**Case Study**

**Hygiene Promotion & Menstrual Hygiene Management**

Summary

**Background**

During the response phase of aftermath of FANI, the requirement was for water, sanitation and hygiene (WASH) interventions which were fully supported by Government / Unicef or other humanitarian agencies; such as water distribution, latrine reconstruction / repair and hygiene kit distribution. However, WASH services were best put to use when community owned the services, behaviour change took place across the communities otherwise these services or assets could have resulted in dependency or could become unsustainable.

During the response phase of the FANI cyclone Unicef, Odishahad assessed that WASH interventions would not have been effective unless the interventions were participatory and demand-driven and that would have spiralling effect on other sectors. To incorporate the demand-driven approach in the WASH interventions, Unicef focussed on participatory facilitation and promotion techniques, and then on training various stakeholders to support the campaign.

**Context**

Villages of Puri have been pummelled by an unprecedented cyclone FANI on 3rd May 2019. While intense tropical weather is common in Puri, the cumulative effect of cyclone, heavy rains, and chronic vulnerability has far challenged the capacity of Government and other organisations to meet the immediate basic needs of the affected populations. Widespread heavy rains, temporary displacement, limited access to WASH services and loss of livelihoods have had an impact on issues related to water and sanitation. WASH infrastructures have been damaged and basic WASH services have been disrupted in the affected areas. The combined effect of these factors could have resulted in diseases and death rates if it had not been addressed in a timely manner.

**The problem: Needs Assessment**

In case disasters like FANI cyclone, hygiene promotion had become extremely critical during the response phase. The use of WASH facilities and the adoption of safe hygiene practices were essential to prevent post cyclone related diseases.

- Increased open defecation as a result of destruction, breakage or damage to toilets and latrines
- Loss or lack of key hygiene items
- Standing pools of contaminated water in the village drains and near hand-pump tube wells.

- Contamination of drinking water

Secondly, the menstrual hygienemanagement was neglected. As menstruation was handled in secrecyand provisioning for basic needs such as food and other things got priority while the pressing need ofsecuring menstrual hygiene was neglected. As discussed with girls never storedtheir menstrual cloths for such emergencies. There is a difference in the time ofdisaster and in normal time in regards to using menstrual cloths. It was not possible to buy the sanitary pads as the markets were closed and communication had broken down.

**Objective of the intervention**

- To prevent the outbreak of WASH communicable diseases associated with inadequate and unsafe water supplies, lack of sanitation facilities and promote good hygiene practices post the cyclone phase.
- To facilitate Menstrual Hygiene Management though provision of appropriate materials, facilities and information and communications that will ensure women and girls can privately, safely and hygienically manage their monthly menstrual flow with confidence and dignity in the post cyclone phase. .

**Strategy for Demand Driven Response**

After participatory discussions with community members in villages like Badabenakudi village it was discovered that there was a lack of understanding of the link between safe sanitation and health and it was more acute during emergencies. Therefore the decision was made to trial WASH interventions focussed on creating demand for safe water, sanitation and hygiene. Uniecf, Odisha through its partner; OXFAM focused its efforts on facilitation, promotion and training. The programme adopted a high intense promotional approach, which involved the systematic application of demand creation techniques, to achieve specific behavioural changes for a social good.

The first objective was for the community to understand how contaminated water and bad hygiene and sanitation practice contributed to poor health. The second objective was to stimulate demand for household water treatment systems, household sanitation facilities, and hygiene behaviour improvements. The third objective was to train and equip local masons / artisans to support in construction and retrofitting of toilets thereby creating a social capital in the villages. These objectives were achieved through; (1) facilitation of a Community Approach to Sanitation (CAS); (2) facilitation of a participatory hygiene and sanitation transformation process; (3) promotion of household water treatment.

**Community Approach to Sanitation (CAS)**

Community Approach to Sanitation (CAS) is a time tested participatory approach applicable both during normal and emergency situation. The trained facilitators of Unicef organised CAS tools in the identified villages. The aim of the CAS process was to establish an understanding of the link between

open defecation and diarrheal disease in order to stimulate demand for safe sanitation. Both women and men were involved in the process, although due to the cultural context events tended to be held separately for men and women. With this in mind Unicef and OXFAM employed high capacity female facilitators to work with the women and girls, while at the same time male facilitators targeted the men and boys within the same community. The involvement of Village Leaders was critical to the success of this process. Uniceffocussed its resources on the CAS facilitation process, and after 'triggering' the community suddenly realised the connection between open defecation and poor health), re-building of latrines was left for households and local masons. Since the village is low-lying and flood prone area, it was promoted to build raised latrines.

The Government of Odisha along with other national & international agencies have worked closely to identify needs and plan interventions in the most-affected areas. Heavy rains and cyclone have left already vulnerable populations, including those who are temporarily displaced or who have lost their belongings and/or livelihoods, at increased risk for water-born and vector-transmitted diseases.

A three staged intervention hygiene promotion strategy was planned i.e. short, medium and long term measures for the affected community and based on the level of intensity and scale of the interventions.

Hygiene promotion focussed on:

- Community Mobilization for hygine practices
- Toilet usage and safe disposal of excreta
- Hand washing at critical times
- Ensure non contamination of household drinking water

As a part of Hygiene Promotion strategy in the affected areas of it was planned to look into two matters namely; one the distribution of Hygiene Kit and secondly the implementation of a hygiene program The following interventions were taken for carrying out a hygiene promotion campaign in the early emergency stage:

The campaign was planned based on the requirement of the affected villages, key risk hygiene practices, priority risk groups, priority at-risk groups and the most effective hygiene promotion approaches and activities. The identified components were as follows

- Community Participation in all 20 villages
- Distribution of Hygiene Kits in two Gram Panchayats
- Communication on WASH with stakeholders in all 20 villages
- Use of sanitary facilities
- Monitoring.

As a part of initial assessment it was identified the key risk practices and the level of knowledge of the communities, the practices and level and understanding of WASH, Identifiedthe practices that were the most harmful to human health. The larger objective of the campaign was to targetspecific hygiene practicesto have the greatestimpact and which were achievable.

**Unicef approach for Menstrual Hygiene Management (MHM) in FANI Cyclone**

Unicef, Odisha addressed Menstrual Hygiene Management (MHM) in the calamity by supporting three essential components:

I. Supplies for Menstrual Hygiene Management (MHM)
II. Supporting facilities for MHM
III. Communications for MHM.

As a part of the Hygiene Kit, sanitary pads were distributed. The program also had taken into cognizance that considered how women and girls will use, wash, dry and dispose of sanitary materials along with local culture and preferences. Bucket, soap was also provided as part of hygiene interventions. To make the private space particularly in case of toilets, the partially damaged toilets were motivated for repair. These enabling factors for menstrual hygiene, including access to private changing, bathing and disposal facilities were addressed so that MHM is effective. Besides WASH, other sectors namely health, School, & Nutrition had a strong multi-sectorial approach and coordination especially to avoid duplication of distributed items. Special sessions with boys and men were held so they are aware of the needs of women and girls, are supportive of activities, to reduce stigma and to help address harmful cultural taboos or restrictions.Menstrual hygiene is an intensely private subject, and there are often strong taboos for women to discuss this topic with men. Continuous engagement and consultation with women, girls, men and boys was critical, to ensure the MHM response addresses their needs and challenges, is appropriate and can adapt when needed.

**Results & Impact**

UNICEF (WASH), Odisha and along with its partner OXFAM responded to 32,000 households in the FANI calamity situation. Unicef leveraged its long-standing association with Odisha Government for humanitarian response and extensive interventions in field. UNICEF strengthened coordination mechanisms and mobilized partners for more effective humanitarian action.

- Men, women and children took action to reduce public health risks by e.g. preventing contamination of, and treating drinking water and practising effective hand washing at key times
- All sections of the affected population made the best use of, and help care for and maintain, the water and sanitation facilities, products and services provided.
- Appropriate hygiene items (including sanitary materials for women) were identified and distributed

- Water quality tests completed within randomly selected households have shown that in most cases the water consumed at Point of Use meets the Drinking Water Quality Standards.

**Challenges & Lessons Learnt**

**Challenges**

- When dealing with communities that lack basic hygiene knowledge and have poor hygiene practices. A lack of understanding regarding pre-existing knowledge of disease transmission, traditional hygiene practices, and hand washingbehaviour prior to the calamity. Such a lack of understanding prevented the intervention from making important pathways regarding appropriate hardware to promote hand washing.
- Since the intervention was across various communities, thsei diversity within the population had additional challenges related to interpersonal communication and adapting messages to address varying bottom line sociocultural practices and knowledge associated with water–related diseases and hygiene.

**Key lessons**

- Hygiene promotion is not to be taken as optional in a water and sanitation calamity response but should be integrated with all the components of the hardware response.
- Hygiene promotion is beyond the dissemination of hygiene messages. It is tobe based on participatory exercises and extensive interaction with the affected communities in order to address issues during calamity.
- Campaigns should be for all target groups such as men, women, children and those with disabilities and based on their requirements should be integrated with to ensure optimal use of facilities.
- Enabling factors such as toilets or soap should also be present to ensure hygiene promotion takes place in the intednde way. Local conducive conditions do affect the likelihood of sustained hygiene practices.
- A variety of methods, media and approaches can be employed to promote hygiene and provide information to affected populations. However, interactive methods may be more successful in mobilizing communities to make the best use of the WASH facilities and to protect their health.