15. Health promotion and community participation

15.1 Definitions

This chapter presents two aspects of disaster management that are essential to all the technical and management aspects presented in previous chapters: community participation and health promotion. In this book, the following definitions are used:

Community participation

Community participation is the active involvement of people from communities preparing for, or reacting to, disasters. True participation means the involvement of the people concerned in analysis, decision-making, planning, and programme implementation, as well as in all the activities, from search and rescue to reconstruction, that people affected by disasters undertake spontaneously without the involvement of external agencies. While the opportunities for community participation may vary greatly from place to place and at different points in the disaster-management cycle, a participatory approach to disaster-related activities should be promoted to achieve sustainable development.

Health promotion

Health promotion was defined in the Ottawa Charter as "the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being" (World Health Organization 1986). In the context of disaster management, health promotion involves working with people to prevent, prepare for, and respond to disasters so as to reduce risk, increase resilience and mitigate the impact of disasters on health. Community participation is the basis of successful health promotion.

Health education and hygiene education

Health education is one important activity that is commonly undertaken to promote health. It is the communication of information that enables people to make informed decisions about health-related activities at all stages of the disaster-management cycle. Health education might involve subjects such as the risk of flooding in areas where people are building houses, the location of earthquake shelters, or the areas where safe defecation is possible in a new emergency settlement.

Hygiene education is concerned specifically with communicating on those areas of health that are related to water supply, sanitation, vector-borne disease control, and hygiene practice. Following a disaster, hygieae education is particularly important for reducing the risk of communicable disease and its transmission.

Hygiene promotion

Hygiene promotion follows the same approach as health promotion, in that it is concerned not only with the transmission of information, but with understanding and promoting the capacities of people to improve their own health, chiefly through their ability to: make best use of prevailing environmental-health conditions and existing services and facilities; act to improve environmental-health conditions; and make behavioural changes to reduce certain environmental risks at the household level. Hygiene promotion is concerned with achieving improvements in health through the joint efforts of individuals, families and communities on one hand, and external agencies, health authorities, etc. on the other. It is a process in which environmental-health conditions and hygiene-related behaviours are assessed, and changes in conditions, services and behaviours are achieved. A key feature of hygiene promotion is that it depends for its success on the careful analysis of people's constraints, opportunities and strengths in any situation, to seek solutions to hygiene problems that are realistic and appropriate to people's desires and ways of living. Recent work on hygiene promotion in development and emergency situations has underlined the advantages of hygiene promotion over the more traditional and narrower approach of hygiene education and health education (United Nations Children's Fund, 1999; Ferron, Morgan & O'Reilly, 2000).

In this chapter, the terms hygiene promotion and hygiene education are used broadly to include aspects of health, such as avoiding exposure to all types of hazards, as well as aspects more narrowly defined as relating to hygiene, such as the control of communicable diseases in an emergency.

15.2 Hygiene promotion and community participation in the disaster-management cycle

Vulnerability reduction is achieved not solely by physical measures to mitigate the destructive effects of a hazard. Social measures that help to reduce negative impacts and enhance the resilience of the population are also essential. Safety and health promotion, environmental awareness, and the strengthening of community organization are essential elements in helping people to become less vulnerable to emergencies and disasters.

Moreover, the success of any technical intervention—whether before or after a disaster strikes—depends on the way that it is received and used by the community involved. People must be consulted about their needs and wishes, and be involved in planning as well as in implementation. Their knowledge and capacities must be acknowledged and strengthened as appropriate. Community participation is thus an essential element in emergency-management planning (see Section 3.5.4).

Health promotion and community participation activities are important at all stages of the disaster–management cycle, before and after disaster events, as follows:

- **Emergency prevention and preparedness**: community participation in assessing risks and vulnerability; promoting awareness of environmental hazards and safety consciousness; and strengthening community resilience and organization. Awareness raising and training are essential aspects of disaster mitigation and emergency preparedness.
- **Emergency response and recovery**: community participation in the response phase and in the communication of specific health messages in the immediate aftermath of a disaster; ensuring sustainable and incremental improvements in environmental health.

Emergency prevention and preparedness are rarely followed immediately by an emergency requiring a response. Prevention and preparedness programmes should therefore

promote environmental health and support the development needs of communities, regardless of the benefits that they may offer if an emergency occurs. These programmes should be part of the ongoing development activities of communities.

The occurrence of a disaster produces a fundamental change in the way that a community functions. In a relatively short time, the health needs of the people, their capacities to respond, and the community support available to them may change dramatically. Much of the success of emergency management depends on the ability of prevention and preparedness programmes to mobilize people at risk and help develop their awareness and knowledge about managing the hazards they face. The opportunities and needs for community participation and health education in the various phases of emergency management are summarized in Table 15.1.

15.3 Community participation

The involvement of the community is essential for reducing vulnerability to disasters, for facilitating recovery after a disaster has struck, and for stimulating community organization that is the basis for sustainable development.

Both research and practical experience have shown that people are most committed to implementing programmes that they have helped plan. This is as true of disaster-related programmes as of any others. People should be encouraged to take part in identifying the hazards that they face, in assessing their own vulnerability, and in planning ways to increase their preparedness for a disaster. For example, representatives from a community may be invited by emergency-management planners to inspect the area that they inhabit. They may be asked to discuss existing or potential health hazards and to identify vulnerable people and places. This will achieve two very useful objectives:

- Emergency planners will gain very detailed information about local hazards and vulnerability.
- Communities will become more aware of the health risks that they face.

Communities should also be involved in planning environmental-management programmes that seek to reduce the risk of disasters.

The best way for a community to increase its preparedness for, and recovery from, a disaster is to develop strong community organization and leadership with experience in mobilizing its members and coordinating programmes. It is important, therefore, that vulnerable communities are supported with community development programmes *before* a disaster strikes.

However, even where there is no history of strong local organization, community participation should be an essential part of disaster relief and recovery. In an emergency, when rapid action is needed, it is all too easy for the providers of relief to make assumptions about people's priorities. In the immediate aftermath of a disaster, it may indeed be difficult to set up an effective mechanism for consultation and participatory planning. Nonetheless, every effort should be made at least to establish the principle of consultation and participation, which can then be developed over time.

A major disaster can sometimes provide a unique opportunity for reinforcing community organization. People have their own ways of coping with disasters. They are not helpless or passive. Forms of organization emerge spontaneously after a disaster (see Box 15.1), producing new leaders who are able to inspire and mobilize their communities. Building on this new leadership can be a useful way of promoting community involvement in long-term development programmes. However, care must be taken to avoid increasing the influence of leaders who are not motivated by the well-being of the affected community.

Table 15.1 **Opportunities and needs for community participation and hygiene promotion in disaster management**

Disaster-management phase	Community factors	Time factors	Opportunities and needs for community participation	Opportunities and needs for health promotion
Prevention	Baseline situation	No special limitations	Identification of community leaders and groups Identification of health problems Identification of emergency health hazards Study of safety and health beliefs and practices	Preparation of messages based on existing problems and practices and potential emergency health hazards Adaptation of methodologies to actual and potential needs Promoting good health practices in community development and everyday life
Preparedness	Baseline situation	Few, if any, limitations	As above, plus identification of emergency preparedness needs and allocation of responsibilities Training of volunteers and health professionals	Preparation of additional messages geared to emergency health-response strategy
Emergency response	Unstable but adapting	Limited or severely limited	Community cohesion sometimes affected Family units, neighbours, etc. will be essential in search and rescue Heavy reliance on volunteers and trained professionals in the identification of needs and priorities Community participation in assessment of situation and definition of response	Review of actual health situation as modified by the emergency Strong focus on basic emergency health needs Identification of specific messages and communications methods appropriate to the situation Adjustment of health-promotion activities to prevailing environmental health conditions and scarcities, if any
Recovery	Setting into new situation	No special limitations	Community leadership may be strong, loose, evolving, or in turmoil. If necessary, adjustment of community participation plan based on lessons learned in the preceding phase	Use of messages based on problems and practices associated with recovery phase Gradual blending into more stable conditions, focusing of health-education messages on differences from pre-emergency situation, if any Need to deal with psychosocial problems of unsettled situations and uncertain futures
Long-term postemergency situations	From unstable to settled	No special limitations	Identification of new needs for health leadership Building on solidarity of small units (families, tribal groups) to accept responsibilities in protecting environmental health Replacement of traditional channels of communication affected by the emergency	Building a sense of community responsibility in protecting the environment Focus on disaster preparedness and prevention

15.3.1 Principles of community participation

Community participation means the involvement of people from the earliest stages of the development process, as opposed to simply asking their opinion of project proposals that have already been developed, or for their contribution to the implementation of projects imposed from outside.

Participatory approaches have been widely tested in the fields of water, sanitation and hygiene, and experience has shown that involvement of the community can produce wide-ranging benefits. The main principles are:

- Communities can and should determine their own priorities in dealing with the problems that they face.
- The enormous depth and breadth of collective experience and knowledge in a community can be built on to bring about change and improvements.
- When people understand a problem, they will more readily act to solve it.
- People solve their own problems best in a participatory group process.

Community-focused programmes therefore aim to involve all members of a society in a participatory process of: assessing their own knowledge; investigating their own environmental situation; visualizing a different future; analysing constraints to change; planning for change; and implementing change. As shown in Figure 15.1, the success of participatory action depends on a continuous community dialogue, where provisional goals are set and tested, subsequent action is based on analysis, research, and education, and experience is fed back into the process.

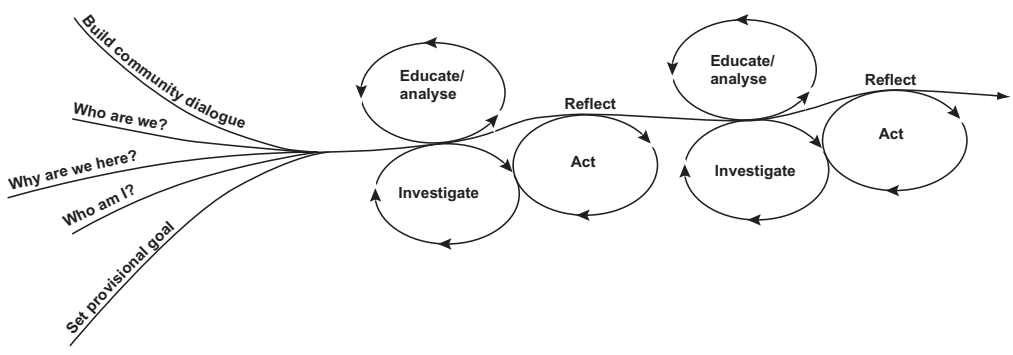
Box 15.1 Spontaneous organization by Salvadoran refugees[1]

Refugees from El Salvador, arriving in Honduras in 1981–1982, quickly set up camp committees responsible for ensuring that their concerns were represented before the United Nations High Commissioner for Refugees and the nongovernmental organizations that became involved. In time, subcommittees were formed to deal with specific issues, such as public health, sanitation, hygiene and education.

Refugees who had arrived as illiterate farmers soon acquired effective skills in management, administration and negotiation, and built up a sustainable social structure on which they would build on their return to El Salvador.

[1] Source: Oxfam (1995).

Figure 15.1 **The process of participatory action**



15.3.2 Obstacles to community participation

While past experience has taught the value of community participation, it has also highlighted the difficulties of mobilizing people. These difficulties are summarized here:

Apathy and disempowerment

There are real difficulties in involving people who are not used to making decisions, who feel powerless, who are apathetic or who are dependent on others. Those in authority may be unwilling to allow people to participate in decision-making. Political, religious and commercial interests may discourage participation.

Conflicts and divisions

Most communities include people from a wide range of social and economic backgrounds, with different needs and interests: rich and poor, young and old, men and women, people from different ethnic or religious groups. A community project designed for the common good may in fact be divisive if it is seen as benefiting one section of the society more than another. Where paid employment is involved, jealousies and conflicts can ensue. There may also be conflict between individual and group interests. For example, in a densely-populated urban slum, discussions might reveal the need to relocate some houses to make fire breaks or drainage channels that would benefit everyone. But the questions "Whose house?" and "How will the owner be compensated?" may give rise to conflicts and divisions.

Poverty

Lack of resources, ill-health and poverty prevent people from participating. Many people work seven days a week for long hours just to be able to feed their families, and may not have the time to participate. As the poorest members of the community, these are often the most vulnerable people and their opinions are most valuable. Special efforts must be made to enable them to participate.

Cynicism

In the past, the word "participation" has often been misused. People have been invited to participate in plans and projects and found later that they were being asked only to "rubber stamp" official plans. Worse, they may have simply been asked to contribute their labour, for example digging trenches for water pipes, a task that would normally be done by municipal authorities in middle-class areas. In the light of such experiences, people's unwillingness to participate is understandable.

15.3.3 Overcoming obstacles and reaching the community

Methods of overcoming obstacles to community participation include the following:

Finding an entry point to the community

It is essential to find an appropriate entry point to the community. This will most often be an existing community-based organization with its roots in the community.

Where a primary health-care system exists, a community-health worker may provide the necessary entry point. Much of what the community-health worker tries to do is highly relevant to risk reduction, especially education on oral rehydration therapy, food and water hygiene, water-supply protection, vector-borne disease control, and disposal of wastes. When the health worker is supported by a community-health committee, this

can provide a useful core structure for efforts to prevent or mitigate hazards (such as contamination of drinking-water sources, landslides due to poor building practices, etc.). Care must be taken, however, not to delegate too many additional tasks to community-health workers without providing the necessary extra support in the form of materials, transport and finances.

It is also possible to use existing local health programmes as the starting point. Thus, in Indonesia, a system called local area monitoring has been successful in achieving high childhood immunization coverage. As a result, there were plans for other health programmes, including an environmental health programme, to take advantage of this community-based system (S. Nugroho, personal communication, 1992).

Working with community leaders

A proven method for achieving community participation is to work through individuals who are able to bring people together and promote action. Political and religious leaders must be involved in their official capacity, but selecting other types of leaders may provide a useful balance. Different leaders will need to be identified to reflect the ethnic, caste and religious diversity of the population. Women leaders are particularly important for their ability to represent and articulate women's interests and needs. A method of identifying women leaders is described in Box 15.2.

Once interested leaders have been identified, they may require training, not only in health matters, but also in skills in dealing with people, listening, encouraging and sharing responsibilities and power in emergencies. They must also be supported and their credibility within the community maintained by ensuring that they participate in emergency-planning processes.

It is often important to work with people with strong political, religious and commercial influence, to encourage participation, or at least to overcome obstacles to participation.

Box 15.2 Methods of identifying women leaders

- Ask a random sample of women to name the three women they would go to for advice about sickness, a family quarrel, money problems, etc.
- Note the names most often mentioned and then ask these women to name the women they themselves would consult.
- A shorter list will emerge and the top names can be singled out as leaders.

Ensuring official support for community-led projects

Any community-based programme will need support from health workers and educators. These in turn will need the full support of their managers and of municipal, ministerial and other officials. People's investment of their own time in discussing risk and vulnerability reduction should be seen to produce visible results.

Understanding the socioeconomic make-up of the community

To overcome conflicts of interest, environmental-health personnel must take care to understand the socioeconomic make-up of the community, its divisions, and its past history of self-help community projects (especially if these have failed). For methods of social analysis that can be used to develop an understanding of the socioeconomic make-up of refugee communities, see United Nations High Commissioner for Refugees (1992b).

Making special arrangements to encourage participation

Special arrangements should be made to encourage the participation of all members of the community, for example providing free child care to allow parents of young children to participate.

15.3.4 Community organization in urban and rural areas

Even the poorest and apparently most chaotic village or neighbourhood is organized to a certain extent. Environmental-health workers and disaster-prevention planners need to understand the forms of organization if they are to find appropriate ways to mobilize people to reduce their vulnerability to hazards.

Formal (or political) organizations can be divided into three types: those headed by traditional leaders (chiefs, elders, etc.); those headed by appointed leaders (i.e. selected local representatives); and those headed by elected local representatives.

In addition, there are many kinds of traditional or informal social relations. People may exchange labour and services, there may be patterns of kinship and friendship, and religious groups and special-interest groups may provide a common centre.

In urban areas, informal organizations may include:

— workers' guilds or trades unions, which may unite people practising the same trade or working for the same employer;
— cultural and sports clubs, such as carnival dance clubs or local football clubs;
— political action groups, which often link people in very efficient communications networks.

In rural areas, ties of kinship may be stronger than in urban areas, and tribal or clan elders may have considerable influence. Other examples of informal rural organization include:

— rural industries, such as plantation work or logging, which may create a sense of solidarity among the workers concerned;
— cooperative societies for farmers or other producers: where well-run and successful, these can be a major resource; on the other hand, they will not be useful if they are unpopular because of high service charges, late payments to farmers, or even corruption;
— health establishments and schools: these often provide a social focus in rural areas (the local school head or teacher may enjoy high prestige and be a leader in the community).

Recently-created informal urban settlements in many of the fast-growing cities of the world may present great challenges, as they often lack both the traditional social structures found in rural areas and the formal structures of established urban areas. People in these settlements are also often particularly vulnerable to disasters because of the nature of the land on which they are settled, combined with high levels of poverty.

Environmental-health workers attempting to encourage local participation in a community programme should be aware of the potential usefulness of all these kinds of social organization. They may provide, for example, a forum for the discussion of risk reduction, a source of local knowledge and experience of the hazards faced in an area, and an efficient communications network for disseminating messages and ideas.

In addition, local or international nongovernmental organizations may have ongoing projects in an area that may provide a basis for new work on vulnerability reduction and emergency preparedness. For example, there may be literacy groups, microenterprise support groups, and health and sanitation projects. Before a commitment to collaboration is made, however, it is essential to investigate the history and

nature of such projects to understand how effective they are and how they are perceived by the community and the local authorities.

15.4 Hygiene promotion and hygiene education

15.4.1 Perception of risk and predisaster awareness raising

Although most communities have considerable collective understanding of environmental hazards and how to deal with them, some underestimate the risks that they face. Others may be aware of the risks but feel there is little they can do: they underestimate the possibility that risks and/or vulnerability can be reduced, or may simply lack the organizational or physical means to change the situation and may have no alternative. These communities are often those most at risk, because of their poverty, for example, or because of environmental degradation.

Perception of risk may be formed by personal experience, recent local events or folklore. A rich tradition of coping with recurrent risks is often built into cultural practices and passed on informally from generation to generation. However, familiarity with uncommon hazards may be limited, so that people do not recognize their causes and danger signs, or the threats posed to health and the environment.

Public awareness raising and mobilization programmes therefore play an essential part in reducing disaster vulnerability by:

— increasing public awareness of environmental health hazards;
— informing people how disasters can be prevented or how their impact can be reduced;
— increasing people's awareness of the threats to health and safety that may result from a disaster, or that may exist and intensify during an emergency;
— encouraging people to participate in protecting themselves, their environment and their health services from disaster and the effects of disaster.

The promotion of awareness and safety consciousness is not something to be considered only during disasters and emergencies. It should be a routine, long-term, continuing activity that starts with the identification and analysis of risks to specific geographical areas and communities. This analysis is essential for preparedness and prevention activities, and should include information that needs to be communicated to communities at risk (see Sections 3.4 and 3.5). Communities themselves should be involved in the identification and assessment of the risks they face, and the participative approaches described in Section 15.3 should be used to promote community involvement.

Communications activities designed to promote awareness of hazards, risks and appropriate countermeasures may take many forms, such as:

— education in schools for children and adolescents;
— special education programmes for adults, either specifically on disaster preparedness or as an integral part of ongoing health or development programmes;
— public information through the mass media;
— information and mobilization through local organizations and community groups.

A combination of communications methods is usually appropriate.

Programmes for promoting awareness of environmental hazards should be participatory, focused and specific, without being alarmist. The emphasis should be on strengthening existing organizations and activities in the community, and on encouraging people to participate in community activities and to change their own behaviour. To this end, education campaigns should focus on populations in particular settings, such as schools and workplaces, and in the many local organizations already in place, such as

cooperatives and women's groups. People should be encouraged to participate in community groups concerned with hazard awareness, disaster prevention and safety. Messages must be specific and deal with the particular hazards to which a population is vulnerable. Care should be taken not to create panic or anxiety. Messages should therefore emphasize mitigation and prevention rather than emergency responses, emphasizing that these activities often produce immediate benefits.

15.4.2 The need for hygiene promotion in emergencies

Following disasters, hygiene promotion may be particularly important because:

- People will expect information about the disaster itself and its aftermath. They will need to know, for example, how they can be reunited with friends and family and where it is safe to stay. In some cases, such as chemical and radiation emergencies, there may be a good deal of suspicion, misinformation and rumour, and it is then essential that people have access to authoritative information.
- There may be many unfamiliar arrangements for water and food supply, excreta disposal, etc., especially when people are forced to evacuate their homes. Rapidly available information about the new arrangements and the importance of complying with them (e.g. the importance of using designated defecation fields) is essential.
- Environmental health staff need to understand rapidly the health risks faced by the affected population and the services required to reduce those risks. They need to know what can be provided by the affected population, how much external assistance will be required, and the best way to organize external assistance to meet the needs and wishes of the affected people.
- Disaster-affected people may face greatly increased risks to their health, and will need to develop adequate responses. For example, under normal circumstances, defecation in fields around houses may be quite customary and safe, but in a crowded camp the same behaviour poses a serious hazard. Water sources may become contaminated as a result of overcrowding, which may also lead to increased transmission and incidence of communicable diseases.

15.4.3 Setting up a hygiene promotion programme in an emergency

A possible plan of action might include the following activities:

- Rapidly establish a team to deal with hygiene promotion and to provide information on environmental health.
- Rapidly assess the health risks to be addressed using information, education and mobilization, and focus on:
  - key health problems, in order of priority and magnitude;
  - physical resources needed and those available (the types of shelter, food, water, sanitation, etc.);
  - human resources available for hygiene promotion activities (health workers, teachers, religious leaders, nongovernmental organizations with available staff, writers, artists, etc.);
  - community characteristics (whether and to what extent there is a sense of community, a pattern of leadership, or local organization, and whether there are cultural traditions regarding health);
  - means of communication and hygiene-education materials available (radio transmitters and receivers, visual material, megaphones, newspapers, printing and copying equipment, and traditional communications channels, such as singing and story-telling).

- Form close liaison with the community. This may be achieved by working through existing community organizations such as women's groups, trade unions, etc., or by establishing community-health committees.
- Choose the subjects to be covered and the type of preventive action to be taken (e.g. promoting hand-washing, ensuring water safety), with a focus on priority issues, rather than a broad range of topics. Actions that can have the greatest impact on reducing morbidity and mortality should be emphasized. Behaviour changes that are promoted should be chosen on the basis of the assessment of health risks, environmental health facilities, and services available in each situation.
- Identify and select trainers, health motivators and leaders from the affected population and from nongovernmental organizations, including children, women and others who can provide peer-group education. It is particularly important to involve women: in many societies women play a major role in water collection and domestic and personal hygiene and they may also be particularly affected by the change in environmental health conditions.
- Develop clear health messages and choose the educational approach and methods to be used. This can be based on pre-prepared messages and communications systems, but must be done in collaboration with selected trainers and community representatives to ensure that the cultural background, traditional practices and perceptions of the target population are taken into account.
- Develop, field-test and use new educational materials, or review existing materials (e.g. posters, leaflets, radio scripts, health talks) and adapt them as necessary.
- Review activities and their immediate impact, and revise and adapt approaches to reflect changes in conditions and health status, if necessary. This may involve interviews, observation and questionnaire surveys to evaluate changes in knowledge, practice and environmental health conditions.

To help meet the needs of particularly vulnerable people among new arrivals at emergency settlements, special measures may be needed to raise their awareness about health risks, hygiene practices, arrangements for water supply and sanitation, and about the support for families and community groups.

Hygiene promotion activities should be coordinated to ensure that messages address priority issues, are consistent and complementary, and that hygiene education is integrated with measures to improve services and facilities.

15.4.4 Participatory approach to hygiene promotion

Hygiene promotion necessarily involves close liaison with the affected population, even in an emergency. To establish successful contacts with the community, it is necessary to:

- Avoid making assumptions about what people already know or do not know about health, hygiene, sanitation, etc. Even the most obvious request or arrangement should be discussed with the community health committee or equivalent representatives, who may themselves need to take soundings from the population.
- Establish rapid procedures for obtaining reactions, ideas and information from communities. Appropriate activities include observing current practices, in-depth interviews with key informants (such as local leaders, teachers, midwives), survey interviews, discussions with focus groups, and various other forms of participatory appraisal techniques.
- Approach people with respect and empathy.
- Build on indigenous knowledge and practices (while explaining how to adapt to emergency conditions in which such practices may become difficult or danger-

ous). This approach may give rise to useful innovations and improvisations by the community.
- Remember, that in all communities there are people with useful ideas, skills and experience that can be shared with others.

For further information on community liaison, see Pan American Health Organization (1994).

15.4.5 Environmental health messages in emergencies

Following disasters, environmental health is concerned with areas that include water supply and sanitation, waste disposal, vector control, personal hygiene, shelter and food safety. These, in turn, may be subdivided and specific health messages identified, as suggested in Annex 6. It is most important that only a small number of very important messages are chosen for communication, based on an assessment of health risks, to avoid confusing the target audience, and wasting efforts on be havior changes that have little impact on health.

Hygiene messages and communications methods should be chosen in answer to four key questions (United Nations Children's Fund, 1999):

- Which specific practices are placing health at risk?
- What could motivate the adoption of safe practices?
- Who should be targeted by the programme?
- How can one communicate with these groups effectively?

15.4.6 Communication methods

Communication of health information is most effective when a variety of methods, approaches and materials are used. Broadly speaking, there are three main approaches:

Person-to-person contact

Captive audiences may be found at clinics, feeding centres, food-distribution centres, water-collection points and so on, where health workers and trained volunteers will be able to give advice. In nonemergency periods, health clinics, schools and workplaces may provide similar audiences. Meetings may be called for specific groups, or selected individuals may be brought together for focus group discussions on specific topics, and individual families may also be visited. The influence of existing local groups or social organizations can be very useful in increasing the impact of the information.

This direct approach, particularly if it involves some interaction between health workers and individuals, is most effective in tackling specific issues and encouraging particular changes in behaviour, and in checking that messages are seen as relevant and useful by the people concerned.

Activities suitable for person-to-person exchanges or for small groups include the discussion of personal feelings and experiences, demonstrations, story-telling, role-playing, case studies and educational games (particularly in nonemergency situations).

Teaching aids

Suitable teaching aids include printed materials, posters, films, slides, videos, murals, flannel graphs and flip charts. These are useful for transmitting information and as support to the spoken word, but must be reinforced by interaction and personal contact with members of the target audience.

Using mass communication

Radio, audiocassettes, television, video, newspapers, placards, plays, puppet shows and megaphones are effective means of communicating information quickly to a large number of people and creating awareness of a problem or idea. The relevance and impact of messages, and the effectiveness with which they are communicated, need to be evaluated by discussion with a sample of people.

Following a disaster, mass media may be unavailable or at least severely disrupted. However, radios may be available, and in long-term emergency settlements it may be possible to produce a camp newspaper and to make arrangements with a nearby radio station to broadcast regular programmes on health issues.

15.4.7 Choosing an approach

When deciding on the message and the communications methods to use, it is essential to:

- establish the need for, and relevance of, the hygiene education activity through an assessment that is as participatory as possible, given the nature and urgency of the situation;
- be aware that a hygiene education campaign may be aimed at some people who are not literate: in such circumstances, participatory learning techniques are the most appropriate;
- select and adapt methods to suit the characteristics and interests of the particular target group—young/old, male/female, membership of a religious group, etc. (e.g. fables about animals may be more suitable for children than adults);
- establish procedures at the outset for evaluating the effectiveness of the health promotion campaign, by selecting appropriate indicators for measuring changes in people's health status, behaviour and environment;
- reinforce existing health practices that are beneficial and discourage those that are harmful;
- choose messages that are positive, attractive and based on what people already know, what they want and what they consider to be achievable;
- involve people in the community in the production of their own teaching materials (this is educational in itself and will ensure that such materials are relevant and culturally appropriate);
- use the effectiveness of young people and children in teaching and mobilizing others;
- avoid messages that imply that people are to blame for their own or their children's ill-health: messages and methods must not be judgmental.

15.5 Further information

For further information on:

- community participation, see: Chambers (1983), Chambers, Pacey & Thrupp (1989), World Resources Institute (1990), Cernea (1991), Evans & Appleton (1993), Chambers (1994), Eade & Wright (1994), United Nations High Commissioner for Refugees (1996);
- women and children in emergencies, see: Aarons & Hawes (1979), United Nations Children's Fund (1984), International Federation of Red Cross and Red Crescent Societies (1991), United Nations High Commissioner for Refugees (1991), Wiest (1992), Walker (1994), United Nations Children's Fund (1996);
- gender and social diversity, see: Cernea (1991), Moser (1993), Steady (1993), Eade & Williams (1995);

— hygiene promotion and communication, see: Werner & Bower (1982), Downie, Fyfe & Tannahill (1990), Boot (1991), Bunton & Macdonald, eds. (1992), Boot & Cairncross (1993), Hubley (1993), Bentley et al. (1994), Hermann & Bentley (1994), Eade & Williams (1995), Geefhuysen, Bennet & Lewin (1995), Almedom, Blumenthal & Manderson (1997), United Nations Children's Fund (1999), Ferron, Morgan & O'Reilly (2000), Sphere Project (2000).