systems must be considered)
- 1 Litre Storage Container And Lid (for making up ORT)
- Cord For Washing Line
- Toothbrushes X 5 And Toothpaste X 1 Large Tube
- Combs X 2
- Condoms X 20 (depending on levels of acceptance)
- Washing Basin
- Trowel (for burial of children's and infants' faeces especially)
- Oxfam Bucket X 1
- Jerry Can 20 Litres X 2

**(Oxfam buckets & mosquito nets are available from the logistics department in oxfam house: every office should have a copy of the equipment catalogue)**

# Hygiene Promotion Budget

(assumes target population 50,000)

		UNIT	NUMBER	UNIT COST (GBP)	TOTAL COST (GBP)	NOTES
<b>A8</b>	INTERNATIONAL STAFF					
	Hygiene Promoter x 1	months	3	1,649.00	4,947.00	
<b>B8</b>	NATIONAL STAFF					
	HP Co-Ordinator x 1	months	3	100.00	300.00	
	Hygiene Promoters x 4	months	12	50.00	600.00	
	Driver x 1	months	3	30.00	90.00	
<b>G8</b>	LOCAL TRAVEL					
	Double Cab pick Up	unit	1	14,000	14,000.00	Maintenance and first aid kit not included
	Bicycles	unit	2	100	200	
	Motorbike	unit	1	1,950.00	1,950.00	includes crash helmets but not maintenance
<b>I8</b>	RELIEF GOODS					
	200 litre drums with taps	unit	50	10.00	500	
	Oxfam Buckets*	unit	8,000	2.87	22,960.00	may be available locally
	Jerry Cans	unit	8,000	2.50	20,000.00	
	Soap*	unit	150,000	0.05	7,500	may be available locally
	ORS Sachets*	unit	10,000	0.08	800	may be available locally
	ORS Kits*	unit	250	4.0	1,000	jug with lid and spoon for mixing ORT
	Potties	unit	5,000	2.0	10,000	For children under 5 years
	Washable Sanitary Towels	unit	10,000	2.0	20,000	
	Mosquito nets*	unit	8,000	3.38	27,040	
<b>N8</b>	LOCAL LABOUR					
	Incentives for outreach workers (50)	months	150	1.00	3,600.00	
	Latrine/Water point attendants (10)	months	30	1.00	720.00	
<b>Q8</b>	TRAINING					
	Training materials	unit	1	1,500	1,500.00	Photocopying, paper, pens, etc.
	Facilitators Incentives (10)	days	20	5.00	100.00	Invited facilitators
	Resource Books	unit	15	30.00	450.00	Child to Child series - assumes 5-6 books
	Training Incentives	days	100	3.00	300.00	Only when necessary
	Food for training workshops	days	150	1.00	150.00	
	TOTAL				138,707	

This budget is an example of items that **might** be required in an emergency intervention. Materials marked with a \* are priced according to the UK but many materials may be available locally.

**CHOLERA** – is a severe type of watery diarrhoea, which can cause rapid dehydration and death. It is characterised by ‘rice water’ stools and or vomiting. Cholera should be suspected in any death due to diarrhoea in an adult but care must also be taken not to misdiagnose. Even clinicians may diagnose cholera without confirmation and this may cause significant panic amongst those involved.

**DENGUE HAEMORRHAGIC FEVER** – Dengue Fever is characterised by fever, headache, pain behind the eyes, muscular pain and a distinctive rash. Haemorrhagic fever occurs when the body’s immune system over reacts in response to the dengue virus. Diagnosis can only be confirmed by a blood test.

**DIARRHOEA** – The World Health Organisation defines diarrhoea as the production of at least three loose or watery stools in a day.

**DYSENTERY** – is a type of diarrhoea which is accompanied with blood and/or mucus in the stool

**ENDEMICITY** – a disease is said to be endemic when it usually occurs in the population. There are varying levels of endemicity:

**HYPOENDEMIC:** Little transmission, malaria does not affect the general population significantly (spleen rate in children aged 2-9 years is less than 10%)

**MESOENDEMIC:** Typically found in rural communities with varying intensity of transmission (spleen rate in children 11-50%)

**HYPERENDEMIC:** Areas with intense but seasonal transmission where immunity is insufficient to prevent effects of malaria in all age groups (spleen rate in children constantly more than 50% and in adults more than 25%)

**HOLOENDEMIC:** Areas with perennial high-degree transmission producing considerable immunity in all age groups, particularly adults (spleen rate in children constantly more than 75%, but low spleen rate in adults)

**EPIDEMIC** – The occurrence in a community or region of cases of an illness with a frequency clearly in excess of what would normally be expected.

**FALCIPARUM MALARIA** – malaria is caused by a bite from a female anopheles mosquito infected with the plasmodium parasite. This plasmodium parasite can be one of four different species: plasmodium vivax, ovale, malariae or falciparum. The latter is responsible for causing cerebral malaria, which is frequently fatal.

**INCIDENCE** – The number of new cases of a disease over a certain period of time (usually a week) divided by the total population exposed during the same period, expressed as a percentage:

$$\frac{\text{Number of New Cases}}{\text{Total Population Exposed}} \times 100$$

**ITN** – Insecticide Treated Net have been in use for the last ten years and in field trials have been shown to be effective at reducing the incidence of malaria. They also appear to have an effect on the incidence of head lice and even other childhood illnesses – possibly because by preventing malaria they also make children less

susceptible to other illnesses. Bednets are usually impregnated with an insecticide such as permethrin or deltamethrin.

**MORBIDITY RATE** – morbidity is another word for saying sickness

**MORTALITY RATE** – mortality is another word for saying death.

The **CRUDE MORTALITY RATE** refers to the death rate from all causes and all ages. The 'normal' CMR for developing countries is between 0.5 – 1 per 10,000 per day. Over 1 death per 10,000 per day indicates a serious emergency and over 2 deaths per 10,000 per day indicates a situation out of control.

**To calculate the daily crude mortality rate:**

- Total the number of deaths for a given number of days
- Divide the number of deaths by the number of days to give the average number of deaths per day
- Divide this number by the total population at the start of the assessment period
- Multiply this figure by 10,000

The **UNDER 5 MORTALITY** refers to the number of deaths amongst children under five years old. In the acute stage of an emergency this is usually expressed as the number of deaths per day per 10,000 population. A 'normal' child mortality for developing countries is 1/10,000/day.

**To calculate the daily <5 mortality rate:**

- Total the number of deaths under five for a given number of days
- Divide the number of deaths by the number of days
- Divide this number by the total under five population at the start of the assessment period i.e. including those that have died (can be estimated at 20% of total population in most developing countries)
- Multiply this figure by 10,000

**ORT/ORS** – Oral rehydration therapy (ORT) refers to the use of any rehydration solution – home made or manufactured - to counter the loss of fluids associated with diarrhoea or other physiological processes. Oral Rehydration Salts (ORS ) refers to the manufactured rehydration solution dispensed by clinics and health centres.

**PREVALENCE** – The number of existing cases of a particular disease over a certain period of time which will include both the new cases and those people who remain sick

**RESIDUAL SPRAYING** – spraying the inside walls of a building with insecticide leaves a coating on the wall which is subsequently harmful to insects resting on that wall. Residual spraying with a suitable insecticide is the recommended technique for malaria control where the vector is known to rest indoors.

**TYPHUS** – is a disease transmitted by the faeces of contaminated lice through cuts or abrasions in the skin

**VECTOR CONTROL** - a vector is an insect or other animal (e.g. mosquito, flies, rats, scabies, lice) which carries disease and vector control therefore refers to the systematic attempt to reduce or limit such vectors in an effort to control disease

- ADAMS, J. (1999) **Managing Water Supply And Sanitation In Emergencies**, OXFAM
- ALMEDOM, A. BLUMENTHAL, U. & MANDERSON, L. (1997) **Hygiene Evaluation Procedures, Approaches and Methods for Assessing Water and Sanitation Related Practices** INFDC
- CHALINDER, A. (1994) **Water and Sanitation in Emergencies**, Relief and Rehabilitation Network: Good practice Review, London: ODI
- CHAVASSE, D. REED, C. & ATTWELL, K. (1999) **Insecticide Treated Net projects – A Handbook for Managers** Malaria Consortium and LSHTM
- CHILD TO CHILD RESOURCE BOOK 1 ACTIVITY SHEETS
- CURTIS, V. & KANKI, B. **Hygienic, Happy And Healthy**: UNICEF / LSHTM
- ESREY, S. FEACHEM, R.G. HUGHES, J. (1985) Interventions For The Control Of Diarrhoeas Diseases Among Young Children: Improving Water Supplies And Excreta Disposal Facilities, **Bulletin Of The World Health Organisation** 63: 757-772
- ESREY, S.A. POTASH, J. B. ROBERTS, L. AND SHIFF, C. (1991) Effects of Improved Water Supply on ascariasis, diarrhoea, dracunculiasis, hookworm infection, schistosomiasis and trachoma, **Bulletin of The World Health Organisation** 69(5): 609-621
- FERRON, S. MORGAN, J. & O'REILLY, M. (2000) **Hygiene Promotion A Practical Manual For Relief and Development** IT Publications
- GOSLING, L. and EDWARDS, M. (1995) **Toolkits: A Practical Guide to Assessment, Monitoring, Review and Evaluation, Development Manual 5**, London : SCF
- HANBURY, C. (1993) **Child to Child and Children Living in Camps**
- HUBLEY, J. (1993) **Communicating Health: an action guide to health education and health promotion**, London: Macmillan Press
- PRETTY, J. GUIJIT, I. THOMPSON, J. & SCOONES, I. (1995) **Participatory Learning and Action: A Trainer's Guide**, London: IIED
- ROHR-ROUENDAAL, P. (1997) **Where There is no Artist**, London: London: IT Publications
- ROZENDAHL, J. (1997) **Vector Control: Methods for use by individuals and communities**: WHO, Geneva
- SRINIVASAN, L. (1990) **Tools for Community Participation: a manual for training trainers in Participatory Techniques**, Washington DC: Prowess/UNDP
- THE SPHERE PROJECT: HUMANITARIAN CHARTER AND MINIMUM STANDARDS IN DISASTER RESPONSE 1998**

THOMPSON, M. (1995) **Disease Prevention through Vector Control, Guidelines for relief Organisations** Oxfam practical Health Guide No. 10, Oxfam: Oxford

UNHCR (1997) **Vector and Pest Control in Refugee Situations** PTSS/UNHCR, Geneva

WHO / Malaria Consortium U.K. (1998) **Partnerships For Change & Communication: Guidelines for Malaria Control**

Other useful Oxfam documents:

**GOMA INTERIM EVALUATION:** Hygiene Promotion section and Recommendations for each sector

**HYGIENE PROMOTION IN EMERGENCIES:** A review of programmes since 1996  
Simon Bibby December 1999