

BEHAVIOUR CHANGE COMMUNICATION IN EMERGENCIES: A TOOLKIT

For every child
Health, Education, Equality, Protection
ADVANCE HUMANITY

unicef 

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Cover Photo: UNICEF/HQ/Jeremy Horner

MALDIVES: Rizuana, 11 years old, is among 352 people who lost their homes in the 26 December 2004 tsunami disaster and are living in a temporary camp for the displaced in Male, the capital.

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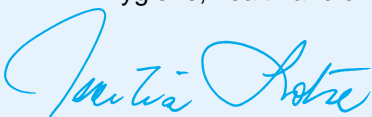
FOREWORD

South Asia is a region that is frequently visited by natural disasters - floods, earthquakes, droughts, tsunamis and other natural phenomena. These have resulted in large scale loss of lives, devastation and humanitarian crises. This tragic reality impels us to be better prepared in disaster and risk communication, an area that has often been neglected in emergencies. Communication preparedness when a disaster strikes allows us to proactively assist as well as mobilise partner agencies, families and communities in mitigating the impact of such natural disaster.

Preparing and responding successfully to emergencies require that evidence-based behaviour change communication strategies become an integral part of emergency preparedness plans and training. Our communication efforts will result in improved health, hygiene, protective and caring practices. It will also lead to positive collective action and informed demand among affected communities for emergency assistance, supplies and services. All these actions are crucial in protecting and promoting the well-being of children, women and their families when a disaster strikes.

Experience has shown that affected members of communities can become effective agents of behaviour change and mobilisers for disaster preparedness and response. We emphasise the participation of adults, children and young people in recovery, relief and rehabilitation as integral to any strategic communication action plan. Participation has proven to promote psychosocial healing and cohesion among affected community members during times of crises. That affected communities are too shocked or helpless to take responsibilities for their own survival and recovery has proven to be a myth. On the contrary, many affected people, especially the children, find healing and strength and are therefore able to return to normalcy faster when they participate in helping others during and after an emergency. This has been proven for example, by the many inspiring stories shared by both children and adults who were affected by natural disasters in 2004 and 2005 like the tsunami that hit India, the Maldives and Sri Lanka, the floods in Bangladesh and India, and the earthquake that hit northern India and Pakistan.

We extend our gratitude to the many partners and colleagues who contributed their time, expertise and experiences into the preparation of this Toolkit. UNICEF ROSA is pleased to share this Toolkit and invites you to use the many resources it makes available to guide you in training staff and partners as well as in planning, implementing and monitoring behaviour change communication that supports hygiene, health and child protection goals in emergency situations in South Asia.



Cecilia Lotse

Regional Director, UNICEF Regional Office for South Asia

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PART ONE

OVERVIEW



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CHAPTER - 1

INTRODUCTION

CHAPTER - 1

INTRODUCTION

INTRODUCTION

WHAT IS IN THE TOOLKIT?

PART I: OVERVIEW

PART II: PROGRAMMATIC AREAS

PART III: TOOLS

WHY WAS THIS TOOLKIT DEVELOPED?

WHO IS THE TOOLKIT FOR?

HOW WAS THE TOOLKIT DEVELOPED?

HOW TO USE THIS TOOLKIT

INTRODUCTION

This toolkit is a resource for everyone working in emergency situations caused by natural disasters. It is designed to help programme managers from UNICEF, UN agencies, NGO partners and government personnel to prepare, plan, implement and monitor behaviour change communication initiatives supporting health, hygiene and child protection efforts in emergencies.



BANGLADESH: A boy and a girl child carrying her young sibling walk across a flooded village road in Mymensing.

The toolkit stresses the importance of participation and consultation with affected individuals, particularly children and young people. Complementary to this toolkit, UNICEF ROSA has developed an Education in Emergencies Training Package intended for UNICEF education programme officers at all levels - region, country and headquarters.

Behaviour change communication (BCC) in emergencies is a consultative process among communication specialists, technical experts, local change agents and communities. It addresses the knowledge, attitudes and practices of individuals, families and communities. It aims to share relevant and action-oriented information and to motivate programme specialists to work with communication specialists in preparing strategic communication for disasters - so that if a disaster strikes, people in affected communities would know what actions to take to maintain and protect their health and well-being as well as how and where to access emergency services and supplies. BCC should be planned in close cooperation with a given programme as an integral part of an emergency preparedness and response plan.

BCC is grounded on the human-rights based and results-based approach to programme planning and development. It is geared towards facilitating community

mobilisation and participation in preparing and responding to disasters. That affected communities are too shocked and helpless to take responsibilities for their own survival has been proven to be a myth. On the contrary, many affected people, especially children, experience psychosocial healing and are able to return to normalcy faster when they participate in helping others during and after an emergency.

WHAT IS IN THE TOOLKIT?

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You do not have to be a communication expert to use this toolkit. But you should be ready to use participatory approaches which are proven to influence people to make informed decisions, take action and adopt positive behaviours.

The toolkit has three parts: an overview section, several programmatic chapters and many practical tools to plan, implement and monitor a BCC initiative for emergencies. If you require more technical background information on the different programmatic areas, please refer to *UNICEF's Emergency Field Handbook* or *UNICEF's Technical Notes: Special Considerations for Programming In Unstable Situations*, or see some of the other literature recommended in the Further Reading section of the Resource Bank offered at the end of each programmatic chapter.

Part I: Overview

In the overview you will find three chapters. The first maps out the toolkit and will guide you on your journey to planning an effective behaviour change communication initiative for an emergency. Chapter 2 introduces you to the rationale for the toolkit – the abundance of natural disasters in South Asia. You will find some of the most common emergency situations in South Asia; the direct and indirect humanitarian

consequences on the affected community, the risk factors that emergencies cause on health and nutrition, hygiene, sanitation and water supply, immunization and vitamin A, breastfeeding, safe motherhood and child protection. Chapter 3 introduces UNICEF's Core Commitments for Children in Emergencies (CCC) – the overarching organisational framework for UNICEF's humanitarian response. Finally, you will review the definition and rationale for behaviour change communication (BCC) in emergency situations; and principles and action points on how to plan a BCC initiative.

Part II: Programmatic areas

This section has chapters that focus on the following essential programmatic areas in emergencies:

- Hygiene promotion.
- Promoting measles vaccination and vitamin A supplementation.
- Promoting breastfeeding.
- Promoting safe motherhood.
- Supporting child protection and psychosocial development.

We selected these programmatic areas based on UNICEF's Core Commitments for Children in Emergencies (CCC). We designed this kit as a starting point for planning behaviour change communication initiatives for emergencies. You can apply the basic principles and processes presented in this toolkit to other programmatic areas in the CCC that are not included in this volume.

The programmatic chapters follow a standard format that offers information on:

■ Essentials about the subject

This section provides you a snapshot of the programmatic area, explains the importance of, for example, hygiene or breastfeeding promotion during emergencies, and offers some key definitions of terms and concepts. For more detailed guidance on technical matters, consult UNICEF's Technical Notes: Special Considerations for Programming in Unstable Situations, UNICEF's Emergency Field Handbook and other relevant technical guidelines.

■ Principles in promoting the subject

This section outlines the core principles in your communication to help you promote the humanitarian/programmatic area at hand. These principles are derived from good communication practices and lessons learned in emergencies. In some topics such as hygiene promotion, there are firmly established tenets for behaviour change communication. In other areas, the kit offers general principles to fit the specific issue. These principles are by no means exhaustive - rather, it offers

programme planners and managers like you a foundation for your communication initiative. Over time and with accumulation of more evidence, you may review and adapt these principles.

■ Doing the groundwork

Formative research, communication analyses and drawing from standard surveys and rapid assessments are your core elements in the ground work phase. This should ideally take place as part of emergency preparedness. We selected a few tools to help you with the communication-related groundwork. You can find more tools to plan a communication initiative in Part III. Some chapters, e.g., hygiene promotion, provide sample behavioural results. However, since the development of your behavioural result(s) depends on the cultural and emergency context as well as on set priorities and capacities of the affected communities, we have provided a generic tool in Part III on how to develop behavioural results.

■ Getting the message right

This section outlines key messages which you should share quickly in an emergency situation with different audiences - caregivers, service providers, community leaders, etc. We referred to *Facts for Life* in identifying key messages for most of the chapters in this toolkit. You will need to tailor and test the generic messages to the specific context and audience. It is essential for you to involve caregivers, communities, service providers, children and youth and other critical groups in message development, dissemination and feedback gathering across all programmatic areas.



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SRI LANKA: (Left-right) Grade 2 students Vidhurshan Amurthan and Prabin Arulanatham draw and colour in a class in Thampaddai Government School in the eastern district of Ampara. The boys' crayons and the plastic bag bearing the UNICEF logo that is on their desk are from a recently arrived shipment of school-in-a-box supplies. Classes are now being held in temporary structures set up next to the Thampaddai Thidal Camp for people displaced by the tsunami disaster. The school, whose students are from the Tamil community, has been at this site since 20 January 2005. Their original school, located less than 40 metres from the sea, was destroyed during the disaster. UNICEF is also supporting psychosocial activities, including art therapy for traumatized children in schools and camps.

■ Communication actions to promote the subject

This section outlines UNICEF's Core Commitments for Children in Emergencies in different programmatic areas. We included suggested behaviour change communication and social mobilisation activities that have proven to be effective

from past experience. You will need to develop the specific communication actions in partnership and collaboration with relevant government bodies, UN partner agencies, NGOs, other partners and the affected communities.

■ Monitoring milestones

This section outlines suggested indicators to measure and track if the communication efforts are contributing to behavioural changes. The final choice of your indicators will depend on the choice of the behavioural results you want people to manifest.

■ Practical examples

This section provides practical experiences from behaviour change communication and social mobilisation efforts in previous emergencies from South Asian countries and from other parts of the world.

■ Resource bank

This section offers information resources for your further reading, related web sites you can visit and a short glossary explaining the main terms and concepts.

PART III: TOOLS

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PAKISTAN: A young boy helps his older sister carry a pail of water to their tent in one of the camps for families affected by the South Asia earthquake on 8 October 2005.

This section provides several tools that are meant to help with the range of communication planning, rapid assessment and monitoring activities that you may need to undertake for an emergency response. Some tools may come in handy as guides for developing print materials, radio spots, information on ethical issues and more. The tools are divided into three sections: planning, assessment and monitoring, and materials development.

WHY WAS THIS TOOLKIT DEVELOPED?



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MALDIVES: At the start of the new school year, boys stand in a queue at the UNICEF-assisted Qatar School on Gan Island in Laamu Atoll, some 265 kilometres south of Male, the capital. The school is also receiving children who have been displaced from nearby Mundoo Island because of the tsunami.

Many communication efforts launched in emergency responses, such as those following the 26 December 2004 tsunami, tend to focus on media advocacy and public information.

Such communication efforts cater to policy makers, donors and the general public and are designed for advocacy, fund-raising and public awareness of the general situation. While this type of communication is indispensable, it is only one component of a communication response: a holistic communication strategy in an emergency must cater as much to the communication needs of affected families through interactive behaviour change communication and social mobilisation. Behaviour change communication is not a luxury in emergency situations, it is necessary and urgent for it ensures that the most vulnerable – the children and women and their families - have access to accurate and instrumental information about proper practices, available services and supplies that provide sustenance, prevent disease, harm, abuse and exploitation.

While a tenet of communication is to provide information, past experiences show that information alone is insufficient to support behaviour change. Influencing healthy behaviours and creating a supportive social environment in an emergency situation requires that we stimulate an appetite for learning and participation through regular dialogue with the affected community, far beyond the initial response. This type of behaviour change communication and social mobilisation will work when actions, messages and materials are strategically planned, managed, monitored with the affected communities – and supported by the necessary financial and human resources.

We have learned many lessons from the emergency response to the 26 December 2004 tsunami and other natural disasters in South Asia. And we have many proven strategies and tools to support behaviour change communication and social mobilisation efforts that can be applied during emergencies. We developed this toolkit to bridge this critical gap between knowledge and action. We hope that this toolkit will be a useful resource that would further translate our knowledge and past experiences into results-oriented communication actions, by allowing us to better plan, implement and monitor behaviour change communication in emergencies.

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SRI LANKA: A girl washes dishes with other children at a temporary water point at Al-Arham Vidyalaya School in the Addalaichenai area in the eastern district of Ampara. The school, whose students are from a Muslim fishing community, has been relocated to a temporary structure on rented land. The original school, located less than 40 metres from the sea, was completely destroyed by the tsunami. Two of its 350 students were killed during the disaster, and 80 percent of the children's homes were damaged or destroyed. Many of the students have been traumatized and are afraid to return to the original school site. UNICEF has provided the materials for a temporary school building, as well as 12 school-in-a-box kits.

WHO IS THE TOOLKIT FOR?

This toolkit is developed for programme managers from UNICEF, other UN agencies, government and NGO partners and humanitarian organisations who prepare and respond to natural disasters in South Asia.

We also hope that programme managers in Southeast Asia, Africa, Europe and the Americas can use or adapt the information in this toolkit, as a complement to their respective communication initiatives addressed to and involving families and communities affected by natural disasters.



MALDIVES: Children and women, formerly displaced, return to their homes on the island of Diffushi one week after the tsunami disaster.

HOW WAS THE TOOLKIT DEVELOPED?

From early May until the end of June 2005, UNICEF ROSA went on several visits to India Sri Lanka and the Maldives as part of the regional documentation of the tsunami response.

In India, site visits were conducted in camps, temporary schools, health centres and scores of affected communities, including in Nagapattinam, one of the worst affected districts in Tamil Nadu. Affected caregivers, service providers, community volunteers, government officials, UNICEF staff and others were interviewed on behaviour change communication and social mobilization initiatives in various programmatic areas. In Sri Lanka, service providers, caregivers, community leaders, government officials, UNICEF staff and other partners were interviewed in Ampara district and Colombo.

Literature review

Following the country visits, UNICEF ROSA conducted a review of the literature, including lessons learned, good practices and available monitoring tools. This process included reviewing current emergency preparedness and response plans of UNICEF offices in South Asia – and examining how behaviour change communication and social mobilisation efforts are planned for disasters.

Technical review

We invited a number of international experts in communication and disaster management to review and provide feedback on the draft toolkit. In addition, colleagues from UNICEF country offices and the Regional Office for South Asia reviewed, critiqued and contributed materials for the toolkit.

HOW TO USE THIS TOOLKIT

This toolkit aims to generate ideas and provide some stepping stones for programmers to get started in planning, managing and monitoring behaviour change communication for emergencies.

We realize that during an emergency, you do not have the luxury of time to pour over voluminous material, nor to follow long procedures. You can go through a selected programmatic chapter separately, according to your priority or area of interest, and apply only those areas that you deem practical and useful according to your circumstances.

For example, if your interest lies in Safe Motherhood, you can turn to Chapter 7 and look for what you need without working your way through the other chapters of the toolkit. However, there are obvious advantages to reading each chapter as humanitarian issues are cross-cutting and ideas from one programmatic area can be useful for the others.

PAKISTAN: Boys scouts assist in distributing communication materials bearing hygiene messages to children and their families displaced by the 2005 South Asia earthquake.

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The UNICEF East Asia and Pacific Regional Office (UNICEF EAPRO) produced a parallel initiative called CREATE!, a DVD collection (“toolbox”) of ready-to-use or easy to adapt communication materials for emergencies with sample messages on various programmatic areas, including avian flu.

As you develop the strategic communication plan and implementation protocol for an emergency using this toolkit as a guide, you can then match the messages using adapted or modified images and other materials from the CREATE! toolbox to fit your audience’s socio-cultural and physical contexts.



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CHAPTER - 2

NATURAL DISASTERS IN SOUTH ASIA

CHAPTER - 2

NATURAL DISASTERS IN SOUTH ASIA

INTRODUCTION

FLOODS

EARTHQUAKES

DROUGHT

CYCLONES, HURRICANES AND TYPHOONS

EXTREME TEMPERATURES

TSUNAMI

RESOURCE BANK

INTRODUCTION



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Earthquakes, floods, droughts, and cyclones are some of the natural disasters that frequently strike countries in South Asia, causing large scale devastation that affect millions of people.

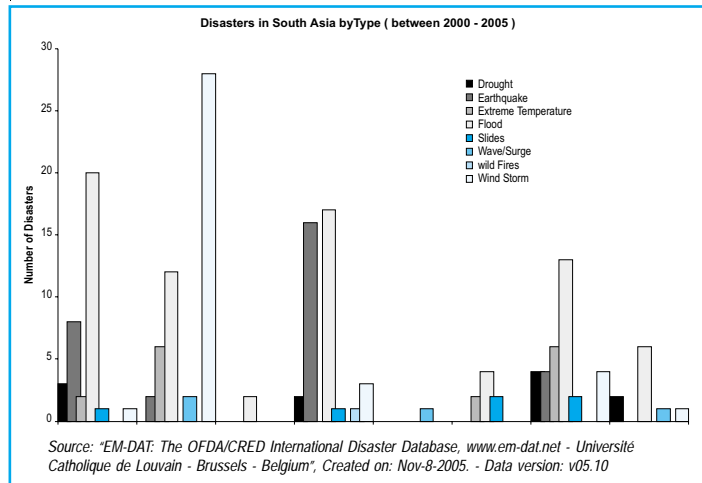
NATURAL DISASTERS
IN SOUTH ASIA

SRI LANKA: Minhaz Haque, 15, stands in his neighbourhood, now destroyed by the tsunami disaster, in the village of Maruthamunai in the eastern district of Ampara. Many of Minhaz' friends are missing and his family house is gone. When the tsunami struck - Sunday, 26 December 2004, when schools were closed - Minhaz was fitting tiles on a roof. He clung to the roof as the water rose, but the house collapsed from under him. He grabbed first a tree, then a refrigerator that was floating by, then managed to find shelter on the roof of another building. When the water receded, Minhaz found that his family - both his parents and five siblings - had survived and are now living in a relief centre.

The graph on the right shows the number of natural disasters by type in South Asia countries from 2000 to 2005.

Natural disasters are commonly differentiated as **rapid-onset** disasters such as storm surges and earthquakes. These calamities can cause

immediate loss and disruption. The other type is called **slow-onset** disasters such as droughts. Both types impact on members of the affected community in many different ways and with varying degrees. This is expressed in terms of **vulnerability** – the people's potential to suffer from harm or loss. Communities may differ in their vulnerability depending on their location (e.g. shoreline or proximity to geologic fault lines), stage of development and other characteristics. Emergency plans may therefore differ accordingly from community to community.



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MALDIVES: (Left-right) Jaushan, 3, and Shabab, 14, look out to sea from their seat on a fallen tree, amidst flotsam from the tsunami that has washed onto the beach, on Meedhoo Island in Dhaalu Atoll, some 145 kilometres south of Male, the capital.

Emergencies call for a range of responses to effectively assist affected families and communities to prepare — and recover. These responses include research-based and experience-based communication activities that enable communities to prepare for emergencies, avoid risks and create an informed demand for urgently needed supplies and services and their proper use.

When you plan behaviour change communication (BCC) for emergencies, be sure to tap on local knowledge and religious practices. Design messages with the community including children and youth. This way, you are sure that the messages, materials and methods of dissemination, whether interpersonal, group or mediated, are socio-culturally acceptable. Closely coordinate with the technical, service and supply components of the larger emergency plan and the humanitarian response. This means that you need to work with partners in mobilising communities with the essential elements of a BCC and social mobilisation initiative as a way of preparing for or responding to the a disaster.

Below is a brief overview of the frequent natural disasters in South Asia countries and their common consequences.¹ Remember that for all these disasters, the consequences on children, women, the physically challenged and other marginalised groups, are likely to be more severe. This is why we must not just mobilise communities to respond to emergencies, but to educate them on how and what to prepare for in order to mitigate injuries, suffering and deaths.



BANGLADESH: A woman walks with her children through floodwater looking for shelter in Kamrangir Char, Dhaka, 2004.

FLOODS²

Floods routinely occur in South Asia leaving thousands displaced and disrupt public, educational and health systems. The severity of a flood depends on the depth and speed of water, duration, rate of rise, frequency and season. Floods are categorised as sudden onset phenomena and have the following main classifications:

- Flash floods
- River floods (mostly seasonal)
- Coastal floods, associated with tropical cyclones, tsunami or storm surges
- Urban floods

Humanitarian consequences

The consequences of floods are felt in the water and sanitation sector because of disruptions to the water supply and sanitation infrastructure. Water pipes and tube wells are blocked. Accessible water is commonly contaminated and pose serious health hazards caused by debris, toxic wastes, chemicals, raw sewage, or even decomposing bodies of animals and humans. Toilets and latrines are destroyed. Thus, defecating and bathing in toilets become unsanitary. Cooking becomes very difficult.

Outcomes can include:

- Drowning
- Grave scarcity of potable water
- Waterborne and vector transmitted diseases
- Hepatitis
- Worm infestation
- Eye and ear infections

- Scabies and other skin infections
- Electroshocks
- Injuries like lacerations or punctures
- Interruption of basic public health services
- Food shortages
- Loss of livelihood and unemployment
- Loan burden is aggravated
- Homelessness/displacement
- Damage to infrastructure, power supply, roads, telecom, and airports
- Disruption of education systems
- Loss of property and support systems
- Negative psychosocial effects on children
- Increased risk of mine injury resulting from movement of landmines by floods and mudslides
- Separation of children from their primary caregivers
- Increased risk of sexual abuse and exploitation.



PAKISTAN: A school that was damaged by the South Asia earthquake.

© UNICEF Pakistan

EARTHQUAKES

Earthquakes can be defined as the shaking of the earth, caused by the movement of waves on and below the earth's surface. This causes surface faulting, tremors vibration, liquefaction, landslides, aftershocks and/or tsunamis.³ South Asia is prone to earthquakes as many countries in the region are situated on or along fault lines, or are in the seismic range of earthquakes.

Humanitarian consequences

The consequences of an earthquake can vary tremendously, from near-total devastation of infrastructure in a heavily populated area, to limited destruction of areas that are sparsely inhabited. Strong underwater earthquakes can cause major movement of water masses, or tsunamis.

Outcomes can include:

- Internal injuries, crush syndrome and death
- Asphyxia
- Trauma
- Dust inhalation (acute respiratory distress)
- Exposure to the environment (i.e. hypothermia)
- Minor cuts and bruises, fractures
- Burns and electroshocks
- Disruption of food and water supply
- Interruption in basic health care services
- Damage to water and sewer systems
- Diarrhoea and cholera outbreaks
- Homelessness/displacement
- Negative psychosocial effects on children
- Increased number of children separated from primary caregivers
- Increased risk of sexual abuse and exploitation
- Damage to infrastructure energy lines, roads, telecom, and airports
- Isolation and physical inaccessibility to relief supply sources
- Disruption of education systems

DROUGHT

Drought is a prolonged dry period in a natural climate cycle. It is a slow-onset disaster caused by too little rainfall combined with other predisposing factors. Drought leads to water and food shortages and is likely to have long-term environmental, economic and health impacts.

Humanitarian consequences

Drought can often be anticipated and commonly requires an immediate, long-term and well-coordinated response. Although warning is possible, a sudden movement of people to an extremely dry or drought-affected area (because of unrest, conflicts or other natural disasters) can have great consequences on the health and nutrition of small children.

Consequences can include:

- Lack of potable household water and agricultural water supply
- Damage to crops and disruption of agriculture-based livelihoods
- Reduced food intake and lack of varied diet
- Protein-energy malnutrition
- Micronutrient deficiency such as iron, vitamin A and C
- Communicable diseases
- Lack of hygiene and sanitation facilities
- Cholera, typhoid fever, diarrhoea
- Acute respiratory infections
- Migration
- Erosion of coping and caring capacities of caregivers

CYCLONES, HURRICANES AND TYPHOONS



BANGLADESH: Girls traveling by makeshift raft in the outskirts of Dhaka, 2004

© Fatima Khan/FP/UNICEF

Tropical cyclones are among the most destructive and fearful natural phenomena. The impact from cyclones extends over a wide area, with strong winds and heavy rains. However, the greatest damage to life and property is not from the wind, but from secondary events such as storm surges, flooding, landslides and tornadoes. Drowning and catching water borne and vector-borne diseases increases if the cyclone is accompanied by floods and sea surges.⁴

Humanitarian consequences

Humanitarian consequences of cyclones, hurricanes and typhoons can vary considerably, and relief responses are similar to those for earthquakes and floods. In most cases, priority is given to health, water and sanitation interventions to avoid the risk of epidemics, contamination, pollution and disruption of the public distribution systems.

Outcomes can include

- Trauma
- Injuries and death
- Asphyxiation due to entrapment
- Electroshocks or drowning
- Short and long term mental health effects
- Water borne and vector transmitted diseases
- Damage to health infrastructures and lifeline systems
- Food shortages and interruption of basic public health services
- Loss of property, livelihoods, crops
- Interruption to educational system
- Separation of children from their primary caregivers

EXTREME TEMPERATURES⁵

Extreme climate and weather patterns affect communities in many countries in South Asia. While people adapt to the conditions in which they live, extremely cold and hot weather can have powerful impacts on the health and life of families and communities.

Humanitarian consequences

Marked short-term fluctuations in weather can cause acute adverse health effects. In extremely cold temperatures, acute respiratory infections that may lead to pneumonia are the major risks for children. Extreme cold can also cause hypothermia, an extreme lowering of the body's temperature and death.

Outcomes can include:

- Extremes of both heat and cold can cause potentially fatal illnesses, i.e. heat stress or hypothermia, as well as increasing death rates from heart and respiratory diseases.
- In cities, stagnant weather conditions can trap both warm air and air pollutants - leading to smog episodes with significant health impacts.
- Damage to crops, land
- Potential food shortages

TSUNAMI⁶



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MALDIVES: A child's drawing shows the chaos caused by the tsunami, with a girl taking refuge on the roof of a house that is, like the tree beside it, half-submerged in the water. Both the girl and the house top are depicted in red. The Government's Psychosocial Support Unit notes that the choice of a particular colour can be an indicator of stress, with red often denoting strong emotions. The artwork was created as part of a Government-sponsored psychosocial programme to help children recover from the trauma they experienced. Materials from UNICEF-supplied school-in-a-box kits were used in the project.

Tsunamis are giant sea waves that are produced by an underwater earthquake or slope collapse into the seabed. Tsunamis can travel thousands of miles at high speed with very little loss of energy. They reach the coast with devastating impact on shoreline communities. Successive crests can arrive at intervals of every 10 to 45 minutes and wreak destruction for several hours.

Humanitarian consequences

The destruction level along the shores affected can be immense, with vast coastal areas deprived of their infrastructures and entire communities washed away. The humanitarian consequences are directly proportional to the power of the tsunami, the geography of the coastline, the level of the infrastructure and the size of the communities living along the affected coasts.



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NATURAL DISASTERS
IN SOUTH ASIA

Outcomes can include:

- Drowning
- Injuries
- Water borne and vector transmitted diseases
- Outbreaks of communicable diseases
- Poor sanitation, hygiene
- Negative psychosocial effects on children
- Food shortages
- Interruption of basic public health services
- Disruption to educational systems
- Loss of property, livelihood, crops
- Damage to infrastructure
- Large scale displacement
- Separation of children from primary caregivers
- Increased risk of sexual abuse and exploitation

MALDIVES: Two boys search through debris that has been piled up on a beach on the atoll of Haraa one week after the tsunami disaster.

RESOURCE BANK

Further reading

- 1 International Federation of Red Cross and Red Crescent Societies, World Disasters Report, Focus on Information in Disasters, London, 2005.
- 2 ITDG South Asia, RDPI, Livelihood Centered Approach to Disaster Management: A policy framework for South Asia, ITDG, Colombo, 2005.

Web sites

1. Asian Disaster Preparedness Centre
<http://www.adpc.net/>
2. Centre for Hazards and Risk Research at Columbia University
<http://www.ldeo.columbia.edu/chrr/>
3. Centre for Research on the Epidemiology of Disasters (CRED)
<http://www.cred.be/sitemap.htm>
4. Emergency International Disaster Database
<http://www.em-dat.net>
5. Humanitarian Early Warning Service
<http://www.HEWSweb.org>
6. The International Federation of Red Cross and Red Crescent Societies
<http://www.ifrc.org/index.asp>
7. The Sphere Project
<http://www.sphereproject.org/>
8. US Centre for Disease Control and Prevention
<http://www.bt.cdc.gov/disasters/>

Footnotes

- ¹ Much of the following information has been adapted from United Nations Children's Fund, *Emergency Field Handbook*, UNICEF, New York, 2005 and World Health Organization, *Floods - Technical Hazard Sheet - Natural Disaster Profile*.
- ² Adapted from World Health Organization, *Floods - Technical Hazard Sheet - Natural Disaster Profile*.
- ³ Adapted from World Health Organization, *Earthquakes - Technical Hazard Sheet - Natural Disaster Profile*.
- ⁴ Adapted from World Health Organization, *Cyclones - Technical Hazard Sheet - Natural Disaster Profile*.
- ⁵ Adapted from World Health Organization, *Climate and health Fact sheet*, July 2005.
- ⁶ Adapted from World Health Organization, *Climate and health Fact sheet*, July 2005.



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CHAPTER - 3

BEHAVIOUR CHANGE COMMUNICATION IN EMERGENCIES

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BEHAVIOUR CHANGE COMMUNICATION IN EMERGENCIES

UNICEF'S CORE COMMITMENTS FOR CHILDREN IN EMERGENCIES

BEHAVIOUR CHANGE COMMUNICATION PRINCIPLES FOR EMERGENCIES

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RESOURCE BANK

UNICEF'S CORE COMMITMENTS FOR CHILDREN IN EMERGENCIES



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UNICEF's support for behaviour change communication in emergencies is guided by the Core Commitments for Children in Emergencies (CCC), which provide the overarching organisational framework for a humanitarian response.¹

Core Commitments for Children in Emergencies

UNICEF's Core Commitments for Children in Emergencies are not merely a mission statement - they are a humanitarian imperative - in health and nutrition, water, sanitation and hygiene, protection, education, HIV/AIDS and programme communication or behaviour change communication. Emergencies particularly in South Asia have grown increasingly complex, and their impact is especially devastating on the most vulnerable. In the midst of these crises, children and women are not only incidental victims, but increasingly are often targets of wilful violence and abuse. In many cases, they are denied access to basic services and essential relief supplies. The CCC provides a framework from which to work with partners from the government, United Nations and non-governmental sectors.

The commitments outline UNICEF's role in providing protection and assistance to children and women. They make a clear distinction between life-saving interventions, which should be carried out immediately - within the first six to eight weeks of any

The two fundamental tenets supporting all UNICEF operations are:

- The Convention on the Rights of the Child, and
- A commitment to a human-rights based approach to programming.

crisis - and the broader spectrum of essential activities that may be added beyond the initial response. Although this distinction is clear for sudden onset emergencies, the logic of the CCC should apply to all humanitarian crises: focus first on interventions proven to be essential for immediate survival and protection.

UNICEF adheres to the following key principles in fulfilling its Core Commitments for Children in Emergencies:

- Children in the midst of armed conflict and natural disasters such as droughts, floods and earthquakes have the same needs and rights as children in stable conditions.
- UNICEF's response will recognise the priority of humanitarian action while assuring safe access to affected populations, and the safety and security of staff and assets.
- The emergency response will build on existing activities and partnerships developed through the country programme of cooperation.
- The response will be based on nationally defined priorities and UNICEF's comparative advantage.

Behaviour change communication plays an essential, albeit often neglected, part in any emergency. In the past, many emergency responses in South Asia tended to focus on providing supplies and setting up services. Little attention was paid to addressing risky practices, poor habits and communication needs based on the existing knowledge, beliefs, attitudes and practices of the affected individuals and families. Also insufficiently addressed was creating awareness and demand for emergency supplies, services and assistance among affected families and communities.

Experiences from the tsunami response in South Asia showed that communication preparedness for emergencies, risk communication and behaviour change communication (BCC) initiatives that benefit affected individuals and communities were not always adequately given importance, funding, and thus were not coordinated, planned, managed or monitored well. Fulfilling the Core Commitments for Children in Emergencies, however, requires that BCC initiatives become an integral part of preparing and responding to emergencies.

The following section offers you an overview of the basic communication related principles to help you prepare for and respond to in an emergency. It outlines the essential steps you need to take in developing a rapid communication action plan. It points out some issues you need to consider when designing appropriate communication messages and channels with the affected communities during emergencies.



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BEHAVIOUR CHANGE COMMUNICATION PRINCIPLES FOR EMERGENCIES

Keep in mind the following basic principles for your BCC initiatives. These principles are built around the CCCs and thus contribute to overall efforts to prepare and respond to emergencies.

Before an emergency strikes:

- **Prepare accordingly**

Planning and preparation for BCC are vital steps that must take place long before an emergency strikes. UNICEF country offices have the responsibility to identify and develop 'Emergency Preparedness and Response Plans' (EPRP) for potential natural or man-made disasters. Based on experience and evidence from past emergencies, define what kinds of results, that is, behaviours, in terms of specific knowledge, attitudes and practices your intended audience groups need to develop, perform or reinforce, and sustain. You need to also define what kinds of communication support and resources your team of partners would need so that the BCC response would support the overall humanitarian response.

- **Invite different partners to come together to plan jointly**

BCC initiatives are prepared with partners from different sectors, including government, UN agencies, NGOs and humanitarian agencies. Keep in mind that communication efforts, to influence positive behaviours, have to be closely linked to other programme, service and supply plans for an emergency. Therefore, you will need to ensure that you establish a sustained collaborative arrangement with relevant partners.

- **Engage communities in preparing and planning for emergencies**

The human rights-based approach to programming stresses participatory approaches that engage communities in planning, implementation and monitoring

processes. This means that we should build on what people already know and that we recognize their social and cultural strengths. However, communities are not homogeneous. Keep in mind that vulnerabilities related to age, gender inequalities, ethnicity, caste, socio-economic status and disability, are factors that may affect people's ability to take part in decision-making processes.

- **Invest in communication research**

Communication research addresses the critical information gaps that you need to fill to enable you to adequately prepare and plan for emergencies.

Conducting communication research will be a wise investment for it will save you time and resources later. Ensure that you disaggregate data from such research by sex, age and other variables which can impact on people's behaviours, such as ethnicity and income levels. In the face of an emergency, when information from previous communication research is not available, the best alternative is to conduct a rapid communication assessment. Prepare a monitoring and evaluation (M&E) plan as well. M&E enables you to track your progress and impact at given periods of the emergency response in terms of message and channel reach, resource use and most of, all in terms of desired behaviour results.

- **Prepare action oriented communication materials**

Be ready with sample messages and materials that have been pre-tested such as those on maternal health, nutrition, immunization, disaster-related stress, water and sanitation, and child protection. This will save you precious time and resources. Countries with landmines will also need mine-risk education materials in advance. Having a central website with downloadable files ready for printing will be useful preparations for an emergency. It will also be handy to set up a database of available writers, editors, designers, printing houses, and radio and TV producers so that contracts could be quickly drawn up.

- **Develop a communication protocol and partnerships that will collaborate in communication efforts**

During an emergency, information overload and confusion is likely to happen, especially when the impact is large scale and if there is little coordination among different actors providing assistance. Agree with key partners and have a plan which outlines how communication efforts will be coordinated, with clearly defined roles and responsibilities. Agree on how information will be managed. This should also help to prevent and manage rumours and misinformation, two unwanted results that often happen during emergencies.

- **Train service providers in interpersonal communication skills**
In times of stress and trauma caused by a disaster, health workers and other service providers need to possess and maintain good interpersonal communication skills to inform, motivate, counsel and encourage people affected by emergencies. They also need to know how to deal with the distress and anxiety experienced by people who come for assistance as well as among themselves.
- **Test the communication plan by drills and exercises**
Many BCC plans for emergencies fall short when they clash with harsh realities. You need to test your assumptions and nurture positive mindsets and skills that can be harnessed when everything is in chaos. Test your communication approaches. Carefully test and review them with affected people, to ensure that these are practical and feasible under the circumstances of the emergency. This also implies that your BCC plan should help build the necessary confidence and skills among staff and partners to overcome fear, stress and anxiety.

If an emergency strikes

- **Establish a central health education and communication coordination centre**
Partners from government, UN agencies, NGOs, religious communities, media, children and youth groups and others need to coordinate, plan, manage and monitor communication initiatives with affected communities during the emergency response. This will avoid duplication, misunderstanding, rumours and misinformation and maximize communication efforts.
- **Participate in sectoral assessments**
When health, water and sanitation, child protection and education assessments are conducted in the initial phase of an emergency, it is critical that the different sectoral assessments also identify any high risk practices that have implications for behaviour change communication among affected caregivers and communities. This information is critical to map out the detailed emergency responses for different sectors.
- **Conduct a rapid appraisal of communication channels and resources**
Assess the availability and reach of media and other communication channels. Determine media access among affected communities. Are media and other communication channels (e.g., national, provincial and community based radio) still functioning? What about commercial as well as university based radio stations, are they ready to support BCC in an emergency? Can they be

mobilized, for instance, for hygiene promotion, disease prevention and the protection of displaced/unaccompanied children? What logistical requirements, as well as gaps and problems could you anticipate? What appropriate, low-tech communication channels could be urgently set up that would work without electricity? As the response unfolds, look out for new as well as existing opportunities for persuasive interpersonal channels that existing or newly set up community communication channels could support - for example, the Military, Red Cross workers, children and youth groups like Girl Guides, Boy Scouts, Child Clubs, other community-based channels - for communicating quickly with affected populations.

- **Focus on re-establishing existing behaviours and norms**
In the initial emergency phase, concentrate on re-establishing positive behaviours that existed prior to the emergency. Focus not only on individual behaviours and actions, but seek to re-establish positive social and cultural values that are temporarily disrupted. However, depending on the situation, be aware that emergencies might also provide opportunities to promote new behaviours.
- **Forge alliances**
Build alliances to include relief workers, service providers, journalists and others so that they are able to support directly desired behaviours of affected people.
- **Facilitate community and children's participation**
Be pro-active in creating opportunities for affected caregivers and communities, including children and young people, to participate in determining issues and solutions in the emergency response. Take particular care to include especially vulnerable groups, whether this requires inviting representatives from children and young people's organisations, women representatives, religious leaders, asking vulnerable populations to nominate spokespersons or advocating with camp management and local authorities to consult affected communities.
- **Follow humanitarian imperatives**
Humanitarian needs should always take precedence over political and other agendas. In our communication efforts, we also might have to advocate for cross boundary cooperation, support and compassion.
- **Have a detailed communication plan**
Based on your emergency preparedness plan, develop with your team and partners the details of the communication initiative(s) for the different phases of an emergency. In the following section, you can gain from an overview of the essential steps in developing a communication plan.



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STEPS IN DEVELOPING A COMMUNICATION PLAN

Developing a communication plan to influence behaviour change or reinforcement does not have to take long. But it is an essential component of the overall emergency plan. A plan is necessary to ensure greater behavioural impact. It allows you to get the most out of your budget, to measure any changes, to motivate people to achieve intended results – and is just plain good management.

When you develop a behaviour change communication plan, design each step to be as participatory as possible. Participation in all steps of the process allows community representatives to participate in decisions, develops a sense of ownership and helps affected communities achieve a sense of normalcy in their disrupted system.

If an emergency strikes, usually the exact details of a communication plan will have to be outlined - often under pressure and with little time. Here are some essential steps you can follow when developing the details of a communication plan for an emergency.

Step One

Bring all stakeholders together: Work with the various stakeholders together (from a given programme or related sectors at a time, e.g., health and hygiene) from government, UN agencies, NGOs and community representatives as quickly as possible to determine:

- What behaviour results should your communication plan for this programme or sector achieve in the rescue and survival phase; in the recovery phase; and the rehabilitation and development phase of the emergency?
- What are the roles and responsibilities of the different partners?

- How will the plan be funded, implemented, monitored, documented and reported?
- How will the monitoring results be used in the different phases of the emergency?

Step Two

Plan and conduct a rapid communication assessment based on an appropriate combination of tools and applying the next steps below. (Please see also Part 3: Tools)

Step Three

Determine your audience/s and define SMART behavioural objectives and results.

Based on the rapid assessment and on data from any pre-existing communication research, determine who your audience groups are among the affected population. Define the specific desired behavioural objectives or results you would like to achieve from your communication plan. These behavioural results may vary for the different phases of an emergency response. Define behavioural results so that they are:

1. **Specific** in terms of an issue (a behaviour, a skill, knowledge, attitudes), of a specific group and of the geographical location.
2. **Measurable** in such a way that changes in people's behaviour can be measured, either quantitatively or qualitatively.
3. **Achievable** in that the behavioural results correlate to a target that can feasibly be attained by the programme partners with UNICEF and others' support, and that all necessary resources are identified and budgeted.
4. **Relevant** so that the planned behavioural result(s) represent a milestone in the results chain, and will contribute to the achievement of commitments for the emergency response.
5. **Time-bound** in that a time frame has been set within which change is expected to happen.

Keep in mind that behavioural results have to contribute to the overall results - health and nutrition, child protection, education, water and sanitation - in the emergency.

Step Four

Based on the specific intended behavioural results, determine the details of the communication plan:

- Which combination of communication strategies to use: advocacy, BCC, social mobilization?
- Which groups of people to involve as partners, to mobilise, orient or train?
- What specific training needs and orientations are required, for which group/s for the plan to be carried out quickly?

- Which communication activities, main messages and materials? Where can you obtain examples of messages and materials that you can quickly adapt?
- What mix of communication channels (e.g. mass media, interpersonal communication, community media, etc) by which phase of the emergency?
- What is the dissemination plan for the communication messages and materials?
- What is the timeline for communication activities during different phases of the emergency?
- What is the monitoring (including indicators and means of verification), evaluation, documentation and reporting plan?
- What is the total budget?

Step Five

When implementing the plan, keep the following in mind:

- Pre-test messages and materials with representative groups from different affected communities;
- Conduct the training early on, which may include training of interpersonal communicators such as animators, peer educators, health workers, teachers and young people;
- Orient and involve journalists in your efforts;
- Mobilise partners and communities to support and implement the plan.

Step Six

Establish a monitoring system

Manage and monitor communication activities as part of the overall emergency programme monitoring effort. Ideally, use community monitoring systems among affected population groups. Based on the monitoring data, adjust activities and materials accordingly. Programme and service delivery data, such as immunization drop out, decrease in diarrhoea rates, also serve as monitoring information and should be used to modify communication activities or messages.

Step Seven

Evaluate and re-plan: Based on the desired behavioural results, assess outcomes and if possible any behavioural impact. Disseminate results to partners - including affected community members. Determine the need for follow-up and for continued support to shape behaviours, and for communication support in the recovery and rehabilitation phase of an emergency. In evaluating impact, contributions that can be linked to communication efforts should be an integral part of a programme evaluation rather than a separate evaluation of communication initiatives.

COMMUNICATION STRATEGIES IN EMERGENCIES

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INDIA: A woman and a girl draw water from a pump set up in a tent camp for people displaced by the tsunami in the seaside village of Mudtukadu, near Chennai, capital of the southern state of Tamil Nadu, India.

Communication initiatives are not a 'luxury' in an emergency. It is a necessary component of efforts to ensure the survival, health, development, protection and psychological recovery of an affected population.

In past emergencies, many relief and humanitarian aid workers relied on IEC (information, education and communication) materials alone without the benefit of strategic planning with relevant partners and affected communities based past evidence or on a rapid assessment. Posters and pamphlets were churned out without clearly defined behavioural results and without a communication plan in place. This was done with the hope that behaviours would change if the affected people receive the "right" information as quickly as possible. While providing information to affected populations is essential, it is only one ingredient in the larger process of behaviour and social change in an emergency.

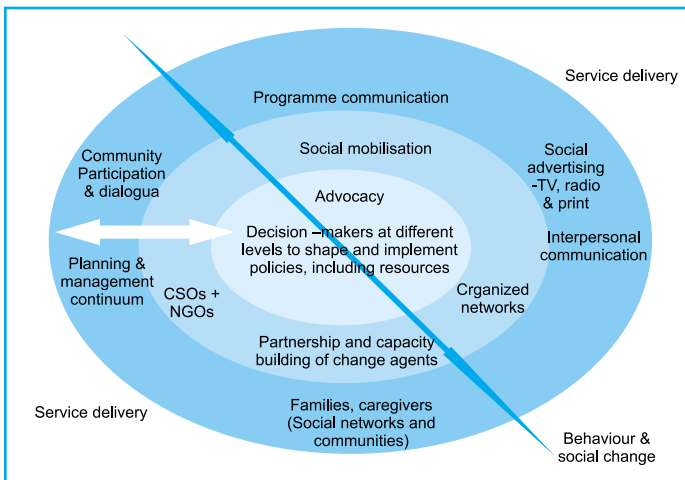
We need to keep in mind that effective communication strategies for emergencies, as for stable situations:

- Are grounded on concepts that range from social psychology, learning theories, role modelling through audience-appropriate combinations of mass media and interpersonal communication approaches, and the proper use of advocacy and social mobilisation.
- Are informed by the policy and legislative environment.
- Are evidence-based and results-oriented.
- Never work in isolation. Communication initiatives must be planned, based on evidence, coordinated and implemented in close synchrony with the programmatic, service and relief supply components of an emergency response.
- Are based on dialogue with and active participation of affected community members, including the children.
- Are based on close collaboration and networking with partners to synchronize messages, materials and channels, and to scale up communication efforts.

UNICEF engages three strategic communication approaches: behaviour change communication, social mobilisation and advocacy. The following figure illustrates how the three distinct dimensions of communication are united through the planning and management continuum (represented by the arrow on the left). The figure shows how communication is integral to programmes and affirms the importance of linking communication activities to service delivery.

Strategic communication model²

Communication approaches: some definitions



Remember that information alone, using IEC materials, is not enough to influence sustainable healthy behaviours and to create a supportive social environment in an emergency situation. If your strategy is dominated by one-way information dissemination, it may result in increased awareness but may have limited impact on improving behavioural and social norms. It is critical for you to stimulate shared learning through dialogue, participation and discussions with members of the affected communities in emergencies. Involving affected families and communities allows them determine among themselves what needs to be done, and by whom in the long run, thus establishing a sense of ownership of the processes in the different phases of their recovery. To support such positive behaviour and social changes, you need to employ three interrelated, interdependent and interactive strategic communication approaches in emergency situations.

Behaviour change communication

Behaviour change communication (also referred to as programme communication in UNICEF) attempts to bridge the gap between information, a person's knowledge, attitudes and subsequent behaviour. This approach addresses the knowledge, attitudes, practices and skills of individuals, families and communities as they relate to specific programme goals. Within a participatory communication framework, individuals and communities gain knowledge, appreciations and skills that motivate them to develop positive, healthy and protective practices. BCC requires a sound understanding of the audience(s) and the use of an appropriate mix of communication channels - interpersonal, group, community and mass media. It also recasts the role of the "communicator" as facilitator rather than "expert". Behaviour change communication has proven to be more effective when complemented by well-planned and implemented advocacy and social mobilisation strategies.

Social mobilisation

The purpose of social mobilisation is to bring together relevant inter-sectoral partners to determine needs and raise awareness for a particular objective in an emergency response. It involves the identification of organisations, institutions, groups, networks and communities who can contribute their efforts and resources. It involves facilitating their participation to realise the goals of an emergency response. Social mobilisation helps build the capacity of these mobilised groups in the process, so that they are able to mobilise resources, plan, implement and monitor programme activities with the community or camps as the case may be. This approach should support actions and priorities identified by communities, especially the most vulnerable groups whose rights tend to be consistently denied. Social mobilisation activities should stem from community action, but must receive support and coordination services.

Advocacy

Advocacy is directed at different levels of decision makers - people who have the power to create policies, programmes and structures and to allocate resources. By persuading decision makers to decide in favour of a cause, advocacy seeks to develop, change or modify an existing law, policy and/or administrative practice that would enhance the emergency response. It is a continuous and adaptive process of gathering, organising and transforming information into arguments. These arguments are then communicated to decision makers, to influence their choices to raising resources (human and financial), or demonstrate political or social leadership and commitment to an emergency response. A goal of advocacy is to influence leaders and decision makers at different levels to make it easier for affected communities, families and individuals to make healthy choices for their own physical and social well-being, and ultimately to protect the rights of children.

USING APPROPRIATE COMMUNICATION CHANNELS

In the initial relief phase of an emergency you must find ways to reach as many affected people as fast as possible with your messages. During this phase, communications systems may be temporarily out of

commission. Low cost and low-tech communications systems are often the most practical and effective during such difficult circumstances. Megaphones, car battery-operated public address systems, community radio (also powered by battery or generators) are good ways to quickly disseminate messages to affected families and communities. Properly organised public gatherings and community or camp meetings provide further opportunities to quickly share information.



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INDIA: With the aid of a mobile loudspeaker system UNICEF animators demonstrate how to prepare Oral Rehydration Salts (ORS), part of a health campaign in relief centres for tsunami-affected displaced people, in the Union Territory of Pondicherry. The teams are promoting the use of ORS and good hygiene practices to prevent and treat diarrhoea and other water-related diseases.

Choose more than one communication channel to help reinforce the information. Beyond using mass and small media, interpersonal and participatory community based media are indispensable channels to lead communication efforts aimed at improving or changing behaviours and in sustaining such behaviours.

To choose the right mix of channels in the different phases of an emergency response, consider the following:

- How do affected families and communities seek information?
- How do affected families and communities share information?

- Who are trusted and respected spokespeople in the community or relief camp?
- Which groups have access to generators, mobile phones, megaphones, public address systems, radio or TV? Which groups among the affected population do not have access to any media?
- What traditional, telecommunications and mass communication channels are available? If available, using these in an emergency is often easier and more efficient than setting up new ones.
- Which groups can you reach via community-based group channels such as social or religious functions?

Example of mixing communication channels

UNICEF India supported the following post-tsunami child protection initiatives in Tamil Nadu using a mix of different channels and strategies:

- Government officials attended a conference with multi-media presentations designed to educate them on the importance of preventing child abuse, trafficking and other harmful practices to children.
- A child protection awareness campaign was initiated where booklets, posters and banners with information on abuse and trafficking were printed along with phone numbers of a helpline to report child trafficking cases.
- Posters with relevant messages and Child Line hotline phone numbers were printed and distributed to schools and child care centres.
- Several hundred community "watch dog" committees were set up and trained to identify and report child abuse and trafficking cases.
- A state level action plan was drafted to respond to trafficking issues and commercial sexual exploitation of children and women.

Soon after the tsunami that hit on 26 December 2004, UNICEF Maldives collaborated with the Health Education Unit of the Ministry of Health to produce, approve, pre-test and disseminate a new package of materials on the proper disposal of dead fish and dead bodies, on mosquito control, diarrhoea prevention and treatment guidelines. This was done via fax and emergency supply channels. Videos were also produced and aired as TV spots and shown in hospitals and health centres that were equipped with Closed Circuit Television (CCTV). Radio spots were also produced and aired by the Voice of Maldives, the state-run station.

In the Maldives, 24 hours after the resumption of telecommunications services, TV transmissions were available on almost all the islands that have a high penetration of TV and radio signals. The director-general of health services delivered messages on how to prevent and control diarrhoeal diseases and on personal hygiene and sanitation via his daily TV address.

Useful communication channels in an emergency

Mass media

The mass media include print, radio, television and cinema. When operating during an emergency, these media can reach large numbers of people in a short time. The mass media are most effective when coupled with other communication approaches through which the affected community can talk about the new information with someone whom they trust, such as community opinion leaders.

Consider these points when you use mass media in an emergency:³

- Depending on the consequences of an emergency, the mass media can reach a substantial number of people.
- Enjoys credibility.
- Can be important channel for advocacy as it can reach and get the attention of policy-makers, senior officials and community leaders.
- Not participatory in nature.
- Messages may tend to be for general consumption, not taking into account the unique needs of the affected community.
- Might reinforce gender based stereotypes (e.g. portraying women as helpless victims)
- The affected population may not have access to radio or TV.

Small format community media

Small format community media are often the most practical, useful and effective in reaching affected people during an emergency. These media include community radio (generator or battery-powered FM transmitters), community bulletins or flyers, and loudspeakers or megaphones - stationary (e.g., those in mosques) or itinerant (connected to vehicles). In an emergency, you can use these types of small community media to quickly disseminate information to a camp or affected community. With community coordination and support, you can plan, conceptualise, produce and disseminate messages with affected community members.

Points to consider in using small format media in an emergency:

- Participatory in nature, involving all possible community groups.
- Requires how-to knowledge, therefore you need to engage participants in basic training.

UNICEF India used the loudspeakers from mosques to broadcast news about the measles and vitamin A campaign in the tsunami camps of Nagapattinam. During the first two days, more than 14,000 children were immunized and given vitamin A.

- Easy to set up.
- Needs oversight to make sure it is not abused or exploited by political factions.

Interpersonal communication channels

Interpersonal communication (IPC) refers to face-to-face communication. IPC can either be one-to-one or in a small group. IPC makes it possible for people to exchange information, express their feelings and obtain immediate feedback, respond to questions and doubts, convince and motivate others to adopt certain behavioural practices. IPC requires listening skills, the ability to empathise and be supportive. IPC in a crisis situation is particularly useful in counselling approaches such as through hotlines, clinic consultations, in training service providers and community volunteers as peer educators, through pep talks by specialists, and for facilitating group meetings where the affected community can share and discuss the issues at hand.

Peer educators

Peers are persons who belong to the same age group and social cultural background. In addition to promoting healthy behaviours, we can build local capacity by training peer educators in effective communication and participatory approaches. Even after the end of a emergency communication initiative, these individuals can continue to pass on messages through casual conversations with friends, family members and their wider peer group.

Points to consider in tapping peer educators in an emergency:

- They can be easily organised in emergencies but you must invest in training which takes time.
- They need supportive supervision.
- Affected individuals can both give and receive information.
- Does not need to be costly.
- If planned and supported well, can be an effective way to motivate people.
- Affected people may not have a lot of time in an emergency to participate in meetings.
- Sharing personal information may not be culturally acceptable in some affected communities and will require time to establish trust.
- Messages spread via word-of-mouth may diminish message accuracy.

Through the community-based approach, UNICEF Sri Lanka worked with partners to train individuals within villages to identify, assist and refer other community members who may need psychosocial support. UNICEF reported that an estimated 43,000 children participated in and benefited from this effort.

Participatory drama

Participatory drama is an important aspect in the preparedness and recovery phases.

This type of communication method allows the affected community to be directly involved in the drama itself. This gives individuals greater control, and helps them to explore issues and possible solutions. Participatory performance emphasises working with and from the affected community's own reality, and choosing their own modes of expression. Local people replace outside scriptwriters, illustrators, editors, directors and actors and become actively involved in creating and exploring solutions to a real life situation. Through participatory drama, you can encourage participation in the decision-making, implementation, monitoring and evaluation phases of relief and recovery projects.⁴

Points to consider when using participatory drama in an emergency:⁵

- Stimulates critical thinking, stresses process rather than outcomes.
- Community can prioritise their needs.
- Develops a sense of community ownership.
- Offers a creative approach to deal with distress and trauma and thus supports healing among affected community members.
- Can be time consuming for the initial emergency response because of need to raise consciousness through IPC and relationship-building while it promotes sustainability.
- Castes, class, gender and other social variables can create different realities for some members of the affected community. Be sensitive to the cultural and gender-based specifics and act accordingly, by resorting to locally appropriate and innovative means of achieving equal participation.
- Community members may lack the commitment to the process if there are no perceived benefits.

Local folk media

Local folk media can include music, local art forms, local theatre, puppetry, drawing or dance. Many affected communities have their own traditional media forms to express themselves. Local ways of communicating are powerful avenues to stimulate psychosocial healing, return to normalcy and motivate affected families and communities to practice healthy behaviours.

Points to consider for an emergency:

- Information can be presented in the most culturally appropriate forms.
- Messages can be adapted to suit the needs of the affected community by local as well as imported experienced performers.
- Most folk media are entertaining and hold the attention of the audience, allowing them to be temporarily distracted from the realities at hand.
- It takes time to research on which folk media are acceptable to the affected community.
- Local participants need to be identified and trained on the messages to be shared.

- Technical information can be difficult to communicate.
- The actors may not be able to ad-lib or be spontaneous in acting out the local art forms.

Information, education and communication (IEC) materials

IEC materials with prepared messages can be conceptualised as part of a communication preparedness plan before a disaster strikes. You can easily adapt and produce these as part of your BCC programme provided messages, design and presentation are duly pre-tested with the intended audience groups. Once a disaster strikes, producing and disseminating IEC materials can be a quick way to reach a large number of affected people. This form of communication typically leads to 'awareness raising' of an issue, and serves to reinforce existing knowledge and



practices, such as the importance of hand washing, but this may not necessarily lead to changes in behaviour. IEC materials include radio public service announcements in print form, posters, leaflets, brochures, videos, flip charts, banners, and promotional items like T-shirts and badges.

Points to consider when using IEC materials in an emergency:

- Generic messages addressed to and pre-tested with specific audience groups, for example, on hygiene, can be conceptualised, researched, tested and printed before a disaster strikes.
- Easy to do in initial response.
- Good way to get information out fast.
- Awareness of message does not equal action.
- Messages disseminated can easily be ignored, forgotten or cause confusion.
- Each message needs repetition and reinforcement through other communication channels.

To prevent loss of lives due to landmines that might have been unearthed by the tsunami, UNICEF Sri Lanka launched a land mine awareness campaign. A total of one million school timetables with mine risk education messages were produced and included in the school-in-the-box.

When you decide on the communication channels to use in an emergency situation, keep in mind to mix media and interpersonal communication channels based on audience realities to achieve better results. Numerous communication research studies have documented that individuals are particularly influenced to adopt new or improved practices through interpersonal communication with their peers or with opinion leaders. The studies have shown that using communication materials tend to reinforce the effectiveness of interpersonal communication.

PRACTICAL EXPERIENCE

Community Based Disaster Preparedness: A life saving strategy using interpersonal communication⁶

A community based disaster preparedness (CBDP) programme was praised as a life and livelihoods saving intervention in the 2004 West Bengal, India floods. The project was launched by the Inter Agency Group (IAG)⁷ and the Government of West Bengal after the 2000 floods affected over 22 million people in the state. In 2004, the project had reached more than 1,500 villages in four districts of the state.

"CBDP saved our lives and our livelihoods" said Sujit Kumar Roy, Gram Pradhan of Bahirgachi Gram Panchayat (GP), which has about 6,000 families. When the project team visited one of the worst affected villages of the GP, community women said that during the previous flood, they were very afraid. All of them reported that this time they were not fearful of the floods because they were better prepared.

Significant outcomes of the Bahirgachi Gram Panchayat CBDP programme:

- Water supply was not affected because community raised the level of hand pumps and disinfected tube wells.
- Hardly any disease outbreak occurred.
- There were no food shortages as each family stockpiled food for 7 to 10 days to meet their immediate needs.
- No reports of children losing textbooks.
- Two deaths in the GP occurred (which were not due to floods).
- No loss of cattle; practically no loss of poultry.
- No families reported any loss or damage to their documents.

This is a marked difference from the aftermath of the 2000 floods where 11 people died; 700 cattle and 10,000 poultry were lost; nearly 3,000 families lost some/all of their valuable documents; and more than half of children's textbooks were lost or damaged.

"CBDP really made a difference in the lives of the flood-affected community" said Rajesh Pandey, District Magistrate. "Besides preventing loss of life, CBDP greatly reduced the loss of livelihoods of people by saving their cattle and poultry. More importantly, the CBDP made the community more resolute and better organised in tackling floods. It also brought about community togetherness in that all elected representatives belonging to the different political parties worked hand in hand with the community to minimise the risk arising out of the flood situation."

The process

Using Participatory Learning and Action (PLA) tools in their emergency preparedness communication initiative, each community prepared an action plan for their village.

1. Produced a **village vulnerability map** that identified the safe places, low risk areas, highly vulnerable areas and the estimated number of families residing in each of these zones.
2. Catalogued the number and location of the **vulnerable groups** such as the elderly, disabled, lactating mothers, pregnant women, seriously ill persons and small children in their village. Information related to the number of persons belonging to each of these categories was also collected.
3. Described **history** of earlier floods and elaborated in detail the damage that occurred in the 2000 floods. The plan also mentioned the key elements at risk such as life, health, property, livestock and livelihood, the resources required/at hand for bringing down the level of risk.
4. Listed **key activities** that the community would do before, during and after the flood. The key activities identified before the flood were flood warning, household readiness regarding the positioning of family survival kits and safe keeping of valuables and important documents, formation of different task forces, training on health and first aid, water and sanitation, and rescue and relief.
5. Identified **key local resources** such as bamboos, banana plantations, and so on, for use in the preparation of *machans* (temporary shelters) and local rafts. The community also identified hand pumps that needed to be raised above the flood level to protect their source of water.
6. Stated the **specific places** where the affected community would go along with their cattle to take shelter in event of a flood. Some of them also acquired the technology to construct small boats, life jackets and other materials for successful rescue operations.
7. **Specified the roles of different stakeholders**, quantitative and time schedule for all activities including mock drills. Overall the activities were prioritised and thus requirements became more realistic.

SPECIAL NOTE ON CHILDREN'S PARTICIPATION IN EMERGENCIES

Emergencies push children to discover new roles for themselves in the face of difficult and unstable situations. The Convention on the Rights of the Child provides the basic principle that should guide UNICEF's programming in child and adolescent participation in emergencies - that children and adolescents have the right to appropriate information, the right to be heard and the right to have a meaningful involvement in the emergency response, according to their best interests.

From a November 2005 discussion in Thailand among child-focused NGOs, UNICEF and with tsunami affected children from, India, Indonesia, Sri Lanka, the Maldives and Thailand⁹ who were involved in various ways in the tsunami response, here are some arguments put forward in favour of children's participation in emergency situations:

- Children and their associations – child clubs, child ‘parliaments’, children’s unions, etc. make important contributions to relief, rehabilitation and reconstruction efforts, for example in health and sanitation services and in the distribution of relief supplies;
- Children’s participation can make the delivery of relief more effective. They can identify who needs what, where, how;
- Children can be effective communicators in their families and among their peers
- Children have strong connections and networks among themselves and can become effective agents of behaviour change in the community;
- Children’s views and concerns differ from those of adults. Rapid emergency assessments are of better quality if they are also based on information from children.
- Children who are informed about relief efforts are better able to survive and to protect themselves;
- Children provide emotional support in their community. Their participation has proven to promote psychosocial healing;
- Children provide valuable feedback on relief efforts;
- Children know their communities and have access to some information and knowledge that adults may not have;
- Children are a large segment of the community;
- Children are willing to help, to participate and to mobilise others;
- They can foster cohesion among affected community members during times of crises.
- Children can save and care for other children;
- Children are best placed to build rapport and trusting relationships with other children;
- Children can be more resilient than adults – they can bounce back faster;
- Children are less concerned with social and economic divisions in their communities than adults. They are more inclusive;
- Children are less attached to material things than adults; and
- Children find it easier than adults to understand other children.

Save the Children offered some recommendations in involving children as social actors in emergencies and transition phases:¹⁰

- **Involve children as social agents or “social entrepreneurs” in their own right, with the capacity to influence their situation and their communities in a positive way.** Supporting children’s wellbeing requires the perspective not just that children need special protection, but that they have valid insights into their well being, valid solutions to their problems and a valid role in implementing those solutions for their own benefit and that of their communities.
- **Approach children with a focus on their competencies and strengths, on regenerating resiliency as understood by those children and their elders.** Through participatory approaches, educators and development workers can be encouraged to learn about children’s own perspectives and understandings of adversity and their own ideas about coping and resilience.

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AFGHANISTAN: Adolescent girls raise their hands in class at a girls' high school in Faizabad, capital of the north-eastern province of Badakhshan -- part of the less than 10 per cent of the country not controlled by the Taliban.

- **Focus on rebuilding a sense of community through the restoration of normal every day routines and activities.** Where possible, such strategies could include rebuilding family and community networks, re-establishing productive capacity, providing opportunities for recreation and play, developing mechanisms for justice and retribution, among other interventions.
- **Understand that relief and reconstruction efforts have a psychosocial dimension,** where needs are defined by local people and reconstruction efforts engage the people to meet their own basic needs and recreate the necessary social spaces for social healing to take place.
- **Recognize that psychosocial needs are long-term, and therefore it is essential to give attention to participatory processes to address issues of sustainability.** Ensure that all efforts contribute to the promotion of girls' and boys' ongoing and long-term development in the best ways possible.
- **Base relief, emergency and development processes on an accurate assessment of capacities and vulnerabilities with full participation of girls, boys, women and men of the affected communities.** All information should be disaggregated according to gender, age, as well as other social variables.
- **Ensure efforts are non-discriminatory.** No child should be discriminated against due to gender, ethnicity, caste, religion, disability, or nationality. Monitoring efforts should include a focus on which children are included or excluded in relief and emergency efforts.
- **Engage with girls, boys, women and men from the target population as agents of their own recovery,** so that relief efforts do not increase the recipients' feelings of powerlessness and dependence.
- **Include a focus on capacity building - training, mentoring, resources - for local caregivers to work with children,** rather than sending foreign psychosocial workers to work directly with war-affected children for short-term missions.

- **Encourage opportunities for girls and boys to express issues which concern them and involve them in discussing issues of immediate local concern.** This will help them to learn problem-solving skills and to gain a sense of control over their lives. Sharing grief with others may help children to overcome their sense of loss.
- **Maximise opportunities which make use of space for creative forms of expression such as art, drama, story telling, play, poetry, music, puppetry and other cultural art forms.**
- **Develop child protection approaches which build upon local resources and local understanding of girls, boys, women and men.**
- **Promote programmes which encourage children's active participation in decision-making, problem-solving, team building and peer mentoring to reinforce individual attributes in children that contribute to self-esteem, self-efficacy and coping.**
- **Encourage cultural activities, games, sports and recreational activities which enable children to relax, to have fun and to cooperate with one another.**
- **Provide safe spaces for interaction with peers and promote positive opportunities for girls, boys and youth to come together and to organize themselves and their own programmes.** There is considerable evidence that social support from peers can enhance children's resilience. Furthermore, through collective organization, children can learn the art of self-protection, self-representation and self-advocacy.
- **Promote and support peace and respect for human rights.**
- **Cooperate, coordinate and integrate work with other agencies**
- **Take every opportunity to promote efforts by other agencies which respect children as competent social actors, and validate self-efficacy and decision making ability of girls, boys, women and men in the affected communities.**

RESOURCE BANK

Further reading

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Web sites

1. Center for Communication Programs (CCP)
<http://www.jhuccp.org>
2. Development Gateway
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4. IDS Participation Group Page
<http://www.ids.ac.uk/ids/particip/index.html#pghome>
5. InfoDev <http://www.infodev.org/>
6. Janathakshan.org <http://www.janathakshan.org>
7. The Communication Initiative <http://www.comminit.com>

Footnotes

- ¹ United Nations Children's Fund, *Core Commitments for Children in Emergencies*, UNICEF, New York. 2005.
- ² UNICEF ROSA, *Strategic Communication for Behaviour and Social Change in South Asia*, Kathmandu, Nepal, 2005, p. 7.
- ³ Adapted from McKee et al., op.cit., pp. 50-51.
- ⁴ Waisbord, S., *Family Tree of Theories, Methodologies and Strategies in Development Communication*, (unpublished paper), Rockefeller Foundation, pp. 20-21.
- ⁵ Adapted from UNICEF ROSA, *Strategic Communication for Behaviour and Social Change in South Asia*, p. 28.
- ⁶ Source: Jude Henriques, Programme Communication Officer, UNICEF Office for West Bengal and Assam.
- ⁷ The IAG consists of the members of the international organisations such as UNICEF, DFID, CARE, OXFAM, CRS, CASA, CARITAS, Rama Krishna Mission, LWS, MCC, SCF, WBVHA and Children International, USAID, Action Aid, CINI (GOAL), World Vision, SPADE and ABCD.
- ⁸ Additionally, ATI, GOWB, DFID, CARE, CARITAS, CRS, WBVHA, OXFAM and other agencies participated in the monthly review meetings and provided technical assistance.
- ⁹ Based on a paper by Joachim Theis, EAPRO Youth and Partnership Officer, presented during the Children and Young People's Participation in the Tsunami Forum and Fair, Phuket, Thailand, November 2005.
- ¹⁰ From a paper entitled "Responding to Children as Social Actors in Emergency Relief Response" by Claire O'Kane, Project Co-ordinator, "Children, Citizenship and Governance" Save the Children Alliance (South and Central Asia), October 2001

PART TWO

PROGRAMMATIC AREAS



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CHAPTER - 4

HYGIENE PROMOTION

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HYGIENE PROMOTION

WHY PROMOTE HYGIENE IN EMERGENCIES?

PRINCIPLES OF HYGIENE PROMOTION

DOING THE GROUNDWORK

GETTING THE MESSAGE RIGHT

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WHY PROMOTE HYGIENE IN EMERGENCIES?

Hygiene is the practice of keeping oneself and one's surroundings clean, especially in order to prevent illness or the spread of disease. Emergencies create an environment in which germs flourish: over crowding, traumatised immune systems, poor (or no) access to facilities, latrines, safe water and exposure to disease pathogens - all of which endanger people's health and survival.



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PAKISTAN: A mother washes her daughter's hands with soap and water near their temporary shelter.

Common myths in hygiene promotion that you can avoid.

1. People are empty vessels into which new ideas can simply be poured.
2. People will listen to me because I'm medically trained.
3. People can learn germ theory in a few sessions at the health centre.
4. Health education can reach large populations.
5. Knowing means doing.

Source: Curtis, V⁵

Research shows that hygienic practices can have an equal or greater impact on disease prevention than water supply and sanitation facilities. Modern thinking suggests that the two must go hand-in-hand to effectively combat disease and to boost healthy, sustainable hygienic behaviours.

What is hygiene promotion?

Hygiene promotion empowers people to prevent disease. It is the process of influencing people's knowledge, attitudes and practices, and an agency's knowledge

and resources which together enable family members to avoid risky behaviours related to water use, waste and excreta disposal and cleaning habits.¹

The key ingredients to effective hygiene promotion are:

- A mutual sharing of information and knowledge.
- Mobilising communities for concerted action.
- Providing essential supplies and facilities.

We can group hygiene promotion into three categories:²

- Reducing high-risk hygienic practices.
- Promoting appropriate use and maintenance of facilities.
- Promoting participation in programmes.

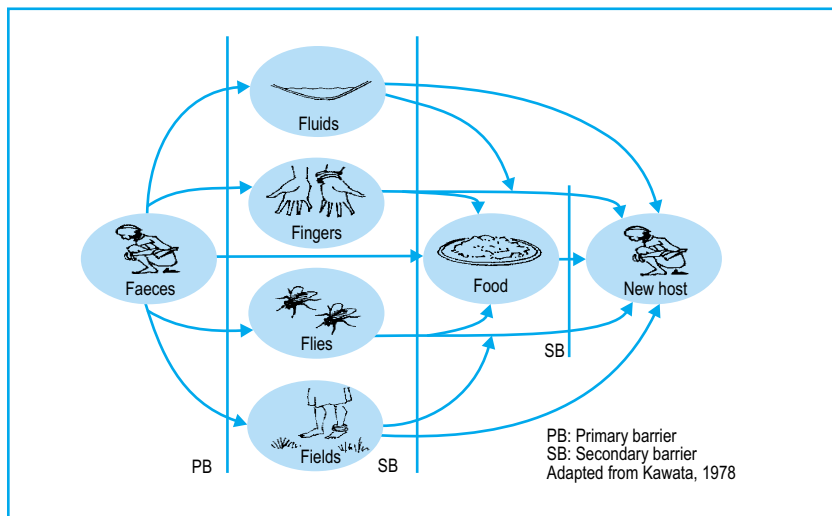
Such a multi-pronged approach should enable the affected community to practice hygienic behaviours and stay healthy.

The role of hygiene promotion in emergencies

Preventing diarrhoeal infection by promoting hygienic practices should be your communication priority Number One in an emergency situation. In camp situations, diarrhoeal diseases can account from 25 to 40 percent of deaths in the acute phase of an emergency. More than 80 percent of the deaths usually occur in children under 2 years.

The F-diagram below illustrates the different routes diarrhoea microbes take from faeces to a person. Interrupting the transmission chain, thus, should be your first priority.

F-diagram: How do people catch diarrhoea?⁴





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NEPAL: Teaching proper hand washing techniques in Pundi Bhumdi, 2004.

PRINCIPLES OF HYGIENE PROMOTION

In emergency situations, you have to coordinate closely with all agencies involved in relief work on a small number of hygiene messages of proven public health importance.

Coordination of programme communication activities avoids

duplication of efforts and wasting of time and resources - both of the programmes and of the affected community. Apply the following essential principles to hygiene promotion:

1. Focus on a small number of risk practices

To control diarrhoeal disease, your messages should highlight the priority hygiene practices: hand wash with water and soap, or when not available use ash after contact with faeces; and safe disposal of adults' and children's faeces to prevent infection and contamination – i.e. clear scattered faeces, control open defaecation and shallow trench latrines, repair toilet facilities and/or build temporary family or communal latrines.⁶

2. Involve specific participant groups

Involve fathers, mothers, children, older siblings, opinion leaders and other influential persons and groups in the affected community. Public health promoters need to identify primary child caregivers and those who influence and make decisions for them. Involve these influencers in the different stages of a health promotion initiative.

3. Identify the motives for adopting positive behaviours

By working with the various participant groups from affected communities you can discover individual views of the benefits of safer hygiene practices. This insight can provide the basis for a motivational strategy.

4. Keep hygiene messages positive

People learn best when they laugh and pay attention longer if they are entertained. Programmes that attempt to frighten the audiences will tend to alienate them. Therefore, avoid the mention of death in hygiene promotion programmes.

A special word on female hygiene

Provisions for female hygiene have often been neglected in hygiene promotion programmes. Recent lessons from emergency responses in South Asia clearly show that many girls and women find it difficult to practice female hygienic behaviours because of one or more of the following constraints:

- Unavailability of underwear and sanitary napkins.
- Inaccessibility to sanitary napkins; and/or the manner in which sanitary napkins are distributed in the camps and affected areas.
- Lack of clean water and soap for washing and laundering.
- Lack of privacy to change and wash, launder underwear and menstrual rags (in the absence of disposable sanitary napkins).
- Inappropriate positioning of female latrines.
- Social taboos attached to menstruation.
- Lack of knowledge or sensitivity among camp managers and relief workers to hygiene and sanitation-related needs and requests.



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These issues make a strong case for the need of a gender-sensitive emergency response team in the camps/affected areas. These also call for sensitivity training for male camp managers, government officials and health workers to ensure that the needs of women and girls are provided for.

A case in point

In the 1998 Bangladesh floods, adolescent girls reported perineal rashes and urinary tract infections because they could not properly wash themselves, and launder and dry menstrual rags in private. They also lacked access to clean water. The girls said they wore the still damp clothes because they did not have a place to dry them.

Women and girls of reproductive age must have access to appropriate materials for absorption and disposal of menstrual blood. Hygiene promoters should advocate for providing private facilities for girls and women to wash themselves, wash and dry underwear and sanitary clothes, and properly dispose of women's sanitary napkins.⁷

DOING THE GROUNDWORK

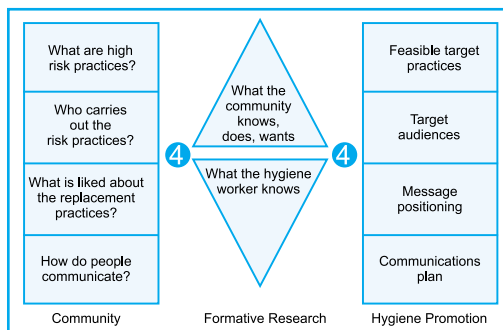
Doing the groundwork for your hygiene emergency response depends on how well you were prepared in the first place, what data and capacities exist, and which partnerships and networks you work with - whom you can quickly tap. When you do your ground work (rapid communication assessment), keep in mind to build on what people already know rather than importing ideas from people the community regards as “outsiders”. This should be the basis for any hygiene promotion programme.

The following diagram shows how your planning team should work together with representatives of the affected community in the rapid communication assessment, which is also a formative research process. Your aim is to answer four main questions: Which specific practices are placing the people's health at risk? What messages are most crucial? What or who could (serve as effective channels) motivate them to adopt new practices? Who should be targeted by the hygiene promotion initiative? And how can we communicate with these groups effectively?

Assessment stages

In an emergency situation one of the first steps to doing the groundwork is the rapid assessment. There are different stages involved in the doing the assessment. These stages help you to plan, monitor and adjust your hygiene promotion programme according to behavioural results and feedback from affected community groups, health and relief workers, camp managers and other stakeholders.

RAPID COMMUNICATION ASSESSMENT FOR HYGIENE PROMOTION⁸



Stage I: You can do an initial rapid assessment using tools such as exploratory or transect walks and interviews with key informants from the camps or affected areas, as the case may be, in order to identify priority issues. You need to do this in the first few days after a disaster, working with the emergency rapid assessment team.

Stage II: Use the initial data from Stage I in group discussions with camp managers and dwellers, as appropriate, with assessment tools such as mapping, network analysis, focus group discussions and household observation. This could be undertaken between weeks two and four after a disaster.

Stage III: Obtain a deeper understanding of what people know, do and think, by using tools such as matrix ranking, seasonal calendars, three pile sorting, pocket charts and gender analysis (see below), also as appropriate and feasible. You can choose to do this after you have collected the initial data.

Assessment tools

Please refer to **Part III of the toolkit** for further participatory assessment and planning tools. You can also use the two simple examples below to help you understand the hygiene practices and beliefs of the affected community.

Ranking exercise

In a ranking exercise, ask participants to rank their health needs and priorities on a numerical scale that you would have prepared earlier. A facilitator then guides a discussion with the participants on the relevance and appropriateness of their choices. Ranking provides a quick way to assess the affected community's hygiene and sanitation practices and gets them involved in the initial stages of a hygiene promotion programme. **Please see Tool 7 in Part III of the toolkit.**

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PAKISTAN: Women and children who were displaced by the South Asia earthquake in October 2005 fetch water from a water tank provided by UNICEF.

Focus group discussions

You can do focus group discussions (FGDs) in an emergency situation even among a few participants, say three to five. FGDs help you determine what motivates people in the affected community to adopt safe practices and barriers for doing so. It is more productive to group the older women, young women, adolescent girls, men, etc., separately. By so doing, you can elicit uninhibited responses. The qualities of the facilitator and the democratic manner in which the discussions are conducted are critical to your effectiveness in eliciting reliable information. Consider that most hygiene-related information is personal in South Asian cultures and affected groups may share this information only with trusted and/or respected persons, among peer groups or in private.

Note on focus groups:

You can make arrangements for an FGD at any stage of an initiative. You can also use it to share new information with affected community members, while learning about their practices and beliefs. **Please See Tool 8 in Part III of the toolkit.**

Developing behavioural objectives

Once you have completed the initial rapid assessments, you can then develop SMART behavioural objectives for your hygiene promotion programme. The behavioural objectives depend on many factors including the severity of an emergency, pre-existing knowledge and practices, access to and availability of water and sanitation facilities. **Please see Tool 1 in Part III of the toolkit.**

GETTING THE MESSAGE RIGHT



© UNICEF/Nepal

NEPAL: A young girl fetches water from deep well.

Be mindful that in emergencies, having too many messages can create confusion. The only way to make a sensible choice is to know the main risk factor for disease and death - diarrhoeal infection - and to know what practices are common among the affected families and communities. Messages also need to reach the emergency and camp managers and health workers to ensure that the required supplies, facilities and services are available to the affected community groups.

While there are many factors that can help prevent diarrhoeal infection, evidence suggests that the two main factors are:

1. Hand washing with soap or ash after contact with faeces.
2. Safe disposal of adults' and children's excreta.

These are the two most important practices that you need to promote to prevent diarrhoeal infection in the initial emergency response.

What is the correct way to wash hands?

Use at least 0.5 litres (8 ounces) of water, and soap or ash, and rub your hands in at least three different directions.

Note: Use locally understood measurements!

Source: The sustainability of hygiene behaviour and the effectiveness of change interventions.⁹

The key-hygiene related messages for all family members, including children are:

- Wash your hands thoroughly with water and soap, or, if soap is not available, water and ash, after contact with faeces and before touching food or before feeding children.
- Dispose of all faeces safely. The best way is to use a toilet or (pit or trench) latrine, or other appropriately safe alternatives.

When diarrhoeal infection is not the most important risk factor anymore, address the range of other risk factors through good hygiene practices like drinking safe water, clean food preparations and safe disposal of household refuse.

Key messages can include:

Keeping water clean and safe

- Use only water that comes from a safe source or is purified.
- Boil water until the bubbles appear.
- Drink only safe water.
- Use clean containers with lid/cap to store water.
- Use a clean cup for drawing water from the container, making sure your hands are clean too.

Handling food safely

- Wash hands with soap or ash before preparing food.
- Always cover cooked food.
- Keep kitchen and cooking utensils and water containers clean.
- Keep rubbish bin away from food and cooking.

Safe household refuse disposal

- Put rubbish in bin with lid.
- Empty your rubbish in a collective pit.
- When full, cover rubbish in collective pit with soil.

Building a local lexicon

Discovering local names for diseases helps the affected community link illnesses with causes, preventions and cures; and it allows programmers to tailor the messages.

In Zaire, people use 6 names to describe illnesses that are accompanied with loose stools. A survey found that more than 50 percent of the respondents used ORS to treat kuhara, but less than one-sixth of the respondents used ORS to treat lukungga and kilonde ntumbo - all diseases with diarrhoea symptoms. Programmers adjusted the messages to promote ORS use for each of the six diseases separately rather than using a general term such as diarrhoea.

Source: Strategic Communication for Development Projects¹⁰

- If you have a problem with your rubbish, contact:
 1. Camp management.
 2. Municipal council.
 3. Urban council.

Developing and choosing the right and appropriate local variations of these basic messages depends on (1) your knowledge of the main risk factors for disease and death in the emergency situation, and (2) your knowledge of which practices are common among the affected families and communities.

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PAKISTAN: Children wait for their turn to use the latrine in one of the camps for people displaced by the South Asia earthquake.

COMMUNICATION ACTIONS FOR HYGIENE PROMOTION

UNICEF's response to emergencies is guided by the Core Commitments for Children in Emergencies (CCC), which provide the overarching organisational framework in a humanitarian response (see Chapter 3). The table below outlines UNICEF's Core Commitments for Children in Emergencies in the areas of Water, Sanitation and

Hygiene. We included suggested BCC and social mobilisation activities that have shown evidence to improve hygiene situations in an emergency. Remember to plan your risk communication and social mobilisation actions with the participation of the affected community, the children, youth and your partners, and to carefully monitor and evaluate the programme.

When you choose the mix of communication actions remember that a key aspect to hygiene promotion is to target a small number of risk practices only. For this reason, it is important for you to plan the activities in stages rather than trying to tackle all risky behaviours at once.¹¹ Your mix of hygiene promotion actions depends on the impact of the disaster; identified priorities; cultural and socio-economic contexts of the affected community; availability of facilities; and existing partnerships and capacity – both human and financial.

TABLE: UNICEF's CCC in the areas of Water, Sanitation and Hygiene and corresponding BCC and social mobilisation support

FIRST SIX TO EIGHT WEEKS	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
1. Ensuring the availability of a minimum safe drinking water supply taking into account the privacy, dignity and security of women and girls.	<ul style="list-style-type: none"> ■ Make sure that those who are providing water supplies are in dialogue with women and girl representatives to determine the best modes, times, locations and/or distribution points for water supplies.
2. Providing bleach, chlorine or water purification tablets, including detailed user and safety instructions in the local language.	<ul style="list-style-type: none"> ■ Make sure the affected community and service providers receive information on the importance of and how to use bleach, chlorine or water purification tablets – i.e. through loudspeaker announcements, printed materials, and IPC. ■ Train motivated and interested people who live in or near the camp to provide group demonstrations on how to use bleach, chlorine and water purification tablets. ■ Enable service providers through communication skills and counselling training to communicate with and motivate affected individuals and families to use bleach, purify water with chlorine or water purification tablets. ■ Mobilise and engage community volunteers to monitor changes.
3. Providing jerrycans, or an appropriate alternative, including user instructions and messages in the local language on handling of water and disposal of excreta and solid waste.	<ul style="list-style-type: none"> ■ Assess the level of knowledge on hygiene aspects in the different populations of the affected community (since it can vary widely) remembering that this is an area where most related activities are carried out by women and girls.

TABLE: UNICEF's CCC in the areas of Water, Sanitation and Hygiene and corresponding BCC and social mobilisation support Contd..

FIRST SIX TO EIGHT WEEKS	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
	<ul style="list-style-type: none"> ■ Ensure affected community receives information on importance of and how to handle safe water, dispose of excreta and solid waste – i.e. using a combination of loudspeakers, IEC materials, community radio, and/or peer educators. ■ Enable hygiene promoters, facilitators, peer educators, animators to provide one-to-one or small group participatory hygiene education. Ensure they can handle questions and clarify doubts. ■ Enable service providers to communicate with and motivate affected individuals and families to wash hands, handle safe water, and dispose of excreta and solid waste. ■ Engage motivated school-aged children or other interested groups to observe and share information on the handling of safe water, disposal of excreta and solid waste.
<p>4. Providing soap and disseminating key hygiene messages on the dangers of cholera and other water- and excreta-related diseases.</p>	<ul style="list-style-type: none"> ■ Establish and train a team that is familiar with local practices and social structures. ■ Use local languages or pictograms if possible. ■ Work through existing social structures to: ensure affected communities receive soap and information on benefits of hand washing, cholera prevention and the prevention of other excreta-related diseases. ■ Ensure that affected communities, especially primary caregivers, know how to wash hands with soap, and how to prepare ORS to prevent dehydration, by giving demonstrations on hand washing and how to make ORS/ORT. ■ Train female communication agents, including community health workers, volunteers and Girl Guides to ensure women's and girls' access to basic health and hygiene information.

TABLE: UNICEF's CCC in the areas of Water, Sanitation and Hygiene and corresponding BCC and social mobilisation support *Contd.*

FIRST SIX TO EIGHT WEEKS	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
	<ul style="list-style-type: none"> ■ Train motivated school-aged children or other groups to demonstrate proper hand washing techniques, and for them to observe community practices as part of monitoring.
<p>5. Facilitating the safe disposal of excreta and solid waste by providing shovels or funds for contracting local service companies; spreading messages on the importance of keeping excreta (including infant faeces) buried and away from habitations and public areas; disseminating messages on disposal of human and animal corpses; and giving instructions on, and support for, construction of trench and pit latrines</p>	<ul style="list-style-type: none"> ■ Make certain that affected community receives information on importance of and how to keep human (including infant) faeces from public and living areas, the importance of using latrines – i.e. using IEC materials (including flip charts), demonstrations on how to dispose of infant faeces/diapers. ■ Engage positive deviants or people who bury infant faeces and dispose solid waste properly, as positive role models. ■ Enable service providers to communicate with and motivate affected individuals and families to safely dispose of excreta and solid waste, safely dispose of human and animal corpses, and the use of trench/pit latrines. ■ Train motivated young people to be “link leaders” between camp residents and government officials – i.e. to report on broken and unsanitary facilities, observe facility maintenance and use; and help with monitoring.

In the initial response of an emergency, many activities are likely to be led by programme staff, relief workers and government officials with the assistance of a rapidly mobilised task team of community volunteers. It is essential that you only implement the basic immediate actions this way. Be sure to plan, implement and monitor all long-term aspects of the programme in partnership with affected community groups and other relevant stakeholders.¹²

BEYOND INITIAL RESPONSE	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
1. Making approaches and technologies used consistent with national standards, thus reinforcing long-term sustainability.	
2. Defining UNICEF's continuing involvement beyond the initial response by:	
<ul style="list-style-type: none"> ■ Establishing, improving and expanding safe water systems for source development, distribution, purification, storage and drainage, taking into account evolving needs, changing health risks and greater demand. 	<ul style="list-style-type: none"> ■ Make sure the affected community has the knowledge of how excreta contaminates water and contributes to the spread of diarrhoeal disease, and the relation between unsafe water and cholera – i.e. through group discussions, children volunteers, loudspeakers, community radio, community theatre and IEC materials. ■ Mobilise the community to keep water safe – i.e. train camp residents as water source attendants who encourage people not to defecate near water sources; train support workers to chlorinate all wells and test for residual chlorine levels.¹³ ■ Train health workers and other service providers on specific cholera, diarrhoea prevention methods. Enable them to motivate affected community to handle safe water, purify water through boiling, chlorination or water purification tablets.

BEYOND INITIAL RESPONSE	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
<ul style="list-style-type: none"> ■ Providing a safe water supply and sanitation and hand washing facilities at schools and health posts. 	<ul style="list-style-type: none"> ■ Strengthen community knowledge of handling safe water and importance of and how to wash hands with soap, using latrines – i.e. through IPC like animators, IEC materials, etc. ■ Train educators, health workers, school-age children and camp/community residents to demonstrate proper hand washing techniques. ■ Empower service providers with tools and information to motivate school-age children and community to use latrines and to wash hands with soap or ash after defecation. ■ Observe pump and latrine maintenance and promote hand washing practices at schools and health posts as part of monitoring.
<ul style="list-style-type: none"> ■ Supplying and upgrading sanitation facilities to include semi-permanent structures and household solutions, and providing basic family sanitation kits. 	<ul style="list-style-type: none"> ■ Involve the community in the design, implementation, and maintenance of sanitation facilities so that the facilities are culturally appropriate, private, child-friendly, accessible by the disabled – and in line with the Sphere Standards, which can be reviewed at http://www.sphereproject.org. ■ Enable service providers to motivate the affected community to use sanitation facilities and basic family sanitation kits. ■ Specifically enable female service providers or community health volunteers to communicate with girls and women about female hygiene. ■ Ensure that girls and women have access to appropriate materials for absorption and disposal of menstrual blood, that facilities allow the disposal of women’s sanitary napkins or provide the necessary privacy for washing themselves and for drying sanitary clothes.

BEYOND INITIAL RESPONSE	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
	<ul style="list-style-type: none"> ■ Train motivated school-age children and interested groups to attend and monitor latrines – i.e. report on broken or unsanitary latrines and water pumps, observe facility/latrine use for monitoring purposes, and put up motivational IEC materials with hygiene messages, e.g. posters.
<ul style="list-style-type: none"> ■ Establishing regular hygiene promotion activities. 	<ul style="list-style-type: none"> ■ Identify main risk practices to adjust your hygiene promotion initiative in affected areas. ■ Ensure that affected individuals and communities understand good hygiene practices – i.e. by using a mix channels like street plays, traditional folk media, video showings, and other appropriate art forms that draw out local talents. ■ Provide supportive supervision to ensure that hygiene promoters are discussing ways to prevent diarrhoea, cholera and other excreta-related diseases with affected communities – i.e. by advocating hand washing with soap or ash and the use of latrines and by organising training sessions for community and opinion leaders on ways to reduce risk of diarrhoea, malaria or cholera cases/outbreaks.¹⁴ ■ Mobilise community to monitor any changes – i.e. hold community meetings to discuss and share monitoring findings. Jointly decide on how the initiative can be improved.
<ul style="list-style-type: none"> ■ Planning for long-term solid waste disposal. 	<ul style="list-style-type: none"> ■ Facilitate water-related discussions on making safe water available. Clearly identify the relationship between safe water, waste disposal and disease and relate those factors to action – both in the preparedness and emergency phases. ■ Engage affected communities in planning safe ways to dispose of solid waste – i.e. by involving them in identifying solutions and developing monitoring plans.

MONITORING MILESTONES

One of the main aims of a hygiene promotion initiative in an emergency situation is to ensure that all populations of the affected community know and adopt the priority hygiene practices to protect their health. The following section presents the key indicators to measure hygiene practices related to excreta disposal.¹⁵ **Tool 13 in Part III lists possible sources of information to help you measure the indicators.**

Key indicators for good hygiene practice

- People use the toilets available and children's faeces are disposed of immediately and hygienically.
- People use toilets in the most hygienic way, both for their own health and for the health of others.
- Household toilets are cleaned and maintained in such a way that they are used by all intended users and are hygienic and safe to use.
- Parents (mothers and fathers, or other primary caregivers) demonstrate

knowledge of the need to dispose of children's faeces safely.

- Families and individuals participate in a family latrine programme by registering with the agency, digging pits or collecting materials.
- People wash their hands after defecation and handling children's faeces and before cooking and eating.
- People demonstrate correct hand washing and know when to engage in this behaviour.

Key indicators for the design and implementation of your hygiene promotion programme

Ideally, you should base your hygiene promotion activities on the specific vulnerabilities, needs and preferences of all populations in the affected



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PAKISTAN: A woman cleans a latrine in one of the temporary camps for people who were displaced by the South Asia earthquake.



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PAKISTAN:
Adolescent girls
cooking outside
their family tent in
one of the camps
for earthquake
affected families.

communities. These are often influenced by factors like displacement, age, gender, ethnicity, disability and socio-economic status. Take note of the following key indicators for measuring the design and implementation of your hygiene promotion programme:¹⁶

- Key hygiene risks of public health importance are identified.
- Programmes include an effective mechanism for representative and participatory input from all users at all phases, including the initial design and location of facilities – making sure that latrines accommodate the disabled; are well-lit and designed to protect women from sexual molestation; and provide girls and women the privacy to cleanse themselves, wash underclothes and sanitary rags.
- All groups within the affected community have equitable access to the resources or facilities needed to practice or continue the proper hygiene practices.
- Hygiene promotion messages and activities address key behaviours and misconceptions and reach all participant groups. Representatives from these groups participate in planning, training, implementation, monitoring and evaluation.
- Participants take responsibility for the management and maintenance of facilities as appropriate, and all populations of the affected community contribute equitably.

Note: Plan the behavioural monitoring and set indicators from the start and encourage follow-up action. In other words, encourage your staff, partners and affected communities *to do something* with the results of monitoring. In planning the monitoring and evaluation indicators, you need to be concerned about *information for action* rather than “information to be more informed”.¹⁷

PRACTICAL EXPERIENCES



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INDIA: (Second from left) UNICEF Programme Officer Geeta Athreya briefs a team of UNICEF animators before they visit relief centres for tsunami-affected displaced people, in the Union Territory of Pondicherry. The teams are promoting the use of ORS and good hygiene practices to prevent and treat diarrhoea and other water-related diseases. Team members are wearing T-shirts bearing the UNICEF logo.

College students trained to promote hygiene in tsunami relief camps, India

As UNICEF worked to provide and install water storage tanks in Nagapattinam and other tsunami-affected districts in India, one of the priority goals was to prevent an outbreak of diarrhoea. With thousands of homeless huddling in 200-odd camps, the threats from diarrhoea, dysentery and dehydration loomed.

Just one week after the tsunami hit, UNICEF in partnership with a social marketing agency, trained 140 college students and cadets to deliver ORS demonstrations. A team consisted of three student animators, supervisors and UNICEF staff. They travelled by van, from camp to camp to the worst-hit areas.

One such team stopped at the Shakuntaladevi Ramaswami Kalyana Mandapam – a reception hall for marriages cum temporary home – to some 300 people. The animators, supervised by UNICEF's Geeta Athreya, talked about how diarrhoea breaks out in crowded, unsanitary conditions; the importance of washing hands with soap and water after defaecation, before handling food and feeding children. They organised hand washing demonstrations; trained community volunteers to show others how to prevent diarrhoea and recognise the symptoms of dehydration. They instructed the affected individuals on how to prepare ORS.

This experience shows that even in the initial response, group communication approaches can be used to influence participants to adopt healthy practices. In this case live demonstrations occurred simultaneously with flyer and pamphlet distribution. Posters displaying messages about diarrhoea prevention and ORS were also tacked in public areas. By engaging a mix of communication channels, the hygiene promotion team was able to increase the possibilities of hygiene messages being heard, remembered and applied.

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CHAPTER - 5

PROMOTING BREASTFEEDING

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WHY PROMOTE BREASTFEEDING IN EMERGENCIES?

PRINCIPLES OF BREASTFEEDING PROMOTION

DOING THE GROUNDWORK

GETTING THE MESSAGE RIGHT

COMMUNICATION ACTIONS FOR BREASTFEEDING

MONITORING MILESTONES

PRACTICAL EXPERIENCES

SPECIAL CONSIDERATIONS

RESOURCE BANK



AFGHANISTAN: Children and women wait to be attended to at a therapeutic feeding centre for displaced persons run by the international NGO Medecins Sans Frontieres, on the outskirts of the western city of Herat, capital of the province of the same name. Most of the displaced are from the drought-affected provinces of Badghis and Ghor, north-east of Herat, as well as from conflict areas.

WHY PROMOTE BREASTFEEDING IN EMERGENCIES?

In nearly all contexts, breastfeeding is the most beneficial form of infant feeding for both mother and baby. Infant feeding is an important issue in emergencies because:

- Nutrition is closely linked to an infant's health and survival in the short and long-term.
- A child's early nutrition will affect his/her later growth, health and mental development.
- Infant feeding practice offers the first bonding between mother and baby.

PRINCIPLES OF BREASTFEEDING PROMOTION

An emergency is an ever-evolving situation that creates challenges and opportunities to promote exclusive breastfeeding. The following principles should guide your breastfeeding communication initiative:¹

1. All infants, including those born into populations affected by emergencies should normally be exclusively breastfed for the first six months.
 - The beneficial effects of colostrum in breast milk, particularly in building the infant's immune system, are especially important. Infants should be breastfed on demand from birth, within the first hour after birth.
 - Every effort should be made to identify ways to breastfeed infants whose mothers are absent or incapacitated.
 - Re-lactation should be attempted before the use of infant formula is considered.

2. Every effort should be made to create and sustain an environment that encourages exclusive breastfeeding for the first six months, and continued frequent breastfeeding thereafter up to two years.
3. The quantity, distribution and use of BMS at emergency sites should be strictly controlled, using the following guidelines:
 - Nutritionally adequate infant formula (BMS), fed by cup, should be available to infants who do not have access to breastmilk.
 - Those responsible for feeding BMS should be adequately trained and equipped to ensure its safe preparation and use.
 - Feeding infant formula to the minority of children who cannot be breastfed should in no way interfere with protecting and promoting breastfeeding for the majority who can.
 - The use of infant feeding bottles and artificial teats in emergency settings should be actively discouraged and cup feeding promoted instead, as cups are much more hygienic and easier to keep clean.

Note:

Recognise a mother's right to make and implement decisions regarding infant feeding, and acknowledge the actual and potential role of family members, and the affected community in influencing those decisions.

10 steps to successful breastfeeding: ²

Every facility providing maternity services and care for newborn infants should:

- 1 Have a written breastfeeding policy that is routinely communicated to all health care staff.
- 2 Train all health care staff in skills necessary to implement this policy.
- 3 Inform all pregnant women about the benefits and management of breastfeeding.
- 4 Help mothers initiate breastfeeding within half an hour of birth.
- 5 Show mothers how-to breastfeed, and how-to maintain lactation even if they should be separated from their infants.
- 6 Give new-born infants no other food or drink other than breastmilk, unless medically indicated.
- 7 Practice "rooming-in" to allow mothers and infants to remain together 24 hours a day.
- 8 Encourage breastfeeding on demand.
- 9 Give no artificial teats or pacifiers (dummies or soothers) to breastfeeding infants.
- 10 Foster the establishment of breastfeeding support groups and refer mothers to them upon discharge from the hospital or clinic.

DOING THE GROUNDWORK

Your communication initiative to promote breastfeeding will depend much on which pre-emergency partnerships you have established, for instance with healthcare providers, community groups, community health workers, maternity caregivers, school and youth groups, government agencies and other relevant stakeholders. It will also depend on how much you know about the affected community's pre-existing knowledge, attitudes and practices regarding infant feeding. This, along with rapid assessments, will give the information needed to set SMART behavioural results (**Please see Tool 1 in Part III of the toolkit**) and design effective breastfeeding promotion strategies. Doing the groundwork will ensure that your breastfeeding communication actions, messages and materials are based on an adequate understanding of the key factors that influence a woman's decision to breastfeed.

Focus group discussions

Experiences from past emergencies show that common barriers and disincentives to breastfeeding can include following:

- are mothers believing that they do not have sufficient milk;
- women not breastfeeding prior to the emergency;
- breastfeeding practices changing during the emergency;
- some breastfed infants appearing malnourished;
- unacceptability of wet nursing due to cultural taboos or HIV prevalence;
- separated or orphaned infants;
- and/or bottle feeding is the norm.³

Focus group discussions are useful to examine barriers and disincentives regarding infant feeding in detail, and to educate women and service providers on the importance of exclusive breastfeeding. **See Tool 10 in Part III of the toolkit.**

FOCUS GROUP DISCUSSION IN NAGAPATTINAM

As part of the Indian emergency response to the tsunami, several focus group discussions were organised to probe into women's infant feeding beliefs and practices in Nagapattinam district, located in the State of Tamil Nadu. Besides getting an inside view on why women in this community chose bottle feeding over breastfeeding, the FGDs also provided opportunities to clarify myths and doubts and to counsel women on optimal infant feeding practices and other maternal child health aspects.

Separate focus group discussions were organised with adolescent girls, newly married couples, and antenatal and postnatal mothers in an attempt to gain information across the board. A common finding, however, was the strong influence of traditional beliefs and cultural values on women's attitudes and practices towards infant feeding. Another common finding was the need to increase women's understanding of maternal and child health.

Specific findings from the FGD included:

- Many mothers believed that bottle feeding was a harmless and hygienic practice.
- Several mothers did not recognise the traditional practice of giving infants mercury drops immediately after birth as harmful to the infant. They believed this would avoid skin rash.
- Some mothers regularly gave their infant "rubber nipples" or pacifiers.

Dr. Durairajan Gopinath, UNICEF Health and Nutrition District Coordinator in Nagapattinam, explains that the FGDs brought out the following important lessons:

Lessons Learned

1. Prevent or stop the supply of BMS and bottles as a form of relief to mothers.
2. Encourage the supply and use of properly cleaned stainless steel spoons and cups for artificially fed infants.
3. Gain a thorough understanding of the affected community's cultural beliefs and traditions before launching a breastfeeding promotion initiative.
4. Develop clear and precise messages such as:
 - Only breastmilk from birth until 6 months.
 - Stop bottle feeding (unless an exceptional case).



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AFGHANISTAN: A woman is feeding solid food to her baby.

Pocket chart

A pocket chart can be used to explore or examine the affected women/ community's infant feeding preferences and practices more closely. This exercise can also be used as a means of information exchange – to protect, support and promote breastfeeding – by increasing knowledge and engendering supportive attitudes across all sections of the affected community. **See Tool 6 in Part III of the toolkit**

Setting behavioural results

Once you have identified the incentives and barriers to breastfeeding in emergencies, you can easily develop SMART behavioural results. Some points to consider when setting behavioural results are the cause and severity of the disaster, the affected community's pre-existing infant feeding practices, and social taboos and misconceptions about breastfeeding and wet nursing. **Please see Tool 1 in Part III of the toolkit.**

Common myths about breastfeeding in emergencies

MYTH: Women under stress cannot breastfeed.

TRUTH: Women under stress **CAN** successfully breastfeed.

Milk production is stable; but milk release (let down) can be affected by stress. The treatment for poor milk release and for low production is increased suckling and social support. The most effective support for a breastfeeding woman comes from other breastfeeding women.

MYTH: Malnourished women don't produce enough milk.

TRUTH: Malnourished women **DO** produce enough milk.

It is extremely important to distinguish between true cases of insufficient milk production (very rare) and mistaken perceptions. Milk production remains relatively unaffected in quantity and quality except in extremely malnourished women. Malnourished women and children are best served by feeding the mother and letting her breastfeed the infant. By doing so, you protect the health of both mother and child. Giving supplements to infants decreases suckling and so can reduce milk production.

GETTING THE MESSAGE RIGHT

When developing breastfeeding promotion messages, remember that women, mothers and primary caregivers are often the main audience for behaviour change in an emergency, as humanitarian workers are communicating messages for diarrhoea prevention, measles vaccination, and other hygienic practices to keep children and adults alive and well.

Consider three main factors to getting the message right:

1. It is important to only focus on a few messages that are vital to influencing women to exclusively breastfeed. Use participatory communication methods such as group meetings with primary caregivers, peer educators and one-to-one counselling to discuss these vital infant and child health related messages.
2. You may have to counter some harmful messages and

The treatment for insufficient milk production—real or perceived—is to increase suckling frequency and duration, ensure the mother has sufficient food and liquids, and offer reassurance from other breastfeeding women.

MYTH: Breastmilk substitutes are needed during an emergency.

TRUTH: Usually, breastmilk substitutes are NOT appropriate.

There are appropriate guidelines on the use of breastmilk substitutes and other milk products in emergencies. They include the WHO International Code of Marketing of Breastmilk Substitutes (May 1981), the UNHCR guidelines on the use of milk substitutes (July 1989), and the World Health Assembly resolution 47.5 (May 1994). Under the Code, donors must ensure that any child who receives a breastmilk substitute is guaranteed a full, cost-free supply for at least six months.

Health workers may need training on how-to help women who have difficulty breastfeeding because of incorrect positioning, cracked nipples or engorgement. A mother's fear that she "may not have enough milk" is often a cause of early termination of breastfeeding. This (mis)perception may be intensified by the stress of an emergency situation.

Health workers should encourage optimal breastfeeding behaviours.

advertisements regarding the use of BMS with positive ones that reinforce the benefits of breastfeeding.

3. Different groups of women, families and communities in an emergency are likely to have unique infant feeding beliefs, practices and challenges that we have to understand before launching a communication initiative. Note that the emergency may lead to a breakdown of internal family support systems – partners, mother, mother in law, sisters, aunts – and other people in the family who traditionally influence and support mothers' infant feeding choices.

Keep in mind:

Past emergencies have revealed two main behaviours that keep babies alive and healthy:

1. Women that can breastfeed do so exclusively for the infant's first 6 months.
2. Women that cannot breastfeed have access to an adequate amount of appropriate BMS, can safely prepare it, and cup-feed their infants.

In the initial response of an emergency, the above mentioned are the two most important infant feeding practices that should be promoted.

MYTH: General promotion of breastfeeding is enough.

TRUTH: Breastfeeding women **NEED** assistance; general promotion of breast-feeding is **NOT** enough.

Most health practitioners have little knowledge of breastfeeding and lactation management. Women who are displaced or are in emergency situations are at increased risk of breastfeeding problems. They need help, not just motivational messages. Health workers may need to be trained to give practical help to women who have difficulty breastfeeding because of incorrect positioning, cracked nipples or engorgement.

A mother's fear that she "may not have enough milk" is often a cause of early termination of breastfeeding. This (mis)perception may be intensified by the stress of an emergency situation. Health workers should encourage optimal breastfeeding behaviours, even if they require selective feeding of lactating women.

Policies and services which undermine optimal feeding, such as giving food supplements to infants less than six months and using bottles for Oral Rehydration Salts (ORS) delivery, should be avoided.

What do we need to know?

The following messages cover a range of information on what different audiences (adolescent girls, pregnant/lactating women, mothers, health workers and other service providers) need to know.

Breastfeed exclusively for the first 6 months⁴

- Almost every mother/woman can successfully breastfeed.
- Breastmilk *alone* is the only food and drink an infant needs for the first six months.¹
- Breastfeeding helps protect babies and young children against dangerous illnesses, and creates a special bond between mother and child.
- Stress doesn't necessarily prevent a mother from producing milk.
- Continue breastfeeding babies who have diarrhoea.
- Frequent breastfeeding stimulates milk flow.

Minimise the dangers of artificial breastfeeding

- Bottle-feeding can lead to illness and death.
- Use safe water to prepare BMS.
- Use clean cups to feed BMS; never use bottles.

Create an enabling environment for women who breastfeed

- Help breastfeeding women with food preparation, childcare.
- Ensure that lactating women eat nutritious food and take supplements.
- Establish "safe havens" and support groups for pregnant and lactating women to help reduce stress.
- Provide breastfeeding women with special rations, water and supplements, and provide re-lactation support if needed.

Priorities of alternatives for infant feeding in emergencies

1. Breastfeeding
2. Wet nursing*
3. Breastmilk from Milk Bank
4. Generically packaged infant formula
5. Locally purchased branded formula
6. Stop-gap home made recipes

*The practice of wet nursing may be unacceptable or inappropriate in situations of high HIV prevalence where testing, support and counselling are not available.

Source: UNICEF Technical Notes



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Healthcare workers are key to breastfeeding promotion

- Initiate breastfeeding within 30 minutes of birth to stimulate milk flow.
- Help mothers return to exclusive breastfeeding by increasing frequency of feeds and ensuring “emptying” of breasts.
- Re-stimulate lactation where milk production has been affected by stress.

Prevent solicitation of unnecessary donations of powdered milk and powdered formula, and help prevent unsolicited donations from being delivered to the camp, shelter or affected community

- Breastmilk keeps infants in an emergency alive and well.
- BMS are not affordable to most women in developing countries, and may be hard to obtain once the emergency stabilises.

COMMUNICATION ACTIONS FOR BREASTFEEDING

UNICEF's emergency response is guided by the Core Commitments for Children in Emergencies (CCC) that provide the overarching organisational framework in a humanitarian response (see Chapter 3). The table below outlines the CCC in the areas of Health and Nutrition related to infant feeding. Included are suggested behaviour change communication (BCC) activities that have proven to improve infant feeding in an emergency. Remember to plan your communication and social mobilisation actions with the involvement of the affected community and your partners, and to carefully monitor and evaluate the programme.

TABLE: Extract from UNICEF's CCC in health and nutrition and corresponding BCC and social mobilisation support.

FIRST SIX TO EIGHT WEEKS	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
<ol style="list-style-type: none"> 1. Based on rapid assessments, provide child and maternal feeding: support infant and young child feeding and therapeutic and supplementary feeding programmes with the World Food Programme (WFP) and NGO partners. 	<ul style="list-style-type: none"> ▪ Ensure that affected women receive information on the importance of feeding newborns colostrum and exclusive breastfeeding for the first 6 months – i.e. group meetings/ discussions, IEC materials, flip charts that explain benefits of exclusive breastfeeding, audiovisual demonstrations. ▪ Make sure that health workers and other service providers understand the importance of breastfeeding <u>and</u> are able to communicate it to women, by involving government and health

FIRST SIX TO EIGHT WEEKS	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
	<p>associations in training and supporting service providers in giving advice and support to women in choosing the appropriate feeding methods.</p> <ul style="list-style-type: none"> ■ Provide health workers, peer educators, and breastfeeding counsellors training and support to increase the breastfeeding ability of lactating women; guarantee that women know how to breastfeed in a way that stimulates milk production, make sure that women who cannot breastfeed know how to safely prepare BMS and cup feed; give accurate information and correct breastfeeding misconceptions; introduce breastfeeding women to each other in the camp; and increase awareness on the benefits of colostrum. ■ Mobilise the community to support breastfeeding women by facilitating mother-to-mother support networks, “safe havens” for pregnant/lactating women, women’s groups, etc. ■ Advocate and mobilise support with the local government, camp management, private sector, and humanitarian agencies to increase knowledge on the dangers of unnecessary, unsolicited and inappropriate BMS in emergencies, and promote compliance to the International Code of Breastmilk Substitutes regarding the prevention of the marketing of BMS among health and aid workers.

FIRST SIX TO EIGHT WEEKS	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
<p>2. Introduce nutritional monitoring and surveillance.</p>	<ul style="list-style-type: none"> ▪ Facilitate participatory monitoring and evaluation methods – i.e. monitoring chart, ongoing FGDs – to systematically monitor the nutritional status of children and women.

Communication interventions that span beyond the initial response should build upon those implemented pre-emergency and during the initial response. Besides increasing knowledge and optimal infant feeding know-how, community participation and advocacy efforts are central in protecting, promoting and supporting breastfeeding.

BEYOND THE INITIAL RESPONSE	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
<p>3. Support infant and young child feeding, complementary feeding, and when necessary support therapeutic and supplementary feeding programmes with World Food Programme and NGO partners.</p>	<ul style="list-style-type: none"> ▪ Ensure that health workers, community volunteers are trained to provide support to breastfeeding women – i.e. ongoing advice, and encouragement at health centres and homes through motivational talks, flip charts, one-to-one counselling; motivating breastfeeding women by sharing with them how they can produce enough milk and providing assistance, if needed. ▪ Provide supportive supervision (and, if needed, further training) to health workers, peer educators, and breastfeeding counsellors to increase the breastfeeding ability of lactating women; guarantee that women know how to breastfeed in a way that stimulates milk production, make

BEYOND THE INITIAL RESPONSE	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
	<p>sure that women who cannot breastfeed know how to safely prepare BMS and cup feed; give accurate information and correct breastfeeding misconceptions; introduce breastfeeding women to each other in the camp; and increase awareness on the benefits of colostrum.</p> <ul style="list-style-type: none"> ▪ Mobilise the community to support breastfeeding women by facilitating mother-to-mother support networks, “safe havens” for pregnant and lactating women, women’s groups, etc.
<p>4. Provide health and nutrition education, including messages on the importance of breastfeeding and safe motherhood practices.</p>	<ul style="list-style-type: none"> ▪ Ensure that the affected mothers, community and service providers know the health and nutrition benefits of colostrum and breastfeeding and other safe motherhood practices; know how to breastfeed and how to safely prepare BMS and cup feed – i.e. through interpersonal communication channels such as individual and/or group counselling, community health education, cooking demonstrations, mother-to-mother support networks, activities in women’s groups/clubs, trials of new feeding practices - depending on the duration of the emergency - and positive deviance approaches.⁶ ▪ Train health workers, peer educators, breastfeeding counsellors, TBAs, midwives and other relevant stakeholders on how

BEYOND THE INITIAL RESPONSE	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
	<p>to communicate health and nutrition education messages to mothers in a way that motivates them to feed infants colostrum, exclusively breastfeed, and adopt nutritious habits (including taking vitamin A supplements).</p> <ul style="list-style-type: none"> ▪ Advocate and mobilise support with local authorities, camp management and other relevant stakeholders to provide women a safe place to breastfeed, prevent the solicitation of unnecessary donations powdered milks and formulas, and help prevent unsolicited donations from being received into the camp.

MONITORING MILESTONES

One of the main goals of breastfeeding promotion is to improve infant survival and decrease risks of malnutrition, diarrhoea and other diseases. Your communication initiative has to support this goal.

The following are some key indicators to monitor whether our communication initiative is on track (**Tool 13 in Part III lists possible sources of information to help you measure the indicators**):

- Health workers, peer educators, birth attendants, midwives and other relevant service providers are trained on infant and child feeding practices, and can communicate and motivate affected women to exclusively breastfeed and safely prepare appropriate BMS and cup feed (in exceptional cases).
- Women with newborns know the benefits of colostrum and the importance of/ how-to breastfeed. Women who cannot breastfeed know how to safely prepare appropriate BMS and cup feed. The affected community is mobilised to support breastfeeding women via, mother-to-mother support networks, “safe havens”, trials of new feeding practices, activities in women’s groups, etc.

- Infants less than six months are exclusively breastfed, wet nursed (where acceptable), or in exceptional cases, have access to an adequate amount of an appropriate BMS.
- Local governments, humanitarian agencies, camp management and other service providers know the international guidelines on the marketing of BMS, the appropriate use of BMS in emergencies, and are supplying it to artificially-fed infants without undermining the breastfeeding population at the camp.

PRACTICAL EXPERIENCES

Advocacy helps Maldivian mothers breastfeed after tsunami

During the aftermath of the 26 December tsunami which affected 11 Indian Ocean countries, many private sector companies and individuals flooded camps and affected communities with infant formula. This gesture – perhaps rooted in good will, but doing more harm – was aimed at feeding orphans and babies whose mothers were believed to be too stressed to breastfeed.

The following example from the Maldives demonstrates the effect of quick-and-high level advocacy with the government; the importance of having guidelines on breastfeeding promotion in emergency situations and the need to train health workers in breastfeeding promotion and counselling skills.

In the Maldives, prior to the 26 December Tsunami, breastfeeding practices were generally good and the use of breastmilk substitutes (BMS) was not widely practiced. After the tsunami, many affected mothers felt that they could not properly breastfeed their babies. This was coupled with the sudden widespread availability of BMS, which prompted many to switch to the bottle. What's more, when the tsunami hit, many community health workers were unaware that they should encourage mothers to continue breastfeeding – even in emergencies. Many health workers didn't know how to handle the deliveries of BMS and supported bottle feeding in the initial response.

It was only after UNICEF shared the international infant feeding guidelines with the government – which in turn educated health workers – that they realised the benefits of exclusive breastfeeding in emergencies. Subsequently, health workers started to promote and support breastfeeding to affected mothers via one-to-one talks and counselling. Follow-up reports show that many of the health workers would have an added benefit of interpersonal communication and counselling training to promote breastfeeding beyond the initial response.

The Maldives experience illustrates the positive impact that swift advocacy can have. This is a reminder that messages on the importance of breastfeeding, and the guidelines on the use of BMS should be easily accessible and quickly shared in emergencies. It also highlights that information is necessary but not sufficient on its own to influence positive behavioural change. It was through advocacy, education and health worker training that mothers learned to engage in optimal infant feeding practices. We should remember that health workers are necessary and valuable partners in breastfeeding promotion. Our communication initiatives should include training them with the necessary communication skills to protect, promote and support breastfeeding in emergencies.

Lessons Learned

1. Breastfeeding promotion works best when it is a joint-effort between health workers, camp managers, government officials and other humanitarian workers.
2. Don't assume that health workers have knowledge on best breastfeeding practices in emergencies, or are aware of the international standards on the use of adequate and appropriate breastmilk substitutes.
3. Include health worker training as part of the emergency preparedness and recovery phases of your breastfeeding promotion initiative.
4. Be sure to quickly share knowledge with all relevant sectors of the concerned humanitarian and government organisations in an emergency, to ensure that breastfeeding messages are harmonious and disseminated to the intended audiences.

SPECIAL CONSIDERATIONS: BREASTFEEDING AND HIV



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In South Asia, where HIV prevalence is still considered relatively low, promoting and supporting exclusive breastfeeding is vital to significantly reduce the risk of a newborn's death - which diarrhoeal infections can easily cause - and exclusive breastfeeding can just as easily prevent.

However, where HIV rates are known to be high, it is important that we standardise HIV and infant feeding messages so that women and their partners are not confused on the issue of breastfeeding and the possibility of mother-to-child transmission (PMTCT). Admittedly, communicating these facts to mothers may be difficult; dialogue and pictorial aids will often be needed. In addition, partner and family involvement, if feasible, and depending on the consequences of the emergency, will be crucial. It may be possible to draw a risk analogy that is based on cultural knowledge and traditions. This, however, should be carefully researched.

In an emergency, the following information must be taken into account before an appropriate infant feeding and communication strategy is developed:

- Assessment of the prevalence of HIV in the affected population – using secondary sources (including pre-emergency estimates) and relevant information from health information systems; whether it is a high HIV prevalence country of South Asia (pre-emergency) or not? This is particularly important before we can recommend wet nursing.
- Assessment of the knowledge of HIV status: Were voluntary counselling and testing facilities available pre-emergency? Are there such services available now?
- Are there any relevant policies on infant feeding and HIV, from the host and/or home countries?

RESOURCE BANK

Further reading

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11. *HIV and Infant Feeding Guidelines for Decision Makers*, UNICEF, UNAIDS, WHO and UNFPA, Geneva, 2003.

Web sites

1. Baby Friendly Hospital Initiative
<http://www.babyfriendlyusa.org/eng/01.html>
2. Breastfeeding.com
<http://www.breastfeeding.com>
3. CDC Breastfeeding Page
<http://www.cdc.gov/breastfeeding/index.htm>
4. Department of Nutrition for Health and Development (NHD)
<http://www.who.int/nut>

5. International Baby Food Action Network (IBFAN)
<http://www.ibfan.org/>
6. La Leche League International (LLLl)
<http://www.lalecheleague.org/>
7. The Academy of Breastfeeding Medicine
<http://www.bfmed.org/>
8. The Emergency Nutrition Network
<http://www.enonline.net>
9. The Linkages Project
<http://www.linkagesproject.org>
10. UNICEF
<http://www.unicef.org/nutrition/index.html>
11. Wellstart International
<http://www.wellstart.org/>
12. World Alliance for Breastfeeding Action (WABA)
<http://www.waba.org.my/>

Glossary

Breastmilk Substitutes (BMS) Any food being marketed or otherwise represented as a partial or total replacement of breastmilk, whether or not suitable for that purpose; in practical terms this includes milk or milk powder marketed for children less than 2 years and complementary foods, juices and teas marketed for children less than 6 months.

Colostrum The thick, yellowish milk the mother produces in the first few days after birth. It is very nutritious and helps protect the baby against infections by building the baby's immune system.

Exclusive breastfeeding Only breastfeeding or breastmilk feeding and no other foods or fluids (no water, no juices, no tea, no pre-lacteal feeds), with the exception of drops or syrups consisting of micronutrient supplements or medicines.

Infant An infant is a child under 12 months. For the purpose of breastfeeding promotion, however, where prime concern is for the period of the infant's life when milk feeding is essential, the term infant is used for those below 6 months only. This age coincides with the period for which exclusive breastfeeding is recommended by the World Health Assembly (WHA) in Resolution 47.5, 1994.

International Code of Breast-milk Substitutes The International Code of Marketing and Breast-milk substitutes was adopted by the World Health Assembly (the policy-setting body of WHO) in 1981. The aim of the code is to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breastfeeding, and by ensuring the proper use of breastmilk substitutes, when these are necessary, on the basis of adequate information and through appropriate marketing and distribution.

Optimal infant and young child feeding Exclusive breastfeeding for the first six months of life, followed by continued breastfeeding with adequate complementary foods for up to two years and beyond.

Re-lactation The re-establishment of breastfeeding after the breastmilk supply has stopped, or is reduced.

Spill-over The feeding behaviour of new mothers who either know that they are HIV-negative or are unaware of their HIV status – they do not breastfeed, or they breastfeed for a short time only, or they mix-feed, because of unfounded fears about HIV or of misinformation or of the ready availability of breast-milk substitutes.

WHA resolutions Since 1981 the World Health Assembly has passed a number of Resolutions all of which have equal status with the Code. The Code and subsequent Resolutions aim to ensure that information on infant feeding is not influenced by commercial considerations, and that marketing practices do not undermine breastfeeding. The Code and Resolutions are therefore important safeguards for health workers, parents and infants, including those in emergency and relief situations.



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CHAPTER - 6

PROMOTING MEASLES VACCINATION AND VITAMIN A SUPPLEMENTS

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MEASLES VACCINATION AND VITAMIN A ESSENTIALS



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AFGHANISTAN: A health worker gives an oral polio vaccination to a six-week-old held by his mother, in a health clinic in the New Nasir Bagh camp for Afghan refugees -- also called 'Camp-e-Noa -- in the city of Peshawar. The camp's population fluctuates frequently with the ongoing movement of refugees in and out of neighboring Afghanistan. Estimated at well above 14,000, the camp's inhabitants have recently received notices from local authorities to move, but with no indication as to where they should go.

Measles is a highly contagious respiratory viral infection that is commonly identified by its distinctive skin rash. It can be quickly transmitted through airborne droplets from person to person. The highest fatality rates are usually among children under five, and up to 20 percent of infants who are less than a year old. Children who catch measles may suffer lifelong disabilities such as brain damage,

blindness and deafness. Measles remains the leading vaccine-preventable disease that causes child deaths in the world.

Malnourished children are especially at risk of complications and death following an acute attack of measles.

Measles is common and especially dangerous in emergencies because of the following factors:⁴

- Populations are displaced and live in overcrowded conditions.
- Sanitation and shelter are poor.
- Food and safe water are in short supply.

During an emergency situation, especially if the affected community is displaced, the existing expanded programme on immunization (EPI) operations may become disrupted, leaving the youngest and most vulnerable children unprotected. In emergencies, priority must be given to preventing measles outbreaks and efforts must be made to immunize all young children as completely and as quickly as possible.⁵

This could mean that in the initial emergency response, your first measles vaccination communication action will be in support of an emergency measles vaccination campaign conducted by the Ministry of Health and other concerned organisations.

Measles vaccination and vitamin A supplementation go hand-in-hand as vitamin A deficiency is particularly potent as a co-factor in severe measles. Deficiency in vitamin A increases the likelihood that a child will die from the viral disease. We know that not enough vitamin A can lead to blindness. But even before blindness occurs, a child deficient in vitamin A faces a 25 percent higher risk of dying from measles, malaria or diarrhoea.⁶ vitamin A deficiency (VAD) is associated with increased incidence, duration and severity of measles, diarrhoea and respiratory infections.

Vitamin A supplementation is a simple measure with wide-reaching and long-lasting impact on the health of children. Ensure that children get enough vitamin A, especially in emergency situations. This increases their likelihood of surviving poor living conditions in a camp or emergency site.

Successful measles and vitamin A campaigns require well planned, coordinated and managed communication and social mobilisation activities. This will gain the trust of caregivers, community leaders, children and youth groups and other critical groups; help them to understand the importance of the vaccination campaign; and motivate them to support and participate in the efforts to prevent, control and treat measles and vitamin A deficiency.⁷

“Protecting more children against measles will make a significant contribution to reducing child deaths – a key millennium development goal.”

Ann M. Veneman, Executive Director
UNICEF.

Did you know that -

- In conflict or emergency areas, WHO and UNICEF have a commitment to ensure that, at a minimum, measles vaccine and vitamin A supplements¹ are administered?
- Along with the measles vaccine and vitamin A, children in temporary shelters can also be given other vital health interventions such as insecticide-treated mosquito nets to prevent malaria and anthelmintics for deworming?

Did you know that –

- The **measles virus** remains active and contagious in the air or on infected surfaces for up to two hours?
- It can be transmitted by an infected individual from four days prior to the onset of the rash to four days after the onset?
- If one person has the disease, it's highly possible that those who come into close contact with them will also become infected?
- The highly contagious nature and severity of measles makes vigilant immunization promotion, education and social mobilisation imperative to ensure the health and protection of the population?

Saving Orissa's children

Bright saris and stifling crowded rural rooms. These are India's mind-boggling logistics: posterizing every wall, training hundreds of helpers, supplying the remotest communities. What happens here is played out 19, 000 times today in each "booth": children standing in long lines, receiving polio drops, having liquid vitamin A spooned into their mouths.

What makes Orissa's National Immunization Day 1999 so special? It's the first Indian state to combine vitamin A supplementation and polio immunization. All day long... by sunset images blur together: bright green fields, white-clad village teacher, young children in siblings' arms, fathers with infants, a child with measles, the maps, the ice boxes, the palpable determination of health workers and volunteers to reach all targeted children in the entire state – that's over 4 million – in just three days.

One week later, in October 1999, a massive cyclone hit Orissa, devastating its homes, villages and roads. Its vitamin A distribution just days before may have helped participant children stave off the infection and disease which followed.

Source: UNICEF ROSA, Micronutrient Deficiencies: Combating vitamin A deficiency.

PRINCIPLES IN PROMOTING MEASLES VACCINATION AND VITAMIN A

You can learn more about the technical principles for an emergency vaccination campaign - such as planning and organising vaccines, vaccination teams and supplies, storage conditions, vaccination cards, etc. in UNICEF's *Technical Notes*.⁸

Keep in mind the following key principles in PROMOTING an emergency vaccination campaign, i.e. creating informed demand, support and action at the household and community level for the campaign. The main vaccination communication principles tell us to:

1. Closely plan, coordinate and monitor the communication and social mobilisation initiative with the service components of the vaccination programme, particularly if there is a measles outbreak.
2. Ensure that caregivers receive timely and accurate information about vaccination – the venue, date and time; the warning signs of measles and where to seek treatment.

3. Address possible inequalities in access to vaccines by employing social mobilisation efforts and health education specifically for the most vulnerable and 'hard-to-reach' groups.
4. Involve caregivers, community leaders, children and youth groups and other critical groups to garner understanding, participation and support for the emergency vaccination campaign.
5. Pro-actively address possible myths and doubts. Many cultures in South Asia may believe that it is necessary to withhold food and fluid when a child is ill or is known to have measles – a belief which can prove fatal for a sick and dehydrated child.
6. Be prepared for possible adverse events following immunization (AEFI). During a vaccination campaign, a clustering effect of AEFI might occur and, with it, a heightened public and media interest in vaccine and related issues.
7. Mobilise partners and the community to use all available means of communication (radio, loudspeakers, community meetings, etc.) and organisational structures (government bodies, NGOs and community based groups) to quickly reach the affected population.

DOING THE GROUND WORK

An emergency vaccination campaign programme is likely to have two major components:⁹

- Measles outbreak response.
- Measles prevention.

Groundwork for measles outbreak control

If there is a measles outbreak you will not have much time to do groundwork. You will have to quickly mobilise community volunteers and other groups to provide accurate health education to caregivers and community leaders.

Groundwork for a measles prevention response

When you are doing the ground work for an emergency vaccination programme, you will most likely have to look at the following factors to get your communication initiative off the ground:

- What are the pre-emergency routine vaccination rates?
- Who are the hard-to-reach population groups and what are the main reasons these groups are hard to reach? Remember, emergencies usually have the worst



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effect among the disadvantaged groups of the population. These groups' pre-emergency vaccination rates are often below the national average.

- Do the healthcare providers and vaccinators have the communication and people skills to impart the advantages of measles vaccination and vitamin A supplementation? Can they answer questions or clarify doubts?
- What is the availability of community volunteers, faith-based organisations and other partners who can be quickly mobilised for health-education campaigns and social mobilisation activities?
- What are common beliefs, attitudes, practices and barriers regarding vaccination and vitamin A supplementation?

This, along with rapid health and immunization assessments, will help you develop SMART behavioural results and develop the communication actions for an immunization initiative. By adeptly doing the groundwork (using findings from formative research, communication analysis and immunization assessments), you ensure that all communication strategies, messages and materials are based on an adequate understanding of the key factors that influence a caregiver's decision to have his/her child receive the measles shot and vitamin A supplements.

Consider some common barriers

One of the main reasons caregivers do not bring children for vaccination is that the child has a fever, cough, diarrhoea or some other illness on the very day of the vaccination. However, it is your role to influence health workers and other local opinion leaders to proactively communicate to mothers that it is safe to vaccinate a child who has minor symptoms of illness.

Sometimes a health worker advises against vaccinating a child who is disabled or malnourished. You must make health workers understand that this advice can yield negative consequences. A measles vaccination can save a malnourished child from death as the infection can be extremely dangerous to children in this fragile state. Not only is the vaccination safe, but it is key to boosting the immune system of a malnourished child – especially if the malnutrition is severe.¹⁰

Consider also that a child in the affected community may have had a bad reaction to a measles shot. Or, caregivers who may have heard negative rumours about vaccinations may become apprehensive and prevent their child from getting vaccinated.¹¹

Message development: using culture as strength

Not presenting children for measles vaccination and vitamin A supplementation, along with a host of other health-related issues are sometimes rooted in an affected community's traditions that are entrenched in political, social, cultural and economic structures.

In *Health and Culture: Beyond the western paradigm*, Nigerian professor Collins Airhihenbuwa advises health educators not to assume that culture always represents an obstacle. He divides cultural traditions into three categories: positive, neutral, and negative. Cultural traditions such as breastfeeding and transmission of important messages through song and dance are positive building blocks for health education. Beads tied around a child's wrist to ward off evil spirits offer no threat to health. But gender inequity, female circumcision, and withholding fluids during diarrhoeal episodes have negative consequences. **He recommends building on the strengths of the culture to reinforce the positive and gently undermine the negative.** While we should aim to develop culturally appropriate messages, we cannot, in good conscience, promote messages that are contrary to the best interests of the child. When an affected community's culture conflicts with best practices, we must negotiate and advocate with respected community members leaders to help bring about positive change in the attitudes and beliefs. This also calls for creativity on the part of communicators who may have to dig deeply into the culture to find traditions that support positive behaviours.

Ethnologist Dwight Conquergood illustrates this approach in his work in a Hmong refugee camp. After an outbreak of rabies in the camp, a mass dog vaccination campaign failed to produce a single dog for inoculation, and Conquergood, who lived with the Hmong, was asked to design a better campaign.

He organised a Rabies Parade led by Hmong who played important characters in their own folktales—the tiger danced and played a traditional instrument; the dab (a spirit who lives in the jungle and causes epidemics when disturbed) sang and banged a drum; while the chicken, known for its power of predictions, explained what must be done to avoid rabies. The next day, the health centre was overwhelmed by Hmong men and women bringing their dogs for vaccination.

Source: Health and Culture: Beyond the Western Paradigm¹² and, The Spirit Catches You and You Fall Down¹³

Understanding and responding to common beliefs and practices among caregivers and health workers is an important element when doing your ground work. Formative research will help you to determine these barriers, and enable you to develop communication strategies, messages and materials to quickly supply children in emergencies with the vaccine and vitamin A supplements.

Some tools to do the groundwork

Rapid assessment tools

In emergency situations rapid assessment (RA) techniques can be appropriate tools in finding out the practices and beliefs of an affected community with regard to vitamin A, measles and other vaccine preventable diseases. In the initial response of most emergencies may not be feasible to carry out a wide range of RA techniques – or to mobilise the community to fully participate in the groundwork. While it may be possible to facilitate some basic ranking exercises, in practice, only two main rapid assessment procedure tools are feasible to yield the baseline data and information needed to launch an emergency vaccination communication effort. These are the semi-structured interviews and direct observation.¹⁴

Semi-structured interviews with key informants

Semi-structured interviews involve one-to-one talks or discussions with three groups: the affected primary caregivers; the local health authorities; and the relief staff. Interviewing in emergencies call for great sensitivity on the part of the interviewer, as the affected population is often in an unfamiliar, chaotic and stressful environment. The affected participants may be unable to speak with the confidence level that they possessed prior to the disaster, may not have a complete understanding of the issue at hand, or may give the answer that they believe the interviewer wants to hear. **Please see Tool 5 in Part III of the toolkit.**

Direct observation

Direct observation is a data gathering approach that allows you to obtain firsthand information on the affected community's actual vaccination processes and practices. Your aim would be to focus on the most important aspects, rather than writing down what you observe. Therefore, you need to develop an observation checklist with the key attitudes, skills and practices that you want to observe. Then mark the specific characteristics by indicating with a check whether the knowledge, attitude, skills and/or practices are present. You will find a sample checklist for observing specific skills (e.g. communication) in Part III of the toolkit. **Please see Tool 10.**

GETTING THE MESSAGE RIGHT

Messages should be culturally sensitive, appropriate and create an informed demand and support for emergency measles vaccination and vitamin A supplementation. They should clearly communicate the benefits of immunization and vitamin A – as a morbidity and mortality prevention strategy. Involving the key populations in the affected community in developing, fine-tuning and choosing the right mix of messages will boost your communication effort. Coordinate messaging with partners. Remember that messages have to be consistent with those of the other partners involved in the campaign.¹⁵

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NEPAL: Female Community Health Volunteer in a meeting with village leaders, Kalika in Kaski district, 2004.

Messages for a measles outbreak¹⁶

If a measles outbreak is declared at a camp or emergency site, there is likely to be widespread public concern and media attention. It is important to keep the affected families and communities informed about the outbreak and the response. We can communicate via interpersonal and mediated channels - workers, vaccinators, community meetings loud speakers, community-based radio stations, health. During an outbreak, disseminate messages that remind caregivers the importance of getting the measles vaccination at this crucial time, and where to get appropriate treatment for children who are sick. This will also help to allay fears. Reinforce IPC with pre-tested, pre-produced printed and audio-visual media - posters, banners, radio-TV public service announcements, spots and plugs, etc., and use community and mass media, as appropriate and feasible.

During a measles outbreak, prepare localised messages that:

- Provide accurate information on the natural history of measles infection, the symptoms that should prompt a parent to seek expert advice, and the appropriate care of a child with measles.
- Encourage parents whose children have had a recent onset of rash and fever to notify health workers.

- Convey clear information on the ages for immunization, the location and time-schedule for the vaccination and vitamin A supplementation.

Your messages should convey to all caregivers **why, when, where and how many times** the child should be immunized. Remind caregivers that it is safe to immunize the child even if he or she is malnourished, ill, or disabled.¹⁷

Generic messages for primary caregivers may include:¹⁸

- Disease can spread quickly when people are crowded together. All children living in congested conditions have to be immunized immediately, especially against measles, to protect them from dangerous illnesses.
- Measles vaccination and vitamin A protect children and are safe for children, including those who have a minor illness, disability or are malnourished.
- Vitamin A helps children fight infection and malnutrition and prevents blindness.
- If your child has a fever, cough, rash, runny nose or red eyes that lasts for three days or more, immediately seek help from a trained health care provider.
- Children who are sick or recovering from measles are at risk of dehydration and need adequate food and water.
- Continue to breastfeed babies with measles.

A special note:

Since women are commonly the primary caregivers of children, most messages will be directed at them. This is OK as long as we don't forget to develop messages and activities that inspire the entire community to participate in averting or controlling a measles outbreak.

Messages for service providers may include:¹⁹

- All children aged six months to 14 years have to be immunized against measles in an emergency situation. Infants who have been vaccinated at 6 months should be vaccinated again at 9 months.
- As diseases such as measles spread quickly, a child with measles should be isolated from other children and examined by a trained health worker.¹
- Measles vaccination is a golden opportunity to promote vitamin A.
- A new or sterile needle and syringe must be used for every child vaccinated.
- It is safe to immunize a child who is malnourished, has a minor illness or disability.
- After an injection, the child may cry or develop a fever, a minor rash or a small sore. This is normal. However, if you observe more serious side effects, report these immediately to the district health/medical officer or your supervisor.
- Promote immunizations by encouraging and praising caregivers who present their children for the vaccination, and by treating them and their children kindly.

COMMUNICATION ACTIONS TO PROMOTE MEASLES VACCINATION AND VITAMIN A

UNICEF's emergency response is guided by the Core Commitments for Children in Emergencies (CCC) that provide the overarching organisational framework in a humanitarian response (Please see Chapter 3). The table below outlines the CCC in health and nutrition areas related to measles vaccination and vitamin A supplementation. We have included some suggested behaviour change communication (BCC) and social mobilisation activities that have proven effective. Remember to plan your communication and social mobilisation actions with the participation of the affected community and your partners, and be mindful about gathering feedback, monitoring and evaluating your BCC initiative.

TABLE: Extract from UNICEF's CCC in health and nutrition and corresponding suggested BCC and social mobilisation support.

FIRST SIX TO EIGHT WEEKS	SUGGESTED BCC AND SOCIAL MOBILISATION ACTIONS
<p>1. Vaccinate all children between 6 months and 14 years of age against measles; at minimum children from 6 months to 4 years of age must be immunized. Provide vaccines and critical inputs such as cold-chain equipment, training and social mobilisation expertise and financial support for advocacy and operational costs. Along with the vaccination, provide vitamin A supplementation, as required.²¹</p>	<ul style="list-style-type: none"> ▪ Launch a public awareness campaign via mass media. In affected communities, low-tech media are usually the most practical - loudspeakers, megaphones, etc. Work with community-based radio stations where they are operational. Distribute and post printed and audio-visual materials – posters, banners, etc. as appropriate. Through these community media, you can share with affected families and communities the what, why, when and where to go for the vaccination and vitamin A supplementation.

FIRST SIX TO EIGHT WEEKS	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
	<ul style="list-style-type: none"> ▪ Mobilise community volunteers and service providers to personally tell primary caregivers the details of the emergency vaccination campaign, and the benefits and safety of vaccination and vitamin A supplementation. ▪ Make special efforts to reach vulnerable and hard-to-reach communities with information and vaccination services. ▪ Distribute basic messages that would help caregivers recognise measles symptoms and complications to help reduce measles mortality. ▪ Involve community and faith leaders in the planning of the emergency vaccination campaign, if possible. At a minimum, ensure that they know when, where and why the vaccination campaign will take place. ▪ Build the capacity of health workers and vaccinators with the necessary communication skills to talk about the advantages of immunization and are able to handle questions and clarify doubts. ▪ Use camp registration points as a communication channel to provide information on the measles vaccination and vitamin A. Children can receive vaccination here and adults can learn when and where to go to receive the health services. ▪ Train volunteers to visit temporary and roving schools to share with principals, teachers and students vital information on measles vaccinations and vitamin A.

FIRST SIX TO EIGHT WEEKS	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
	<ul style="list-style-type: none"><li data-bbox="592 296 1072 496">■ Employ child-to-child methodologies – i.e. children singing songs related to immunization, so that they can become informal promoters by, for instance, singing the lyrics in the community or at public events.<li data-bbox="592 505 1072 878">■ Engage motivated school-aged children, boy scouts and girl guides, or other local children’s groups, eg, Child Clubs in Nepal and local Children’s Parliaments in India, as “calling parties” the day before and during vaccination and supplementation to remind caregivers of the date and venue. This is also a creative way to get children involved in their own health.<li data-bbox="592 887 1072 1190">■ Train and deploy community volunteers throughout the camp to meet with caregivers and to discuss child health related issues, including the severity of measles, the need to protect children from disease, the safety of the vaccine and injection, and the need to continue with routine immunization.<li data-bbox="592 1199 1072 1399">■ Invite and engage people who have lost children to measles as peer educators, counsellors as they can be strong advocates because they have witnessed the virility and consequences of the disease.<li data-bbox="592 1407 1072 1503">■ Monitor any immunization coverage and shifts in the community’s attitude regarding immunization.

Measles song

Children learn 'measles songs' from their teachers; teachers tell the children to bring their younger siblings to get immunized; children march through the streets or in a camp in parades, holding up signs and singing to let everyone know about the importance of vaccination.²²



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MALDIVES: A baby is vaccinated against polio on Kudahuvadhoo Island in Dhaalu Atoll, some 150 kilometres from Male, the capital. An immunization campaign against measles and polio, aimed at all children under age two, is under way following the tsunami disaster.

I am measles, killer disease
I am measles, killer disease
I am measles, killer disease
Take your child for immun-I-zation....
November XX
November XX
November XX
Take the shot for immun-I-zation....
From the age of six months
To the age of fourteen years
Our parents work hard
Take your child for immun-I-zation....
Immun-I-zation everywhere
Immun-I-zation everywhere
Immun-I-zation everywhere
Take your child for immun-I-zation...

MONITORING MILESTONES

Indicators are needed to measure and demonstrate whether or not our communication initiatives are meeting the behavioural results. But advocacy and communication activities alone can not improve emergency vaccination efforts. This also depends on service delivery factors and disease control efforts. Most communication indicators are therefore process-oriented and measure inputs and outcomes of activities conducted. Indicators are most effectively measured and monitored at district and community level through a combination of qualitative and quantitative methods (i.e. focus group discussions, exit interviews with caregivers, observation of vaccination and community mobilisation sessions and so on).

The impact and outcome of communication efforts is tied to other EPI indicators and must therefore be measured within that context. Listed below are a range of indicators.²³ **Tool 14 in Part III lists possible sources of information to help you measure the indicators.**

Input indicators include:

- Presence of a communication component for EPI in the emergency preparedness and response plan.
- Amount of funds allocated for the communication component to support the EPI programme in an emergency situation.
- Number of planned outreach activities in the affected communities and camps.
- Number of materials produced.
- Percentage of communication plans that map resistant or difficult groups, including “zero-dose” children, and proposed strategies for reaching them.

Output indicators include:

- Percentage of emergency vaccination programme budgets used for a) broadcast media, b) print materials, and c) strengthening interpersonal communication skills.
- Percentage of planned activities to reach the hard to reach population groups actually conducted.
- Number of materials disseminated, made visible and used in health facilities.
- Number of health workers and mobilisers trained in immunization communication. What is the number of training sessions conducted?
- Number of meetings held with community and faith leaders.
- Percentage of health workers/vaccinators/care-givers who know how to recognise measles and where such a case should be reported.

Outcome indicators (linked to EPI indicators) include:

- Percentage of health workers/vaccinators providing key messages during immunization sessions.
- Percentage of caregivers with vaccination cards.
- Percentage of caregivers who know where to go for vaccination and vitamin A supplementation.
- Percentage of caregivers who know where to take a sick child for treatment.
- Percentage of households in affected communities/camps visited by community health volunteers/mobilisers.
- Percentage of budget spent on communication activities according to the plan.

Impact indicators (EPI indicators) include:

- Percentage of children vaccinated with measles.
- Percentage of children who received vitamin A supplements.
- Percentage of drop-out rates.
- Percentage of planned outreach sessions actually conducted.
- Percentage of reduced measles incidents among the child population from date A to date B.

PRACTICAL EXPERIENCES

Uganda Red Cross mobilises community to promote measles immunization

While a measles communication initiative should not rely strictly on campaigns, stickers and posters – a mass vaccination campaign may be the first line of defence in an emergency situation. In a disaster, one of the top health priorities is to give the measles shot to all children in the camp/affected area who are between 6 months and 14 years of age. Overcrowding, poor sanitation, diarrhoea and malnourishment are conditions that make it easy for a measles outbreak to occur.

Be mindful that in emergencies the affected community may be busy doing household chores, searching for work, standing in lines for food/humanitarian assistance, gathering fuel or water, recovering lost items, or caring for the family. This will prevent them – particularly women with children – from attending public events, standing in long lines for immunization/health services, or pay much attention to matters that don't seem urgent to them.

The Ugandan Red Cross communicated with such hard to reach populations through a mix of communication channels including interpersonal communicators, mass media, volunteers, and community theatre in its November 2001 measles campaign. One of the behavioural results was to ensure that every mother or primary caregiver in a particular district understood the need for their children to be immunized, and subsequently took them to the health centre for the shot. Red Cross workers recruited volunteers from the communities that were targeted for the campaigns, educated and trained the volunteers on the process, and gave them the necessary resources to carry out their mission. Supplies included costumes to put on plays, vests for identification, brochures, and money for the volunteers' lunches, posters, banners, and other items.

Volunteers – travelling by whatever method available – met with the primary caregivers, usually the mothers, to communicate the importance of protecting children against measles; the safety of the vaccination process; and the need to follow-up and keep up with the immunization schedules. The volunteers made lists of children in each

household who were eligible for vaccination; then cross-referenced the names with the list of children who had received the vaccination. This method helped them confirm if any child had been missed.

Clearly this type of measles communication initiative takes planning. You can most effectively mobilise the community during the emergency preparedness phase of your BCC programme, and also beyond the initial response. While emergencies usually result in widespread social disruption, it is to your advantage to partner with the leaders of the affected community who have the ear, mind and heart of the people – religious leaders, traditional healers, TBAs, tribal chiefs, teachers, clan leaders and other relevant stakeholders – to gain support for the measles vaccination. You should also be prepared to deal with misconceptions, myths and past adverse events related to the measles shot. In this particular Ugandan district, a local anti-government radio station was advising parents against immunization, saying the vaccine would kill their children, not save them. Red Cross activated more volunteers to counter this message with positive ones to help allay parents' fears.

Don't neglect to tap into your most precious resources in emergencies: motivated young people can be quickly mobilised to spread the immunization message. If the education system is still in place (or if a temporary one has been established), educators can teach schoolchildren the 'measles songs', and tell students to bring their younger siblings for the vaccination. In Uganda, one schoolgirl in the Pallisa district looked sternly at the crowd as she sang the measles song, shaking her finger at the crowd during the verse, "take your child for immunization."

Source: Adapted from the Measles Initiative²⁴

Lessons Learned

1. Be aware of the affected community's pre-existing beliefs about the cause of measles and its cure before the disaster occurs.
2. Engage traditional healers, religious leaders, health workers, key informants, volunteers and other respected community leaders to support a measles vaccination initiative.
3. Enlist motivated school-aged children, boy scouts, girl guides and children's organisations to promote the measles shot to the affected community and parents.
4. Don't use fear to motivate parents; but, inform them of the consequences of not vaccinating their child.
5. Be prepared with positive information and communication actions to counter misperceptions and myths surrounding measles vaccinations.

RESOURCE BANK

Further reading

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13. US Agency for International Development, *Immunization Essentials: A practical field guide*, USAID, USA, 2003.

Web sites

1. Agency for Toxic Substances and Disease Registry
<http://www.atsdr.cdc.gov/HEC/primer.html>
2. Allied Vaccine Group
<http://www.vaccine.org>
3. Centre for Disease Control and Prevention: Communication at CDC
<http://www.cdc.gov/communication/>
4. GAVI Advocacy Resource Kit http://www.vaccinealliance.org/Task_Forces/Advocacy_Task_Force/Documents/other_materials_2.php
5. Global Alliance for Vaccines and Immunization (GAVI)
<http://www.vaccinealliance.org>
6. Gates Children's Vaccine Program at PATH
<http://www.childrensvaccine.org/html/resources.htm>
7. Immunization Resources from The Media/Materials Clearinghouse (M/MC) at Johns Hopkins University
<http://www.m-mc.org/>
8. Polio Eradication Initiative
<http://www.polioeradication.org>
9. Safe Injection Global Network (SIGN)
<http://www.injectionsafety.org>
10. The Communication Initiative
<http://www.comminit.com>
11. The Measles Initiative
<http://www.measlesinitiative.org/>
12. The Vaccine Page
<http://www.vaccines.org>
13. United Nations Children's Fund
<http://www.unicef.org>
14. World Health Organization
<http://www.who.int/vaccines>

Glossary

Adverse event following immunization (AEFI) is a medical incident that takes place after immunization which causes concern and is believed to be caused by the immunization.

Adverse reaction is an undesirable outcome caused by a vaccine (or drug) where there is evidence suggesting a causal relationship. The difference between adverse

events and adverse reactions is that adverse events may coincide with (i.e. occur at the same time), but not necessarily caused by, vaccine administration.

Cluster are two or more cases of the same or similar adverse event related in time, geography (e.g. at a health unit or immunization outreach post), vaccinator and/or vaccine administered.

Epidemic an outbreak of a contagious disease that spreads rapidly and widely

Mass vaccination vaccinations of large numbers of people at the same time, usually when several cases of a disease have been reported, causing concern that there may be a general outbreak of the disease

Measles is an acute viral illness caused by a virus in the paramyxovirus family. As a respiratory disease, measles virus normally grows in the cells that line the back of the throat and in the cells that line the lungs. Measles is a human disease with no known animal reservoir.

Vitamin A deficiency causes Xerophthalmia, blindness and death. Eye signs: poor vision in dim light, dryness of conjunctiva or cornea, foamy material on the conjunctiva or clouding of the cornea itself. These signs may appear after several months of an inadequate diet, or following acute or prolonged infections, particularly measles and diarrhoea.

Footnotes

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- ⁷ *Technical Notes*, p. 38.
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- ⁹ World Health Organization and United Nations Children's Fund, *Measles, Mortality Reduction and Regional Elimination Strategic Plan 2001–2005*, WHO/UNICEF, Geneva, 2003, p.24.
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- ¹² Slim, H., et al., *Rapid Assessment Procedures: Qualitative methodologies for planning and evaluation of health related programmes*, 'The application of RAP and RRA techniques in emergency relief programmes', International Nutrition Foundation for Developing Countries (INFDC), Boston, 1992, Section 18.

- 13 Adapted from *Sphere Project: Humanitarian charter and minimum standards in disaster response*, The Sphere Project, Geneva, 2004, p.264.
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- 22 Measles Initiative, *Measles Song*, <http://www.measlesinitiative.org>.
- 23 Adapted from Shimp, L., *Strengthening Immunization Programs: The communication component*, BASICS II for USAID, USA, 2004, pp. 14-15.
- 24 'Uganda Red Cross Mobilises Community to Promote Measles Immunisation', Measles Initiative, <http://www.measlesinitiative.org>.



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CHAPTER - 7

PROMOTING SAFE MOTHERHOOD

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PROMOTING SAFE MOTHERHOOD

WHY PROMOTE SAFE MOTHERHOOD IN EMERGENCIES?

PRINCIPLES OF SAFE MOTHERHOOD PROMOTION

DOING THE GROUNDWORK

GETTING THE MESSAGE RIGHT

COMMUNICATION ACTIONS FOR SAFE MOTHERHOOD

MONITORING MILESTONES: TRACKING BEHAVIOUR RESULTS

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RESOURCE BANK

WHY PROMOTE SAFE MOTHERHOOD IN EMERGENCIES?



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PAKISTAN: A healthworker checks a woman's blood pressure in a health center tent in one of the camps for families affected by the South Asia earthquake.

During an emergency it is easy for pregnant women to become exhausted, malnourished and anaemic because of stress, lack of food and water, a hurried evacuation, or the need to travel long distances to reach safety or humanitarian assistance. Transportation routes may be cut off, distribution networks dissolved and health facilities destroyed. Maternal

support services that are normally available to the affected community may have been destroyed or operating at reduced capacity; and existing supplies may fall far short of demand when large numbers of people move into a new location.²

These circumstances put women at a higher risk of death or disability from complications during pregnancy and/or delivery. In close partnership with health providers, you can support the protection of infants and pregnant women in emergency situations through safe motherhood promotion, social mobilisation,

Identify key audiences for each of the prioritised behaviours:

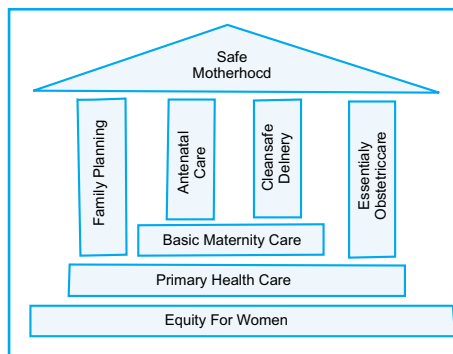
- Pregnant and post-partum women.
- Family decision makers (this may vary depending on culture, situation, and household composition).
- Community opinion leaders (religious, women group leaders, locally elected leaders, others).
- Birth attendants (professional or traditional).
- Community health providers involved in maternity care.
- Health facility based health professionals (private and government).

Source: Saving Mother's Lives!

and advocacy with local governments, health providers and humanitarian agencies.³

The pillars of safe motherhood, as illustrated below, highlight the strategic safe motherhood interventions that you can promote in your communication initiative. During the initial emergency response it would be wise to focus on a few risk-reducing behaviours that are discussed in the *Getting the message right* section.

The “four pillars” of safe motherhood⁴



PRINCIPLES OF SAFE MOTHERHOOD PROMOTION

Safe motherhood promotion in emergencies should focus on a limited number of practices that are proven to decrease infant and mother deaths. Your communication effort should result in women having the power to have healthy pregnancies, safe deliveries and positive birth outcomes. Consider the following principles when planning your communication initiative to support safe motherhood goals:

- 1. Prioritise behaviours, emphasising the ones with the most potential to reduce death and disability.**

To reduce death and disability in mothers and infants the priority safe motherhood practices are seeking antenatal care within the first three months; a safe and clean delivery; and receiving immediate post-natal support.

- 2. Involve the decision makers in a mother’s life.**

In many South Asian cultures, a mother-in-law, husband or other family decision maker influences the antenatal and postnatal practices of new and expectant mothers. Identify and involve the family decision makers and include them as key participants in participatory assessment, community mobilisation and support efforts as well as in monitoring activities. However, be aware that

the household composition may have changed as a consequence of the disaster. Some expectant women and mothers may be alone, or new heads of the household. You will need to know this too!

3. **Disseminate positive safe motherhood messages.**
Messages should show how safe motherhood practices benefits mother, baby and family.
4. **Your communication support should be aligned with and in support of the national maternal health plan/policy.**
Don't reinvent the wheel; build on the country's existing health policies and find ways to fill in the gaps.

DOING THE GROUNDWORK

Before any emergency strikes, communicators should form alliances and work in coordination with key partners in safe motherhood promotion. These allies could be the community health workers, birth attendants (professional and traditional), nurses, doctors (private and government), district

Continued access to family planning in emergencies

Family planning is especially important when health services have been damaged or destroyed by war or natural disaster. Experience has shown that in emergencies women, girls and adolescents are sometimes raped; forced into having sex in exchange for food and other needed items; and otherwise sexually abused.

We should be mindful of the weakened/absent law enforcement in emergency situations and ensure that emergency contraceptives are available; and that women who have been using family planning services pre-disaster continue to have access to these services.

Communication actions should ensure that women, men, and adolescents know when, where and how-to access family planning services and supplies; know the importance of seeking medical care and counselling if raped or sexually abused; and know where to go for these services.

Be sure that your family planning/safe motherhood actions are in line with the affected community's national reproductive plan, and that your messages are in sync with other concerned agencies.

Source: Adapted from Family Planning²

health officers, faith-based leaders and others. If you establish these partnerships your groundwork will become a process of filling in the gaps - combining pre-existing knowledge about the affected community with new information received from rapid assessments. By information and feedback gathering - both pre-and-post emergency - you will be able to influence relevant behavioural results, safe motherhood communication actions, messages and materials.

Keep in mind that during emergencies it may be harder for an affected community to part from social and cultural beliefs, practices and traditions that vary from the positive behaviours you are presenting. Understanding such barriers will be critical in planning your communication initiative.

Some tools to do the groundwork

Key informant interviews

There is sufficient evidence that in many countries in South Asia, a woman's beliefs, practices and attitudes toward pregnancy are influenced by family decision makers such as husbands, mothers-in-law, and community and family elders. These decision makers are often the ones who decide whether a woman needs antenatal or post-natal care, should breastfeed, or go to a health facility for an obstetric emergency. In emergency situations, this tradition will depend on factors such as the extent of community disruption, displacement, mortality and morbidity rates. You can use key informants – affected pregnant women, adolescent girls, health workers, men and family decision makers – to provide insight on the decision making processes that form the beliefs, attitudes and practices on pregnancy, delivery and other safe motherhood-related issues. **Please see Tool 5 in Part III of the toolkit.**

Focus group discussions

In stabilised situations mothers have many obstacles to making sure that they have a safe pregnancy and delivery. In an emergency, ensuring safe motherhood becomes even more difficult. Some women may not know how to have a healthy pregnancy; rumours can spread about health services or providers; or the affected community does not support a woman's choice to adopt safe motherhood practices. Through focus group discussions identify the cultural traditions, practices and beliefs that are disincentives to positive change in the cultural

context of the country and the emergency. The added value of focus groups is that participants not only provide information for your communication initiative but can also carry lessons learned back to the affected community. **Please see also Tool 9 in Part III of the toolkit.**

By using these tools in different stages of an emergency, you can determine whether the priorities that centre on safe motherhood issues change at different phases of an emergency.

GETTING THE MESSAGE RIGHT

In emergencies, new mothers and pregnant women will receive messages on hygiene, breastfeeding, child protection and measles vaccination.

Prevent message clutter and focus on messages on the two main risk-decreasing strategies.

These strategies are:

1. Creating demand and support for antenatal and post natal care.
2. Knowing how to have a clean and safe delivery.

Promote the above strategies with clear, concise and easily understood messages. Choosing the right mix will depend on which key behaviours you have prioritised as the most critical ones to save the lives of infants and new and expectant mothers in the emergency. Your choice of messages will also depend on who your main audiences are – for example, pre-and-post partum women, community health

Pointers on using counsellors in a safe motherhood BCC programme^{5, 6}

A component of safe motherhood promotion can include training health workers and peer educators to counsel and communicate the benefits and importance of safe motherhood practices to the affected women, their families and community.

Counselling is beneficial in that it can be used to reinforce safe motherhood messages disseminated via IEC materials and the mass media. It can also help bridge cultural, ethnic, and social gaps between healthcare providers, TBAs and affected women.

Counselling should only be used if you have the resources and capacity to do so. This can be challenging in an emergency situation, because there is often a poor client-counsellor ratio. However, if you have the resources and capacity, consider that the affected women and families should receive:

Information - To learn about the benefits and availability of the services and access to services regardless of gender, creed, colour, marital status or location.

workers, village elders and/or relief workers. Involve women and other key audience members in developing the messages. This will go a long way in ensuring that the messages are effective, clear and understood by all of the intended target audiences. Safe motherhood messages might include:⁷

1. It is important for all family members to be informed about and able to recognise the warning signs of problems during pregnancy and childbirth.
2. Make a birth plan and know where to get immediate skilled help if problems during pregnancy or delivery arise.
3. A skilled birth attendant, such as a doctor, nurse, or trained midwife, should check the woman at least four times during every pregnancy and assist at birth.
4. All pregnant women need particularly nutritious meals and more rest than usual throughout the pregnancy.
5. Smoking, alcohol, drugs, poisons and pollutants are especially harmful to pregnant women and young children.
6. Physical abuse of women and children is a serious public health problem. Abuse during pregnancy is dangerous both to the woman and the foetus.
7. Every woman has the right to health care, especially during pregnancy and childbirth. Health care providers should be technically competent and treat women with respect.

Choice To understand and be able to apply all pertinent information and make an informed choice, freely ask questions, and receive answers in an honest, clear and comprehensive manner.

Safety A safe and effective service.

Privacy To have a private environment during counselling or services.

Confidentiality To be assured that any personal information will remain confidential.

Dignity To be treated with courtesy, consideration and attentiveness.

Comfort To feel comfortable when receiving services.

Continuity To receive services and supplies for as long as needed.

Opinion To express views on the services offered.

COMMUNICATION ACTIONS FOR SAFE MOTHERHOOD

UNICEF's emergency response is guided by the Core Commitments for Children in Emergencies (CCC) that provide the overarching organisational framework in a humanitarian response (see Chapter 3). The table below outlines the CCC in the areas of Health and Nutrition related to safe motherhood. Included are suggested behaviour change communication (BCC) and social mobilisation activities that have been effective in improving women's health during pregnancy and delivery in an emergency situation. Remember to involve relevant members of the affected community and your partners in planning your communication and social mobilisation actions, as well as to carefully monitor and evaluate the programme.

TABLE: Extract from UNICEF's CCC in health and nutrition and corresponding suggested BCC and social mobilisation support.

BEYOND THE INITIAL RESPONSE	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
<ol style="list-style-type: none"> 1. Support the establishment of essential health-care services, by providing outreach services and home-based management of childhood illnesses and emergency obstetric care services, and treatment for malaria, diarrhoea and pneumonia. 	<ul style="list-style-type: none"> ■ Ensure that affected women, family decision makers, birth attendants, and traditional healers know the warning signs during pregnancy and danger signs in a delivery that mean that they must get help immediately. They must receive information on when and where to seek antenatal care and emergency obstetric care – i.e. through group discussions, women's shelters, maternity caregivers, health workers, counselling and IEC materials.

BEYOND THE INITIAL RESPONSE	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
	<ul style="list-style-type: none"> ■ Ensure that health workers and other service providers know and understand the importance of seeking professional emergency obstetric care and are able to communicate this to women. ■ Involve government agencies and professional health associations in training support service providers, in giving advice and support to women on preparing a birth plan and planning for potential obstetric emergencies. ■ Mobilise the community to support pregnant women in obstetric emergencies by designing a community-based birthing plan and increasing knowledge on danger signs during delivery through talks with women's groups, mass media, IEC materials, audiovisual presentations, flip charts, etc. ■ Advocate and mobilise support with the local government, camp management, private sector and humanitarian agencies to increase knowledge on the need for reliable emergency obstetric care for all affected women, providing reliable transportation systems, and training of birth attendants.
<p>2. Provide tetanus toxoid with auto-disable syringes and other critical inputs such as cold-chain equipment, training and behavioural change expertise, and financial support for advocacy and operational costs for immunization of pregnant women and women of childbearing age.</p>	<ul style="list-style-type: none"> ■ Ensure that all affected women and family decision makers know the benefits of tetanus toxoid shots to both mother and baby; when, and where to get the vaccination – i.e. one-one-counselling/talks, health worker visits, women's representatives, midwives, and IEC materials.

BEYOND THE INITIAL RESPONSE	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
	<ul style="list-style-type: none"> ■ Train birth attendants, health workers, counsellors and service providers on how to communicate the importance of tetanus toxoid vaccinations to affected mothers and family decision makers. ■ Advocate and mobilise support with local authorities, camp management and other relevant stakeholders to provide tetanus toxoid vaccinations to all affected women (especially those of reproductive age). ■ Involve public figures in advocating the benefits of tetanus toxoid vaccination to affected women and communities.

Communication to support safe motherhood initiatives in emergencies has to be timely, appropriate and based on the nationally identified priorities and national maternal health policies. Remember to build on existing activities and partnerships!

BEYOND THE INITIAL RESPONSE	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
<p>3. Support the establishment of essential health-care services, by providing outreach services and home-based management of childhood illnesses and emergency obstetric care services, and treatment for malaria, diarrhoea and pneumonia.</p>	<ul style="list-style-type: none"> ■ Ensure that affected women, family decision makers, birth attendants, and traditional healers know the warning signs during pregnancy, and danger signs in a delivery that mean get help immediately; and that they know when and where to seek antenatal care and emergency obstetric care – i.e. group discussions, community based radio, women’s shelters, maternity caregivers, health workers, counselling and IEC materials.

BEYOND THE INITIAL RESPONSE	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
	<ul style="list-style-type: none"> ■ Ensure that health workers and other service providers know and understand the importance of seeking professional emergency obstetric care and are able to communicate this to women. ■ Involve government agencies and professional health associations to train and support service providers in giving advice and support to women on preparing a birth plan and planning for potential obstetric emergencies. ■ Mobilise the community to support pregnant women in obstetric emergencies by designing a community-based birthing plan and increasing knowledge on danger signs during delivery through talks with women's groups, mass media, IEC materials, audiovisual presentations, flip charts, etc. ■ Advocate and mobilise support with the local government, camp management, private sector and humanitarian agencies to increase knowledge on the need for reliable emergency obstetric care for all affected women, reliable transportation systems, and training of birth attendants.
<p>4. Provide health and nutrition education, including messages on the importance of breastfeeding and safe motherhood practices.</p>	<ul style="list-style-type: none"> ■ Ensure that affected women and family decision makers know the components of maternal nutrition – a pregnant woman needs the best foods available to the family; should avoid food restrictions; needs iodised salt, vitamin A and iron supplements. Understands that a woman should exclusively breastfeed for the first 6 months (unless in exceptional cases in which the infant

BEYOND THE INITIAL RESPONSE	SUPPORTIVE BCC AND SOCIAL MOBILISATION ACTIONS
	<p>should be cup fed an adequate amount of appropriate BMS); receive antenatal/postnatal care; seek and use clean delivery kits (where available); have an attended birth; and get immediate care for warning signs during pregnancy or delivery – i.e. counselling, health workers, audiovisual presentations, women’s representatives, birth attendants/midwives, and IEC materials.</p>
	<ul style="list-style-type: none"> ■ Ensure that health workers, birth attendants and maternity caregivers, women’s representatives, counsellors and other relevant stakeholders know and can communicate to affected mothers and family decision makers the factors of maternal nutrition; exclusively breastfeeding for the first 6 months (unless in exceptional cases); receiving antenatal/postnatal care (including tetanus injections); and immediately seeking help for emergency obstetric situations. ■ Mobilise the community to support pregnant women and new mothers by facilitating mother-to-mother support networks, women’s group, community-based birthing plans, referral systems, etc.

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AFGHANISTAN: Woman receives vaccination in a clinic.

MONITORING MILESTONES

The result of a safe motherhood programme in an emergency situation is to reduce maternal and neonatal mortality and morbidity through timely and appropriate safe motherhood interventions.⁸

This is usually the overall objective your communication initiative should seek to support. It is critical to monitor whether your communication support to the safe motherhood programme is on track. On which indicators you need to monitor your communication efforts depends on which specific behavioural results you seek to achieve from the affected groups. The following are, however, some common core indicators listed to give you an idea. **Tools 12 and 13 in Part III lists possible sources of information to help you measure the indicators.**

- Health workers, midwives, women's representatives, counsellors and other relevant stakeholders are trained on maternal nutrition and breastfeeding facts and communicate the importance of antenatal and postnatal care visits, clean and attended delivery, the warning signs during pregnancy and danger signs during pregnancy.
- Affected women and their families know the benefits of and practice healthy eating, taking vitamin A supplements and iron; receiving tetanus shots; having a clean and attended delivery; seeking antenatal and postnatal care.
- Affected women and their families know the warning signs during pregnancy; when and where to get immediate help, and seek medical help when complications occur.



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SRI LANKA: Deputy Principal Mohammad Hanifa Abdul Rahman teaches social studies to Grade 8 boys in a temporary classroom at Al-Arham Vidyalaya School in the Addalaichenai area in the eastern district of Ampara. The school, whose students are from a Muslim fishing community, has been relocated to a temporary structure on rented land. The original school, located less than 40 metres from the sea, was completely destroyed by the tsunami. Two of its 350 students were killed during the disaster and 80 percent of the children's homes were damaged or destroyed. Many of the students have been traumatized and are afraid to return to the original school site. UNICEF has provided the materials for a temporary school building as well as 12 school-in-a-box kits.

- The affected community demonstrates support to pregnant women via mother-to-mother support networks, women's group, community-based birthing plans and referral systems, etc.
- Local governments and humanitarian agencies have allocated the resources needed for adequate care and affordable quality services; have established the necessary transportation systems, supplied essential drugs, clean delivery kits – and have formed necessary partnerships to supply these.

SPECIAL CONSIDERATIONS: SAFE MOTHERHOOD AND HIV

In an emergency situation, the effects of poverty, powerlessness and social instability are intensified and the social norms regulating behaviour are often weakened. Women – including those who are pregnant – and children are at an increased risk of violence, and can be forced to have sex for them to gain access to basic needs such as food, water or security. These are all factors which make affected women and children more vulnerable to HIV infection.⁹

In South Asia, where HIV prevalence is still considered to be generally low, communication initiatives must take into account whether HIV and AIDS prevention, treatment and support should be part of the communication strategy to support the larger goals of safe motherhood. When you plan and prepare a behaviour and social change component for a safe motherhood response in an emergency situation, which includes an HIV/AIDS communication component, consider the following factors:

- What were pre-emergency HIV incidence and prevalence figures?
- What is the general knowledge level among the affected population regarding HIV and AIDS?
- Were comprehensive PMTCT services available prior to the emergency? Are they available post emergency in the affected area (this includes determining if anti-retroviral prophylaxis and treatment are available for mothers and their newborns prior to the emergency)? If yes, the rapid assessment which is conducted in the initial phase of an emergency will have to establish if there was an interruption of anti-retroviral therapy caused by the emergency.

- Are voluntary and confidential HIV counselling services available in ANC services?
- Are trained HIV counsellors available?
- Does the country have a national HIV and infant feeding policy? If not, we should seek guidance from global policies.¹⁰

RESOURCE BANK

Further reading

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<http://www.hsph.harvard.edu/Organizations/healthnet/>
2. Reproductive Health Outlook
<http://www.rho.org/index.html>
<http://www.rho.org/html/menrh.htm>
3. Saving Women's Lives Initiative
<http://www.savingwomenslives.org>

4. The Safe Motherhood Initiative
<http://www.safemotherhood.org>
5. United Nations Children's Fund
<http://www.unicef.org/health/index.html>
6. United Nations High Commissioner for Refugees
<http://www.unhcr.ch>
7. United Nations Population Fund
<http://www.unfpa.org/emergencies/index.htm>
<http://www.unfpa.org/icpd>
8. US Center for Disease Control and Prevention (CDC)
<http://www.cdc.gov/nccdphp/drh/>
http://www.cdc.gov/nccdphp/drh/mrh_mens.htm
9. White Ribbon Alliance for Safe Motherhood
<http://www.whiteribbonalliance.org>
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Footnotes

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- ² Adapted from 'Family Planning', retrieved from <http://www.unfpa.org/emergencies/planning.htm> on 9 October 2005.
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CHAPTER - 8

SUPPORTING CHILD PROTECTION AND PSYCHOSOCIAL RECOVERY

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WHY PROMOTE CHILD PROTECTION IN EMERGENCIES?

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WHY PROMOTE CHILD PROTECTION IN EMERGENCIES?



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NEPAL: A child club meeting at Khairnistar High School, 2004

Child protection is a special concern in emergencies as many of the defining features of a disaster - displacement, breakdown in family and social structures, erosion of traditional value systems, potential violence, weak governance, absence of accountability, and inaccessibility to basic social services - put children at risk of being injured, disabled or separated

from their primary caregivers or being orphaned; for trafficking, physical and sexual abuse, and other forms of exploitation. In the South Asian context, where girls are often marginalised even in stabilised situations, the environment in a camp or emergency site can make them even more vulnerable to abuse and exploitation.

The threat of physical harm to children is compounded by the stress and trauma created by the emergency. Nearly all children and adolescents who have experienced catastrophic situations will initially display various symptoms of psychological distress, including intrusive flashbacks of the stress event, nightmares, withdrawal and an inability to concentrate. Child development professionals consider that the key element in promoting a child's recovery is building resilience as well as meeting basic needs.²

In emergency situations where people are displaced, parents/primary caregivers are faced with situations where:

- Boys and girls are in unfamiliar surroundings with people they do not know (i.e. in camps or in temporary shelters).

- Increased alcohol consumption may be prevalent – because of the general destabilisation and higher availability of cash among men from relief efforts.
- Adolescents may also be psychosocially affected, which can increase the risk of sexual and physical abuse of children, especially among girls.
- Crowded living conditions, where families share sleeping quarters, can lead to adults having sex in front of children.

Moreover, parents/primary caregivers might feel helpless in the aftermath of disasters because of destroyed support systems. They may attempt to lessen their responsibilities by forcing girls to marry early or live with distant relatives; sending children to work with “employers” who are traffickers; and engage in other actions that put children, especially girls, in harm’s path.

UNICEF recommends the following child protection strategies in an emergency situation:³

- Advocacy and increasing knowledge.
- Ensuring written commitments.
- Monitoring and reporting violations.
- Creating safe environments.
- Strengthening local institutions

Depending on the detailed priorities of the child protection and psychosocial development response efforts, your communication initiative should support the above priorities in partnership with the government, affected community, camp management, sister UN agencies and other relevant stakeholders.

Child protection in emergencies

Remember: Children in the midst of armed conflict and natural disasters, such as droughts, floods and earthquakes, have the same needs and rights as children in stable environments.¹

Communication initiative key to protecting children in Sri Lanka tsunami camps In Sri Lanka, an estimated 5,000 children lost one or both parents, and countless more lost relatives, friends and teachers. UNICEF’s response to protect these children in the camps focused on the issues of injury, being orphaned or separated from their primary caregivers, child abuse, trafficking, exploitation and other vulnerabilities. UNICEF put emphasis on advocacy and awareness raising campaigns on these issues. Actions were taken to identify the relevant protection messages using available means to mobilize the affected community and to ensure that the messages reached the intended audience.

UNICEF partnered with the National Child Protection Authority on a set of key messages on the protection of women and children against sexual abuse and exploitation. The messages were sent out as part of instructions to all police officers in the camps from the Police Headquarters. Posters on child abuse were also developed and posted in strategic places within the camps. The same messages were distributed by *Sarvodya*, the largest Sri Lankan NGO, in the camps.

These messages covered the following four issues:

- Giving extra love and attention to children during this difficult time.
- The importance of family unity and protecting children from being separated from their families, injuries, sexual abuse and exploitation.
- Procedures for reporting unaccompanied and separated children; the need to avoid institutionalization of unaccompanied children; the importance of following national laws and procedures when handing over children to caregivers.
- Mine-awareness (education messages were produced and included in the school-in-the-box), because landmines may have been carried by the tsunami.

PRINCIPLES OF CHILD PROTECTION PROMOTION



Communication efforts to support child protection in emergencies require a multi-pronged approach - advocacy, social mobilisation and behaviour change communication. These efforts should seek to improve the prevailing knowledge, attitudes and practices of the various stakeholders (at all levels) toward child protection, wellness and survival. The following principles provide some guidance for your emergency child protection communication programme.

- 1. Emphasise behaviours that decrease risks of child trafficking, abuse, exploitation and separation**

To protect children, some of the practices emphasised are the ones that prevent abuse and violence from happening in the first place – i.e. not leaving children unattended; knowing the normal/abnormal reactions to stress and how to manage them; parents and primary caregivers using camp-or-shelter provided education/recreation activities; and reporting abuse to authorities. Special attention should be paid to protecting girls from different forms of exploitation and abuse.

- 2. Strengthen local capacity through communication activities**

Communication initiatives should equip the affected parents/primary caregivers, health workers, teachers, police officers, social workers, children and youth groups and other relevant partners with the knowledge, authority and motivation to identify and respond to child protection issues.

- 3. Develop communication activities that give children life skills, knowledge of their rights, and the ability to protect themselves**

Children need information and knowledge to help protect themselves. If children are unaware of their rights, or of the signs and dangers of abuse, they become more vulnerable in emergencies. Children also need to be provided with safe and protective channels for participation and self-expression. Communication initiatives

that support life skills should be gender sensitive, and encourage the development of non-traditional life skills for both, boys and girls.

4. **Advocate with affected communities, local governments, police and law enforcement agencies to strengthen child protection mechanisms and systems in an emergency**

Communication interventions must recognise and build upon the local community's coping mechanisms to protect affected children within the community. Our efforts should focus on increasing the affected community's knowledge and ability to practice behaviours that protect their children. Moreover, we should support legal mechanisms and systems that allow communities to quickly report cases of child abuse, trafficking or violence.

In the India tsunami shelters, UNICEF supported the printing and distribution of more than 5,000 booklets and posters, along with 1,000 banners on trafficking awareness. The materials had phone numbers of a helpline and helped to report child trafficking cases quickly. These communication actions took place in early 2005.

In planning for disasters and seeking to mitigate its' potential impact on the emotional and physical well-being of children, we have to prepare communication efforts in advance.

Communication channels

UNICEF mobilized several communication channels to get the message out to the affected community: mass media, small media and capacity building via the training of local NGO workers and community volunteers.

Mass media

Child protection messages were broadcast over local radio stations both in government and Liberation Tigers of Tamil Eelam (LTTE)-controlled areas. The same messages were also printed in both Sinhalese and Tamil and distributed to the affected communities.

Small media

Previously developed leaflets were distributed in all camps on the prevention of under-age recruitment into the army. Given the large number of new agencies operating in the North and East who are not familiar with these policies relevant to child recruitment, UNICEF briefed INGOs on procedures for registering cases of under-age recruitment.

Capacity building

Capacity building took place on several levels: UNICEF provided training to all staff members of Sarvodya, a Sri Lankan NGO, on psychosocial activities and on the use of UNICEF psychosocial kits. The Department of Social Services, Tamil Relief Organization (TRO) and SCISL coordinated the training of community volunteers and SCISL volunteers on protection issues and activities. They were trained on conducting awareness campaigns on the Rights of the Child so that volunteers could sensitize communities on child rights, child abuse and reporting of abuse.

DOING THE GROUNDWORK



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The details for your groundwork will largely depend on how well you were prepared, what kind of capacities and resources you have at your disposal, and which partnerships are already in place. For instance, do you have any partnerships with the police, military, journalists, lawyers, humanitarian organisations, UN sister agencies, local governments, religious leaders, academic institutions and others? These types

of alliances can provide valuable assistance in an emergency in your communication initiative towards building a protective environment for children. Also, explore if any qualitative and quantitative data exists from which you could draw from to plan your communication initiative.

Some tools to do the groundwork

Group discussions/observations

If the affected community is one where attitudes or traditions facilitate abuse – for example, sex with minors, the appropriateness of severe corporal punishment, the application of harmful traditional practices or differences in the value of boys and girls, or ethnic and disabled children – it is likely that the environment will not be protective. In societies where all forms of violence against children are taboo, and where the rights of children are broadly respected by custom and tradition, children are more likely to be

What is psychosocial development (PSD)?

“Psychosocial” refers to the dynamic relationship that exists between psychological and social effects, each continually interacting with and influencing the other. “Psychological effects” are those that affect different levels of functioning including cognitive (perceptions and memory as a basis for thoughts and learning), affective (emotions), and behavioural. “Social effects” pertain to altered relationships, family and community networks, and economic status.¹

The psychosocial effects of a disaster can be long-lasting if appropriate and



SRI LANKA: Children gather around as sports and other games from a UNICEF Recreation Kit are distributed at a relief camp for people displaced by the tsunami, in Rahula College in the southern city of Matara. Each kit contains recreational items for 80 to 90 children.

protected.⁴ You can find out the practices and attitudes toward child protection via group discussions, key informant interviews, observing the treatment of children in the camp or household, etc. **See Tool 5 in Part III of the toolkit.**

Observations and group discussions can also help determine the need for psychosocial counselling of children and adults.

Other tools

Participatory activities that are geared toward children such as role play, drama and other play activities can be used as means to provide information on child protection issues.

A note on police records as information sources:

Police records may provide useful information about the extent and type of abuse and violence against children, both pre-and-post emergency. Be aware that there may be gross under reporting.

Observations from India

In some districts in India, adults left the tsunami camps during the day either to work or to go back to their original residences leaving children considered to be “old enough to take care of themselves” alone in the camps. These children were not technically considered “unaccompanied” or “separated” but their situation posed a risk to their safety and protection. Girls were put in a rather risky situation considering the observed increase of alcohol consumption among the men folks in shelter camps. Many feared that this could lead to both sexual and physical abuse.

GETTING THE MESSAGE RIGHT

Child protection messages will most likely focus on preventing and reporting child abuse, trafficking, exploitation and on monitoring children’s psychosocial development.

Initially you may have to focus on three immediate risk-reducing strategies.

1. Don't leave children unattended in the camps/temporary shelters.
2. Send children to education or camp activities to restore a sense of normalcy.
3. Give extra love and attention to children in emergencies.

Fight child trafficking

- Inform authorities in the camp or community if you know of suspected traffickers that enter the camp or the affected community.
- Take note of strangers entering the camp.
- Talk to your children about traffickers and ensure that they know the danger signs for trafficking.
- Do not leave children alone in camps or in the affected community.

Reporting cases of child abuse and trafficking took on different forms in the three South Asian countries which were hit by the tsunami in December 2004. In the Maldives and India, they used telephone hotlines. In Sri Lanka, confidential boxes were strategically installed in various camps so that child abuse cases could be anonymously reported. In India, community-based networks were established to prevent child abuse and trafficking. These experiences show that in future emergencies it would be worthwhile to combine the different strategies.

Prevent child separation

- In case of migration, have children walk in front to prevent separation.
- Insist on the importance of registering children at birth to aid in tracing efforts in case of separation.

Prevent and monitor abuse

- Report child abuse to camp authorities.
- Children should report abuse to themselves (or their friends) to a trusted adult.

Encourage mothers primary caregivers to aid in the recovery of children

- Know the signs of ab/normal reactions to stress.
- Help children get back to daily routines.
- Don't discourage children when they verbalise their feelings or use other forms of communication such as drawing, playing, etc.
- Seek help if children continue to show abnormal signs of stress even after one month.

- Allow children to attend recreation/education activities.
- Don't minimise children's fears, and ensure that you respond with correct information.
- Don't send children away from you, to get them away from the scene of disaster; separation from parents/loved ones will traumatise them even more.

Observations from the Maldives

After the tsunami hit the Maldives in December 2004, mothers in Ishdhoo Island agreed that there was much fear among children. "They wake up during the night, cannot sleep, and easily cry", the mothers reported. Children refused to stay alone in the house, not even with elder family members. Often, they could not go to the toilet alone, and needed someone to be near when they studied for school. A child protection communication initiative used a mix of communication channels: counsellors and TV programmes disseminated psychosocial development messages about child stress management, the importance of being honest about the tsunami, and organising play groups so that the children didn't have to play alone. Afterwards, mothers said that they could more easily talk to their children about the aftermath of the disaster, answer their questions, and be honest about the possibility of another tsunami.

What camp authorities and service providers should know

Create a protective environment

- Regulate alcohol selling and consumption.
- Make sure camp is well lit.
- Build separate latrines for men and women.
- Build latrines that give women privacy.
- Immediately register unaccompanied, separated children.
- Provide proper security guards for camps and settlements.
- Provide a play/recreation area for children within the camp or temporary shelter, close enough to be observed by adults.
- Encourage older children to look out for the younger ones.

In the Maldivian tsunami shelters, there were situations where three or more families were living together in one room. This increased the risk of sexual abuse to women and children. Night posed special dangers because the latrines were not well lit and were far from the sleeping quarters. While some might argue that this is a camp management issue, communicators can disseminate child protection messages to camp managers, and advocate for appropriate living quarters, well-lit latrines that are close to the sleeping quarters, and the designation of safe play areas for children.

Protect separated/orphaned children

- Separated/orphaned children have the right to participate in and be informed of plans being made for them.
- Place unaccompanied, separated and orphaned children in the care of reputable affected community members.
- Adoption should not be the first option for orphaned children.
- Register all unaccompanied, separated and orphaned children and make sure that they receive the essential basic needs.
- Avoid institutionalisation of children until all other alternatives have failed.

Sample media release: Unaccompanied and separated children

The below media release was issued by UNICEF Sri Lanka, National Child Protection Authority, Department of Probation and Child Care, and Save the Children a few days after the tsunami had devastated parts of the country in December 2005.

“Many of the children who survived last week’s (26 December 2005) lethal earthquake and tsunami were separated from their families and caregivers. The Government of Sri Lanka, UNICEF and Save the Children Sri Lanka (SCiSL) are working together closely to ensure that these children remain in safe environments, protected from violence, exploitation and abuse. The National Child Protection Authority (NCPA), Dept of Probation and Childcare, UNICEF and SCiSL have mobilised teams to identify and register all unaccompanied and separated children. Joint teams are identifying children living in temporary camps for the displaced as a priority. They will then be working with communities to identify and register all children who have been separated from their immediate families.

The agencies are asking communities to contact any of the above agencies at their local offices, with information on separated children within their communities.

The teams will be tracing the children’s closest relatives, in order to reunite them as quickly as possible. If relatives cannot be found, Probation Officers will make comprehensive assessments to plan for the best possible care. Options include fostering, adoption or, as a last resort, a home for children. The agencies stress that children will not be considered for adoption during the emergency phase, and until every opportunity to locate family members is exhausted. Adoption is a lengthy process and takes many months. The relevant authority for this is the DPCC.

Family members or others who are caring for children who have lost their parents should register with the Divisional Secretary or the Department of Probation and Child Care (DPCC). Even if children are being cared for they should register the children so that tracing of their family can be activated for the child – in the case of children whose parents have died other family members will be traced.

Parents and other family members who have lost children should go to any of the following agencies to register details of their child: District Child Protection Committees, Department of Probation and Child Care, Save the Children Sri Lanka or UNICEF”.

Prevent recruitment of children

- Increase knowledge among camp officials on the international laws on child rights and recruitment.
- Advocate with military groups and local authorities for the demobilisation of child soldiers.
- Be on alert for “creeping recruitment”.

Some child protection issues in Sri Lanka after the Tsunami devastated the country in December 2004:

Within the first 10 days of 2005, there were 14 verified reports of underage recruitment by the Liberation Tigers of Tamil Eelam (LTTE) in Sri Lanka. Because of the presence of the militia groups, and reported cases of forced recruitment, UNICEF widely distributed previously developed leaflets on the prevention of underage recruitment. Efforts such as this can be strengthened by encouraging parents/primary caregivers not to leave their children alone, promoting the provision of supervised child activities and play, and advocating with camp officials to design camps that are safe for children.

COMMUNICATION ACTIONS FOR CHILD PROTECTION

Child protection communication actions will depend on the priorities of the emergency, capacity, established partnerships and the knowledge, attitudes and practices of the affected community in regards to child protection and survival. UNICEF commits to the protection of children and women from violence, exploitation, abuse and neglect.



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The table below outlines UNICEF’s Core Commitments for Children in Emergencies in the area of Child Protection. Included are suggested behaviour change communication (BCC) and social mobilisation activities that have proven to be effective in improving child protection and psychosocial development in emergency situations. Remember to plan your communication and social mobilisation actions with the involvement of the affected community and your partners. And to carefully monitor and evaluate the programme.

PAKISTAN: Children gather outside a tent in the Jalalabad camp for people displaced by the earthquake, in Muzaffarabad, capital of Azad Jammu and Kashmir (AJK), in Pakistan-administered Kashmir. About 1,500 people are sharing cramped quarters in 170 tents in the camp. In some cases, 30 people in 3 families, more than half of whom are children, are living in one tent.

TABLE: Extract from UNICEF's CCC in child protection and corresponding suggested BCC and social mobilisation support.

FIRST SIX TO EIGHT WEEKS	BCC AND SOCIAL MOBILISATION ACTIONS TO SUPPORT
<p>1. Conduct a rapid assessment of the situation of children and women. Within the appropriate mechanisms, monitor, advocate against, report and communicate on severe, systematic abuse, violence and exploitation.</p>	<ul style="list-style-type: none"> ■ Ensure that the affected community receives information on severe, systematic abuse, violence and exploitation of women and children and knows how to monitor and report it to camp management, local authorities and relevant humanitarian agencies – i.e. hotlines, IEC materials, establishment of camp watch groups, peer educators, etc. ■ Train social workers, healthcare professionals and other service providers on the signs of abuse, violence and exploitation, and how to monitor and report it to the proper agencies/authorities. ■ Advocate and mobilise support with camp management, social welfare departments and local authorities to establish simple monitoring and reporting systems on abuse, violence and exploitation, – i.e. boxes for anonymous reporting, etc. ■ Work with camp management to design camps that provide well-lit latrines that are close to sleeping quarters and safe spaces for children to play to decrease the likelihood of abuse, exploitation, trafficking, etc. ■ Increase knowledge among humanitarian workers and all UN staff members and partners about the code of conduct and zero tolerance policy on abuse and exploitation. ■ Provide all humanitarian workers the six core principles to prevent sexual exploitation.

FIRST SIX TO EIGHT WEEKS	BCC AND SOCIAL MOBILISATION ACTIONS TO SUPPORT
<p>2. Assist in preventing the separation of children from their caregivers, and facilitate the identification, registration and medical screening of separated children, particularly those under 5 years of age and adolescent girls.</p>	<ul style="list-style-type: none"> ■ Ensure that the affected parents/primary caregivers know how to prevent child separation in camp situations migration/evacuation; that separated children should be registered; where and how to register separated children, and the policies regarding separated children. In addition, ensure that separated children know their rights to be informed of-and-participate in the plans being made for them, and know where to go to receive essential services. ■ Train social workers, police, and camp managers to communicate with affected parents/primary caregivers on how to prevent child separation, how to register separated children, and how to reach communities with the child protection messages, particularly those on keeping girls safe. ■ Advocate and mobilise support with the local government, camp management, social welfare departments and humanitarian agencies to provide families' basic needs to prevent intentional separation; immediately implement systems to register separated children straight away, and to increase knowledge on the rights of separated children to receive medical screening, and other essential services.
<p>3. Ensure that family-tracing systems are implemented with appropriate care and protection facilities</p>	<ul style="list-style-type: none"> ■ Ensure that the affected parents/primary caregivers and separated children know where to go for family-tracing services and the process – i.e. social workers, healthcare professionals, mass media and IEC materials.

FIRST SIX TO EIGHT WEEKS	BCC AND SOCIAL MOBILISATION ACTIONS TO SUPPORT
	<ul style="list-style-type: none"> ■ Advocate with camp officials, local authorities, social welfare departments, religious institutions and other relevant stakeholders to establish family-tracing services that use community monitoring; and provide appropriate follow-up services.

BEYOND THE INITIAL RESPONSE	BCC ACTIONS OR SOCIAL MOBILISATION TO SUPPORT
<p>4 Within established mechanisms, support the establishment of initial monitoring systems, including on severe or systematic abuse, violence and exploitation.</p>	<ul style="list-style-type: none"> ■ Establish and build upon the initial response to ensure that the affected community continues to receive information on severe, systematic abuse, violence and exploitation of women and children and knows how to monitor and report it to camp management, local authorities and relevant humanitarian agencies – i.e. hotlines, IEC materials, establishment of camp watch groups, peer educators, etc. ■ Provide refresher training to social workers, healthcare professionals and other service providers on the signs of abuse, violence and exploitation; and how to monitor and report it to the proper agencies/authorities. ■ Continue to advocate and mobilise support with camp management, social welfare departments and local authorities to maintain systems to monitor and report abuse, violence and exploitation. ■ Increase knowledge and provide refresher training among humanitarian workers and all UN staff members and partners about the code of conduct and

BEYOND THE INITIAL RESPONSE	BCC ACTIONS OR SOCIAL MOBILISATION TO SUPPORT
	<p>zero tolerance policy on abuse and exploitation. Provide all humanitarian workers the six core principles to prevent sexual exploitation, and ensure that they are able to adhere to the principles.</p>
<p>5 In cases where children are separated, or at risk of being separated from caregivers, work directly or through partners to:</p>	
<p>(i) assist in preventing the separation of children from their caregivers;</p>	<ul style="list-style-type: none"> ■ Ensure that affected parents/primary caregivers know where/how to register their children at birth to facilitate tracing in the event of a separation, know how to prevent separation in the camp or in case of migration/evacuation, etc. – i.e. counselling, social workers, IEC materials, mass media, etc. ■ Enable social workers, healthcare professionals, humanitarian agencies and other relevant stakeholders to communicate with parents/primary caregivers on how to prevent the separation of children. ■ Advocate and mobilise support with the local government, camp management, and humanitarian agencies to provide the basic needs of families to prevent intentional separation, particularly for those under five and adolescent girls, and to implement evacuation plans. ■ Enable social workers, camp leaders, humanitarian workers to facilitate emotional and social support to single parents/primary caregivers, to ensure that they take on/continue their parenting responsibilities.

BEYOND THE INITIAL RESPONSE	BCC ACTIONS OR SOCIAL MOBILISATION TO SUPPORT
<p>(ii) facilitate the identification, registration and medical screening of separated children, particularly those under five and adolescent girls;</p>	<ul style="list-style-type: none">■ Build upon communication initiatives implemented in the initial response to ensure that the affected community knows and can help separated children register and be medically screened, knows where to register separated children, and is aware of the policies regarding separated children. In addition, ensure that separated children know their rights to participate in and be informed of the plans being made for them, and know where to go to receive essential services.■ Provide refresher training to social workers, police, camp managers and service providers on the policies regarding separated children, the importance of working with the community to immediately identify, medically screen and register separated children – and how to communicate this to the affected community.■ Continue to advocate and mobilise support with the local government, camp management, social welfare departments and humanitarian agencies to provide the basic needs of families to prevent intentional separation; to immediately implement systems to register separated children straight away, and to increase knowledge on the rights of separated children to receive medical screening, and other essential services.

BEYOND THE INITIAL RESPONSE	BCC ACTIONS OR SOCIAL MOBILISATION TO SUPPORT
<p>(iii) facilitate the registration of all parents and caregivers who have lost their children;</p>	<ul style="list-style-type: none"> ■ Ensure that affected parents/primary caregivers and separated children know where to go to register for tracing services and the procedures – i.e. social workers, service providers, IEC materials, mass media. ■ Ensure that social workers, camp officials, and service providers know how to communicate the tracing process to parents/primary caregivers who have lost their children. ■ Advocate with camp officials, local authorities, social welfare departments on the relevant laws, standards and good practices in the protection for and care of separated children.⁶
<p>6. Support the establishment of safe environments for children and women, including child-friendly spaces, and integrate psychosocial support in education and protection responses.</p>	<ul style="list-style-type: none"> ■ Ensure that the affected community knows where to take their children for recreation/education activities and the importance of doing so – i.e. IEC materials, loudspeaker announcements, social workers, etc. ■ Promote child protection and psychosocial development through the establishment and facilitation of child-friendly spaces, life skills promotion, art, drama, theatre and class activities. ■ Ensure that camp officials, police, local authorities know how to make camps safe for women and children and participate in doing so. ■ Provide training for community workers, camp volunteers and teachers to organise recreation groups and activities for children.

MONITORING MILESTONES

The objective of an emergency child protection programme is to protect children and women from violence, exploitation, abuse and neglect. Be sure to monitor whether your communication strategy is supporting this objective. Identify the indicators you will need to monitor your communication efforts based on the behavioural results and actions you have defined from the outset. The following are some common core behaviour result indicators. **Tool 13 in Part III lists possible sources of information to help you measure the indicators.**

1. Parents/primary caregivers know the importance of children's participation in recreational activities in hastening healing from trauma and psychological recovery. They also know where these activities are provided in the camp and are sending their children there.
2. Parents/primary caregivers know the dangers of leaving their children unattended, and are aware of the unsafe areas for children in the camps.
3. Parents/primary caregivers know how to prevent child separation in the camp, during migration or evacuation and are doing it.
4. Parents/primary caregivers understand the risks of sending their children away for employment and marriage and refrain from doing so.
5. Camp officials know the importance of lighting latrines, providing adequate camp security and designating safe spaces for women and children and are making the necessary adjustments.
6. The affected community knows to report strangers, (suspected) traffickers that enter the camp and are doing it.
7. Parents/primary caregivers who have lost children know how to register and where to go to facilitate tracing.
8. Separated children know their rights to be involved in the decisions being made for them; know where to go to register, facilitate tracing and receive essential services.
9. Social workers, camp managers, service providers know the rights of separated children and how to communicate these rights to them.
10. Community members know the signs of abuse, trafficking, molestation; and know where to report it.
11. Affected children know where to report abuse to them or friends.

PRACTICAL EXPERIENCES

Participatory drama helps children move on after tsunami

It is 3 p.m. at the IDH Watte camp in Galle, Sri Lanka. The community centre is crowded. More than 50 children are anxiously waiting for the play to start. Eight-year old Rajan and his friends are beaming with delight. As the animators enter the room and address the young audience, it springs to mind that this is not a regular performance: this is an awareness programme on the tsunami using high drama.

"Is this the sea?" asks one animator.

"Those days we loved the sea", answers the other.

"What did you do at the sea?"

"Playing, fishing, bathing..."

"What do you know about the tsunami?"

"We are the people who got caught by the big waves. Our homes were damaged and washed away".

"We used to fly kites on the beach".

Rajan and his friends mime flying kites. They laugh and eagerly answer questions from the audience. Most of the children belong to fishing communities in Galle that were terribly affected by the tsunami. Most are still living in camps or transitional shelters. As the two actors move on with the show, personal memories amongst the audience are triggered and they begin to think about their own experience on 26 December 2004.

Rajan becomes more involved in the stories they tell and he too remembers. The big wave that the actors are pointing at in the picture destroyed his house. He had to run away, but the water caught him and his mother. They had to cling to a tree and wait for the wave to withdraw. His little sister didn't survive. "But now I am happy I can play with my friends", he says. "I still have my mother and my father, and I can go to school".

"What is a tsunami? Have countries other than Sri Lanka suffered from the waves? Will another tsunami come again? How can we protect ourselves from another tsunami?" These are the questions raised during the one-hour long programme.

"After the tsunami, UNICEF quickly identified the need for an Awareness Programme. Nobody was prepared for the tsunami. Nobody expected it and it was a great shock to the country", explains UNICEF Child Protection Officer Sarah Graham. "There were many rumours and unanswered questions: Will another tsunami come? Why did it hit Sri Lanka? Is the water poisoned? Can we eat fish again? People wanted and needed to learn more about the tsunami and tsunamis in general so UNICEF decided to work on a programme to answer their questions".

UNICEF's Tsunami Awareness Programme gives children and adults the opportunity to learn, participate, and reflect on their own experiences. The tsunami awareness materials come with a guide that is used by community support workers, youth leaders and teachers to facilitate the programme. It is designed so that each child or adult can participate in their own way. Some will sit and listen, others will share their ideas and some will stand up and interact with the facilitators.

"Each material was carefully planned to initiate a discussion based on children's personal experience and perceived notions, the facts and what they can do to insure their safety and to rebuild their lives", Graham said.

UNICEF has tested the Tsunami Awareness materials in affected areas across Sri Lanka. In the South, this was carried out with support from Multi Diverse Community (MDC), a local organisation that is implementing child well-being programmes in camps around Galle. "The reactions were very positive, Graham said. "We tested the materials in Hambantota the day after the last scare on 28 March 2005. It was amazing to hear people's personal experiences from the night before. They realised that they, as a community, were able to protect themselves and that was very empowering".

Thousands of young Sri Lankans are still haunted by the specter of the tsunami. Although very sensitive issues are tackled through the programme, the children are given the opportunity to interact and reflect on their own experiences. Lack of information about tsunamis had created fear among the Sri Lankan people. But the Tsunami Awareness Programme stimulated discussions amongst children and communities. The programme also provided *accurate* information on what happened that tragic day late last year, along with the role each person has in rebuilding their own lives and community.

RESOURCE BANK

Further reading

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5. Jabry, A. (editor), *After the Cameras Have Gone: Children in disasters, Second Edition*, Plan, England, 2005.
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14. United Nations Children's Fund, *Convention on the Rights of the Child*, UNICEF, 1989.
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16. World Health Organization, *Mental Health in Emergencies: Mental and social aspects of health of population exposed to extreme stressors*, WHO, Geneva, 2003.
17. World Health Organization, *Psychosocial Care of Tsunami affected Populations: Manual for trainers of community level workers*, WHO Regional Office for South East Asia, SEA-EHA-8, New Delhi, 2005.

Web sites

1. Child's Rights Information Network
<http://www.crin.org>
2. Childtrafficking.com
<http://www.childtrafficking.com>

3. Save the Children
<http://www.savethechildren.org/uk>
4. United Nations Children's Fund
http://www.unicef.org/protection/index_3717.html
6. Academy of American Paediatrics
<http://www.aap.org/new/disasterresources.htm>

Glossary

Child means any person under the age of 18, unless under the (national) law applicable to the child, majority is attained earlier (Convention on the Rights of the Child, or CRC, Article 1).

Child protection refers to protection from violence, exploitation, abuse and deprivation from primary givers. Violation of the child right to protection, in addition to being human rights violation, is also massive, unrecognized and underreported barriers to child survival and development. Children subjected to violence, exploitation, abuse and neglect are at risk of shortened lives, poor physical and mental health, education problems, poor parenting skills later in life and homelessness, vagrancy and displacement.

Child-friendly space consists of a safe space where children can go a few hours a day, attending pre-school, taking part in youth activities, playing sports, having access to trained social workers, etc. These hours help children socialize and give relief to overwhelmed caregivers. They can also make it easier to detect children with particular problems and provide assistance to them and their families. Having designated child friendly spaces and engaging in these activities facilitate a return to normalcy.

Fostering refers to situations where children are cared for in a household outside their family. Fostering is usually understood to be a temporary arrangement and in most cases, the birth parents retain their parental rights and responsibilities. The term fostering is used to cover a variety of arrangements as follows:

- **traditional or informal fostering**, where the child is taken into the care of a family or other household that may or may not be related to the child's family – no third party is involved in these arrangements, though they may be endorsed or supported by the local community and may involve well-understood obligations and entitlements;

- **spontaneous fostering**, where a family takes in a child without any prior arrangement – this is a frequent occurrence during emergencies and may involve families from a different community in the case of refugee children;
- **arranged fostering**, where a child is taken into the care of a family as part of an arrangement made by a third party, usually an agency involved in social welfare such as a government department, a religious organization, or a national or international NGO – this arrangement may or may not be covered by formal legislation.

Orphans are children, both of whose parents are known to be dead. In some countries, however, a child who has lost one parent is called an orphan.

Separated children are those separated from both parents, or from their previous legal or customary primary caregiver, but not necessarily from other relatives. These may, therefore, include children accompanied by other adult family members.

Traffic in persons has been defined as: the recruitment, transportation, transfer, harbouring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation.

Unaccompanied children are children who have been separated from both parents and other relatives and are not being cared for by an adult, who, by law or custom, is responsible for doing so.

Footnotes

- 1 *United Nations Children's Fund, Core Commitments for Children in Emergencies, UNICEF, New York, 2005.*
- 2 *United Nations Children's Fund, Emergency Field Handbook, UNICEF, New York, 2005.*
- 3 *United Nations Children's Fund, Technical Notes: Special considerations for programming in unstable situations, UNICEF, New York, 2003, p. 419.*
- 4 *O'Donnell, D., Child Protection, a Handbook for Parliamentarians, UNICEF Geneva, 2004, pp. 18-20.*
- 5 *Save the Children, Psychosocial Care and Protection of Tsunami Affected Children: Guiding principles, SAVE, London, 2005, p. 1.*
- 6 *ICRC, Inter-agency Guiding Principles on Unaccompanied and Separated Children, 2004, p.66.*

PART THREE

TOOLS

HOW TO DEVELOP SMART BEHAVIOURAL OBJECTIVES / RESULTS

Be smart. Always define SMART behavioural objectives or, in the context of the results-based management approach - SMART behavioural results - that are specific to a problem (like reducing diarrhoea outbreaks in a community). Avoid citing generic behaviour results like "to raise awareness" or "to improve knowledge". These are useful only if they lead to behavioural results. The rapid changes that are characteristic in emergencies make your planning and results-setting imperative. It is therefore a **MUST** for you to define behavioural results in specific terms before you develop your strategy and begin to implement.³

Avoid the tendency to proceed with your communication strategy without the benefit of evidence-based planning. The inexperienced would go ahead and say "Let's print a poster to address people's lack of knowledge". Also avoid this mode of thinking: "Let's use the same strategy for polio eradication for our hand-washing campaign". Both approaches are doomed to failure and are not sustainable. Achieving behavioural impact, maintaining the intended behaviour and influencing others to follow suit in a sustained manner - require research and consultation with the participant actors within their own environment. This entails far more than simply printing a poster.⁴

How to do it

1. Answer the following questions to help you develop behaviour objectives/results. To do so, you and your team need to work with the affected community.

- Whose behaviour needs to change to bring about a given desired health or social outcome in the emergency (mothers'; primary caregivers'; fathers'; neighbours'; volunteers'; health workers'; religious leaders', teachers'; politicians')?
- What are the current behaviours? Why are people currently doing it all the time; doing it sometimes, or not doing it at all? What factors account for the difference?
- If they are not doing it now, why not? Are they practising a similar desired behaviour? How can you best influence and support that behaviour? What are the barriers to change?
- What factors - social, cultural, economic, environmental, psychological, physiological, etc. - and who, what, where are the most influential channels that can motivate changing or maintaining the behaviour?
- What skills and resources are needed for the affected groups to practice the desired behaviours?

2. Conduct a rapid communication assessment using a combination (triangulation) of techniques. The rapid assessment will give you the answers to the above questions and will help you define your SMART behavioural results. To do this, you can conduct exploratory or transect walks and participant or non-participant observations. You can also engage in discussions with key informants and opinion leaders such as religious and secular heads, community opinion leaders – usually the elders and local leaders - service providers, relief workers and others. You can further gain insights into people's social habits, attitudes, risk behaviours and underlying vulnerabilities of families and communities through community mapping, network analysis, focus group discussions (men, women and children) and other participatory learning approaches or PLA tools. While they participate in these activities, they too gain collective insights about themselves and their own communities. You can perform these rapid assessment techniques easily and quickly in an emergency setting.

3. Analyse, prioritise, and finalise the statement of behavioural results after you have collected the information you need. Do so with representatives from the affected groups. Remember to keep the list short – too many behavioural expectations are as bad as none at all. Target a few behaviours, if possible not more than three behaviours that are feasible for the intended participant actors to practice.

What is a SMART behaviour objective/result?

Behavioural results are best stated in terms of the **intended behaviour change or the maintenance of an existing desired behaviour**. A behavioural result usually has at least three features, which makes it a **SMART result**:

- Clear identification of the participant group.
- Detailed description of the promoted behaviour (appropriate and realistic); and how many times the behaviour should take place.
- The measurable result you hope to observe over a specific time period.

Examples of SMART behavioural objectives and results:

Behaviour Objective:

Within two weeks from the start of the emergency, to increase from 30 percent to 60 percent the number of caregivers who wash hands with soap or ash and water before preparing food, after going to the toilet and after washing the baby.

Behaviour Result:

Within six weeks from the start of an emergency, the number of Community Nutrition Promoters who provide friendly and accurate answers to questions at every nutrition education session would have increased from 30 percent to 60 percent.

Footnotes

- ¹ SMART is an abbreviation for Specific, Measurable, Achievable, Relevant, Time-bound. See Chapter 2 for more information.
- ² *Adapted from Parks, W., et al., Planning Social Mobilization and Communication for Dengue Fever Prevention and Control, WHO, Geneva, 2004, p. 35.*
- ³ *Adapted from Oxfam UK, Guidelines for Public Health Promotion in Emergencies, Oxfam, London, 2001, p. 34.*
- ⁴ *Adapted from Parks, et al., op.cit., pp. 35-36.*
- ⁵ *Graeff, J., Programme Communication Advisor, UNICEF, Bangladesh Final Report on Behavioural Monitoring Workshop, UNICEF, Dhaka, 2005.*

HOW TO DEVELOP INDICATORS BASED ON BEHAVIOURAL RESULTS¹

How do you know if your efforts in communicating to change behaviour and social mobilisation are actually making a difference in emergency situations?

This is an important question that highlights the value of well-planned monitoring and evaluation (M&E). Unfortunately, M&E is often an afterthought in emergency management planning. This trend tends to reduce the quality and cost-effectiveness of actual and future responses. Likewise, tracking and assessing communication activities during an emergency are often weak, which makes it difficult to report on results.

This tool shows you how to plan the monitoring and evaluation of behaviour change communication and social mobilisation in emergency situations. We look at participatory methods on how to develop indicators based on behavioural results in a participatory way. We consider some simple data collection methods that can be used to monitor and evaluate communication and mobilisation activities.

Let's begin by clarifying the basic terms:

What is an M&E system?

Monitoring provides insight into how well a response or planned set of activities is being implemented. It is part of the evaluation process. Evaluation is a continuous process, done periodically, i.e., at each stage of the programming cycle. It offers a comprehensive review of whether an emergency response is achieving its short-term results and longer-term goals. Continual and careful monitoring of relevant indicators and processes generates information for evaluation and, more importantly, for corrections that may be needed as an emergency response unfolds.

An M&E system refers to a textual, graphical and/or numerical data system used to measure, manage and communicate desired performance levels and emergency response achievements. M&E systems are often based on a combination of evaluation types (see Table 1 below).

Type of evaluation	Broad purpose	Main questions answered
Baseline Analysis/ Formative Evaluation Research	Determines concept and design	Where are we now? Is an intervention needed? Who needs the intervention? How should the intervention be carried out?
Monitoring/Process Evaluation	Monitors inputs and outputs; assesses service quality	How are we doing? To what extent are planned activities actually realised? How well are the services provided?
Outcome/Effectiveness Evaluation	Assesses outcome and impact	How did we do? What outcomes are observed? What do the outcomes mean? Did the response make a difference?
Future Plans/Cost- Effectiveness Analysis	Value-for-resources committed including sustainability issues	What are our next steps and needed resources? Should response priorities be changed or expanded? To what extent should resources be reallocated?

What is an indicator?

An indicator is information on a particular circumstance that is measurable in some form. Indicators are approximations of complex processes, events and trends. They can measure the tangible (e.g., service uptake), the intangible (e.g., community empowerment), and the unanticipated (e.g., results that were not planned). An indicator gives an idea of the magnitude and direction of change over time. But it cannot tell us everything we might want to know.

Indicators need not be perfect - only sufficiently relevant and accurate enough so that those interpreting the information can do so.

Indicators should be easily interpreted. It is very important, therefore, to carefully define any indicators and ensure that the way they are defined "travels accurately" back and forth between languages and cultures (including organisational cultures).

Indicators can also be "progress markers". It is clear that behaviour change communication and social mobilisation in emergency responses must demonstrate impact. Stakeholders - whether members of affected communities, programme managers, donors or policy makers - need immediate data that show the contribution your communication initiative has made. Because behaviour and social change often take time to happen, we sometimes need signpost indicators or progress markers - measures that do not necessarily tell us that the ultimate outcome or impact has been reached, but signals that we are on the right track. In communication programmes, for example, "intent to change" has been used as predictor of actual change.

Types of indicators

Indicators may be pictorial. For example, drawings and photographs that show the situation immediately after an emergency that are then compared with drawings and photographs produced some time after the emergency (e.g., 6 weeks, 3 months, etc.) can promote greater discussion and lead to a better understanding amongst both literate and non-literate stakeholders. We will look at examples of pictorial methods that can generate information for indicators in Table ** below.

Indicators may be in the form of stories. Qualitative approaches to monitoring and evaluation usually include the collection of "stories from the field". These stories often provide meaning to quantitative information or capture real "voices". A monitoring technique known as the Most Significant Change (MSC) has been developed that allows for the systematic collection and interpretation of stories. Please refer to Tool 3 for the MSC Technique.

How many indicators do we need?

In choosing indicators, it is important for you to *limit the number to a set of critical indicators*. A multitude of indicators will create problems when you attempt to interpret results. The challenge then lies in defining what is a *critical* indicator, while at the same time making each indicator comprehensible, measurable, comparable (to ascertain trends) and affordable.

Spending the time working out (and trialing) the few, critical measurements needed to tell your programme's essential story will undoubtedly save you the time (and frustration) later. Applying the Rapid Appraisal principle of **optimal ignorance** helps here. "Optimal ignorance" refers to *the importance of knowing what facts are not worth knowing*, thus enabling the cost-effective, timely collection and analysis of information.¹ Applying this principle avoids collection of irrelevant data but its application requires courage!

How to develop indicators

Each chapter in this Toolkit offers examples of possible indicators. Remember, these examples are intended to foster debate and negotiation about what should be measured amongst those planning and implementing emergency responses. You may end up with a range of locally created indicators that are supplemented by these examples.

Here we consider how to develop indicators based on your programme's intended behavioural results. The emphasis is on completing the bulk of this work before a disaster occurs - in other words, these steps should ideally be taken during disaster preparedness planning. We recognise, however, that much depends on the nature, scale and extent of a particular emergency. For this reason, we offer simple monitoring tools and indicators in the main chapters of this Toolkit that can be used to get a basic M&E system up and running during an emergency. The indicators and data collection methods presented below are likely to be more useful when time allows or when preparedness planning is conducted in a comprehensive manner.

Indicator development is best viewed as part of an M&E process. We can summarise the core steps or stages for this process as follows:

1. Assemble an M&E core team.
2. Clarify the question: who wants to know what and why?
3. Identify indicators that will provide the information needed.
4. Choose and adapt data collection methods.
5. Synthesise, verify data, and analyse contribution.
6. Use M&E results to re-develop future communication/social mobilisation activities.

With each step, we offer questions that you can discuss with relevant stakeholders. Between selected steps, we offer a checklist for you to complete before proceeding to the next step.

Step 1. Assemble an M&E core team

Who should, and wants to be involved in the monitoring and evaluation of a behaviour change communication effort in emergency responses? How should participants be identified and selected? What should participants' backgrounds and interests be? What constraints will they bring to the task (workload considerations, educational limitations, motivation)? What type of skills, knowledge, changes in behaviour and attitudes are required to effectively conduct M&E?

Minimal requirements for core team members are:

- Personal commitment to an interactive process and the principles of participatory monitoring and evaluation.
- Ability to work as a team.
- Competency in a wide variety of research techniques and methodologies, with emphasis on participatory methodologies.
- Group facilitation skills, understanding of group process, dealing with tensions and conflict, equalising participation, running participatory activities, summarising, and being an active listener.
- Ability to communicate with different stakeholders, such as members of affected communities, government representatives, and representatives of international donor and UN agencies.

Additional questions to ask at this step include: How is the training of participants in M&E to be accomplished? To what extent do cultural and linguistic differences impact training effectiveness? Can evaluators and other professionals assume the role of trainer or facilitator with relative ease? How does one listen for the voices that have not been heard yet? How can cultural, language, or racial barriers be addressed?

Step 2: Clarify the question: who wants to know what and why

Gather stakeholders together and pose the question: "Who wants to know what and why?" Responses to this question will help develop the behavioural results - statements of intent that begin with words such as: "To assess..." or "To measure..." or "To monitor..." or "To evaluate..."

Ensure that many stakeholders are involved in this planning step as possible. Different groups of stakeholders will have different interests, values, and information requirements. Excluding stakeholder groups from planning how the communication and social mobilisation will be monitored and evaluated may disenfranchise these groups.

Behavioural results should be derived and linked to what your team is aiming to achieve in relation to the promotion of hygiene, breastfeeding, immunization and vitamin A, safe motherhood, and child protection in emergency situations.

To help you discuss what people need to know and why, you could ask stakeholder groups the following questions:

- From your point of view, what difference will the communication strategy make? In what way will communication influence individual and group behaviour? How will we know?
- Will the communication strategy strengthen individual and affected community communication capacity, decision-making and action? If so, how will we know?
- Do you think the strategy takes into account obstacles to behaviour and social change? If so, how? If not, what could be done to consider these obstacles? How will we know when these obstacles have been overcome?
- In your opinion, will the proposed communication strategy enable previously powerless individuals and communities to take control of the means and content of communication, to achieve their own behaviour and social change goals? If so, how will we know?

*Quick checklist before you proceed to Step 3

Have you assessed the link between project overall results, behavioural results and strategies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you included individuals and organisations that will be affected by the emergency response in your monitoring activities?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are participants involved in the monitoring trustworthy and competent?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have they made an informed decision about where, when and how they want to be involved?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have steps been taken to assure that all stakeholders and the population served will be respected, and their values honoured during the monitoring and evaluation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have conflicts of interest been discussed to ensure that the results or findings will not be compromised?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you described the purpose of your monitoring and evaluation in detail?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is there a written or at least verbal understanding among stakeholders about the purpose of the monitoring and evaluation activities?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Step 3: Identify indicators that will provide the information needed

Identifying indicators is one of the most challenging tasks when setting up an M&E system. More so than any other step, identifying and agreeing on what indicators to use highlights the different information needs and expectations that the different stakeholders have of the monitoring work.

Identification of indicators is best started after a dialogue on the affected community's concerns, goals, issues and obstacles, and the vision of the change they seek. The indicator-specific discussion begins by asking stakeholders to reflect on their M&E results (what they want to know and why) and consider the information they are already collecting; and what methods of information exchange or reporting they are using that may be appropriate. One question you should ask stakeholders is: what behavioural information is needed early on, continuously or frequently to make sure this communication initiative is on track and achieving its results?

Several M&E processes and indicators set for measuring communication and social mobilisation have been created and offered in Tool 3 as useful guides

Step 4: Choose and adapt data collection methods.

M&E systems may use visual (maps, calendars, problem ranking, wealth-ranking, photonovella, pocket charts, story with a gap) and dramatic forms (story telling, songs, dances, sculptures, role plays) of data collection together with more standard methods such as interviewing, observation, focus group discussions, workshops, community meetings, questionnaires, and document analysis. A few of these methods are described in Table 2.

Table 2: Examples of M&E data collection methods

TECHNIQUE	BRIEF DESCRIPTION
Mapping	Establishes connections and local insights into what is "useful" and "significant" in order to understand community perceptions of the local environment, natural and human resources, problems and resources for dealing with them. There are several different types of maps including: spatial maps; social maps (depicting social relationships); temporal maps (showing changes over time); aerial maps (aerial photographs or standard geographic maps); and organisational maps (venn diagrams depicting institutional arrangements or networks).

Seasonal calendars	<p>Ways of illustrating seasonal changes in subjects of interest - i.e. harvests, labour availability, fever, seasonal transmission of HIV and communication resources. Months, religious events, seasons and other local climatic events, for example, are used to illustrate time periods. Issues of interest are then discussed (sometimes using stones, sticks, or marks on paper in relation to these periods). Discussions usually highlight periods of maximum stress, constraints (no time or resources available), or the best time when new initiatives could be undertaken.</p>
Problem ranking/ sorting	<p>Cards with words or pictures are sorted into piles or ranked according to local criteria in order to understand how participants rank problems (e.g., communication obstacles) in terms of frequency, severity, and so on. Ranking provides a systematic analysis of local terms, perceptions or evaluations of local issues. Disadvantage is that ranking can force participants to structure their knowledge in artificial ways unless the ranking criteria are themselves developed through a participatory process. This exercise can be used in pre- and post-intervention evaluations to measure change in particular rankings.</p>
Well-being and wealth-ranking	<p>Uses perceptions of local inhabitants to rank households, families or agencies within a social network or village/neighbourhood according to wealth, well-being or social contacts. For example, names of household heads are written on cards. These cards are then sorted into piles by at least three M&E participants (ideally interviewed separately) according to criteria that they describe to the M&E team member. The resulting classifications are often at odds to conventional socio-economic surveys, revealing locally important well-being or wealth criteria that can be used to measure more subtle and usually important social changes than can be measured in quantitative methods.</p>

Photo-novella	Local people themselves produce visual images through the use of video or instamatic camera. The images then serve as a catalyst to depict, reflect on and discuss social conditions affecting their lives and future possibilities.
Pocket charts	Helps people to assess and analyse their situation in a new way using pictures and a "voting" process based on a simple grid-sheet with rows of pockets, pictures, and markers (clothes pegs, pebbles, etc.). Can be used in group or individual (confidential) situations. Dialogue members place their "vote" (pebble) in a pocket underneath or corresponding to picture they agree with or prefer.
Story with a gap	Engages people to define and classify goals, and to make sustainable plans by working on "before and after" scenarios. A variety of pictures depicting present problems and future possibilities are presented. Dialogue members consider possible reasons for differences in the contrasting pictures, create stories to explain the "gap" between pictures, and identify community solutions to local problems. Can be used in one-to-one interviews but best in group situations.
In-depth individual interview	A semi-structured interview using a flexible interview guide consisting mainly of open-ended questions (questions that cannot be answered with a "yes" or "no" or any other single word or number). The aim is to collect detailed information on the individual's beliefs and attitudes related to a particular topic.
Key informant interview	A "key informant" is someone who has extensive experience and knowledge on a topic of interest to the evaluation. Often key informants are community or organisation leaders. The interviewer must develop a relationship of confidence with the individual so that his/her experience and insights will be shared.

Group interview	There are several different types of group interview such as consensus panels (local experts debate to reach a consensus on a series of issues), structured group interview (participants are asked the same questions as individuals), focus group discussions (a facilitator guides 10-15 participants through a series of issues, with the group interacting with each other rather than just with the facilitator - reaching consensus is not the main aim), community meetings (formal discussions organised by the local group or agency at which the M&E team or facilitator ask questions and/or make observations), spontaneous group discussions (everyday meetings e.g., a sports event, at which groups of people gather around to chat and in which the M&E team or facilitator participates).
Observation	While an activity is ongoing, an observer records what he/she sees either using a checklist or by taking descriptive notes. The observation can include information on: the setting (the actors, context, and surroundings); the actions and behaviour of the actors; and what people say - including direct quotations.
Analysis of secondary data	Reports and other written documents that provide information on the activities planned and carried out.

When choosing the methods needed to collect information for each indicator, core M&E team members should facilitate discussion with stakeholders on:

- The indicator and the kind of data required.
- The technical difficulty and adaptability of the method to a particular level of expertise.
- Cultural appropriateness of the method - will it make people feel comfortable learning, communicating, and interacting?
- Facilitation of learning - does the method facilitate learning?
- Barriers to participation - e.g., levels of literacy, command of language used, social class, physical challenge, age, and time constraints.

You will also have to make decisions on the number and location of data collection sites, the sampling processes involved (random or deliberate), the

characteristics and sample size of people to be interviewed or invited to meetings, the selection of people or events to be observed, and the scheduling of data collection (e.g., the date and time for site visits, meetings, interviews).

Now in the following table (make a copy for each behavioural result):

- List the indicators you have decided to develop or use to monitor progress against each result.
- For each indicator, determine what method or methods will be used to collect information to inform the indicator/s.
- Work out what samples your behavioural indicators will require.
- Then give thought to who will collect the information (e.g., who will conduct the interviews, observations, focus groups, participatory methods, questionnaires).

Quick checklist before you proceed to Step 5

Have you assessed the link between the behavioural results, indicators, methods, and samples?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you checked whether measuring the indicators is feasible in terms of how much information is required, how many methods, how much time, how many data collectors are needed, and their skill levels?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Will the methods and tools you have chosen require development, pre-testing and training of data collectors? If "Yes", make a note in the space below.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you made sure that information will be collected using more than one method (triangulation)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you determined the samples that you will require?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you identified who will be needed to collect the information?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Note here if any tool development, pre-testing or data collector training will be required for one or several of your measurement methods:

BEHAVIOURAL RESULT 1	BEHAVIOURAL INDICATOR/S	MEASUREMENT METHOD/S	SAMPLES	WHO WILL COLLECT INFORMATION AND WHEN

Step 5: Collect, synthesise, verify data, and analyse contribution

Data collection to monitor and evaluate communication in emergency responses is usually drawn out over a number of weeks or months. It is highly desirable that data synthesis and analysis occur **as** the data are collected. In other words, there should not be a distinct period of “data collection” followed by a distinct period of “data analysis” – analysis usually leads to new questions requiring further data collection, and so on.

“Data saturation” is often used as a sign that data collection can be reduced in intensity. **Data saturation** can be defined as the point at which no **new** answers to questions are being recorded and no **new** insights are being generated from the data analysis, which suggest the need for further periods of data collection for the time-being. It is important also to have regular reviews or reflections on the methods. Methods and questions may need to be adapted or modified on occasions.

Step 5 also involves processing and analysing data. Core M&E team members should organise meetings with relevant stakeholders and facilitate critical reflection on problems and successes, understanding the impacts of their efforts, and acting on what they have learned. Will there be a need for computer-based analysis? Is there a need for further training/reading for your team on qualitative and/or quantitative analysis? *What becomes critical is how stakeholders actually use information in making decisions and identifying future action.*

How will you ensure participants can provide feedback (verification) on the information that is collected? Analysis of data should include **data validation** among stakeholders. Data should be presented back to participants for verification and collective analysis. Ways to ensure that feedback and validation occurs can include workshops and meetings, distribution of reports (with follow-up interviews), transcripts of interviews returned to interviewees, and so on.

We asked at the beginning of this tool how do you know if behaviour change communication and social mobilisation are actually making a difference in emergency situations?

How much of the success (or failure) in an emergency response can we associate with communication for behaviour change and social mobilisation? Was the contribution worth the investment? *Perhaps without communication and social mobilisation, the observed changes would have occurred anyway, or would have occurred at a lower level or at a slower pace.*

To *definitively prove* behaviour change communication and social mobilisation is making a contribution, we would need “controlled comparisons” (intervention versus non-intervention) to estimate what happens with communication is in place, versus what would happen without it. But such evaluation designs have ethical and resource implications, especially for emergency response situations.

So the question remains: in the absence of a complex evaluation study, how do we measure contribution?

The first key is to recognise the *limits of measurement*. Definitively determining the extent to which communication contributes to any particular behavioural or social change is usually not possible (even with a meticulously designed evaluation). At best, we should be *satisfied with a reasonable estimate of the magnitude of impact*. Let's focus less on decimal points and more on what Rapid Appraisal practitioners describe as **appropriate imprecision** – not measuring more accurately than is necessary for practical purposes.¹ It is perhaps more useful to measure trends and directions of change, rather than absolute numbers.

When M&E resources are scarce, our second interest should be in *increasing understanding and knowledge rather than worrying about scientific certainty*. We should embrace uncertainty because we will never eliminate it.² If you must know with a high degree of certainty what communication's contribution is then you will need a carefully designed evaluation study (and probably a lot of money).

The third key is to acknowledge that *there is a problem of linking outputs directly to outcomes*. Many factors are at play beyond specific communication and mobilisation activities. We need to be realistic about the outcomes we are trying to influence and acknowledge many potential influences are beyond the control of strategic communication.³

Any reasonable attempt to measure the contribution of communication in an emergency response would accomplish at least three things during the planning stage:

- (1) Intelligently map intended behavioural outcomes related to hygiene, breastfeeding, immunization, vitamin A, safe motherhood, and child protection.
- (2) Develop key indicators that either directly measure these outcomes or can serve as proxies or progress markers towards these outcomes.
- (3) Recognise or list those factors communication has no control over.

Collecting information from this point on might therefore show:

- Outcomes appeared at an appropriate time after your efforts began.
- Outcomes faded when your efforts stopped.
- Only outcomes appeared that you should have affected.
- Outcomes appeared only where or when communication activities were implemented.
- The biggest outcomes appeared where or when you did the most.

The analytical job is then to explore and discuss (and hopefully discount) plausible alternatives that might explain these relationships between effort/time/place and associated outcomes. Identifying what these alternative explanations might be is usually straight-forward. The core M&E team's job is to provide further evidence that discounts these alternatives. If there is little evidence that counters other plausible explanations, then you can possibly conclude that you cannot be sure what the contribution of communication has been. This unfortunate conclusion, however, is not usually arrived at if you have gathered additional, relevant evidence. For example, your communication might have been based on a previously proven theory and/or field experiences elsewhere, in which case, the associations between the communication and outcomes are supported by other examples. Other supporting evidence may be found, not from specific indicators, but from programme reports, meeting minutes, national surveys, or stories from the field.

Step 6: Use M&E results to re-develop future communication/ social mobilisation activities

How is the data being used and for whose benefit? This step serves as an important means of disseminating findings and learning from others' experiences. Core M&E team members should seek agreement with stakeholders (through meetings) on how findings should be used, and by whom. Several versions of M&E reports may be required, each tailored to different requirements and capacities of different stakeholders. Possible areas of future work should be discussed for follow-up. At this key moment, core M&E team members should also clarify with stakeholders if the M&E system needs to be sustained, and if so, how. The M&E system may need to be adjusted accordingly.

Resource bank

Further reading

Participatory M&E

1. Aubel, J., Participatory Program Evaluation Manual: Involving program stakeholders in the evaluation process, Catholic Relief Services, Dakar, 1999.
2. Estrella, M., with Blauert, J., Campilan, D., Gaventa, J. et al., Learning from Change: Issues and experiences in participatory monitoring and evaluation, Intermediate Technology Publications Ltd., London.
3. Feuerstein, M.T., Partners in Evaluation: Evaluating development and community programmes with participants, MacMillan, London, 1986.
4. Parks, W. with Grey-Felder, D., Hunt, J. and Byrne, A., Who Measures Change? An Introduction to Participatory Monitoring and Evaluation of Communication for Social Change. Communication for Social Change Consortium, South Orange, 2005. <http://www.communicationforsocialchange.org>.
5. Whitmore, E., 'Understanding and Practicing Participatory Evaluation', New Directions for Evaluation, No. 80, Jossey-Bass Publishers, San Francisco, 1998.

Data collection methods for M&E

6. Deepa, N., and Srinivasan, L., Participatory Development Tool Kit, The World Bank, Washington, D.C, 1994.
7. Gosling, L., Toolkits: A practical guide to monitoring, evaluation and impact assessment, New Edition, Save the Children Fund UK, London, 2003.
8. Grandin, B.E., Wealth Ranking in Smallholder Communities: A field manual, Intermediate Technology Publications, London, 1988.
9. Patton, M.Q., Participatory Learning and Action (PLA) Notes and Rapid Rural Appraisal (RRA) Notes: Qualitative evaluation and research methods, Second Edition, Sage Publications, Newbury Park, 1990.
10. Pretty, J., Guijt, I., Scoones, I., and Thompson, J. A., Trainer's Guide for Participatory Learning and Action, IIED, London, 1995.

11. Scrimshaw, N.S., and Gleason, G.R., Rapid Assessment Procedures: Qualitative Methodologies for Planning and Evaluation of Health Related Programmes, International Foundation for Developing Countries, Boston, 1992.
12. Srinivasan, L., Tools for Community Participation: A manual for training trainers in participatory techniques, PROWESS/UNDP-World Bank Water and Sanitation Program, Washington, D.C., 1993.
13. Wang, C., Burris, M. A. and Ping, X. Y., 'Chinese village women as visual anthropologists: A participatory approach to reaching policymakers.' *Social Science & Medicine*, 42 (10), 1996, pp. 1391-1400.
14. World Bank, Monitoring & Evaluation: Some tools, methods & approaches, World Bank, Washington, D.C., 2002.

Web sites

Communication for Social Change Consortium
<http://www.communicationforsocialchange.org>

Footnotes:

- 1 *Source: Parks, W.*
- 2 *Rehle, T., Saidel, T., Mills, S. and Magnani, R., Evaluating Programs for HIV/AIDS Prevention and Care in Developing Countries: A handbook for program managers and design makers, Family Health International, Arlington, p. 11.*
- 3 *Hamilton, C., Kumar Rai, R., Shestra, R.B. et al (2000) 'Exploring Visions: Self-monitoring and evaluation processes within the Nepal-UK Community Forestry Project.' In Estrella, M. with Blauert, J., Campilan, D., Gaventa, J. et al (eds) Learning from Change: Issues and experiences in participatory monitoring and evaluation. London: Intermediate Technology Publications Ltd. Pp.15-31. (P.29).*
- 4 *Davies, R. and Dart, J. (2005) The Most Significant Change 'MSC' Technique: A Guide to Its Use. <http://www.mande.co.uk/docs/MSCGuide.pdf>.*
- 5 *Scrimshaw, N.S and Gleason, G.R. Eds. (1992) Rapid Assessment Procedures: Qualitative Methodologies for Planning and Evaluation of Health Related Programmes. Boston, MA: International Foundation for Developing Countries.*
- 6 *Aubel (1999) describes 7 phases and 20 steps for participatory evaluation. See Aubel, J. (1999) Participatory Program Evaluation Manual: Involving Program Stakeholders in the Evaluation Process. Dakar: Catholic Relief Services.*

- 7 Guijt, I. (2000) 'Methodological Issues in Participatory Monitoring and Evaluation.' In Estrella, M. with Blauert, J., Campilan, D., Gaventá, J. et al (eds) *Learning from Change: Issues and experiences in participatory monitoring and evaluation*. London: Intermediate Technology Publications Ltd. Pp.201-216 (p.204).
- 8 Scrimshaw, N.S and Gleason, G.R. Eds. (1992) *Rapid Assessment Procedures: Qualitative Methodologies for Planning and Evaluation of Health Related Programmes*. Boston, MA: International Foundation for Developing Countries.
- 9 Mayne, J. (1999) *Addressing Attribution through Contribution Analysis: Using Performance Measures Sensibly*. Office of the Auditor General, Canada.
- 10 Information on Outcome Mapping is drawn from: Earl, S., Carden, F. and Smutylo, T. (not dated) *Brochure on Outcome Mapping: The Challenges of Assessing Development Impacts*. http://web.idrc.ca/en/ev-26979-201-1-DO_TOPIC.html

MOST SIGNIFICANT CHANGE TECHNIQUE

The **most significant change** (MSC) technique is gaining increasing popularity.¹
In MSC:

- All stakeholders in a program are involved in deciding the changes to be recorded.
- The same questions are asked of everyone.
- Resulting stories are rigorously and regularly collected.
- Stories are then analysed, discussed and filtered (voting), verified, and documented

There are three essential phases to MSC:

- A Determine the sorts of change to monitor.
- B Collect stories, review, select, and feedback.
- C Compile 'selected' stories, analyse, verify and monitor the process.

Phase A and B are often inter-connected.

The MSC technique begins with participants/stakeholders affected by an emergency being asked a simple question in the context of an emergency response program:

"Looking back over the last few weeks, in your opinion, what do you think was the most significant change that took place in the lives of people involved in...[name of response project/program]?"

To collect a few more details for the story, follow-up questions can be asked such as:

- What happened, who was involved, where did it happen, when did it happen?
- Why is the change the most significant out of all the changes that took place in the [time period]?
- What difference did it make already, or will it make in the future for you, for your community?

Stories can be collected from diaries, interviews, group discussions, and community meetings. Groups of stakeholders then meet to discuss and vote for the most significant stories out of those collected. An effective MSC system ensures feedback to storytellers of their selected stories. Some stories can be used to generate press coverage.

MSC is a valuable way of “dignifying the anecdote” – creating a legitimate space for storytelling and giving these stories validity. MSC has already been applied in developed and less developed economies, in participatory rural development projects, agricultural extension projects, educational settings, and mainstream human services delivery.

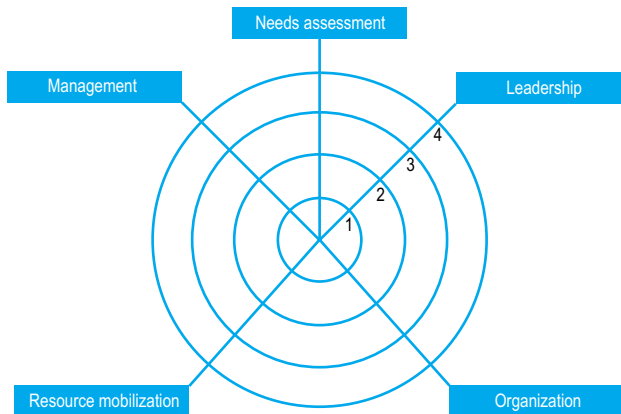
Measuring community participation²

A framework originally proposed by Susan Rifkin and colleagues for measuring community participation in health programs, may be suitable for adaptation to measuring community participation in emergency responses. This framework has been used in Nepal, Cameroon, Indonesia, Sweden, the Philippines, Fiji, Papua New Guinea, and the United Republic of Tanzania.³

Indicator	Questions
Needs assessment	<ol style="list-style-type: none"> 1) How are needs identified? 2) Does identification relate only to health service needs? 3) Is the affected community involved in needs identification and assessment? 4) Does the assessment strengthen the role of a broad range of affected community members?
Leadership	<ol style="list-style-type: none"> 1) Which groups does the leadership represent and how does it do so? 2) Is the leadership paternalistic and/or dictatorial, limiting the prospects of wider participation for various groups in the affected community? 3) How does the leadership respond to the needs of poor and marginalised people? 4) Do most decisions by the leadership result in improvements for the majority of the people, for elites only, or for the poor only?

<p>Organization Resource mobilization Management</p>	<ol style="list-style-type: none"> 1) Are new organisations being created to meet defined needs, or are the existing ones being used? 2) Are the organisations flexible and able to respond to change, or are they rigid, fearing a change in control? emergency responses, and do changes benefit professionals or affected community members? 3) What changes have taken place in the organisations since the introduction of emergency responses, and do changes benefit professionals or affected community members?
<p>Resource mobilization</p>	<ol style="list-style-type: none"> 1) What is the affected community contributing, and what percentage is this of the total response costs? 2) Are resources from the affected community being allocated for the support of parts of the response that would otherwise be covered by government allocations? 3) Whose interests are served by the mobilisation and allocation of resources?
<p>Management</p>	<ol style="list-style-type: none"> 1) Are decisions solely in the hands of professionals, or are they made jointly with affected community members? 2) Are the decision-making structures changing in favour of certain groups, and if so, which groups? 3) Are management structures expanding to broaden decision-making groups? 4) Is it possible to integrate non-health needs?

A ranking for each indicator has to be elaborated to determine the scores assigned to describe each of the five categories. The findings also rely on visualisations to help make various dimensions of the assessment clearer.



Health Communication ⁴

- 1) Is the affected community involved in planning, management and control of the communication for emergency response at the community level?
- 2) Were the felt needs of the community determined at the outset of the response planning and was notice taken of them in planning the behavioural objectives?
- 3) Have local forms of social organisation (e.g., farmer's cooperatives, clubs, churches, political organisations, trade unions, etc.) been involved in the decision-making process and to what extent?
- 4) Is there a mechanism for dialogue between health system personnel and community leadership?
- 5) Is there a mechanism for community representatives to be involved in decision-making at higher levels and is this effective?
- 6) Is there any evidence of the external agents changing their plans as a result of criticism from the community?
- 7) Are deprived groups, such as poor, landless, unemployed, and women, adequately represented in the decision-making process?
- 8) Are local resources used, such as labour, buildings, money?
- 9) Was the community involved in evaluating the project and in drafting the final report?

Social connectedness ⁵

- 1) As a result of the response, is the affected community better able to deal with other problems?
- 2) Are the communication and mobilisation activities building effective collaborative networks between affected communities, other communities, and organisations?
- 3) Are the communication and mobilisation activities contributing to the affected community's capacity to deal with issues it faces?
- 4) Is the affected community being rendered more able to meet its needs or solve current health problems?
- 5) Are organisations and worksites in affected communities demonstrating increased activity in service delivery and emergency response more generally?
- 6) Is 'social connectedness' or an increase in 'social connectedness' or networking among community organisations being created as a consequence of the response?

Measuring communication for social change ⁶

- Are meeting times and spaces creating opportunities for poor and marginalised people to speak, be heard and contribute to making decisions?
- In relation to the issues of concern (hygiene, breastfeeding, immunization, vitamin A, safe motherhood, child protection), what increase or other positive changes have there been in:
 - Family discussion?
 - Discussion among friends?
 - Discussion in community gatherings?
 - Problem-solving dialogue?
 - New ways of sharing relevant information?
 - Coverage and discussion in news media?
 - Focus and discussion in entertainment media?
 - Debate and dialogue in the political process?
- Are more people from all affected community groups involved in dialogue about these issues?
- To what extent do participants listen, evaluate information before they use it, challenge rumour and articulate their voice in private and public? Have there been improvements in these areas?
- Who is creating and telling the stories around the issues? Is that changing?
- What are the cultural norms those stories reveal? Are they changing?
- Are new connections between different groups being established within the community, either through face-to-face encounters or using technology?
- Are members of the affected community making their views known to those who hold official power? How? Is this changing?
- Are affected community members connecting with outside allies, communities and groups who support of their efforts?

Footnotes

- 1 Davies, R. and Dart, J., The Most Significant Change 'MSC' Technique: A guide to its use, <http://www.mande.co.uk/docs/MSCGuide.pdf>, 2005.
- 2 Adapted from Rifkin, S.B., Muller, F. and Bichmann, W. 'Primary Health Care: On measuring participation'. *Social Science and Medicine*, 26 (9), 1988, pp.931-940.
- 3 Bichman, W., Rifkin, S., and Shrestha, M. 'Towards the Measurement of Community Participation'. *World Health Forum*, No. 10, 1989, pp.467-472; Laleman, G., and Annys, S., 'Understanding Community Participation: A health programme in the Philippines', *Health Policy and Planning* (4)3, 1989, pp.251-256; De Koning, K., Bichman, W., 'Listening to Communities and Health Workers: A participatory training process to improve communication skills of health workers in Cameroon', *Learning for Health*, No. 3, 1993, pp.3-7; Nakamura, Y., and Siregar, M., 'Qualitative Assessment of Community Participation in Health Promotion Activities', *World Health Forum*, 17, 1996, pp.415-417; Bjärås, G., Haglund, B., and Rifkin, S., 'A New Approach to Community Participation Assessment', *Health Promotion International*, (6)3, 1991, pp.199-206; Schmidt, D., and Rifkin, S., 'Measuring Participation: First use as a managerial tool for district health planner based on a case study in Tanzania', *International Journal of Health Planning and Management*, No. 11, 1996, pp.345-358; Parks, W.J., and Hill, P., *Kadavu Subdivision Rural Health Project Post-Project Evaluation Report*, AusAID, Canberra, 1997; Parks, W., 'Community Participation in Health Program Design: Experiences from Papua New Guinea', *Health Services Support Program, Health Promotion Working Paper Series*, Brisbane, JTA International, 2000.
- 4 Adapted from Hubley, J., *Communicating Health: An action guide to health education and health promotion*, MacMillan, London, 1993.
- 5 Adapted from: Hawe, P., 'Capturing the Meaning of 'Community' in Community Intervention Evaluation: Some contributions from community psychology', *Health Promotion International*, (9)3, 1994, pp.199-210.
- 6 Adapted from Hunt, J., *Notes on Communication for Social Change*, in process.

GENDER CHECKLIST¹

This checklist can help you clarify instances where men and women's activities overlap with each other and which ones are gender specific. It should also give you ways to ensure that women's views and inputs are represented in your communication initiative.

1. In consultation with local organisations, community leaders, women's representatives, service providers and other relevant individuals who are knowledgeable on gender and disasters, categorise:
 - The specific issues that relate to women.
 - Those that relate to boys and those that relate to girls.
 - Those that relate to the affected community as a whole (issues shared by men and women).
2. Identify locally appropriate, effective mechanisms to gather information and inputs from affected women. Integrate these into the planning, implementation and monitoring process.
3. Pay attention to the concerns of vulnerable groups within the category of women and girls (including the landless, widows, disabled, minority ethnic and religious groups, and others).
4. Ensure that women and girls are not seen as 'helpless victims' by paying attention to the skills and capacities they demonstrate in livelihood and disaster management processes.
5. Have separate discussions with organisations that focus on women's concerns so that the capabilities and strengths of such organisations can be enhanced through their engagement in the communication initiative.

6. Organise consultations with village-level and community organisations that work on issues, and initiate discussions for the appointment of both women and men into leadership positions.
7. Organise and mobilise special women's groups or societies in the affected communities where it is culturally prohibited for men and women to work together.
8. Create and ensure that communication materials have clear graphics and messages, and that other means of communication are available to women to address the concern that women are often culturally restrained in public discussions. Ensure that women and girls are involved in designing graphics and messages.
9. Ensure that emergency communication initiatives include measures that address the gender-based concerns specific to the locality and programmatic issues at hand.
10. Emphasise the importance of sharing and involving both women and men to achieve more focused action on sustained behaviour change and social mobilisation within the affected community.
11. Ensure that women are given space and opportunities within the planning, implementing, monitoring and reporting process to apply their skills and capabilities in your communication initiative.
12. Ensure that there are gender-sensitised women working in the communication effort to interact with affected women.

Footnotes

- 1 Source: Adapted from Ariyabandu, M., and Wickramasinghe, M., *Gender Dimensions in Disaster Management: A guide for South Asia*, ITDG South Asia Publication, Colombo, 2003.

HOW TO CONDUCT A KEY INFORMANT INTERVIEW

The key informant interview is a standard anthropological method that is widely used in health related and other social development inquiry. This is one method used in rapid assessment for gathering information from the affected community. The term “key informant” refers to anyone who can provide detailed information and opinion based on his or her knowledge of a particular issue. Key informant interviews seek qualitative information that can be narrated and cross checked with quantitative data, a method called “triangulation”.

Step 1: Choose the interviewer

The interviewer has to remain neutral and must refrain from asking biased or leading questions during the interview. An effective interviewer understands the topic and does not impose judgments.

Choose an interviewer who:¹

- Listens carefully.
- Is friendly and can easily establish rapport.
- Knows and understands the local customs, behaviours and beliefs.
- Can inspire confidence and trust.

Step 2: Identify suitable key informants

Choose suitable key informants according to the purpose of the interview. A key informant can be any person who has a good understanding of the issue you want to explore. The informant can be a community member, teacher, religious or secular leader, indigenous healer, traditional birth attendant, local service provider, children and young people or others from the affected community. Interviews can take place formally or informally – preferably in a setting familiar to the informant.

Step 3: Conduct the interview²

- Based on what you already know about the issue, develop an interview guide beforehand to ensure that all areas of interest are covered. Use open-ended questions as much as possible.
- Hold the interview in a place that can put the respondent at ease.
- Establish contact first by introducing yourself.
- Thank the participant for making his or her time available.
- Describe the objectives of the interview.
- Go through the interview guide questions, (recording the proceedings with a tape recorder only if this exercise is conducted during the emergency preparedness or recovery phases of your communication initiative), together with your notes.
- If time allows tape recorder use, be sure to ask permission to use the interview.
- After each interview, transcribe the results of your discussion, using the guide questions in recording the responses. Remember to write as legibly as possible to facilitate this step.
- For each interviewee, note down your own observations about the process and content of the interview.

Do not forget to:

- Assure the respondent of confidentiality.
- Avoid judgmental tones so as not to influence responses.
- Show empathy with the respondent and interest in understanding his/her views.
- Let the respondent do most of the talking.
- Be an active, attentive listener.
- Pace yourself according to the time you have allotted for the interview.

Step 4: Crosscheck information³

In the initial response of an emergency each informant may give you new information. But later on, informants usually confirm or clarify the data that you already have. Be sure to confirm that your notes reflect more than one background or viewpoint. If not, your conclusions may end up one-sided or biased.

Step 5: Use the data

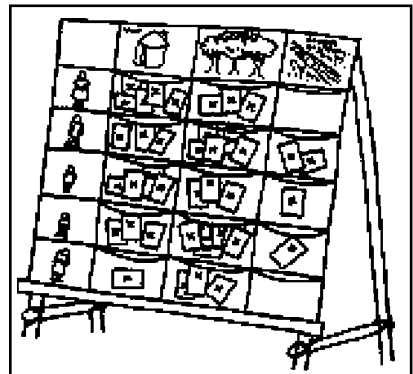
Information from key informant interviews helps you to further probe the needs, wants and priorities of an affected community during a rapid communication assessment exercise. You can use this qualitative information to complement the findings from the initial assessments undertaken in an emergency situation. It can also guide you in developing and adjusting your communication initiative.

Footnotes

- 1 Whitman, C., et al., *Rapid Assessment and Action Planning Process*, Health and Human Development Programs, a Division of Education Development Center, Inc. (EDC), The World Health Organization Coordinating Center to Promote Health through Schools and Communities, p. 7.
- 2 Whitman, C., et al., op.cit., p.7.
- 3 Adapted from *Needs Assessment Techniques Using Key Informant Interviews*, University of Illinois, Extension Service-Office of Program Planning and Assessment, Chicago, p. 3.

HOW TO USE A POCKET OR VOTING CHART

The use of pocket charts is a participatory method that can help you examine an affected community's practices more closely, and to monitor progress. You can lead this exercise in various ways. – a cloth pocket chart can be made from cotton by a local tailor. People can vote using tins or pots, or you place drawings or photographs showing selected behaviours on the pocket chart. Once you have chosen the type of chart to use, ask each participant to vote accordingly and as privately as possible. If privacy is not ensured, participants may change their vote to please others. After the votes are cast, collate them and discuss the results with the group.¹



A step-by-step guide to using the pocket or voting chart²

- Step 1:** Ask a participant who is familiar with the pocket chart to facilitate this activity.
- Step 2:** Set up the pocket chart with a behaviour that is measured and explain what it is and how it is used. Place a vote yourself to show how to use the pocket chart. Make sure you remove your vote and explain that it was a just a demonstration.

Step 3: Position the chart so that people can vote in private. Then invite people to approach the chart one at a time to place their votes.

Step 4: Once everyone has had a chance to vote, ask a participant to count the votes and display the results. Make sure that the counting is in full view of everyone.

Step 5: Facilitate the group discussion on:

- What the pocket chart has shown.
- The reasons why people voted the way they did.
- Whether this result shows improvement (if this is used as a monitoring exercise), or need for improvement.

Step 6: Once the comparison has been made, ask the group to discuss:

- What behavioural changes have been successful?
- What behavioural changes have been problematic?

Step 7: Ask the group to record (in drawings or words) the problems and sort them into three categories:

- Problems the participants do not fully understand.
- Problems the affected community can deal with by itself.
- Problems the affected community cannot solve by itself.

Step 8: Stick the three groups of problems on a wall and ask the participants to decide:

- For the problems not understood, how they will get more information, when they will do this, and whose responsibility it will be.
- For the problems the affected community can deal with, what actions they will take.
- For the problems the affected community cannot solve alone, how they will get outside help to overcome these problems.

Step 9: Use information from the pocket or voting exercise to assess the knowledge of the affected community, feed into the initial baseline data report, adjust your programme to meet the evolving needs of the affected community and to verify indicators.

Sample charts: Water use

	River/stream	Pond	Handpump	Unprotected 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.

Public health practices

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

Purpose	Most widely used source of water		Reasons
	1 st	2 nd	
Drinking			
Cooking			
Washing			
Washing utensils			
Making beer			

Defaecation practices

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

Footnotes

- 1 Adapted from Oxfam UK, *Guidelines for Public Health Promotion in Emergencies*, Oxfam, London, 2000, pp. 79 – 80. Sample charts adapted from Oxfam.
- 2 Adapted from Sawyer, R., et al., 'Part II Step-by-step activities' as cited in *PHAST Step-by-Step Guide: A participatory approach for the control of diarrhoeal disease*, WHO, Geneva, 1998, pp. 90-91.

HOW TO DO A RANKING EXERCISE

A ranking exercise is a simple, participatory and rapid method for establishing what the affected community considers its primary problems and needs. In contrast to simple voting procedures, ranking can help you identify different priorities and the associated facilities and activities needed within a camp of an affected community.

Step 1: Know the exercise

Do the preference ranking in six basic steps:¹

- Identify participants.
- Draw the matrix.
- Rank the items against each other.
- Document each result in the matrix.
- Count the scores.
- Facilitate a discussion and identify the main actions needed.

Step 2: Diversify your participant group

If participants in this ranking exercise represent various groups affected by the emergency - primary caregivers, community leaders, health workers, vulnerable groups such as children, young people, widows, displaced people and so on - you will be able to establish the different priorities, associated actions, facilities and services needed.

Step 3: Facilitate the process

The facilitator helps guide the group in identifying and weighing its priorities as well as identifying and weighing the associated facilities, services and activities needed; however, the ideas should primarily come from the participants.

The facilitator should:²

- Introduce the purpose of the exercise and how it will be used.
- Give either a practical example from a previous ranking exercise – or better – run through it once with one of the participants, where he/she acts as interviewer and the participant acts as interviewee.
- Divide the participants into sub-groups of three persons.
- Instruct each sub-group to select one interviewer, one informant who answers the questions and one recorder who writes the reasons that the informant gave for the preferences. The sub-group exercise works best when to explain and complete each step before the next step is started.
- The sub-groups then present their results and observations to the whole group

Priority Needs	Rank	Associated facilities/activities	Rank
Preventing Diarrhoea	4	Communal latrines	1
		Family latrines	3
		Hand washing	2
Clean Environment	2	Solid waste pits	2
		Cleaning materials	1
Preventing Malaria	3	Wastewater disposal	2
		Bed nets	1
Traditional Funerals	1	Morgue	4
		Burial ground	1
		Coffins	2
		Concrete Grave markers	3
Family Facilities	5	Family latrines	4
		Family solid waste pits	3
		Cleaning materials	1
		Tools	2

The following table shows an sample ranking exercise for sanitation related needs and priorities. The first priority is ranked as 1, the second 2, and so on:³

Step 4: Interpret the results

Priorities may differ greatly and the exercise may produce surprising results. An important advantage is that participants can see how the main needs or problems of a person or a group can be determined. In addition, the affected individuals can learn how to compare the priorities of different groups within the affected community against another. In the above exercise, the group was much more concerned with funeral rites than with diarrhoea.

Step 5: Use the data

For a hygiene promotion programme, you can use ranking to help the affected community prioritise the most significant problems, understand the links between seasonal changes and incidence of disease, understand water sources and use, and sanitation practices. Overall, you can use information gained from ranking exercises as inputs to planning and assessment and for subsequent monitoring and evaluation of your BCC programme.⁴ Remember that priorities and actions differ depending on the impact and stage of the emergency.

Footnotes

- 1 Berg, C. et al., *Introduction of a Participatory and Integrated Development Process (PIDEP) in Kalomo District, Zambia, Vol., 2, Manual for trainers and users of PIDEP*, 1997.
- 2 Adapted from Berg, C., et al., op.cit.
- 3 Harvey, P., et al., *Emergency Sanitation: Assessment and programme design*, London, 2003, p. 184.
- 4 Adapted from Oxfam UK, *Guidelines for Public Health Promotion in Emergencies*, Oxfam, London, 2001, p. 22.

HOW TO FACILITATE PARTICIPATORY EXERCISES

The most important thing to remember about being a facilitator is that you are not a teacher. Your role is to help or “facilitate”.¹ In planning your communication, recognise that command and control, and participatory processes go hand-in-hand. Human rights demand participatory processes in which all stakeholders buy in and contribute to solutions. Participatory processes are valuable in all stages of an emergency programme cycle – from rapid assessment to monitoring and evaluation - but such processes need to be integrated and balanced with command and control procedures during rapidly changing events that require quick decision-making and action.

With that in mind, when leading focus group discussions, doing a ranking or pocket chart exercise, a KAP survey or using any rapid assessment or monitoring and evaluation tool, your role is to help affected individuals and community groups to:

- Identify issues of importance to them.
- Express their problems.
- Analyse their problems.
- Identify possible solutions.
- Select appropriate options.
- Develop a plan to implement the solutions to which they identify and agree.
- Evaluate the outcome of the plan.

So you must not:

- Give information: instead, allow the group to find out information for themselves (although, it may be that in the initial days after a disaster, people will be seeking/needing information).
- Tell the group what they should do. Let them discuss and agree on what they should do and how they would like to do it.
- Make assumptions about what the right response should be to an activity.

Using participatory methods does not reduce the role of the facilitator in an emergency response situation, but rather redefines it. What you can do is encourage and facilitate community involvement; and create an environment in which the participants can discover information for themselves. In so doing, participants will build the confidence and self-esteem necessary to analyse problems and work out solutions.

As a facilitator, you are not a leader who directs the group to where you think it should go. Instead, you help the group to better understand its own situation and to enable them to make informed decisions on how to improve that situation.

Keep these important points in mind:

All participants are equal

The activities in this guide have been developed so that the participation of each group member is considered equally important. The participants must view you as an equal. So you should not present yourself as an authority figure. Information should flow from you to the group and vice versa. By sharing and receiving information, you and the group will remain equal. For this type of information exchange, good listening skills are essential.

There is no one right answer

This means that there can be many correct answers or results. Decisions made by the group reflect what is right for the group and what the group is prepared to take responsibility for.

Create the right atmosphere

If your aim is to reach agreement on priorities for activities, or a plan for improving hygiene behaviours and sanitation, participants must be able to work well together. This is why participatory sessions often begin with a fun activity, something to break the ice and make people laugh. You need to make people feel at ease

throughout the planning process. Most cultures have traditional games and songs that can create the right atmosphere and build group spirit.

Coping with dominant personalities

From time to time the group process may not be able to proceed because one individual wants to control the group's thinking. If this happens, find out whether the dominant individual is a designated leader, or simply a competitive or aggressive person with little or no significant support or influence in the group. Competitive or aggressive persons can either be taken aside and convinced of the importance of the group process, or given separate tasks to keep them busy and allow the group to carry on. If the persons concerned are community leaders, approach them formally or privately – early in the planning phase – explain the process, and try to gain their support. Hopefully, you will convince them that allowing community members to fully and equally participate will result in the personal growth of and better conditions for each participant.

General guidance for all activities:

1. Have all the materials for each activity ready before starting.
2. Make sure the materials are large enough to be seen by all participants.
3. Try to limit the size of your group to no more than 40 persons.
4. Make sure that people can talk to one another easily. Use a circle where possible.
5. Begin each new session with a warm-up activity such as a game or song. Provide refreshments where possible.
6. Go through each activity one step at a time and follow the instructions in the guide.
7. When giving the group its task, use the exact words provided for this purpose.
8. Encourage and welcome the input that individuals make. Remember, there are no wrong answers.
9. Facilitate the group, do not direct it.
10. Try to encourage the active participation of each participant. Be careful not to find fault or make critical comments when you respond to people.
11. Take into account the participants' literacy level and work out ways in which they can keep record of what is discussed and agreed.
12. Have the group keep the materials and records in a safe place.
13. At the end of each activity, ask the group members to evaluate the activity on the basis of what they have learned, what they liked and what they did not like.
14. At the end of each session, congratulate the group members on their efforts and explain briefly what will be covered at the next session.

15. At the beginning of each new meeting of the group, ask the group to review what it has done so far and the decisions it has taken.

Footnotes

- 1 Adapted from Sawyer, R., et al., 'Part I 'Introduction to the PHAST Step-by-step Guide' as cited in *PHAST Step-by-Step Guide: a participatory approach for the control of diarrhoeal disease*, WHO, Geneva, 1998, p. 88.

MONITORING CHART

A monitoring chart can be used to see if the set goals for your communication initiative have been met.¹

Step 1: Have the group look at the monitoring chart to review the goals set during the initial

emergency response. Then ask them to compare these goals with what has been achieved since making the chart. The group might want to make a record of the differences between what was planned and what has been achieved. Encourage participants to make a comparison in any way it wants – using pens, paper, drawings, words, etc.

Step 2: Once the comparison has been made, ask the group to discuss:

- Successes.
- Problems.

Step 3: Ask the group to record (in drawings or words) the problems and sort them into three categories:

- Problems the affected community can deal with by itself.
- Problems the participants do not fully understand.
- Problems the affected community cannot solve by itself.

Step 4: Stick the three groups of problems on a wall and ask the participants to decide:

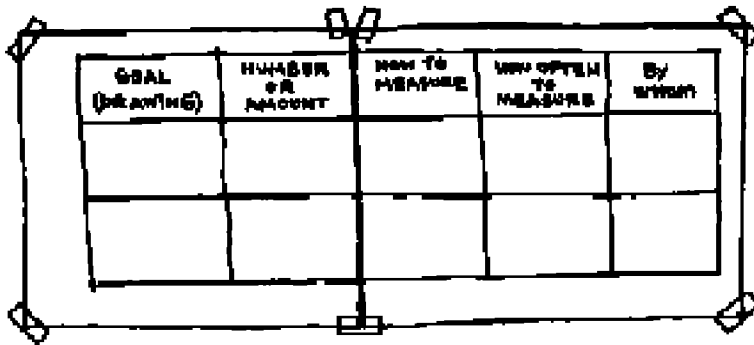
- **For the problems the affected community can deal with**, what actions they will take.
- **For the problems not understood**, how they will get more information, when they will do this, and whose responsibility it will be.
- **For the problems the affected community cannot solve alone**, how they will get outside help to overcome these problems.

Step 5: Discuss possible (or adjustments to existing) communication methods that can help the affected community overcome its problems. Find out whether existing communication channels are reaching the target populations in the affected community.

Step 6: Finish with a discussion on what was learned, liked/disliked about the activity. Investigate

Step 7: Adjust messages, communication channels and behavioural objectives according to the information received.

Sample monitoring chart



GOAL (DRAWING)	NUMBER OR PERCENT	HOW TO MEASURE	HOW OFTEN TO MEASURE	By WHOM

Footnotes

- 1 Source: Adapted from Sawyer, R., et al., 'Part II Step-by-Step Activities' as cited in *PHAST Step-by-Step Guide: A participatory approach for the control of diarrhoeal disease*, WHO, Geneva, 1998, p. 88.

STRUCTURED OBSERVATION CHECKLIST FOR COMMUNICATION SKILLS¹

- **Collect a group of stakeholders to work on developing this checklist:**
This will depend on the programmatic issue but stakeholders can include trainers, relief workers or anyone who is a representative of the people whose behaviour is being observed. Whoever is chosen needs to be acquainted with the event to be measured. A research agency might also be involved.
- **Observe event to be measured:** This can be done in various ways such as a health worker leading a group meeting or a peer educator doing an individual interpersonal communication session. Usually, this is done with a role play. Prepare the person/people doing the role play to demonstrate a “perfect” example of the communication session to be observed.
- **Identify key behaviours or skills observed** in the event. Record them on VIPP cards or flip chart.
- **Through discussion** (and perhaps repeated demonstration of the event) **reduce the number of behaviours/skills to a few items** for the observation check list. While there is no correct number of items for a check list, you will need to strike a balance between capturing the essence of a good communication session, by having a measurement tool that can be correctly (90 percent accuracy by 100 percent of the observers) and easily used. Somewhere from five to eight items can be handled by a trained observer who is scoring a 5-minute event.
- **Operationalise each item selected for the list.** Operationalising means making the item easy for multiple observers to check correctly. For example, the health worker (HW) shouldn’t read the text of the flipchart. The HW must look at the participants at least half the time while he/she is using or discussing the flipchart.
- **Train observers to reach 90 percent agreement** for each item. Use repeated role plays of the event to score and discuss why each observer did or did not check the item. If 90 percent agreement cannot be reached, then re-define the item; clarify exactly what behaviours constitute a “yes”. This can be done by looking at the group once, three times, half the time. Or calling on one, two or three participants who have not been talking, etc.

- **After field testing, discuss whether getting a perfect score on the check list** does, indeed, **capture an adequate, acceptable communication session**. If it does not, consider replacing items with others or adding to the exercise. Remember, the more items on the check list, the more difficult it will be to use correctly.

This is a check list to record observed communication skills only. To record the context of the communication session (time of day, physical conditions, language used, characteristics of the field worker), use another sheet that can be filled out before or after the actual observation.

Community Nutrition Promoter _____

Date of Session _____

Sample Checklist for Community
Nutrition Promoter's Communication
Skills during a Nutrition Advice Session

Community Nutrition Promoter:

Greets all participants	Y	N
When speaking moves head to make eye contact with participants	Y	N
Uses open-ended questions to check for understanding	Y	N
When using material, keeps it visible to all participants	Y	N
When using material, asks questions on content of material	Y	N
Summarises the actions of mothers at end of session	Y	N

OBSERVER COMMENTS:

Footnotes

1 Source: Graeff, J., *Final Report on Behavioural Monitoring Workshop*, UNICEF Dhaka, 2005.

TASKS OF MEN AND WOMEN IN THE COMMUNITY

This exercise can be done to increase knowledge and understanding of which household and community tasks are done by affected women, and which are done by affected men. It can also help identify whether any change in task allocation would be desirable and possible.¹

What to do

1. If there has been a break between this activity and a previous one, start with a group discussion to review what was learned or decided at the previous meeting.
2. Ask the participants to form groups from five to eight people.
3. Using the following words, ask the group to carry out the activity:
“Each group will be given a drawing of a man, a woman and a man and woman (a couple) together, and a set of drawings showing different tasks. Discuss in your group who would normally do this task. When you agree, put the task drawing underneath the drawing of the man, woman or couple based on what you decide. The drawing of the man and woman together means that both sexes perform the task”



- 4 Let the groups work on their own and discuss their findings. They can draw and add other tasks. You should provide them with blank paper for this purpose.
- 5 Once the activity has been completed, ask each group to present its selection to the rest of the participants, explain its choice and answer any questions.
- 6 Facilitate a group discussion on:
 - Who does what tasks.
 - The workloads of men and women.
 - How differences in workloads might affect task allocation for overcoming the new problems in the community because of the disaster.
 - The advantages and disadvantages of changing tasks done by men and women.
 - The potential for changing the tasks done by men or women.
 - Ask the group to identify roles which could be changed or modified in order to improve sanitation and hygiene, and record these conclusions for use in monitoring later on.
- 7 Facilitate a discussion with the group on what it has learned during this activity, what it liked and disliked about this activity.

Special Note:

During this activity men sometimes complain that drawings of their usual tasks have not been included in the set. This is because the set focuses mostly on tasks related to domestic and community hygiene and sanitation, and in most societies these tasks fall to women. If this happens, ask the men to make drawings of tasks they perform, and add them to the activity. The group may decide that three drawings (man, woman, and both together) are not enough and choose to add drawings of boys and girls. This is fine, but the analysis should focus on gender not age.

Footnotes

- 1 Adapted from Sawyer, R., et al., 'Part II Step-by-step activities' as cited in *PHAST Step-by-Step Guide: A participatory approach for the control of diarrhoeal disease*, WHO, Geneva, 1998, pp. 33-35.

A 12- POINT COMMUNICATION MONITORING CHECKLIST

1. Was an assessment done to identify:
 - a. The information gaps among your audience (i.e. health workers, caregivers, volunteers or other critical groups)?
 - b. The information-seeking and sharing patterns of the affected communities (communication network analysis)?
 - c. The main barriers for affected families and communities to practice the intended behaviour (e.g. caretakers taking their children to immunization services, safe hygiene practices)?
2. Did you develop a communication plan that is linked to the service and supply components of the emergency response?
3. Does the plan clearly state the behavioural objectives you seek to influence?
4. Did you prepare an implementation plan?
5. Does it include opportunities for community participation in areas such as material preparation, message design and dissemination?
6. Did you establish a monitoring system to keep track of your efforts and gather feedback?
7. Did you determine the budget?
8. Are messages and materials gender, age and culturally sensitive and appropriate?
9. Did you choose the most appropriate a mix of the most effective communication channels – interpersonal and mediated?

10. Did you invite and receive feedback from the various audience(s) of the affected community on your suggested messages and materials (pre-testing)?
11. Do you know if the material and the messages in it reached the people they were meant to reach (e.g. affected population, health workers, volunteers, etc.)?
12. Do you have a system to share and manage the information with humanitarian organisations, UN sister agencies, government bodies, professional organisations and other concerned partners?

TOOLS TO MONITOR THE MILESTONES

Chapters 4 through 8 each contains a section on *Monitoring milestones*. The section should help you establish simple monitoring and evaluation systems. Importantly, the inclusion of such a section in each chapter emphasises the need for early planning of how communication programmes will be monitored and evaluated. In other words, M&E must be developed during the communication planning stage, if not during the pre-planning or “groundwork” stage. Development of indicators, of course, will depend on specific behavioural results to be achieved, but the indicators presented in each section are useful guides.

Chapter 4 – Hygiene Promotion

Each indicator provided in the monitoring milestone sections needs to be measurable. Some indicators (identified below), may not be measured easily – so we have provided some measurement tools that can help you measure the suggested indicators.

Indicators for hygiene practice	Measurement tools
<ul style="list-style-type: none"> ▪ " People use the toilets available and children's faeces are disposed of immediately and hygienically. " People use toilets in the most hygienic way, both for their own health and for the health of others. 	Observation Self report Focus group discussion

Indicators for hygiene practice	Measurement tools
" Household toilets are cleaned and maintained in such a way that they are used by all intended users and are hygienic and safe to use.	Household observation Focus group discussion
<ul style="list-style-type: none"> Parents (mothers and fathers or other primary caregivers) demonstrate knowledge of the need to dispose of children's faeces safely. 	Focus group discussion Ranking exercise KAPS survey
<ul style="list-style-type: none"> Families and individuals participate in a family latrine programme by registering with the agency, digging pits or collecting materials. People wash their hands after defecation and handling children's faeces and before cooking and eating. People demonstrate correct hand-washing and know when to engage in this behaviour. 	Registration records Observation KAPS survey Demonstration of correct hand-washing

Key indicators for design and implementation of your hygiene promotion programme	Measurement tools
<ul style="list-style-type: none"> Key hygiene risks of public health importance are identified. 	Review of key IEC materials
<ul style="list-style-type: none"> Programmes include an effective mechanism for representative and participatory input from all users at all phases, including the initial design and location of facilities - 	Observation of latrine design, camp adjustments Focus group discussions with girls, women and disabled Reports from health workers

Key indicators for design and implementation of your hygiene promotion programme	Measurement tools
<p>making sure that latrines accommodate the disabled; are well-lit and designed to protect women from sexual molestation; and provide girls and women the privacy to cleanse themselves, wash out underclothes and sanitary napkins.</p>	
<ul style="list-style-type: none"> ■ All groups within the affected community have equitable access to the resources or facilities needed to continue or achieve the hygiene practices that are promoted. 	<p>Observation of latrine design Focus group discussions with girls, women and disabled Reports from health workers, camp managers, latrine attendants Key informant interviews Gender checklist</p>
<ul style="list-style-type: none"> ■ Hygiene promotion messages and activities address key behaviours and misconceptions and are targeted for all participant groups. Representatives from these groups participate in planning, training, implementation, monitoring and evaluation. 	<p>Pre-and-post testing of materials Participation logs of FGDs, ranking exercises, pocket or voting exercises Monitoring chart</p>
<ul style="list-style-type: none"> ■ Participants take responsibility for the management and maintenance of facilities as appropriate, and all populations of the affected community contribute equitably. 	<p>Observation Latrine/facility maintenance reports Tasks of men and women in the community.</p>

Chapter 5 - Breastfeeding

Indicator	Possible measurement tools/sources of information
<ul style="list-style-type: none"> ■ Health workers, peer educators, birth attendants, midwives and other relevant service providers are trained on infant and child feeding practices, and can communicate and motivate affected women to breastfeed exclusively and safely prepare BMS and cup feed (in exceptional cases). 	Register of training events Structured interview Structured observation checklist Demonstration
<ul style="list-style-type: none"> ■ Breastfeeding women know the benefits of colostrum, the importance of/how-to breastfeed, and how-to safely prepare BMS and cup feed - and are doing it. 	Structured interview Structured observation checklist Demonstration
<ul style="list-style-type: none"> ■ The affected community is mobilised to support breastfeeding women via, mother-to-mother support networks, "safe havens", trials of new feeding practices, activities in women's groups, etc. 	Semi-structured interviews Focus group discussions Observation of trials Observation of women's groups
<ul style="list-style-type: none"> ■ Infants under six months are exclusively breastfed, wet-nursed (where acceptable), or in exceptional cases, have access to an adequate amount of an appropriate BMS. 	Mother's self-report (24 hour recall interview) Demonstration of appropriate use of BMS
<ul style="list-style-type: none"> ■ Local governments, humanitarian agencies, camp management and other service providers know the international guidelines on the marketing of BMS, the appropriate use of BMS in emergencies, and are supplying it to artificially-fed infants without undermining the breastfeeding population at the camp. 	Structured interview BMS supply records

Chapter 6: Immunization and vitamin A promotion

Input indicators	Possible measurement tools/sources of information
<ul style="list-style-type: none"> Percentage of communication plans that map resistant or difficult groups, including "zero-dose" children, and propose strategies for reaching them 	Document analysis of communication plans.
<ul style="list-style-type: none"> Is there a communication component for EPI in the emergency preparedness and response plan? 	Emergency response and preparedness plans EPI programme
<ul style="list-style-type: none"> Does the communication component to support the EPI programme in an emergency situation include a budget? 	Financial documents EPI programme proposal
<ul style="list-style-type: none"> Number of planned outreach activities in the affected communities and camps. 	Analysis of communication plan
<ul style="list-style-type: none"> Number of materials produced. 	Literature audit
Output indicators	Possible measurement tools/sources of information
<ul style="list-style-type: none"> Percentage of emergency vaccination programme budgets used for, a) broadcast media, b) print materials, and c) strengthening of interpersonal communication skills. 	Financial plans, budgets
<ul style="list-style-type: none"> Percentage of planned activities to reach the hard to reach population groups actually conducted. 	Programme reports, field observations, structured observation checklist
<ul style="list-style-type: none"> Number of materials disseminated and visible/used in health facilities. 	Observation, material audit, health worker/caregiver self-reports or interviews

Output indicators	Possible measurement tools/sources of information
<ul style="list-style-type: none"> Number of health workers and mobilisers trained in immunization communication. What is the number of training sessions conducted? 	Training logs Programme reports, observation, meeting reports
<ul style="list-style-type: none"> Number of meetings held with community and faith leaders. 	Structured interview including photographs (measles symptoms)
<ul style="list-style-type: none"> Percentage of health workers/vaccinators/care-givers who know how-to recognise measles and where such a case should be reported. 	

Outcome indicators (linked to EPI indicators)	Possible measurement tools/sources of information
<ul style="list-style-type: none"> Percentage of health workers/vaccinators providing key messages during immunization sessions. 	Exit interviews with caregivers Key informant interviews Structured observation checklist Field observations
<ul style="list-style-type: none"> Percentage of caregivers with vaccination cards. 	Vaccination records Self report
<ul style="list-style-type: none"> Percentage of caregivers who know where to go for vaccination and vitamin A supplementation. 	Key informant interviews KAP surveys Self report
<ul style="list-style-type: none"> Percentage of caregivers who know where to take a sick child for treatment. 	Same as above.
<ul style="list-style-type: none"> Percentage of households in affected communities/camps visited by community health volunteers/mobilisers. 	Field reports Self report

Outcome indicators (linked to EPI indicators)	Possible measurement tools/sources of information
<ul style="list-style-type: none"> Percentage of budget spent on communication activities according to the plan. 	Financial documents
Impact indicators (EPI indicators) include:	Possible measurement tools/sources of information
<ul style="list-style-type: none"> Percentage of children vaccinated with measles. Percentage of children who received vitamin A supplements. Percentage of drop-out rates. Percentage of planned outreach sessions actually conducted. 	Health centre records, programme reports, field reports

Chapter 7: Safe Motherhood

Indicator	Possible measurement tools/sources of information
<ul style="list-style-type: none"> Health workers, midwives, women's representatives, counsellors and other relevant stakeholders are trained on maternal nutrition and breastfeeding facts and communicate the importance of antenatal and postnatal care visits, clean and attended delivery, the warning signs during pregnancy and danger signs during pregnancy. 	Training records; self-report of health workers, midwives, counsellors and women's representatives Demonstration
<ul style="list-style-type: none"> Affected women and their families know the benefits of eating healthy, taking vitamin A supplements and iron; receiving tetanus shots; clean and attended delivery; seeking antenatal and postnatal care - and are doing it. 	Health centre registers FGD with affected pregnant women/new moms/family members Key informant interviews Structured interviews

Indicator	Possible measurement tools/sources of information
<ul style="list-style-type: none"> Affected women and their families know the warning signs during pregnancy; when and where to get immediate help, and are seeking medical help when complications occur. 	Same as above.
<ul style="list-style-type: none"> The affected community demonstrates support to pregnant women via mother-to-mother support networks, women's group, community-based birthing plans and referral systems, etc. 	Presence of active support groups in affected community Established referral systems FGD/structured interviews with community members
<ul style="list-style-type: none"> Local governments and humanitarian agencies have allocated the resources needed for adequate care and affordable quality services; have established the necessary transportation systems, supplied essential drugs, clean delivery kits - and have formed necessary partnerships to supply these. 	Transportation systems in place Work plans Financial documents, approved budgets Medicines/clean delivery kits available to women, health facilities

Chapter 8 Child Protection

Indicator	Possible measurement tools/sources of information
Affected parents/primary caregivers know the importance of recreational/educational activities to the psychosocial recovery of children, know where these activities are provided in the camp and are sending affected children.	Structured interview Focus group discussion Group mapping (of camp) Observation of children attending recreational/educational facilities Registers of children at above facilities

Indicator	Possible measurement tools/sources of information
Affected parents/primary caregivers know not to leave their children unattended, and are aware of the unsafe areas for children in the camps.	Structured interview Focus group discussion Group mapping (of camp) Observation of unsafe areas
Parents/primary caregivers know how to prevent child separation in the camp, during migration or evacuation and are doing it.	Structured interview Focus group discussion Story with a gap (pictures illustrating before and after potential child separation) - "Story with a gap" is explained below Registry of reported child separation
Camp officials know the importance of lighting latrines, providing adequate camp security and designating safe spaces for women and children and are making the necessary adjustments.	Meeting reports Interviews with camp officials Observation of camp adjustments
The affected community knows to report strangers, (suspected) traffickers that enter the camp and are doing it.	Focus group discussion (with affected community members) Registers of reported "suspected" traffickers
Parents/primary caregivers who have lost children know how/where to go to register, facilitate tracing.	Structured interview (with parents) Register kept at "tracing centres"
Separated children know their rights to be involved in the decisions being made for them; know where to go to register, facilitate tracing and receive essential services	Focus group (with children) Register kept at "tracing centres" and essential services

Indicator	Possible measurement tools/sources of information
Social workers, camp managers, service providers know the rights of separated children and how to communicate these rights to them.	Structured interview (with social workers, camp managers, service providers) Observation checklist of communication sessions with separated children
The affected community knows the signs of abuse, trafficking, molestation; how-to report it and are doing it.	Structured interview with sample of affected community members Registers at centres dealing with abuse, trafficking and molestation
Affected children know to report abuse to them or their friends and are doing it	Focus group with children Registers at centres dealing with abuse

HOW TO DESIGN A RADIO SPOT

Depending on the impact of the disaster as well as the availability and reach of technology, radio might be a very useful channel to quickly share information and disseminate messages on health, child protection, immunization, water, hygiene and sanitation, safe motherhood or HIV and AIDS in an emergency situation. Take care to find out if the affected community has access to radio and prefers it as a communication source. This information would be best gathered in the emergency preparedness phase of your BCC initiative, but it can be explored in various participatory assessments that you facilitate in the emergency's initial response.

If you find that the affected community prefers and has access to radio, and you have to design a radio spot, or judge the quality of drafts presented to you, consider following points:¹

Step 1: Present one idea

Each radio spot should have one main message, which should be repeated several times during the spot.

Step 2: Choose a credible source of information

Engage and feature a source of information (e.g. a well known public figure) that is suggested or accepted by the affected communities.

Step 3: Break the mould

Try innovative ideas and formats.

Step 4: Touch the heart as well as the mind of the listener

Make the listener *feel* something after hearing the spot or programme — happy, confident that they can do something — but make them *feel*.

Step 5: Stretch the listener's imagination

The voices, music and sound effects can and should evoke pictures and create images in the listener's mind.

Step 6: Write for the ear

Radio spots should have the same natural, spontaneous sound as conversation.

Step 7: Write to the individual

Imagine the face of a person within your participant group and write for that person.

Step 8: Ask listeners to take action

Be explicit about what the listeners can do to resolve their problem.

Step 9: Provide consistency

Develop a similarity of sound in all of your radio materials, providing continuity to the radio materials.

Step 10: Plan more than one spot

Plan a series of spots in concentrated numbers (e.g., 10 spots per evening for a week — if evening is the preferred listening time, rather than one spot per day).

Footnotes

- 1 Source: Adapted from United Nations Children's Fund, 'A manual on communication for water supply and environmental sanitation programmes', *Water, Environment and Sanitation Technical Guidelines Series, No. 7*, UNICEF, New York, 1999, pp. 72 - 73.

HOW TO DESIGN PRINT MATERIALS

Before you develop any print materials, review the behavioural objectives of your communication initiative and consider the main groups you want to reach (e.g. affected caregivers, children, health workers, teachers and/or others); whether they can they read, and if so, whether they like to read. This would be best done before a disaster strikes because it would allow for significant pre-testing, translation to local dialects, and the input of various groups within the affected community. Working on print materials pre-disaster also allows you to design materials with greater assurance that the messages and graphics are culturally, religiously and gender-appropriate.

When designing print materials, keep the following principles in mind:¹

The number one principle is: community engagement

- Involve affected community members in all phases of material development – this goes beyond pre-and-post testing of your print material. Emergency preparedness allows you to engage the affected community to the fullest.

Choose a simple, logical design and layout

- Present only one (1) message per illustration.
- Make materials interactive and creative.
- Limit the number of concepts and pages of materials.
- Messages should be in the sequence that is most logical to the group.
- Use illustrations to help explain the text.
- Leave plenty of white space to make it easier to see the illustrations and text.

Use illustrations and images

- Use simple illustrations or images.
- Use appropriate styles: (1) photographs without unnecessary detail, (2) complete drawings of figures when possible, and (3) line drawings.
- Use familiar images that represent objects and situations to which the affected community can relate.
- Use realistic illustrations.
- Illustrate objects in scale and in context whenever possible.
- Don't use symbols unless they are pre-tested with members of the affected community.
- Use appropriate colours.

Use text to your advantage

- Use a positive approach. Negative approaches are very limited in impact, tend to turn off the affected community, and will not sustain an impact over time.
- Use the same language and vocabulary as your affected community; limit the number of languages in the same material.
- Repeat the basic message at least twice in each page of messages.
- Select a type style and size that are easy to read. Italic and sans serif typefaces are more difficult to read. Use a 14-point font for text, 18-point for subtitles, and 24-point for titles.
- Use upper and lower case letters.

Provide supervision for material production

- Without careful supervision, materials may end up in wrong colours, incorrect alignment, or careless print jobs. Have an experienced member of your team providing close supervision to the printing work.

Special Note:

Combine print materials with small community media, IPC approaches and other participatory communication strategies.

Printed IEC materials are most effective when combined with other forms of communication. In the initial response, print media can be used to quickly dispense life-saving messages to large numbers of affected people. Experience has shown, however, that print materials are more effective when combined with interpersonal communication. This allows the affected community to discuss the new information with someone that they trust.

Footnotes

- 1 Source: Adapted from United Nations Children's Fund, 'A manual on communication for water supply and environmental sanitation programmes', *Water, Environment and Sanitation Technical Guidelines Series, No. 7*, UNICEF New York, 1999, p. 74

PRINCIPLES AND GUIDELINES FOR ETHICAL REPORTING ON CHILDREN AND YOUNG PEOPLE UNDER 18¹

Reporting on children and young people has its special challenges, especially in emergencies. In some instances reporting on children places them or other children at risk of retribution or stigmatisation.

The following principles have been developed to assist journalists as they report on issues affecting children. They are offered as guidelines that UNICEF believes will help the media to cover children in an age-appropriate and sensitive manner. The guidelines are meant to support the best intentions of ethical reporters: **servicing the public interest without compromising the rights of children.**

I. Principles

1. The dignity and rights of every child are to be respected in every circumstance.
2. In interviewing and reporting on children, special attention is to be paid to each child's right to privacy and confidentiality, to have their opinions heard, to participate in decisions affecting them and to be protected from potential and actual harm and retribution.
3. The best interests of each child are to be protected over any other consideration, including advocacy for children's issues and the promotion of child rights.
4. When trying to determine the best interests of a child, the child's right to have their views taken into account are to be given due weight in accordance with their age and maturity.
5. Those closest to the child's situation and best able to assess it are to be consulted about the political, social and cultural ramifications of any news reports.

6. Do not publish a story or an image which might place the child, siblings or peers at risk – even when identities are changed, obscured or unused.

II. Guidelines for interviewing children

1. Do no harm to any child; avoid questions, attitude statements, opinions or comments that are judgmental and insensitive to cultural values, that place a child in danger or expose a child to humiliation, or that reactivate a child's pain and grief from traumatic events.
2. Do not discriminate your choice of children to interview because of sex, race, age, religion, status, educational background or physical abilities.
3. No staging: Do not ask children to tell a story or take an action that is not part of their own history.
4. Ensure that the child and the guardian know they are talking with a reporter. Explain the purpose of the interview and its intended use.
5. Obtain permission from the child and his/her guardian for all interviews, videotaping and, when possible, for documentary photographs. When possible and appropriate, this permission should be in writing.
6. Obtain permission in all circumstances to ensure that the child and the guardian are not coerced in any way and that they understand and agree that they are part of a story that might be disseminated locally and globally. This is usually only ensured if the permission is obtained in the child's language, and if the decision is made in consultation with an adult the child trusts.
7. Pay attention to where and how the child is interviewed. Limit the number of interviewers and photographers. Try to ascertain that the child is comfortable and able to tell his/her story without pressure from anyone, including the interviewer. In film, video and radio interviews, consider what the choice of visual or audio background might imply about the child and her or his life and story. Ensure that the child would not be endangered or adversely affected by showing their home, community or general whereabouts.

III. Guidelines for reporting on children

1. Do not further stigmatise any child; avoid categorisations or descriptions that expose a child to negative reprisals - including additional physical or psychological harm, or to lifelong abuse, discrimination or rejection by their local communities.
2. Always provide an accurate context for the child's story or image.
3. Always change the name and obscure the visual identity of any child who is identified as:
 - a. A victim of sexual abuse or exploitation.
 - b. A perpetrator of physical or sexual abuse.

- c. HIV positive, living with AIDS or has died from AIDS (unless the child, a parent or a guardian gives fully informed consent).
 - d. Charged or convicted of a crime.
4. In certain circumstances of risk or potential risk of harm or retribution, change the name and obscure the visual identity of any child who is identified as:
 - a. A current or former child combatant.
 - b. An asylum seeker, a refugee or an internally displaced person (IDP).
5. In certain cases, using a child's identity – his or her name and/or recognisable image – is in the child's best interests. Take note, that when the child's identity is used, the child must still be protected against harm and supported through any stigmatisation or reprisals.

Some examples of these special cases are:

 - a. When a child initiates contact with the reporter, wanting to exercise his/her right to freedom of expression and his/her right to have their opinion heard.
 - b. When a child is part of a sustained programme of activism or social mobilisation and wants to be so identified.
 - c. When a child is engaged in a psychosocial programme and claiming his/her name and identity is part of his/her healthy development.
6. Confirm the accuracy of what the child has to say, either with other children or an adult, preferably with both.
7. When in doubt about whether a child is at risk, report on the general situation for children rather than on an individual child, no matter how newsworthy the story.

Footnotes

- 1 Sources: The Convention on the Rights of the Child; *Child Rights and the Media: Guidelines for Journalists*, International Federation of Journalists; Media and Children in Need of Special Protection (internal document), UNICEF's Division of Communication; and Second International Consultation on HIV/AIDS and Human Rights, United Nations Secretary-General.



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