

Hygiene and Sanitation: a practical guide for the project facilitators

Inter Aide Ethiopia, 2008

INTRODUCTION

This guide has been designed to support the facilitator in conveying key messages to the community on hygiene and sanitation – particularly related to diarrhoeas –. It describes the main steps of the hygiene and sanitation component and highlights the key messages, behaviours and methods to keep in mind while conducting the animation. A focus is given to the indicators used by the program and to the way to collect, compile and present them to the communities and the different stakeholders. *Remember that data is only useful if it is used and given back to the community.*

Health awareness is acquired when people can describe how diseases are transmitted in their environment and through their own behaviours. This guide is based on the principle that people can and should understand how diarrhoeal diseases are transmitted, and that this understanding may inspire them to change their hygiene behaviours.

Once people understand how transmission occurs, they can identify the different ways to block the transmission routes, they can also weight the advantages and disadvantages of blocking those routes in their households and communities. The cluster sanitation map can help them diagnose and design an operational plan for the construction of their latrines

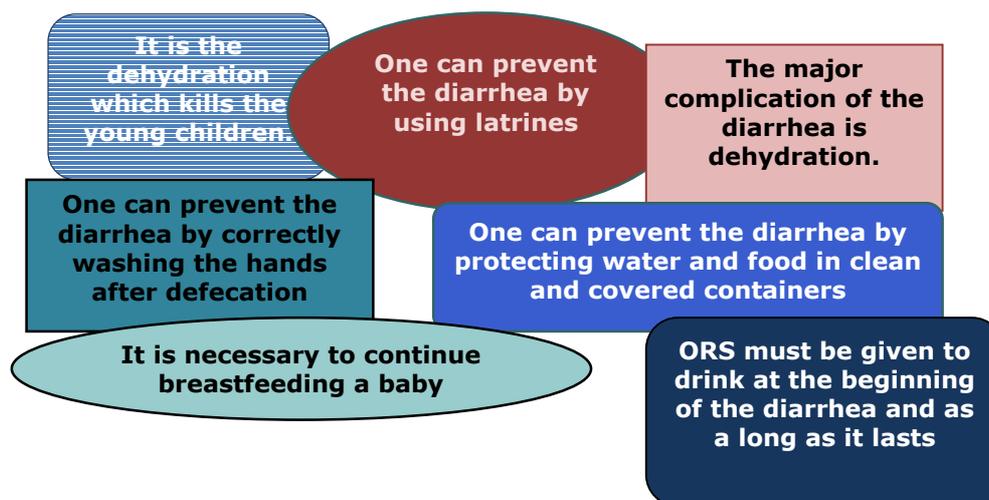
Allowing people to change their behaviours is certainly one of the most complex tasks. Relying on the assets of the community; facilitating discussions, questions and exchanges and being flexible certainly constitute the bases to achieve it...

The key behaviours to prevent diarrhoea

- To have a **safe disposal of faeces** (notably those of babies) in the **latrines** to avoid flies transporting the microbes on the food and to prevent the contamination of rivers by excrements.
- To correctly **wash one's hands after defecation** (with water and ashes) to avoid contaminating oneself or others with the microbes present on the hands
- To **drink potable water** (coming from a protected spring or a well) which does not contain a microbe.
- To **use a clean container** (washed with ashes and rinsed) to fetch water from the water point and to cover the storage container so that water is not soiled.
- To quickly give Oral Rehydration Salts (**ORS**) to children having diarrhoea in order to prevent the dehydration that can be fatal

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The key messages about diarrhoea



The indicators chosen by the program

◆ Sanitation

Access to latrine represents an individual as well as a collective concern. A quantitative indicator on latrine coverage is collected at household level and then aggregated at cluster level:

- ☐ **The presence of latrine by type of latrine** (*No latrine / open pit/ pit with superstructure*) aggregated at cluster level

Respect of basic quality norms must be kept in mind regarding latrines construction. Although not directly collected as indicators, the key recommendations are crucial (see below).

◆ Hygiene

Six indicators are collected at household level:

- ☐ **A safe storage of the drinking water inside the house** (see below)
- ☐ **Hand Washing Facility:** availability or unavailability of a hand washing facility nearby the latrine (or on the way to the latrine nearby the house)
- ☐ **Availability of soap or ash** close to the Hand Washing Facility
- ☐ **Understanding the importance of washing hands after defecation:** to the question *how can diarrhoeal disease be prevented?* hand-washing after defecation with ashes/soap has been quoted

The hand washing practice is assessed throughout 2 combined questions:

- ☐ **The hand washing frequency per day.** Obtained through the question asked to one of the family adult: "How many times do you wash you hands per day?"
- ☐ **The moment of hand washing.** Obtained through the question linked with the previous one "if so, at which moments of the day"

◆ Diarrhoea among children under 5 years old (U5)

The central objective of the hygiene and sanitation component is to reduce the under 5 children mortality rate caused by diarrhoeal diseases. Although more complex to evaluate, two indicators are collected:

- ☐ **The under 5 children mortality rate**
- ☐ **The diarrhoea prevalence**

These two indicators are recorded during the baseline survey. A yearly collection of the same data will allow to have an update vision of the situation and to assess the impact of the intervention.

H&S KEY INDICATORS

Sanitation:

- ☐ Latrine coverage (cluster level) per type (*none, open pit, covered*)

Hygiene:

- ☐ Safe storage of drinking water
- ☐ Hand washing facility
- ☐ Presence of ash or soap
- ☐ Aware of the importance of washing hands after defecation
- ☐ Hand washing frequency
- ☐ Moment for hand washing

Diarrhoea on U5 children:

- ☐ U5 children mortality rate
- ☐ U5 diarrhoea prevalence

The main steps of the intervention

PHASES	ANIMATION DURATION
Community level	
1. Meeting the local actors, definition of the clusters	1 day
2. Baseline survey	½ day + ½ day (feedback)
3. Drama: introducing key behaviours on H&S	1 day
Cluster level	
4.1 The contamination route	1 day
4.2 The cluster sanitation map	
5. Family support: the promotion of simple hygiene rules	2 months
6. Evaluation map	½ day
Community level	
7. Evaluation, feedback and official recognition	1 day

1. Meeting the local key actors

Key idea: Involving the local authorities and civil actors from the beginning to know about possible previous actions and ongoing programs related to latrines and hygiene. Assess the interest and potential of collaboration.

➔ These actors are central for the sustainability and the scaling up of the action.

The main steps consist in:

- Meeting and holding open discussion with the local actors (Health Agents (HEW), Kebele Cabinet members (local authority), Water Committee members, Iddirs' representatives....)
- Know about possible previous or ongoing actions related to hygiene and sanitation
- Present the proposed approach, exchange and assess possible complementarities
- Assess the interest of these actors to collaborate with the program

2. The baseline survey

The baseline survey aims at collecting key indicators at the onset of the intervention to have a better idea of the initial situation and to get a comparative basis to assess the project impact.

During the baseline survey, **7 questions** are raised to the family:

1. Name of the family head
2. Widow headed family (yes – no)
3. Size of the family (people living in the tookoul)
4. Number of children below 5 years
5. Number of children below 5 years died during the last year (by identified cause: diarrhea, fever and other)
6. Number of children below 5 years having diarrhea today
7. Access to latrine (no latrine, simple pit or covered latrine)

These questions allow to measure, at a given time, **the under 5 children mortality rate, the under 5 children mortality that can be attributed to diarrhea, the diarrhea prevalence** and the **access to latrine** at the onset of the intervention. The question related to widow-headed family gives an idea of the need for collective support schemes.

A specific format has been design to collect and aggregate the information (see the appendix). Ideally, **this set of data can be collected by one or several member(s) of the community depending on its size** (not by the facilitator). A basic training, to make sure that the "community surveyors" have well understood the questionnaire, and to practice filling it, must first be organised.

It is crucial to then give a feedback of the survey results to the community (at least to the representatives) and to discussed the figures collected. At project level, the information can be globally summarised and reported as follows:

COMMUNITY	POPULATION			Under 5 years old children				LATRINE		
	HH	population	Widow headed families	Total U5	U5 died last year	U5 died because of diarrhea	U5 having diarrhea	No	Simple pit	Covered
Sadoye 4	34	189	5	72	2	1	4	8	19	7
Sere Esho 1	120	704	17	218	3	1	2	69	28	23
...										

3. A drama on hygiene and sanitation

The main purpose of this drama is to introduce hygiene and sanitation key elements.

The drama makes a comparison between 2 opposite families: one applying good behaviours and the other risky ones. The drama is prepared with and played by some volunteers of the community (generally students).

A first part describes the family practising risky behaviours and lasts about 20 minutes.

Scenario 1: In this part, a facilitator comes to visit the water point. He meets a woman who is fetching water, without cleaning the fountain and her pot, then covering it with dirty leaves of tree. He/she advises her to take care about three points: *keeping the water point cleaned, cleaning the inner part of the pot before fetching and not covering the pot with leaves*. She refuses his advices and jokes on him. At the same time, other users are fetching without waiting their turn, which leads to a fight and a pot is broken.

Another time, the facilitator visits the woman who was joking on him. He/she finds a very dirty house, and her son who is sick and has diarrhea. The son is brought to the clinic and they find out that his disease is due to poor sanitation and poor water quality. They have to sell a goat to buy the medicine.

A second part shows a family who has adopted the basic hygiene and sanitation behaviours. It lasts about 20 minutes as well.

Scenario 2: At his first visit to the water point, the facilitator sees an organized community: people are fetching water turn by turn, everybody bringing some tools to clean the water point.

A second visit brings him to a family. The son has cleaned everything, while the mother was fetching water. The facilitator observes also that pot and cups are not on the floor but on a special seat, and that the container of drinking water is covered. The family members invite him to drink coffee, and show their high motivation for sanitation. He congratulates them before leaving.

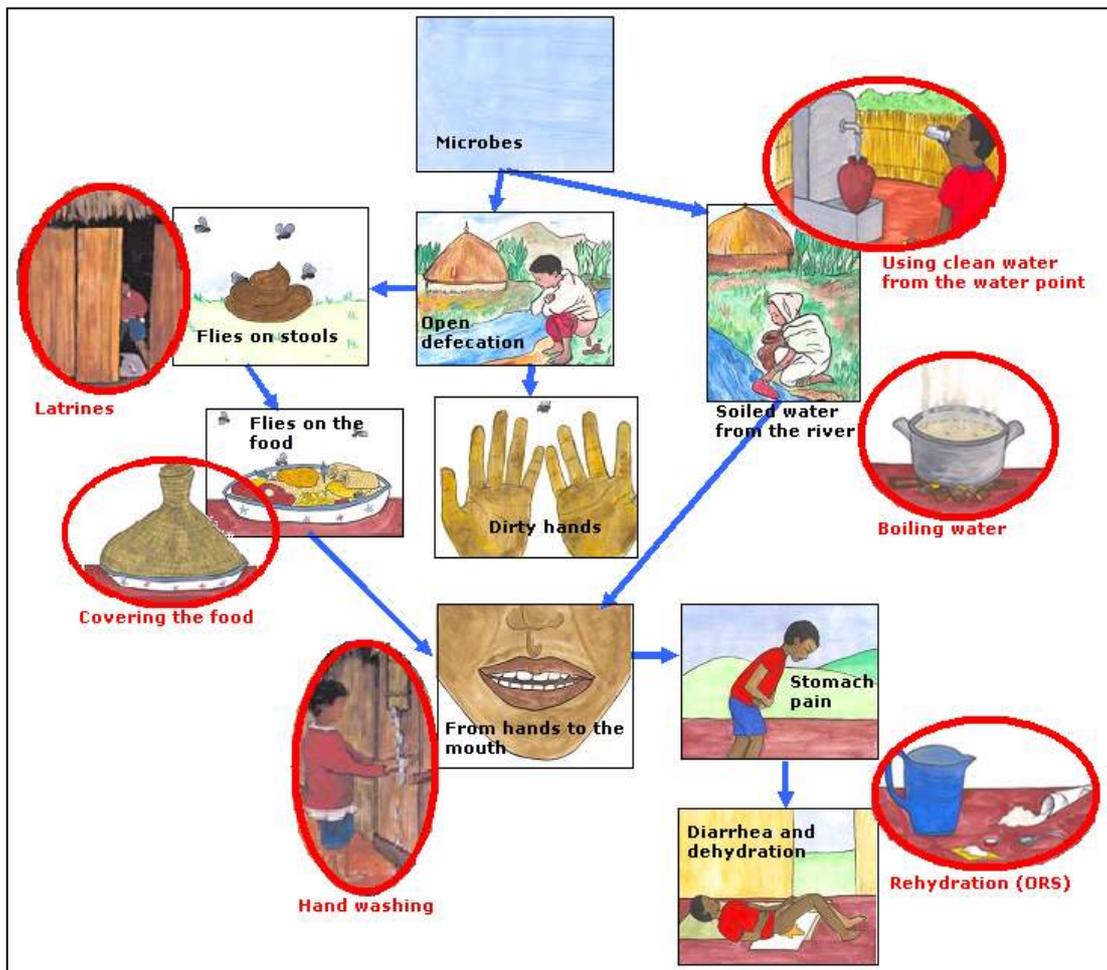
A discussion is then held with the community to interpret what they have seen, what is their feeling about it, why was the son sick in the first scenario, where they would classify their community, what are the most important messages for them...

Progressively, the discussion is oriented about "what remains to be done in their community, now that there is clean water, regarding sanitation, hygiene and more globally, diarrhoeal diseases prevention?".

4.1 The contamination route

The contamination route is a participative game to facilitate the understanding and exchanges on diarrhoea contamination as well as the ways to prevent it. This animation is more specifically organized for the mothers of young children. It focuses on three topics:

- Understanding how diarrhoea is transmitted
- The preventive behaviours (how to block the transmission of diarrhoea)
- The diarrhoea affecting young children, dehydration and ORS



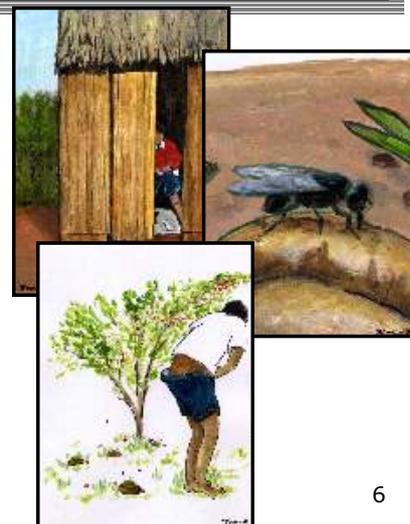
Two essential behaviours to prevent diarrhoea

The participants have understood **the importance of stopping open defecation and of washing their hands after any contact with the stools.**

The program can help them in the implementation of latrines in their community

Diarrhoea is transmitted by microbes that are micro-organisms, too small to be seen by the human eye. The discussion should explain that there are big quantities of microbes in the stools. These microbes can be spread in two ways:

- by the flies coming on the stools that can, after flying away, deposit the microbes on unprotected food.
- The hands (after defecation or after washing the buttocks of the baby) which remain dirty and can transmit the microbes: indeed a young child often puts his hands in his mouth (while playing, eating fruits...), adults also have frequent occasions of bringing their hands to their mouth.



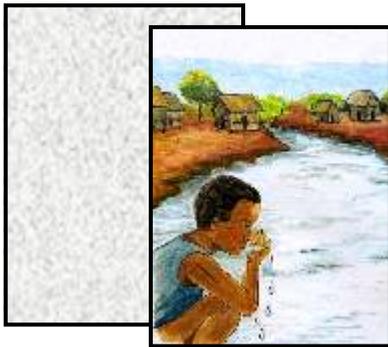


Finally, by exchanging ideas, the participants can imagine together how to prevent the dissemination of microbes:

- by stopping open defecation and by **using latrines**
- by correctly **washing their hands with water and ashes after every contact with stools** (one must not to forget the situation of mothers cleaning their babies' buttocks).

Drinking clean water

The participants have understood that, if the microbes are very numerous in the stools, they are also present in the river water. They perceive the difference between water coming from the river and from the water point.



The discussion between the participants must point out the idea that diarrhoea is due to microbes present in the stools **but also in water**. A comparison between the quality of the water of the rivers and the water of the water point can be done:

- The water of the river can be soiled. With an image, the facilitator can show that if there are stools on the riverbank, the rain will carry the stools into the river which will then be polluted.
- On the opposite, the water from the water point comes from a protected spring box from the mountain. It has not been soiled as it is nowhere in contact with the outside environment. The water is collected in a closed box avoiding external contamination. Then, a pipe

brings the water down to the fountain. Thus, from the spring to the water point, the water is protected and cannot be polluted. One is not likely to swallow microbes when drinking it.

Don't forget to mention that if clean water is fetched in a dirty bucket, it will become soiled. It is thus very important to **clean the bucket with ashes** (or soap) and to **cover it to avoid contamination during transportation and storage**.

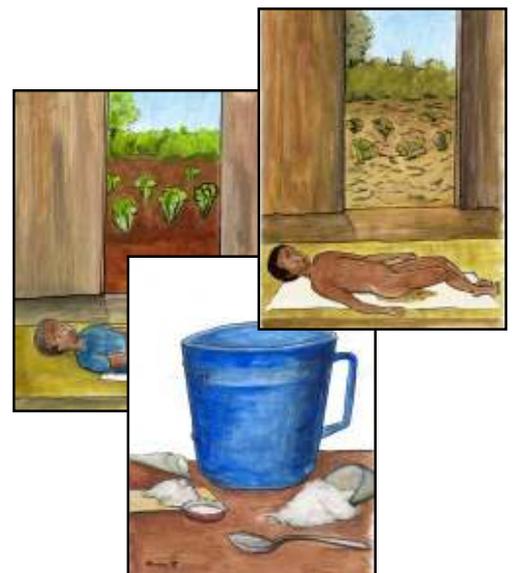
Preventive treatment of dehydration

Before starting the discussion, it is important to point out that diarrhoea is a frequent disease affecting the children. It is serious and even sometimes mortal. The facilitator can ask the participants to precise the signs of diarrhoea: soft or liquids stools, frequent and abundant (4 to 6 per day).

Recognize diarrhoea among their children
Measure the first signs of dehydration
Give the preventive treatment of this dehydration (ORS)

In case of diarrhoea, one must be alarmed by the water loss (illustration showing a dehydrated child and dessicated plants). One must make it clear that the water that is lost in the stools contains all the elements enabling the body to live, to grow (vitamins, sugar and salt...)

When the water loss is important the body does not have anymore "fuel" to work correctly. The child becomes weak, does not play more, and does not eat anymore... If the diarrhoea lasts several days, the water loss increases, the body dessicates ("dries") and, as a plant which is not irrigated, the patient is likely to die.



It is then important to specify that one can avoid this evolution by quickly replacing the lost water. Talk about the ORS (Oral Rehydration Salt) and tell that ORS is available from the Health Extension Worker or in the health posts.

The ORS must be given to the child as long as the diarrhoea lasts. If the situation of the child does not improve quickly, a nurse must be consulted at the health post or the health centre.

In addition, specify also that it is necessary to continue to breastfeed the infant affected by diarrhoea and to continue feeding and giving fluid to the older child.

4.2 The Cluster Sanitation Map

...a participative tool to facilitate a collective diagnosis of access to latrines

What is the cluster sanitation map?

The cluster sanitation map (CSM) is a participative tool for the families to visualise and establish a diagnosis of the current latrine coverage. It also helps them to design and follow the implementation of a global sanitation plan to stop open defecation. Focusing on neighbouring families (cluster), the CSM comes from the idea that changing the behaviours related to the use of latrines requires to work both at the individual and collective level. Working with cluster of families living close by to each other is coherent as these families are concerned by their nearby environment; targeting smaller groups also makes the animation easier and more efficient.

The cluster sanitation map: a participative tool drawn by and for the community

The CSM constitutes a specific animation; it focuses on facilitating access to latrines for all. As the CSM is conducted after the transmission route game, it means that the community has previously expressed its wish to stop open defecation.

Main steps

The following table summarizes the main steps of the intervention that are detailed below:

Preparation	✓ Organise the village into clusters
Diagnosis and design plan	✓ Draw the map
	✓ Establish an initial diagnosis
	✓ Design a sanitation plan
	✓ Display the map in the community
Implementation	✓ Support the implementation of the plan
	✓ Assess the progress
Institutionalisation	✓ Define a local policy on the use of latrines

PHASE 1: PREPARING THE INTERVENTION

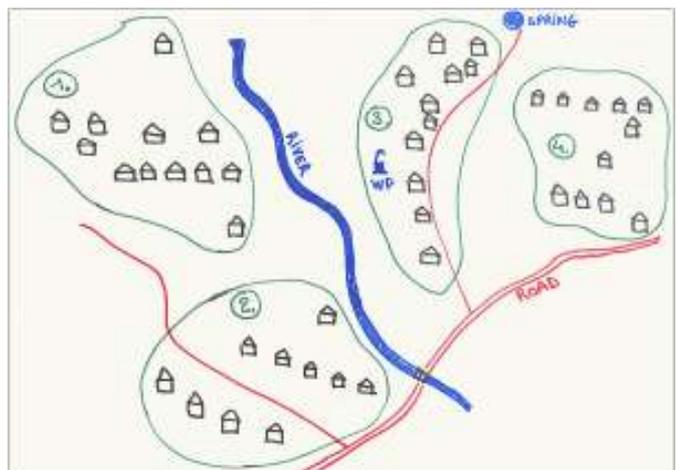
1. Preparation: "clustering" the village

Key idea: A cluster corresponds to a group of neighbouring habitations equally exposed to diarrhoeal contamination risks caused by open defecation. Usually composed of 10 to 30 families, a cluster consists in a group of houses located on the same side of a hill, or separated by streams or by roads. In a scattered housing pattern, clustering the "village" allows to consider the problem of open defecation in a logical way (both geographically and socially). The basic idea is first to mobilise the people on a "cleaned" cluster before scaling up the action at village level to progressively reach a total sanitation coverage.

Steps to be conducted:

- Walk around the "village" with the local actors to see possible clusters
- Draw the map of the entire village and roughly indicate the housing
- Define the clusters

Illustration: *four clusters have been identified for the community. The animation will be organised for each of the four identified clusters.*



PHASE 2: DRAW THE MAP, ESTABLISH A DIAGNOSIS AND DESIGN A SANITATION PLAN

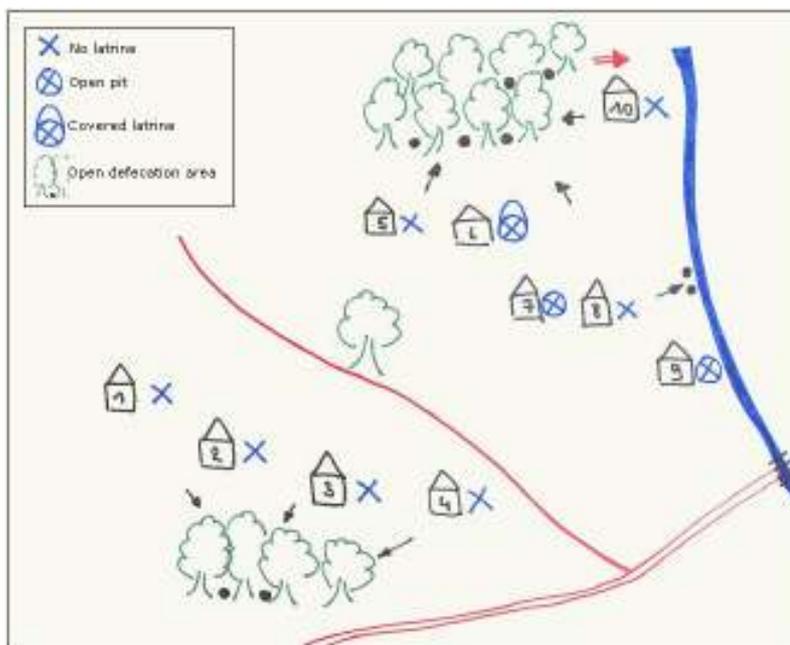
2. Drawing the map

Key idea: A cluster map is drawn by the community to visualise the current situation regarding access to latrines.

Steps to be conducted:

- Designate one or two person willing to draw the map on a large paper (60 x 40 cm by example). Keep some free place in one corner that will be used to add two or three small boxes to indicate the latrine coverage at different moment (see below)

- Ask the people to indicate the boundaries of the cluster, the rivers, ponds, streams, road, path, springs, water sources, the woodlands...
- If any, indicate the schools, churches, health facilities, market places...
- Then ask the people to map all households. To avoid confusion, a number can be given to each house and reported on another paper or on the corner of the poster with the name of the family head.
- For each house, indicate whether they have latrines or not using the three signs: "no latrine; open pit latrine; covered latrine"
- Indicate also the traditional places for open defecation in connection with the concerned households. Ask to point out possible ponds or water sources exposed to contamination.

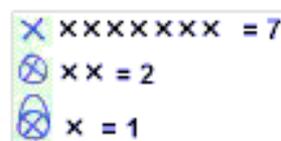


3. Establish a diagnosis of the current situation

Key idea: based on the map, the participants make the diagnosis of the current situation regarding access to latrine and open defecation. This initial diagnosis will serve as a reference for further evaluation the progress made by the community.

Main step:

- Count the number of houses having no latrine, open pit and covered latrine. Ask the participant to make the total and to indicate it in the corner of the map
- Propose to the participants to express their feeling about the results.
- A community walk can be organized so that other additional points can be added on the map

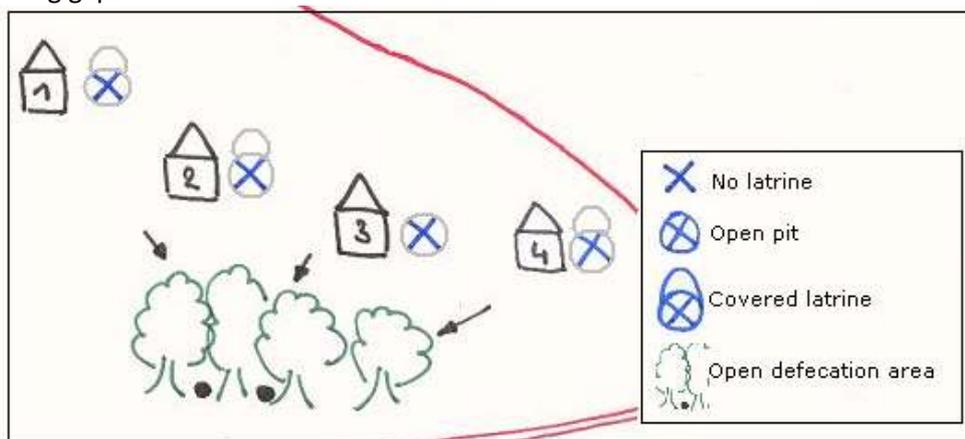


4. Design a sanitation plan

Key idea: from the diagnosis done with map, the participants establish an action plan. Using a pencil, they can visualise their plan and the expected impact on the cluster sanitation.

Main step:

- Facilitate a participatory design of the solutions. If necessary raise practical questions to help the community (*where are the priorities, how will the widow headed houses build their latrines, how to encourage children to use latrines, how to organise the work, collectively or individually, how to mobilise more reluctant persons...*)
- Indicate on the map, using a pencil, the agreed plan to visualise the potential impact and the remaining gaps



- Propose the designation of a "sanitation volunteer" who will represent the cluster for sanitation matters and facilitate (with the help of the facilitator) the implementation of the plan.

Considering widow headed families

Widow headed houses and families lacking labour forces need to be collectively considered. Relying on the Iddir or the Kebele Cabinet or simply the neighbourhood, solidarity actions can be considered such as: provision of bamboo, straw and grass for thatching the latrine room, providing labour to dig the pit...

5. Display the map in the community

Key idea: to keep the map displayed within the cluster so that the members can regularly consult it and adopt it.

Main step:

- ask the group to display its map in a place where it can be seen by the whole community (i.e.: health post, Iddir's representative house)
- propose them to present it to people who were absent during the animation, youths, children...
- explain that the map will be used again as a reference for future steps.

PHASE 3: IMPLEMENT THE CLUSTER SANITATION PLAN AND ASSESS THE PROGRESS

6. Support the implementation of the sanitation plan

Key idea: accompany the families in the construction or improvement of their latrine. Give the members the opportunity to raise questions related to hygiene and sanitation.
This support can be given throughout the house-to-house visit process.

Main step:

- Conduct, with the sanitation volunteer, a house-to-house visit. First ask people's permission to discuss with them.
- Organise cross-visits to allow people getting ideas on "latrine models" from their neighbours

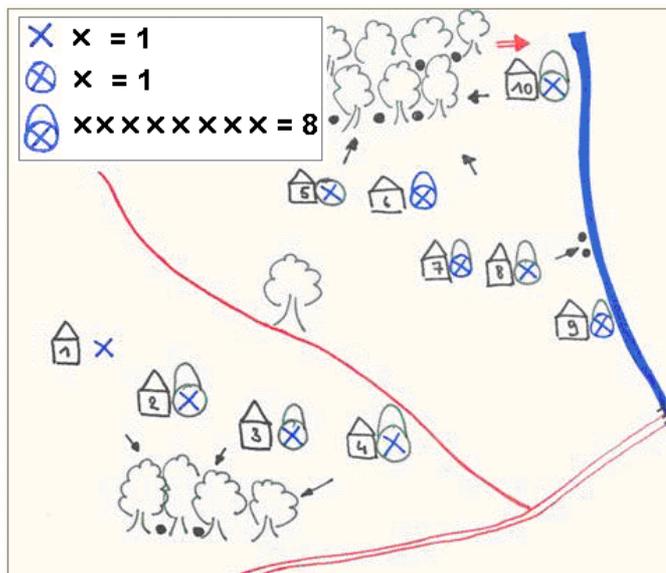
<p><u>Qualitative specifications and recommendations for latrines' construction:</u></p> <ul style="list-style-type: none"> Distance from House: minimum 15 m downstream from the house No flooding risk: latrine site elevated to avoid any risk of water entering in the pit. Flies prevention1: a slab made of wood and clay prevents to see the pit and the flies to enter inside Flies prevention2: the hole has a cover. Pit: 3 m deep with a conic form (smaller diameter at the bottom to avoid collapsing) Cover: roof and walls made of wood and grass, allowing an adult to stand-up inside <i>Soil and ash can be used to cover the faeces (ashes reduce the smell)</i> 	
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7. Assess the results: evaluation on the map

Key idea: help the community to evaluate the implementation of their plan, to exchange on the progress made and the remaining gaps and, possibly, to reorient or plan further sanitation actions.

Main steps

- Ask the people to update the initial map using a different colour on the map to visualise the progress made. *One colour is used for the initial diagnosis; a pencil is used for the plan and a different colour for the implementation.*
- Ask the people then to compile the results and to indicate it in the corner below their initial counting.
- Propose the participants to compare the results with the plans, to comment it and, possibly, to update their plan and plan additional actions to reach a global sanitation coverage.



5. Families follow-up

... support the family in the acquisition of basic hygiene behaviours

The objective is to help the families acquire new behaviours to decrease the incidence of diarrhoeas.

The family initial diagnosis

This first meeting focuses on identifying with the concerned mother the list of what goes wrong, of the risky behaviours while explaining these risks and underlying that it is possible to improve this situation.

The criteria's to accompany the family

One should not seek to obtain changes related to behaviours that cannot be evaluated. It is necessary to limit to the behaviours of the day-to-day life that take place in the house and that can easily be observed:

- the family only drinks water fetch at the water point
- the container for drinking water storage is correctly cleaned and properly covered
- the mother knows about ORS (property, composition, indication)
- the family members use their latrines
- the family members wash their hands after defecation and before manipulating food

Water storage: two safe storage options:

1. Traditional Storing system (pot) with the following specification:

- 30 cm above the ground (to prevent children from putting their hands in the water)
- 50 cm away from the wall
- Covered by plastic plate (not leaves)
- One cup is present in order to fetch water in the pot and to wash
- one pot is present to drink

2. Plastic Jerrican : clean jerrican only for clean water storage purpose (drinking/cooking water)

- 50 cm away from the wall
- Safely closed with a coat

➔ **Storage pot or jerrican are washed every time one goes to fetch water or before refilling**

It is not a question of changing all in once but to define with the family some top priorities which one will try to gradually achieve during the period of accompaniment.

Duration of the family support

After knowing better the family, one can set a determined time needed for the follow-up. The objective is not the support in itself but the durable modifications of the family's behaviours. After a few weeks, it is advisable to redo a diagnosis and to evaluate whether additional support to this family is needed or not.

• Positive outcome

It means that the family has well understood the key messages and have adopted the new behaviours on a daily basis. The family has become autonomous and does not need to be accompanied anymore. It is reasonable to think that the family has acquired the new practices.

• Extending the support

The family encounters some difficulties to understand certain messages or to apply them. However the facilitator perceives that the family is receptive and has the willingness to change their practices. Maybe additional support is needed. Based on these criteria, the facilitator decides to extend the process started. He believes that with additional support, this family will be able to reach the situation described above as "positive outcome".

• Negative outcome

After a sufficiently long period of follow-up, the facilitator notes that nothing or almost nothing changed. He/she wonders whether he/she did his/her work correctly. If he has done his work correctly, the failure of the support can be acknowledged. It is necessary to inform the family and to mention that, at any time, the Sanitation Volunteer will be able to help the family to improve their sanitation and hygiene practices if they wish to.

6. Evaluation, feedback and official recognition

...help the community to evaluate the progresses made on hygiene and sanitation

Sanitation: *auto-evaluation of the latrines coverage at the level of the cluster*

This evaluation is carried out by the community (auto-evaluation) after the community has implemented its plan, by example three months after the cluster sanitation map was drawn. The participatory evaluation should involve as many people as possible from the community as well as other community workers, officials, and perhaps representatives of neighbouring communities. The sanitation map is a good tool to help the community conduct this evaluation. It allows the community to assess where they are as compared to their sanitation plan; to what extent their area is “sanitised” (free from open defecation).

During the evaluation the group will identify:

- how much has been done in the community
- how much of the plan still needs to be done
- what has been successful
- any problems or difficulties encountered
- any corrective action that is needed

Also ask the group to record (in drawings or words) the problems and sort them into:

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

On the basis of this information, the group can then update or adjust its plan and discuss remaining problems with other actors (kebele cabinet, health extension workers...)

Hygiene: the results are measured at the individual level by the families who have expressed their wish to collaborate with the program. It is a review done by the family (preferably by the mother) of the key hygiene behaviours to prevent diarrhoea transmission. It concerns:

- safe water storage
- awareness of the necessity of hand-washing
- availability of a hand-washing facility
- availability of ash or soap
- consistent hand-washing practice
- knowledge of ORS indication

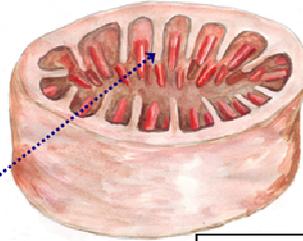
Results can then be aggregated to assess the efficiency of the program more globally. Do not forget to systematically feedback the results to the community and to the main stakeholders.

Officialise the changes made

Once the changes occurred within a community, an official recognition can encourage the efforts made by the community. Recording these results official is a relevant form of recognition. Giving an official recognition is the responsibility of the public sector, namely the local authorities or the health instances. This recognition is particularly relevant in the context of collective concern and notably the use of latrines to stop with open defecation. The decision to record the change in the local society is the local actors’s responsibility. Giving a feedback of the progress made can support the establishment of relevant community rules. The community leaders can then decide on a policy to durably record the changes in the long run.

Appendix A: Understanding the physiology of diarrhoea

It is in the lumen of the intestine that occurs the absorption of the nutrients (proteids, glucids and lipids) and of the water they contain.



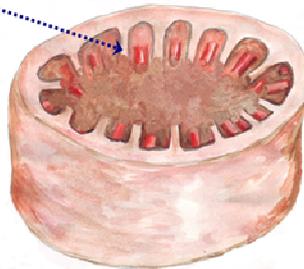
And more precisely at the level of the **intestinal villosities**.

A cross-sectional diagram of the intestine showing a villus with a blue tube representing a blood vessel. Red arrows indicate the movement of nutrients from the lumen, through the villus wall, and into the blood vessel.

The nutrients cross the **wall of the intestine** penetrate in **blood circulation** in order to nourish the various organs of the body (heart, brain, muscles.)

When microbes penetrate in the intestine, they destroy **intestinal villosities**.

The water and the nutrients are not absorbed anymore.

A cross-sectional diagram of the intestine with a blue tube representing a blood vessel. Red and green arrows show the movement of substances between the lumen and the blood vessel, illustrating an inversion of the normal exchange process.

Modifications of the osmotic pressure between the spaces (intestinal and circulatory) cause an **inversion** of the exchanges

A cross-sectional diagram of the intestine with three blue arrows pointing downwards from the lumen, representing the excretion of water.

The water is **excreted** by the intestine causing the diarrheaa

Appendix B: Hygiene and sanitation in the intervention chronogram

1. Reception of a written request	
	<i>A written request is addressed by the community and validated by the Water Office</i>
2. First Contact	
	<i>Discussion about the request motives, first exchange and mutual presentation (the community, the WO and the project)</i>
3. Technical and Social preliminary feasibility survey	
	<i>Assess the technical feasibility (spring characteristics, perennality, first yield measurement, quality of the water, contamination risks, topography) and social feasibility (number of beneficiaries., estimated cost range per benef., community mobilisation and motivation, origin of the request, authorisation of spring field owner)</i>
4. Initial animation process (meeting 1 to 6)	
	<i>Discussion on the benefits of accessing clean water and better sanitation. The project methodology. The main steps of the collaboration. The Water Committee and its role. The place of the women in the Water Committee. The Hydraulic Agents and their roles. The objective of fee collection and maintenance provision. Definition of the amount. The financial management (global overview). Definition of the internal rules. Material and preliminary work required. The location of the water point. Preparation of the Contract.</i>
5. Detailed technical study	
	<i>Detailed technical survey (topographic survey; network profile; pipes types, PN and diameter; defining the elements of the system and their position; specification of the material needed; specification of the material to be prepared by the community; definition of the site schedule for the technical team and the community)</i>
6. Detailed social survey	
	<i>Baseline survey on current hygiene and sanitation practices</i>
7. Contract signature	
	<i>A contract between the community, the Woreda Water Office and Inter Aide is established, understood and signed by all involved actors. The requirements to start the construction phase are completed.</i>
8. Site preparation	
	<i>Preparation of the material by the community and completion of the work to be done before the construction</i>
9. Construction of the water supply system	
	<i>Construction of the water system (springbox, tank, different boxes, waterpoint elements, pipeline...) and practical on-site training of the Hydraulic Agent and the Work Committee during the whole construction</i>
10. Site closure	
	<i>The community, the project and the WWO validate the respect of the specifications of the water system scheme. After validation, the water is connected to the system and a guarantee period of 2 years enters in application. Conduct water quality analysis and feedback the results. Presentation (reminder) of the post-construction process and schedule</i>
11. Training of the Water Committee: management of the system	
	<i>The role of the Water Committee and of each function, how to collect and manage money, how to identify and find ways to solve problems (maintenance and community problems), strengthening the responsibilities of the WC</i>
12. How to maintain the water system (drama for the whole community)	
	<i>What is maintenance, and how to organise the maintenance of the water supply system</i>
13. Changing hygiene and sanitation practices	
	<i>Meeting with involved actors and definition of the sanitation clusters About hygiene and sanitation (drama for the whole community and discussion) The contamination route (participative game - cluster level) The Cluster Sanitation Map Implementing the cluster sanitation plan House to house visit – the promotion of simple hygiene rules (hand washing, safe water storage and latrine) The Cluster Sanitation Map: evaluation – what remains to be done Defining sanitation rules and policies (community level)</i>
14. Stakeholder evaluation as regards to the signed contract	
	<i>After having conducted the post-construction package, evaluation of the Water Committee and the community capacities toward autonomy. Define the content of the selective support phase</i>
15. Toward autonomy: follow-up and selective support	
	<i>Regular assessment and on-field support and training helping the Water Committee and the community to reinforce their capacities. Financial follow-up carried out by an external auditor (WWO) on biannual basis</i>
16. Recognition of the community autonomy (system maintenance and H&S)	
	<i>The Water Committee and the community manage the water system and the sanitation facilities autonomously. The intervention of the project and guarantee period end. The institution in charge for heavy maintenance and support is the WWO</i>

Note: the steps labelled in red are related to hygiene and sanitation