Emergency wash for children

Scoping Study, 2014

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Save the Children

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http://www.humanitarianinnovation.org/
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1. Table of Contents

2. Acronyms

Acronym	Definition
ACF	Action Contre la Faim (Action Against Hunger)
CBM	Christian Blind Mission
CLTS	Community led total sanitation
CLDRR	Child led disaster risk reduction
CRC	Child Rights Committee
DRR	Disaster risk reduction
ECPAT	End child prostitution and trafficking (NGO)
EEHF	Emergency environmental health forum
GBV	Gender based violence
HIF	Humanitarian Innovation Fund
HIP	Hygiene improvement project
HESPER	Humanitarian emergency settings perceived needs scale
HP	Hygiene promotion
IASC	Interagency standing committee
IDRC	International development research centre (Canada)
IEC	Information, education and communication
IFRC	International federation of the red cross red crescent
IMC	International Medical Corps
IQ	Intelligence quotient
LLIN	Long lasting insecticide treated net
MEAL	Monitoring, evaluation, accountability and learning
MHM	Menstrual hygiene management
MR WASH	Minimum requirements for WASH interventions (Oxfam)
NEHWSC	National environmental health and water supply centre (Vietnam)
NGO	Non-governmental organization
OFDA	United States of America office for disaster assistance
PRB	Population reference bureau
SCUK	Save the Children United Kingdom
SCI	Save the Children International
UNCRC	UN Convention on the Rights of the Child
UNHCR	Office of the high commissioner for refugees
UNICEF	United Nations Children's Fund
WASH	Water, sanitation and hygiene
WEDC	Water Engineering and Development Centre (Loughborough University)
WSP	World Bank Water and Sanitation Programme
WSSCC	Water supply and sanitation collaborative council

3. Executive summary

Children under 18 can represent 50% or more of a crisis-affected population and, as such, children are major stakeholders in almost all humanitarian responses. While existing emergency WASH literature often refers to the hardware requirements of children, particularly to excreta disposal options, it almost never takes into account the needs of children of different ages and more often provides very superficial information. Similarly, literature on hygiene promotion focuses on primary school age children; meanwhile case studies and examples from the field of how to adapt WASH programmes to suit children's needs are also very limited. According to the Convention on the Rights of the Child, a child is anyone under the age of 18 years, however children of different ages require very different approaches: children under five are the most vulnerable to water-related diseases, yet most emergency WASH programmes consider primary school age children, neglecting both teenagers and younger children.

Although children are considered as a cross cutting issue in Sphere, most organisations do not consider them as such, and without institutional recognition it is likely that responses aimed at children will remain inconsistent. Save the Children UK obtained funding from the Humanitarian Innovation Fund to research how the WASH sector was currently responding to the needs of children and what guidance was available, in order to identify best practice and make recommendations for further research and development. Current research examined the existing literature, sent out questionnaires and interviewed practitioners and academics and made use of field work in Ethiopia and Bangladesh. This research was guided by Save the Children, International Medical Corps, UNICEF and Oxfam GB.

Field work and questionnaires showed that the problem is not a complete lack of awareness of children's issues but is representative of the difficulty of responding to so many demands in an emergency response, lack of confidence on the part of practitioners, and lack of readily available resources. There is a need to try and incorporate WASH for children into programmes so it becomes a normal part of programming and is more intuitive. Respondents felt that a major obstacle to working with children was the lack of skilled and confident staff with experience of working with children and with knowledge of suitable activities for different age groups.

In general the research has succeeded in identifying a large gap in knowledge and practice, when implementing emergency WASH programmes and in considering the needs of children. While some solutions will need to be child-focused, it seems preferable to consider how to ensure social inclusion for all affected population groups (e.g. women and men, older people, people with disabilities), as well as children.

As a scoping study, this report gathered together information from current literature, practitioners, and from limited fieldwork, but it is not an exhaustive study. Views have been represented as accurately as possible, and this report is an attempt to identify gaps where possible, meanwhile acting as a repository of gathered information.

3.1 Recommendations

Below are some of the key recommendations from the Emergency WASH for Children scoping study as well as some of the knowledge gaps that currently require attention.

Recommendation	Key Implications
1: Additional evidence is needed to explore how Emergency WASH can contribute to children's health and nutritional status; however defining a	• Design and trial an integrated approach that includes Infant and Young Child Feeding, Neonatal Health with supporting WASH. • A greater understanding of how to respond to Environmental Enteropathy is needed.

combined WASH, nutrition and health programming methodology for infants and very young children seems to present a real opportunity to improve their lives in a disaster.	
2: Children's participation in Emergency WASH programmes can and must be improved.	• Move beyond passive inclusion of children and Hygiene Promotion: refer to the participation ladder. • Incorporate participation of children through increased staff training, awareness and buy-in, and through institutionalizing the process, for example by including children's considerations in proposal-writers checklists; and through advocacy. • Consider producing guidelines and piloting a full children's participatory approach during a humanitarian response (with suitable adult involvement).
3: Protection of children is implemented sporadically, and in general children are under-protected due to lack of time and knowledge on the part of WASH teams.	• Staff should be vetted nationally and internationally. • Increase staff training in child safeguarding, using accessible, translated, materials. • Consult children when locating facilities. • Consider several levels of the supply chain during procurement.
4: Emergency sanitation for children can be improved: in particular through the consideration of children of different age groups.	• Operational research is needed on how to provide sanitation for infants: nappies, potties and supporting infrastructure and hygiene messaging for parents. • Gender-appropriate child-friendly latrines designs should be gathered and made available, and designs piloted. • Incorporate MHM and hand washing considerations, including operation and maintenance, from project design onwards.
5: Child-focused Emergency Water Supply has been investigated already, to a certain extent. However efforts to improve tap designs, and improving awareness of good practice in relation to child protection and children's participation in WASH should continue.	• Involve children in the design of facilities and to protect them from damage. • Taps need to be robust: for example a ¾" tap is likely to be preferable to ½" tap. • Distribute moderate-sized buckets and jerry cans (e.g. 10-13 Litres).
6: There are excellent opportunities for the involvement of children in emergency hygiene promotion, especially teenagers, and to make suitable IECs for working with children more accessible to WASH actors.	• Make use of existing methodologies: CHAST and SLTS • Develop, collate and make available Learning is Fun methodologies • Expand IEC material to talk specifically to teenagers • Consider new technologies, which children understand better than adults.
7: WASH in schools, in emergencies should include better planning of operation and maintenance, especially of hand washing facilities, and greater consideration of MHM.	• MHM is often not considered during the implementation of WASH in Schools programmes, although useful new guidelines now exist. • Operation and maintenance of hand washing facilities is poor, globally, with many dysfunctional washing spaces observable. • Incorporate MHM and hand washing considerations, including operation and maintenance, from the start.

Save the Children will take the lessons and recommendations from this scoping study forwards as follows:

- Engage with organisations in the WASH cluster at global level to continue to promote a focus on children of different ages and to disseminate resources to support this;
- Initiate the formation of a group to develop and trial a combined health, nutrition and WASH approach that will maximise the outcomes for infants and young children: considering Infant and Young Child Feeding practices (IYCF), neonatal health, and appropriate sanitation and hygiene adaptations;
- Develop a library of appropriate designs for child-friendly latrines which will be accessible to all practitioners;
- Gather child-friendly Hygiene Promotion materials into a single accessible location, in cooperation with UNICEF and others, and further develop options that take into account the 'learning is fun' principles; options for teenagers; and behaviour change methodologies that include up-to-date technology, such as social networking and mobile phones; and
- Promote greater child participation in emergency WASH programming, initially through advocacy, but also looking to develop and pilot suitable guidelines at a later date.

4. Why consider children in emergency WASH responses?

The primary aim of WASH interventions in emergencies is to prevent or mitigate outbreaks of diarrhoea and other WASH related diseases. Mortality and morbidity rates amongst children under five years of age are often significantly higher than within the general population and therefore they should be a primary target group of humanitarian responses. What's more, children usually represent a large proportion of the population in emergencies.

Women and children of varying ages (both boys and girls) will often be responsible for collecting water and facilities should therefore be designed with them in mind. Girls especially will often be responsible for caring for their younger siblings and can be an effective target for hygiene education.

If WASH responses are to be effective, a greater focus on the population under 18 is crucial: this should not be considered as a 'nice to do' add on but as a fundamental part of all emergency WASH interventions.

4.1 Children are major stakeholders

According to the Convention on the Rights of the Child, a child is anyone under the age of 18 years. This age group often represents a large proportion of the population: 60% in the case of South Sudan. 43% of the population of Sub Saharan Africa and 36% of the population in Syria is under 15 years old (PRB 2012). Population demographics following displacement will often vary from those in more settled contexts but it is still likely that a high percentage of the population will be children under 18 years old. There may well be a larger proportion of children amongst refugees or displaced populations (see Table 1 below).The percentage of children under 5 years of age can in itself be significant and in some countries can be almost 20%. For example the current (2013) under five populations of Haiti is 12.6%, of Syria 12.2% and of Afghanistan 18%.

Table 1: Percentage of children among selected displaced populations

Population	Children under 18 years	Children under five years
Syrian refugees[1]	47.3%	17.6%
Refugees in South Sudani[2]	60%	21%
IDPs in Bangladesh[3]	49.1%	13%

4.2 Access to WASH improves children's health

There is limited data available on the specific impact of water, sanitation and hygiene on rates of diarrhoea in emergency contexts however children under five years of age are clearly a very vulnerable segment of the population. In a non-emergency context childhood diarrhoea is highest in children under 2 years and mortality due to diarrhoea is concentrated in the under one age group, and in any case young children's excreta are more dangerous than adults, containing a higher pathogen load. There is evidence that improvements to water and sanitation can reduce the incidence of diseases such as trachoma, schistosomiasis, helminths and tropical enteropathy. Cognitive development and mental health can also be positively affected by child centred WASH programming.

[1] Date and source: May 2013 http://data.unhcr.org/syrianrefugees/regional.php

[2] Date and source: May 2013 http://data.unhcr.org/SouthSudan/country.php?id=251

[3] Date and source: 2001 census http://www.bbs.gov.bd/home.aspx

Therefore there are strong health drivers to improve how Emergency WASH relates to the needs of children specifically, in terms of the physical health of children and the community as a whole; the nutritional status of children but also in terms of mental health and well-being. The relationship between emergency WASH provision and children's health is discussed in detail in Section 6.1.

4.3 Children have a right to participate

UNICEF, Save the Children and other child-centred organizations argue that the participation of children and adolescents contributes to the fulfilment of a fully-justified, rights based agenda. The Convention on the Rights of the Child clearly states that 'the child has a right to express his or her views, obtain information and make ideas or information known'.

According to a 2007 guide to the participation of children in emergencies:

"The dominant theme of the emergency literature emphasizes children's vulnerability rather than their strengths and resilience" (UNICEF, 2007).

The report goes on to argue that enabling children's participation enhances the effectiveness of measures taken for their protection. It is clear that children are not a homogenous group and it is important to examine the extent to which the needs of different groups of children (relating to age, gender, disability, class etc.) are met as well as the degree to which these different groups are encouraged to have a say in and contribute to the emergency response.

General comment number 12 on children's right to be heard (Child Rights Committee 2009) includes a section on emergencies and states that:

> **"Children affected by emergencies should be encouraged and enabled to participate in analysing their situation and future prospects. Children's participation helps them to regain control over their lives, contributes to rehabilitation, develops organizational skills and strengthens a sense of identity".**

Following the tsunami in 2004, children gathered and burned debris and cleaned toilets in displaced-persons camps and other communal areas. Some even helped pick up bodies and construct coffins, however not all children were comfortable handling the dead: one child noted during a workshop on participation in emergency situations, those who didn't feel comfortable should not feel bad because there were many other demands that needed their hands. In the Maldives, Boy Scouts and Girl Guides helped clear away debris instead (Source: UNICEF 2007).

4.4 Programming can be more effective if children are considered

Clearly it is important to focus WASH efforts on young children to reduce mortality and morbidity. However this will also reduce the amount of time and resources directed at caring for sick children. School attendance is also affected significantly by WASH related disease. Several studies have shown that improvements in hygiene have reduced absenteeism (UNICEF 2012). Meanwhile successful child-focused WASH programming can contribute to reducing malnutrition and, in the long term, stunting.

Young children are more adaptable than adults and it is more likely that they will be influenced by behaviour change communication activities, whether WASH related, or related to other sectors. A variety of sources report that children can also be successful in influencing changes in the behaviour of their younger siblings and parents.

There are numerous reasons why girls and boys of different ages should be a greater focus in WASH programming. This report discusses scoping research findings from a desk study, literature review and fieldwork, with the aim of collecting examples of current best practice, and of identifying gaps in knowledge that need to be addressed by future research.

5. Research methodology and initial findings

5.1 Methodology

DFID's humanitarian innovation fund (HIF) provided funding to Save the Children (UK) to investigate how the WASH sector responds to the needs of children in emergencies. The aim of the research was to identify best practice examples, resources and recommendations for practice and future research on this issue. The project comprised three steps:

- Step 1 Desk study and questionnaire to clarify gaps in knowledge
- Step 2 Fieldwork to solidify knowledge and discuss ideas with field staff.
- Step 3 Finalize outputs: discussion paper and short briefing paper on WASH for children

An overview of the findings from the research, are presented in this section of the discussion paper. Initial findings relate to a completed desk review of existing WASH literature a questionnaire survey to practitioners, interviews with key informants and field visits to Ethiopia and Bangladesh. Initial findings are analysed and discussed in more detail in the remaining sections of the paper followed by more detailed recommendations. The appendices provide a list of key resources as well as some example resources that might be useful to improve the way we work with children in the WASH sector. A bibliography of key WASH documents is available separately.

A steering group with members from Save the Children UK, Oxfam GB, UNICEF and IMC, supported and shaped the scoping study.

5.2 Desk review of existing literature

WASH publications were examined for specific information relating to the needs of children, and emergency focused literature from other agencies or relevant sectors such as child protection and disaster risk reduction has also been examined. Some WASH publications from the development field have also been referenced as they capture useful ideas and suggestions that can be used for emergencies.

Sphere considers children as a cross cutting theme and has specific recommendations about excreta disposal and hygiene promotion. It also mentions keeping children away from solid waste disposal sites, providing water containers that children can manage and has an indicator for menstrual hygiene management for girls.

The WASH Cluster website has a list of nine cross cutting themes but, perhaps surprisingly, children are not included. WASH Cluster technical training refers to excreta disposal in schools, however, there is no mention of provision for children in the community, hospitals or clinics. There is reference made to the safety of women and girls in accessing water and sanitation facilities but safety concerns also exist for boys. However, the needs assessment checklist does refer to the importance of finding out where both adults and children defecate and if latrines have small squat holes that prevent children from falling in. WASH Cluster hygiene promotion materials contain some information and training sessions on how to work with children but this is also limited in scope and makes little reference to working with children of different ages. Now that materials on hygiene promotion, accountability and MHM have been developed, it seems appropriate for the cluster to consider the needs of children specifically.

Engineering in emergencies (1999) has numerous references to children covering excreta management and safety especially; however these issues are not covered in great detail. Close consultation with mothers on the disposal of children's excreta and the provision of small hoes to enable them to bury faeces, is recommended, and the book also stresses the importance of preventing accidents around water points and rubbish sites and in the use of insecticides and other chemicals used for household water treatment.

Much of the literature refers to the importance of working with children and recognizes their vulnerability: however, specific details of how to incorporate children's issues and vulnerability with WASH programming is not usually provided.

Most references on WASH for children focus on the issue of excreta management. However the interagency manual 'Excreta disposal in Emergencies' has only one page on children's excreta disposal options. Oxfam's 'Minimum Requirements for WASH', otherwise known as MR WASH, outlines standards required from programmes and includes a section on working with children, which states that Oxfam staff must ensure:

- Every member of the affected community aged under the age of 18 is treated as a child.
- Specific NFI related needs for children are addressed.
- Child labour is avoided. If children are involved in WASH activities that could be perceived as child labour e.g. a clean-up campaign, this should be clearly discussed and agreed with children, local authorities and parents beforehand.
- They understand the health and other risks facing children (protection, economic) in the specific country context.
- The design and siting of WASH facilities is appropriate for children.

'MR WASH' also includes standards for mainstreaming Protection and Gender that refers to girl's needs for privacy, dignity and safety. Whilst there are minimum requirements relating to working with communities that include promoting the participation of women, there are none relating specifically to children's participation and decision-making. Oxfam has also developed a technical briefing paper that focuses on 'Working with children in humanitarian WASH programmes' as well as WASH briefing papers on socio-cultural considerations and vulnerability that refer to work with children.

ACF Spain (2009) has a PowerPoint presentation on children's excreta management in emergencies but the comprehensive ACF WASH manual 'Water, Sanitation and Hygiene for populations at risk' has few references to children and minimal detail on how to work with them.

In a workshop held in 2011 to identify gaps in emergency sanitation, the issue of toilets for children was raised but not discussed in detail and little progress since then appears to have been made (Johannssen 2011). However, OFDA has funded a consortium of agencies (Oxfam, IFRC and WASTE) to develop various sanitation solutions including a latrine slab specifically aimed at children. The details of this specific element of the project are not yet available.

World Vision has developed a 'Children in Emergencies' manual that contains useful checklists for child friendly WASH and Environmental Health interventions. There are also short child protection training sessions, recommendations for human resources and suggestions on how to work with children that are useful for the WASH sector.

Whilst most WASH assessment tools underline the importance of disaggregating data, there is an absence of detailed child-focused questions and questions rarely examine the needs of different age groups (Sphere 2011, Oxfam 2011, SCF 2010). The HESPER (humanitarian emergency settings perceived needs scale) survey tool states explicitly that it is not suitable for children under 18 years.

A recent publication on Menstrual Hygiene Management has a chapter on working in emergencies, that considers the needs of young girls. A variety of information booklets for girls on menstruation are also becoming available and could be distributed in emergency responses through schools or community mobilisers.

A more detailed summary of information captured from available literature is attached to this report, as Annex C, and is available on request from Save the Children.

5.3 Questionnaire and phone interviews

A short questionnaire was sent out to approximately 120 people with experience of WASH programmes and there were 61 responses. The aim was to obtain feedback on current responses and to identify specific programmes that could provide useful case studies. The questionnaire was not intended to provide a representative survey of the sector, however the data supplied provides an insight into how practitioners view the provision of WASH for children.

5.3.1 Questionnaire responses

The majority of respondents had been involved with some hygiene promotion activities specifically involving children although this may well reflect responder bias. Two engineers, when directly questioned felt that it wasn't worth filling in the questionnaire, as they didn't have any experience of working with children. Most respondents had been involved with child focused hygiene promotion activities but only 24% of respondents said they were working with children from 12-18 years old.

A compilation of the results from the questionnaire can be found in Annex A.

Most child-related WASH activities focus on WASH in Schools with most respondents citing at least the provision of water supply, child friendly toilets and handwashing promotion and handwashing hardware in schools as areas of consideration. However, only 7% cited menstrual hygiene management in schools as an intervention.

Whilst 29% of respondents said they had provided child friendly toilets in schools, only 16% said that they had done so in the community. 17% of respondents had provided potties but neither cloth nor disposable nappies for children were common programme interventions.

Whereas most hygiene kits containing children's items were provided to parents 36% of respondents said they had provided kits directly to children, often through schools and sometimes in conjunction with a school bag and colouring pads and pens. 25% said they had never provided any hygiene kits for children.

Child friendly WASH facilities were sometimes provided in health centres but most often in child friendly spaces.

The following additional WASH programme options were cited in questionnaire responses and key interviews:

- Water saving, child proof 'taflo' taps, or the use of "Play Pumps" powered as children play;
- Handwashing facilities at an appropriate height for children, maybe providing Tippy Taps at an appropriate height, or even using a handwashing device with a foot pedal to avoid having taps left on;
- Provision of child accessible toilets and showers in schools;
- Water filter distribution in schools and assign children and teacher to monitor them
- Garbage bins and disposal facilities in schools;
- Privacy areas for girls with seats / mirrors etc. and provide information on menstrual hygiene, safety and other issues there. Also providing Girls' latrines with an external screen or wall to provide additional privacy near the entrance;
- Blast protection films on windows of school toilets in a conflict area
- Modification to height of facilities and diameter of toilet seats, and raiseable or removable seats for young children; or using smaller key hole pedestals/squat plats on top of normal adult versions;
- Provision of a ramp into the toilets for access for children with disabilities, and handles on inside of toilet;
- Making toilet locks useable by children and making sure toilet doors close inwards to avoid children swinging on them;
- Play kits for hygiene promotion, as well as the provision of drawing colour pencils, writing pads, tooth paste & brush, soaps, 'T'-shirts, caps, school bags etc. in one kit;
- Teaching kids how to pump water and why they shouldn't play with water taps;

- Sanitary materials for young girls also and stitching of own sanitary pads in schools; and
- Children painting the outside of public latrines and bins with pictures to encourage greater ownership and deter vandalism.

Several respondents to the questionnaire mentioned that they were planning to introduce new Menstrual Hygiene Management (MHM) components into their responses such as the provision of sanitary towels to girls, privacy areas for girls and one respondent mentioned counselling for girls on MHM.

According to several respondents, hygiene promotion activities with children are a common component of most WASH interventions although the coverage and quality of this component is believed to be very variable and there is little published information on outcomes or even case studies and examples.

Respondents were also asked to make any other additional comments in relation to working with children. Some respondents were concerned that programmes might try and initiate vertical programmes that only focused on children and several people mentioned the importance of trying to 'mainstream' children's issues into existing WASH responses.

> **"Addressing WASH for children in isolation from family, community or other WASH programmes is likely to create more problems than it resolves".**

Several respondents mentioned that working with children was a neglected area and often not a priority in the first phase of an emergency response:

> **"It is usually only considered to be a second phase activity."**
> **"There has not been a strong child focus in most country programmes."**

There was an apparent lack of confidence in working with children from some respondents and several respondents mentioned the need to employ male and female staff that would focus specifically on involving children:

> **"…many HPs [as well as engineers] did not feel comfortable working with children and I many times thought we are really missing an opportunity here. Generally the feeling was that we did not really know what to do with children, how to engage with them."**
> **"We need to have a specific staff focused on facilitating HP with children. Our staff were multi-tasking."**

It was felt important to identify someone who had previous experience and expertise in working with children and respondents also mentioned the need for more training on working with children. However, the staffing requirements were the subject of debate with some practitioners feeling that additional staff members were not required and that this would be costly.

Some respondents referred to a lack of funding as a reason why children were not specifically targeted but modifications to facilities are not necessarily costly and hygiene promotion should focus on all sections of the affected community. However, significant budgets are required for the recurrent purchase of hygiene items such as disposable nappies, sanitary towels and soap and this can be a major barrier in longer term or chronic emergencies.

Other respondents complained that emergency short term funding did not support undertaking WASH in schools and that important opportunities were being missed in this area.

Some respondents questioned the limits of WASH for children – did this include indoor air pollution, fire safety and other environmental health issues? These issues are not discussed in detail in this discussion paper but it is likely that children will have a role to play in all of these issues and both their needs and their potential contribution to addressing the problem should always be considered.

In summary, it appears that there are numerous initiatives that focus on children in WASH programming but it is rare that this information is documented or shared in wider forums. The field visits also revealed inconsistent attention to the needs of children in WASH.

5.4 Field visits

Field visits were conducted in Ethiopia and Bangladesh (7 days in each country) in April and May of 2013. Key informant interviews were held with NGO staff, women, men, boys and girls in affected emergency communities. In addition, the researcher attended an initial and final debriefing session with key WASH staff from a variety of organizations. A variety of participatory activities and games were used with children to make the research fun and interesting.

In both Ethiopia and Bangladesh children in general said they had not been consulted on the design of programmes nor had they been asked for feedback on the facilities that were provided. However, they had very strong views on how they would have liked things to be done and were able to articulate design modifications that would have been easy to incorporate into the response.

Indicative quotes from children in Ethiopia and Bangladesh:

"We prefer different latrines for boys & girls at school"
"The well is good, but the steps are high, when I am at the pump I stand here and am afraid as the handle is the corner-side"
"I come here 5 or 6 times a day, it takes me about 30 minute each time to walk here, if this pump could be easier to push – it would be better"
"They should use better materials on the plinth, like strong cement, so they don't collapse in the next flood"
"I am happy with the water supply, it saves more time for study"
"No, we were not included in any discussions (about the programme). If we were included we would ask for footballs for the school (boy), water points should be nearer "(girls).
"We like the pipes on the toilets to get rid of smells and we need lights."

(Source: Field visit summary notes, Anne Lloyd)

5.4.1 Ethiopia

The fieldwork in Ethiopia included discussions with various NGO, UNICEF and government representatives and visiting some of the programmes in the drought prone areas of the Somali and Oramiya regions.

One representative stated that the WASH programmes 'considered the whole community' but did not provide 'separate consideration for children'. However, there was some work in schools and there would usually be a school WASH committee and sometimes a feedback or suggestion box in the school. The decision to initiate water trucking was also triggered by (amongst other indicators) an increase in the school drop-out rate.

WASH staff said that children 'were often forgotten in the first phase'. It was also stated that children were rarely given a voice in decision-making and there was only limited awareness of child protection issues. However, Save the Children had recently been running a livelihood project in Dire Dawa that had a child accountability committee and there were some examples of children being involved in the siting of latrines. Children had also been included in the discussions on the contents of hygiene kits although this was not done systematically. It was suggested that children could be involved more in monitoring of facilities.

Menstrual hygiene management was seen as a very important issue by many WASH staff and several girls reported that they missed several days of schooling during menstruation especially if there was

no water at school to WASH with. Some work was being done on the provision of disposable sanitary towels but managing the final disposal of used pads or ensuring water and facilities for washing reusable pads were often problematic.

Mother's groups were used in some places and were seen to be successful. Some mothers were asking for potties after attending health education sessions but in general mothers were not familiar with potties or even nappies. The mothers described how they hold their babies between their legs and then cover the faeces with dirt.

The need for fencing around the school latrines to prevent outside people from using them was highlighted as a problem from several communities. They felt that they were unable to afford this and it had not been budgeted for. CLTS is now the government preferred approach to sanitation promotion and it is being practiced in several areas. However, one area that had a CLTS programme had no usable latrines for children and no handwashing facilities in the local school.

In one location a latrine block had been provided at a clinic supporting outpatient therapeutic feeding but according to young children it was not meant for children, even if they were with their mothers at the clinic. No water for handwashing was available at the time of the field visit even though facilities had been constructed recently: however it has been reported that in this area people prefer to wash their hands inside the toilet cubicle, negating the need for external handwashing facilities. In another village a communal toilet block had been constructed but there were no modifications for children. In many of the places visited, it was also claimed that handwashing facilities had been provided at all the school and community latrines but that 'none are working now'. It is vital that more attention is paid to this issue from both the hardware (improved design) and software (how to manage and maintain) aspects.

A variety of hygiene promotion activities had been undertaken by various agencies. School WASH clubs often appeared to have limited coverage with only a maximum of ten children and one teacher taking part. Some of the WASH clubs had been trained in CLTS but this had not been applied in any meaningful way. The hardware and software often appeared to be disconnected. 'Awareness raising' about hygiene was carried out in the absence of any attempt to enable handwashing or ensure maintenance and use of latrines in schools.

There seemed to be a very limited variety of IEC materials available in this context and only one set of tools was developed for use with older school children. It appeared that most materials had not been pretested with children but it was claimed that they were involved in the design of the SC 'Meta Boards' (large boards that use pictures to narrate stories about health to an audience).
A manager from a large NGO felt that there was no need for separate staff and that this should be a part of everyone's job – especially as far as hygiene promotion was concerned.

5.4.2 Bangladesh

Field work in Bangladesh also included discussions with various NGOs, UNICEF and government staff and field visits to areas which had been flooded in 2011 and 2012, resulting in many people being displaced for several months and returning to their villages where houses, assets and infrastructure had been destroyed.

Some informants in Bangladesh initially expressed surprise that there needed to be a focus on WASH for children and felt that this was already covered by Sphere and other key WASH resources. However, during the visits to the field, staff often remarked that they had not considered different age groups of children and had not thought about consulting with children and young people and it was rare to request feedback from these key stakeholders.

There were some good examples of child friendly toilets with handrails (see the case studies in the accompanying WASH resources, Annex D) but neither potties, nor nappies had been distributed in any programmes, despite the fact that several groups of mothers said they would be very useful. Potties cost approximately BDT 250 (£2 approx.) and were seen by many mothers as unaffordable.

However, one programme manager felt that distribution during emergencies would not be an expensive option. Feedback on the child friendly toilets, established by an NGO in an IDP camp, indicated that some children 'felt shy' to use the latrines as they did not have doors, indicating that different modifications are probably necessary for different age groups.

In an area where flooding is frequent and where raised handpumps and latrines were a normal response, access for children (and other people with mobility problems) was often difficult. Steps built to improve access to handpumps were often precarious and constructed without handrails. Young girls sometimes found that the water pumps were difficult to operate.

Hygiene promotion for all age groups was often very basic and seemed to be focused on information transfer rather than an interactive partnership. Some useful materials and games for children had been developed for both primary and secondary school children. One local NGO has developed an interactive game for children, but not specifically for WASH.

The lack of flexible funding for emergencies was sometimes given as a reason why WASH activities in schools were often not a focus of the response or why attention was not given to excreta disposal for very young children.

In an interesting exercise children in Bangladesh were asked to draw a picture of their ideal toilet. Many drew torches as they were frightened to go to the toilet by themselves. They also drew sandals for use in the toilet (see Figure 1, below).

Figure 1: Drawing of the "ideal toilet" by children in Bangladesh (credit: Anne Lloyd)

5.4.3 Suggestions to improve WASH for children made by practitioners during field visits

The following are some of the suggestions that were made by programme staff in Bangladesh and Ethiopia to improve WASH for children:

- Include a question relating to children on the proposal-writers' checklist, e.g. "have you consulted with children?"
- A focal point within each organisation would greatly help to lobby for greater awareness of child protection and participation;
- All staff & partners should be trained on child protection & participation;
- Information boards & message boxes should be child friendly & should belong to the school/community, so if an agency starts them – they should be handed over;
- There may be the opportunity to establish a child-focused alliance of organizations to share ideas;
- Ensure that all staff (including partner staff) sign the child protection policy /code of conduct;
- Teenagers representatives could be included on WASH committees;
- Consider the provision of a torch in hygiene kits: many children go with their mothers to the latrine at night simply because it is too dark;
- Children may also need 'flip flops' so that they can use the latrine safely;
- Provide handrails by the steps to raised pumps or latrines and a rail inside the latrine for children (and others with mobility/balance problems) and ensure steps do not have too deep a riser so that children (and others) can use them easily;
- Ensure pumps are easy to operate for children, as they are often sent to get water;
- Ask women and girls what they need to manage their menstruation with dignity;
- More work needs to be done to design a child friendly tap that will not get broken easily; and
- Develop more effective hygiene promotion materials by involving different age groups of children in their design.

Figure 2: Children consulted in Bangladesh (credit: Anne Lloyd)

5.4.4 Key learning from the field visits

The following issues represent the key learning points from the field visits:

- It is important to note how infrequently the needs or opinions of children were addressed. There is a strong need to consider the needs of children of various age groups: children from 0 – 5; 6 – 12 and 13 - 18 years have very different WASH needs. They will benefit from and could participate in WASH programmes in different ways;
- There is a need to investigate how to give children more of a say in how children's facilities are designed and listen to their feedback;
- Ensure hand washing in schools is conveniently placed next to the latrines and ensures the provision of soap (or an alternative) and water, and is managed properly;
- Hygiene promotion can and should include child focused components, using a variety of interactive methods, and with children involved in the design and pre-testing of materials used;
- Potties for young children are an option in many situations but the choice of excreta disposal methods for young children must be based on discussions with mothers about use, disposal and cleaning of excreta disposal options;
- Water containers and jerry cans need to be of different sizes, as young children who collect water prefer smaller sizes.

5.5 Other existing and planned research

Related to this scoping study, there are various other initiatives planned or being undertaken simultaneously, and which should be referred.

- OFDA funding has recently been provided to a consortium of agencies (Oxfam, IFRC and WASTE) to develop various sanitation solutions including a latrine slab specifically aimed at children;
- Oxfam's innovation fund has provided support to several child focused programmes. The main focus is WASH in Schools but there is also a project in Indonesia that seeks to develop a framework for working with children in emergencies and a project that specifically considers menstrual hygiene management;
- Oxfam has also been engaged in research on hand washing and has been trialling a household hand washing device;
- Innovations for Poverty Action in the U.S., and Harvard University, are designing a children's latrine training mat made from easy-to-clean plastic that fits over an existing latrine hole. The sturdy but easy-to-move platform has a child-sized hole that eliminates the fear and risk of falling into the latrine (http://www.poverty-action.org/project/0557);
- WEDC had MSc students interested in researching WASH for children;
- Resources to raise awareness about gender based violence (GBV) and WASH and what practitioners need to do to mitigate the risks will be released in mid-2014. This includes both adults and children.

6. Discussion of the key issues

6.1 WASH and children's health

As has been outlined earlier, the impact on children's health (given that the under-fives especially are more vulnerable to ill health from WASH related diseases) provides a strong justification for effective WASH interventions in both development and emergency contexts. Children's excreta is seen by public health specialists to be potentially more dangerous than adult excreta and at the same time it is considered by many carers to be less dangerous. According to some sources, children's stools can contain as much as six times as many germs as the stools of adults because the level of excreta-related infection among children is frequently higher (Feachem et al 1983). Also, in many contexts mothers believe that the faeces of young children are harmless and are therefore less likely to take precautions after handling children's excreta.

Young children's excreta is likely to be more dangerous than adult excreta, for several reasons:

- Children are more likely to have diarrhoeal and intestinal infections, and therefore their excreta contains a relatively higher pathogen load;
- Young children's excreta are mistakenly believed to be harmless; and
- Young children or infants are more likely to contaminate the household as they will often defecate in the home or compound;

The limited research that confirms the risks of babies' or young children's excreta compared to adult excreta suggests that improving excreta disposal for babies and young children should be given a much greater priority.

Improvements to water and sanitation have also been shown to reduce diseases such as trachoma, schistosomiasis and helminths. Based on the available knowledge, it would seem that improving excreta disposal for young children is likely to reduce environmental contamination with faecal matter and therefore reduce public health risks. However, research on the most effective way to manage babies and infant's excreta in emergency settings is also very limited.

Reductions in water borne diseases appear to have an impact on other disease specific mortality rates in non-emergency contexts (Cutler and Miller, 2005; Ewbank and Preston, 1990 in Gunther and Fink 2010) - possibly as a result of reducing the stress level for the immune system. It is arguable that in emergency contexts the risks of other diseases will be higher than in the non-emergency context and improving water, sanitation and hygiene may thus have even more significant benefits.

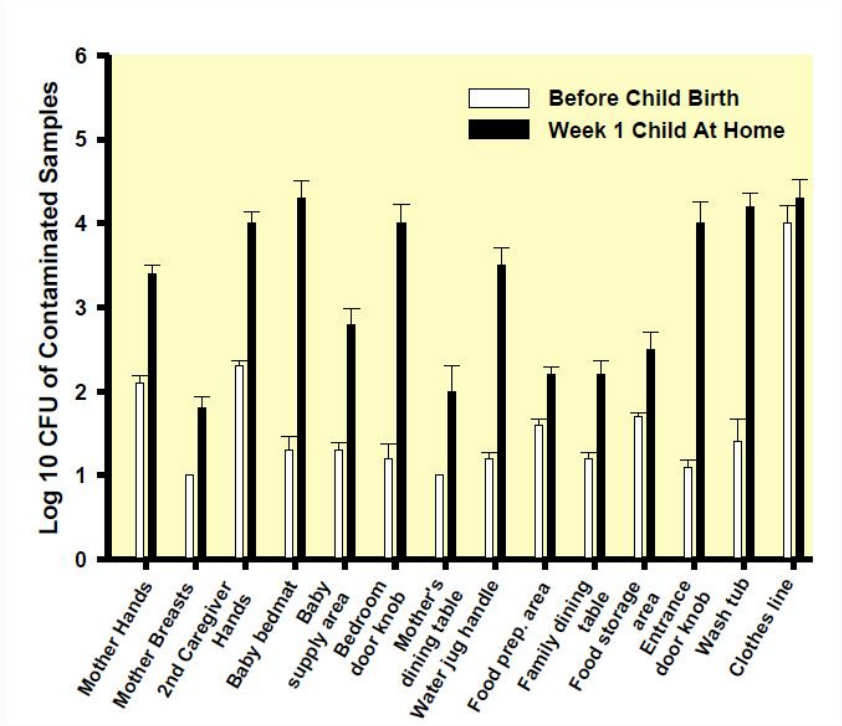
Several large-scale, meta-analyses have demonstrated the significant impacts that water and sanitation have on reducing childhood diarrhoea in non-emergency contexts (Esrey et al 1991, Fewtrell et al 2005, Waddington et al 2009). There is limited data available on the specific impact of water, sanitation and hygiene on rates of diarrhoea in emergency contexts however children under five years of age are clearly a very vulnerable segment of the population. In a non-emergency context childhood diarrhoea is highest in children under 2 years and mortality due to diarrhoea is concentrated in the under one age group. Whilst it cannot be assumed that the same risks apply in acute emergencies, it seems likely that they do.

6.1.1 Neonatal health

Neonatal deaths (within the first 28 days of life) account for 40% of all deaths of children under five and neonatal mortality rates are highest in humanitarian emergencies (Lam 2012). According to recent research examining neonatal care during emergencies, "the promotion of home based care practices such as clean cord care, exclusive breastfeeding and delayed bathing of the newborn to prevent hypothermia do not require technical equipment and can be provided by all programmes working in humanitarian emergencies during routine pregnancy and postnatal visits." It could be argued that hygiene promotion teams are well placed to support such initiatives.

Unpublished research carried out by Odio (2008) in China, on behalf of Procter and Gamble found that the birth of a child led to a significant increase in faecal contamination in the home (see Figure 3, below). The use of both cloth and disposable nappies was associated with increases in contamination of hands and surfaces although the use of disposable nappies led to 30-50% less contamination compared to cloth nappies. The authors suggested that even with the use of disposable nappies, improved handwashing could further reduce faecal contamination of caregivers' hands.

Figure 3: Graph showing faecal contamination of the household following childbirth



6.1.2 Malnutrition

There are important direct and indirect links between WASH and malnutrition. WHO (2008) estimates that 50% of malnutrition in the under five year old age group is associated with diarrhoea or intestinal worm infections. Malnourished children have compromised immunity and are not only more likely to contract diarrhoea (and other communicable diseases), but also suffer from more frequent, severe, and prolonged episodes of diarrhoea. Frequent diarrhoea can also exacerbate malnutrition, as food is not absorbed from the intestine. Worm and helminth infections can cause anaemia and lead to stunting and impaired cognitive development. It is also theorized that sub clinical infections such as tropical enteropathy may also have an important role to play in causing malnutrition (Humphrey 2009).

A recent World Bank Research Paper (2013) documents the strong association between sanitation and stunting and suggests that, "open defecation can account for much or all of the excess stunting in India" compared to Africa[4]. The authors claim that open defecation explains 54% of the international variation in child height whereas GDP only accounts for 29% of this variation and this association is particularly strong in areas of high population density. The same paper presents evidence for the negative effect of one household's open defecation on its neighbours.

[4] Physical height is a predictor of economic productivity but international differences in height are not well explained by differences in wealth, with people in India being shorter than people in Africa despite being richer. However, open defecation is more widespread in India and population densities are greater.

It is thought that tropical enteropathy is caused by the ingestion of faecal bacteria and this causes a sub-clinical (i.e. symptomless) condition that over time destroys the villi in the gut preventing the adequate absorption of nutrients. A short paper in the Lancet by Humphrey (2009) offers the plausible hypothesis that 'the primary causal pathway from poor sanitation and hygiene to under nutrition is tropical enteropathy and not diarrhoea. The faecal oral route is implicated, whether diarrhoea or tropical enteropathy link access to WASH and malnutrition, therefore an effective WASH response remains critical if malnutrition is to be addressed.

Connections between Emergency WASH and infant nutrition are not currently explored sufficiently. For example, nutrition teams may currently recommend that babies under 6 months old should not be given water (because they should be 100% breast fed) but this is not reinforced by the WASH teams.

6.1.3 Food hygiene

According to Cairncross and Valdamis (2006) food hygiene may make a significant contribution to the risk of diarrhoea in children and weaning foods may be particularly implicated. Some studies have suggested that up to 70% of all cases of diarrhoea can be linked to contaminated food – and that microbial counts are often much higher than in water (Brown et al 2013). However, research into this is limited and there is a need for more evidence to confirm the role that poor food hygiene plays. There is also a lack of evidence on the success of behaviour change interventions to improve food hygiene.

6.1.4 Psychosocial impact on children's health

There is evidence that WASH related diseases affect children's cognitive development. According to the World Health Organization, the average IQ loss per worm infection is 3.75 points (UNICEF 2012).

It is not only the provision of services that is important in emergency response, but also the way that they are provided and if this is done supportively it can enhance mental health and support the recovery of children who have suffered significant distress. Involving children in the design and siting of WASH facilities can give them a sense of purpose in the same way it can adults. Organizing activities for children to learn about how to care for the facilities and how to improve hygiene and health can also contribute a focus and structure to their disrupted lives.

Save the Children states that:

> **"It is now widely recognized that in addition to meeting basic needs such as food and shelter, there needs to be consideration given to emotional and developmental support of children." (Save the Children Alliance 2006)**

Save the Children suggests that, "psychosocial programmes need to be based on a knowledge of 'culture, history, traditions and political realities" (SCF 2006). They recommend, 'the creation of a healing environment' through:

- Avoidance of secondary stresses.
- Establishment of good relationships, in which the child is being heard, cared for, respected and accepted.
- The creation of secure and daily routines expressing normalcy.
- The re-establishment of self-esteem or pride through possibilities for fulfilment of the expected norms of society and the ability to bring something to society.
- A future orientation recreated through play and opportunities for growth.

This underlines the importance of and justification for working supportively with children in emergencies and giving them a say in how the WASH programme is delivered. WASH practitioners do not need to be specialists in psychosocial health but all humanitarian personnel should know the basics of psychological first aid (PFA). Providing services in a way that is inclusive and respectful is a part of such 'first aid'.

As the IASC guidelines suggest:

> **"A key to organizing mental health and psychosocial support is to develop a layered system of complementary supports that meets the needs of different groups" (IASC 2008).**

Figure 4 outlines the 'intervention pyramid' for mental health and psychosocial support, showing the fundamental importance of the provision of basic services, such as WASH:

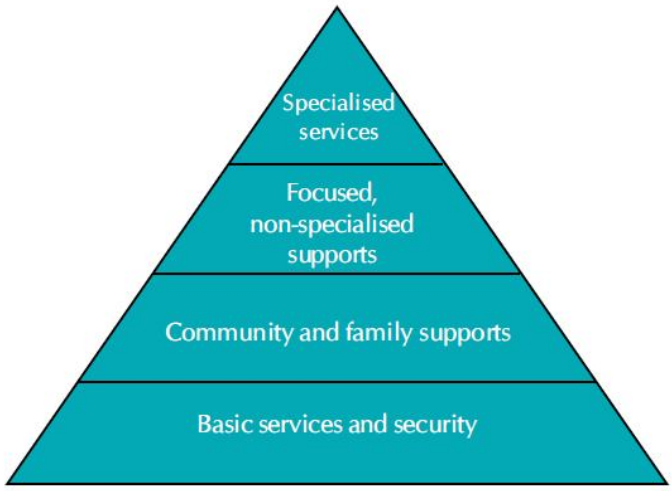


Figure 4: The Intervention Pyramid for Mental Health and Psychosocial Support

Save the Children UK also suggest that:

> **"All field staff & emergency response team members should be trained in children's participation & psychological first aid as part of preparedness". (SCUK 2013)**

What is Psychological First Aid?
Psychological first aid (PFA) is an approach for assisting children and adults after a crisis. Its purpose is to reduce and alleviate the immediate distress, reduce psychosocial chaos in connection with disturbing events, and to promote and support short- and long-term coping and adaptation. Psychological first aid is not psychoanalysis or psychotherapy, since it does not provide treatment. Instead, it gives immediate comfort and support.
Source: Berliner et al (1997) quoted in International Save the Children Alliance (2008)

Whilst psychosocial interventions on their own are not recommended, all staff should be aware that working supportively with children and involving them in any interventions can contribute to relieving their distress.

Children in emergencies will often have experienced traumatic events and the loss of loved ones. Whilst grief is a normal process, they may also experience flashbacks, nightmares, learning and behaviour problems, loss of bladder and bowel control and other physical symptoms. It is important that those working with them (including hygiene promoters) are able to recognize the symptoms of distress, handle them sensitively, and know where they can refer children who exhibit similar symptoms.

Summary Box: WASH and Child Health

Recommendations

1. Agencies and programmes that provide humanitarian WASH, health and nutrition interventions could better integrate their programmes by a focus on those children most at risk from diarrhoeal disease i.e. those under two years of age. This would include hygiene promotion with mothers including practical support for excreta management, improved handwashing and management of diarrhoea as well as food hygiene.
2. A basic awareness of what psychosocial first aid is should be provided to all WASH staff working in emergencies.

Knowledge gaps

1. Whilst neonatal death contributes significantly to under five mortality, it is not clear whether hygiene promotion work with mothers and newborns can contribute to a significant reduction in mortality.
2. The level of risk of very young babies' faeces is not fully understood and it is therefore not possible to prioritize excreta management for children of different ages e.g. should we give greater importance from infancy onwards as opposed to focusing on young babies' excreta?
3. More evidence is needed on the extent to which poor food hygiene contributes to diarrhoea in children and on the effectiveness of behaviour change interventions aimed at improving food hygiene during weaning.
4. More evidence is needed to confirm the suggestion that 'environmental enteropathy' contributes significantly to malnutrition in young children, and to design WASH interventions specifically around this causal pathway.

6.2 Safeguarding and protecting children

All agencies and individuals should proactively aim to safeguard and promote the welfare of children so that the need for action to protect children from harm is reduced. Child protection is an aspect of safeguarding but safeguarding is a broader concept and comprises each organizations' duty to keep children safe by ensuring that the necessary procedures and policies are in place such as, a child safeguarding policy, police checks and staff training.

Sphere states that:

> **'Special measures should be taken to ensure that all children are protected from harm and given equitable access to basic services.**

The child protection working group defines child protection in emergencies (CPiE) as:

> **"…the prevention of and response to abuse, neglect, exploitation of and violence against children in emergencies."**

The Child protection Working Group has also recently defined minimum standards for child protection covering different sectors (see Figure 5, below). The minimum standard for WASH along with outcome and action level indicators are shown below, and "Child protection concerns are reflected in the design, monitoring and evaluation of WASH programmes. All girls and boys have access to appropriate WASH services that minimize risks of physical and sexual violence."

OUTCOME INDICATOR	OUTCOME TARGET	NOTES
1. Percentage of WASH projects where child safety and wellbeing, including family unity, are reflected in design, monitoring and evaluation	100%	(1) "Safe" should be defined and agreed in context and may incorporate criteria such as single sex facilities, locks on the insides of doors, working lights (including for access routes), etc. (4) "Too large" should be defined by CP and WASH coordination mechanisms.
2. Percentage of surveyed sites with communal facilities that have toilet and bathing facilities that are considered safe for women and girls by the population	100%	
ACTION INDICATOR	**ACTION TARGET**	
3. Percentage of schools, child-friendly spaces (CFSs) and health facilities where child-appropriate WASH facilities are in place	90%	
4. Percentage of surveyed communities where children used containers that were too large for children	10%	
5. The female-to-male ratio of representatives in WASH committees	1:1	
6. Percentage of surveyed hygiene promoters who can give the name of at least one place where they can refer a child survivor of violence (including sexual violence)	90%	

Figure 5: Child Protection Indicators for Emergencies (Source: CPWG 2012)

A report by ECPAT (an organization that campaigns against child sexual exploitation) suggests that a child protection policy should be in place for all agencies working with children 'even if it is only in a limited way' (ECPAT 2006).

The UNHCR (2009, 2010) hygiene promotion guidelines contain some suggestions for carrying out an assessment with children. To ensure the protection of children involved they suggest:

- Those carrying out the assessment should work in pairs
- Permission must be obtained from the children's parents before any interventions or activities are organized.
- It is preferable to work with groups of children rather than a child on their own
- Children should know that they are 'allowed' to refuse to answer questions or withdraw from the process at any time.
- Where possible, individuals who have experience of working with children – such as nursery workers, teachers or youth leaders should carry out the assessment.

(Source: UNHCR Draft HP guidelines)

Procedures for recruitment of staff also need to be robust and references must always be followed up and referees should be informed that the potential employee would probably be expected to work with children. It is also important to ensure that so-called 'child friendly' spaces actually do protect children and do not become places that attract people intent on abusing children (Oxfam personal communication 2013).

6.2.1 Child protection policies and procedures

All agencies working with, or having contact with, children, should have a child protection policy. The Charity Commission in the UK, which aims to increase public trust and confidence in charities based in the UK requires agencies to produce policies and procedures for keeping children safe. They recommend that the procedures and systems should include:

- A named person (and deputy) with a clearly defined role and responsibilities in relation to child protection, appropriate to the level at which s/he operates.
- A description of what child abuse is, and the procedures for how to respond to it where there are concerns about a child's safety or welfare or concerns about the actions of a

trustee, staff member or volunteer. Relevant contact details for children's services, police, health and NSPCC help lines should be available.

- A process for recording incidents, concerns and referrals and storing these securely in compliance with relevant legislation and kept for a time specified by your insurance company.
- Guidance on confidentiality and information sharing, legislation compliant, and which clearly states that the protection of the child is the most important consideration.
- A code of behaviour for trustees, staff and volunteers. The consequences of breaching the code are clear and linked to disciplinary and grievance procedures.
- Safe recruitment, selection and vetting procedures that include checks into the eligibility and the suitability of all trustees, staff and volunteers who have direct or indirect (e.g. helpline, email) contact with children. In the case of trustees, because of their position within the charity, we take the view that whenever there is a legal entitlement to obtain a CRB check, in respect of such a trustee, a check should be carried out. This goes beyond circumstances where the trustee comes into contact with children.
- A complaints and referral procedure, which is well publicized but confidential so that adults and children can voice concerns about unacceptable and/or abusive behaviour towards children
- Systems to ensure that all staff and volunteers working with children are monitored and supervised and that they have opportunities to learn about child protection in accordance with their roles and responsibilities.
- Requirements for trustees, staff and volunteers to learn about child protection in accordance with and as appropriate to their roles and responsibilities.

Agency staff are not always aware of the existence of a child protection policy although many agencies now require staff to sign codes of conduct that include (often minimal) reference to children. Such policies also need to be available in different languages and should be discussed with partner organizations. Training available on child protection and safeguarding, for staff of NGOs and other agencies, appears to be minimal, depending on the agency.

Some organizations (e.g. Save the Children UK) carry out CRB (criminal record's bureau but now known in the UK as the disclosure and barring service DBS) or police checks on international staff but the majority of agencies do not appear to do so. The rationale for not doing so is that these police checks rarely identify the people that pose a risk to children and it is preferable to create a culture of safeguarding within an organization than divert resources into carrying out such checks. It is also difficult to obtain checks for national staff. In the UK the checks are free for volunteers or cost £300 when carrying out over 100 checks a year, plus £5 for each additional 'counter signatory' (people within an organization who are allowed to handle DBS applications). The approximate cost for an enhanced check in the UK is £36 and this cost is usually met by the employing agency or organization. However, some other countries e.g. in some Australian States, employees are expected to meet the costs themselves and obtain their clearance online.

The advantages and disadvantages of carrying out police checks (according to WASH practitioners) are outlined in Table 2 below:

Table 2: Advantages and disadvantages of police checks

Advantages of police checks	Disadvantages of police checks
They may pick up people who pose a risk to children (over 60,000 people per year in UK)	There are many people who are not picked up by the police but who are a real risk to children.
It is a deterrent for people who may have a record	Non-UK residents may be more difficult to check and this may take longer, although many countries also hold such records and carry out similar checks themselves.
It will check for spent and unspent convictions, cautions, reprimands, final warnings as well as any other relevant information held locally (enhanced check)	Difficult to do for national staff and it may cause unnecessary doubt of their character leading to reprisals among their own communities or by the police

Practitioners also suggested that in an acute emergency it would slow down the recruitment of staff and could offer a false sense of security that children were protected. However, the safety of children should be paramount and whilst such police checks are only a part of the process of becoming a child safe organization, they remain an important and useful tool to employ. It should be possible to screen all potential employees who might work with children, prior to their acceptance on staff registers and to put in place systems that ensure that staff members do not work with children before such checks have been completed.

6.2.2 Protecting children from physical risks

In 2012, in the Syrian refugee camps in Iraq, two children died as the result of accidents associated with the WASH sector's failure to take adequate safety measures. One child was run over by a desludging vehicle and the other drowned in a pit of water that had been dug during latrine construction (UNICEF, personal communication). Another WASH practitioner recounted the accidental death of a child who was knocked over by a water tanker operated by local contractors. Meanwhile is its surprisingly common to see open or unfenced holes drilled for new pit latrines or septic tanks, and unfenced garbage pits.

Drowning is a major risk in open sources and large tanks and where possible fences should be provided. Environmental heath includes the risks related to indoor stoves, which can be a major source of pollution affecting children especially. It is also important to consider the design of stoves to reduce the risk of fires as well as building well-ventilated kitchens that are separated from living areas.

Several guidelines make reference to the importance of ensuring the safety of children with regard to WASH facilities. It is vital that where contractors are employed that they are also required to follow safety procedures and that they receive appropriate training in child protection. Fences need to be provided around rubbish tips and construction sites. Walls of an appropriate height should be provided around open wells. WASH staff must to be aware of the dangers of accidental poisoning from insecticides and chemicals used to treat household water. Non-food items should not be distributed in plastic bags, if other options are available, because of the dangers of suffocation.

In some responses it may be appropriate to include information about health and safety issues through community mobilisers especially where the use of insecticides or other chemicals is planned. The child protection standards have a standard relating to 'Dangers and Injuries' but do not mention the risk from the construction of WASH facilities. Given that according to WHO, "Injuries are the leading cause of death for children after their first birthday" (WHO 2008), it seems obvious that WASH actors should give this issue greater prominence in emergency responses.

6.2.3 Child labour

Involving children in WASH programmes has sometimes led to accusations of the use of child labour and exploitation, especially in regard to the cleaning of latrines or environmental clean up campaigns,

and even in mainstream WASH programmes there is a substantial possibility of child-labour involvement at the level of materials suppliers, for example in brick factories.

In many countries it is accepted practice for children to be asked to take responsibility for collecting water and cleaning latrines but they do need to be involved in discussions about how this is done and efforts must be made to ensure that this chore does not fall onto one group only (e.g. girls) or that it becomes so burdensome as to interfere with children's ability to attend classes and learn.

UNICEF recommends that all those working with children must protect their best interests and that:

- Child participation should never be child labour.
- Girls and boys should participate equally in cleaning and maintenance.
- Cleaning should not be used as a punishment for poor learning achievement or bad behaviour

Save the Children have also produced a two-page draft paper discussing this issue and recommending best practice (SCUK no date). Involving children in decisions about what activities to undertake and how they should be carried out can help to reduce the risk of exploitation. Meanwhile any water containers distributed should be of an acceptable size for children, basic protective clothing should also be provided to all workers at risk, and information and facilities must be provided to ensure that handwashing is possible. By requiring bidders to adhere to Save the Children's own Child Safeguarding Policy the organisation requires the suppliers themselves to eliminate child labour and exploitation from their supply-chain.

6.2.4 Protecting children from sexual and gender based violence

A survey conducted in South African schools showed that more than 30 per cent of the girls attending school had been raped at school. Many of the rapes had occurred in the school toilets, especially those that were sited too far away from the school (IRC 2005). It is therefore vital that all those involved in the provision of toilets are aware of the risks and involve girls in siting the toilets to maximise safety. The provision of lighting and locks for doors can also enhance privacy and protection.

Safety mapping with girls and boys (see best practice example in WASH for Children resources) has been undertaken in some of the Somali refugee camps in Ethiopia. Whilst the boys felt safe everywhere in the camp, there were numerous locations where adolescent girls in particular felt unsafe, including around the toilets and water points:

> **"Girls consistently indicated in the safety mapping exercise that water points near mosques and on sports fields are concentrated sites of repeated harassment and abuse by men and boys who cluster in these areas." (Schulte and Rizvi 2012).**

In a WASH action research project in Delhi safety audits were carried out in several low-income communities. Groups of women (including adolescent girls) walked around the neighbourhood identifying areas where they felt unsafe. Community toilets were a major concern and they made recommendations on how to adapt these to make them safer and more hygienic (IDRC 2011).

The need to locate facilities sensibly, bearing in mind the risks to women and children, and to provide adequate lighting options such as solar-powered or electrical lighting, lanterns and/or torches, is borne out by the example gathered in this study.

Summary Box: WASH and Child Protection / Safeguarding

Good Practice

1. Ensure that a child protection policy is provided and that all staff working with children are made aware of this and the practical steps they can take to protect children from harm (e.g. during recruitment, seeking permission from parents, working in pairs etc.)
2. Work closely with the protection sector and others (e.g. Ministry of Social Welfare, Education cluster etc,) that have expertise in working with children and safeguarding

3. Ensure that all key child protection documents are translated where required
4. Ensure that the siting of WASH facilities is carried out with groups of women and adolescent girls and that safety is considered

Recommendations

1. WASH agencies should develop a practical and concise training module and/or film on child protection for WASH practitioners (to also cover child labour and health and safety issues)
2. Lobby the WASH sector or Protection cluster to collect and disseminate disaggregated data on accidents involving children in WASH sector
3. Police checks should be carried out wherever possible for all international WASH staff that will be working with children, and consult local human resources people to investigate how best to do background checks on national staff.

Knowledge Gaps

1. Data on child accidents as a result of WASH interventions is not collected, examined or disseminated to support accident prevention

6.3 Children's participation in WASH

Participation is one of the four fundamental principles of the UN Convention on the Rights of the Child (UNCRC). In emergencies, participation of affected communities is seen as essential to effective programme design and can enhance protection and accountability, improve confidence and self-esteem and help children to adjust to psychosocial trauma. However, children under the age of 18 are not often given a say in how WASH programmes are carried out, as documented by fieldwork in Ethiopia and Bangladesh, undertaken as part of this study.

Sphere (2011) considers the participation of children to be an important cross cutting issue and states that:

> **'…it is crucial that (children's) views and experiences are not only elicited during emergency assessments and planning but that they also influence humanitarian service delivery and its monitoring and evaluation.'**

Some commentators suggest that adult attitudes towards children are a major obstacle to their participation, as many adults do not believe that children are capable of making key decisions and cannot see the potential they have for contributing to the response. However, children's participation should be both meaningful and voluntary. Information needs to be provided in a way that they understand and they need to feel comfortable to offer their ideas and suggestions.

Table 1: Levels of children's participation (UNICEF 2007)

Children not involved			Children fully involved
Adults make decisions and take action and tell children what to do	Adults take the lead in deciding what to do but inform children and involve children in action	Children contribute to or lead in setting the agenda and are involved in action	Children take the lead in deciding what is to be done, what roles they will take and what others need to do

It is useful to consider a 'participation ladder' with manipulation and tokenism on the bottom rungs and increasing involvement in decision-making further up the ladder (see Table 4, below). The level of participation that is possible will depend on the maturity and cognitive development of each child as well as the context in which they find themselves. Children's participation begins with active

listening. Children's committees or forums are a useful way to seek the views of different age groups and feedback mechanisms on WASH services could be introduced that are specific to children.

Table 4: Levels of children's participation (UNICEF 2007)

Participation level	Description of involvement
Child initiated but shared decisions with adults	E.g. members of school health club plan hygiene activities and ask teachers for feedback on the plan
Child initiated and directed	E.g. school children decide that they need more soap and approach NGO for help
Adult initiated – shared decisions with children	E.g. latrines constructed on basis of discussions with children, feedback sought on use and modifications made
Consulted and informed	E.g. children asked if they want to have a school health club. Adults then run this.
Assigned but informed	E.g. In the early stages of an emergency it may be necessary to distribute hygiene kits without consultation on contents Activities with children decided by adults and children do what adults tell them to do
Tokenism	E.g. Activities undertaken in an ad hoc way for show rather than impact
Decoration	E.g. Children used for fundraising without any substantial involvement or benefit from programme activities
Manipulation	E.g. Children used as mouthpieces of adults without seeking their consent

UNICEF (2007) also provides an example of an agency checklist for participation:

- Have staff members been trained in child protection – which staff?
- Have staff members been trained in children's participation – which staff?
- Are standards, policy and guidelines for child protection in place?
- Are standards, policy and guidelines for children's participation in place?
- Who is responsible for monitoring and implementing child protection?
- Who is responsible for monitoring children's and young people's participation?
- Are these provisions included in policy and guidelines; when will these activities be done, and who will take the lead?
    - How will children share power and responsibilities for decision-making?
    - How will children be involved in decision-making processes?
    - How will children's views be taken into account?
    - How will children be supported in expressing their views?
    - How will children be listened to?
    - Are there records of consultations with children and have the consultations influenced decision-making?

Save the Children has produced 'practice standards on participation' to describe what children and others can expect from interventions. They are designed to apply to all 'Save the Children child participation work' (Save the Children Alliance 2005).

The guide gives more details on what these standards mean, why there is the standard and how to meet the standard. However, there appears to be little awareness of these standards in many WASH programmes.

Overview of Save the Children practice standards in child participation

- Standard 1: An ethical approach: transparency, honesty and accountability
- Standard 2: Children's participation is relevant and voluntary
- Standard 3: A child-friendly, enabling environment
- Standard 4: Equality of opportunity
- Standard 5: Staff are effective and confident
- Standard 6: Participation promotes the safety and protection of children
- Standard 7: Ensuring follow-up and evaluation

Source: Save the Children Alliance (2005)

A more recent study on children's participation gave rise to the, 'Guidelines for Children's Participation in Humanitarian Programming' (Save the Children 2013) and provides more detailed information on what participation is and how to overcome the challenges, as well as ideas about activities to involve children at different stages of the project cycle. This research found that children had not often been involved in the initial assessment and were usually not involved in providing feedback or monitoring the project.

One of the findings from the Save the Children participation research was:

> **'Apprehension among Save the Children staff and partners to facilitate children's participation in a humanitarian response has also been a key stumbling block.' (Save the Children 2013)**

It is likely that staff in other organizations, are also apprehensive about working with children and this research found that several respondents remarked that they didn't feel confident about working with children. There is a need for more training on how to work with children and how to promote greater participation.

6.3.1 Inclusivity, age and gender

From the findings of the current research it appears that there is a tendency for WASH agencies to think of children as a homogenous group including anyone under 18 years, rather than considering different age groups, gender and different abilities. The WASH sector talks about 'working with children' but children come in different shapes and sizes and will need different responses. Most hygiene promotion work seems to focus on primary school children with the occasional involvement of teenagers. Solutions for excreta disposal sometimes consider young children who can use latrines but do not always think about babies and infants and the age at which children are allowed to use a latrine.

Data can be disaggregated in different ways and the age groups selected will depend on the specific interventions or activities. For example when assessing excreta disposal it will be necessary to first identify the age at which children are expected to start using a latrine or potty and assess the different age groups accordingly. When considering hygiene promotion activities it may be easier to disaggregate age groups in line with school age groupings.

Conflicts and natural disasters will affect men and women, boys and girls differently and it is important that WASH practitioners are aware of this. Failure to recognize the important impacts of gender can often lead to ineffective programming and put affected populations at more risk of harm.

Recently several donors have made it a requirement that the IASC 'gender markers' are used in all proposals and that programmes are reviewed and monitored with these markers in mind. Proposals will be vetted according to four codes (0, 1, 2a and 2b) and it is necessary to show that a gender and age analysis has been considered in needs assessment, activities and outcomes. A WASH Gender

Marker Tip Sheet (IASC 2011) is available to explain the process more clearly. Arguably, there should be a similar "marker" associated with age, or the gender marker should be expanded to include additional vulnerabilities.

WEDC and WaterAid use a social model of inclusion/exclusion that sees difference as a normal part of every society rather than seeing different groups as being separate from society. Interventions then focus on removing the environmental, social and institutional barriers to exclusion for many different groups in society. The model considers the barriers to exclusion at three different levels:

- Physical/environmental level
- Social/attitudinal level
- Institutional/organizational level

This model can be used not only to assess children's access to toilet facilities but also other sanitation and water facilities.

6.3.2 Exclusion of children with disabilities

Disasters often increase the rate of disability in a community and put children with a disability in an even more vulnerable situation. The social model of inclusion/exclusion suggests that children with disabilities exist in every society and are a part of everyday life and their limitations are in part determined by the context in which they live. It is society's responsibility to remove barriers to access and participation. WaterAid and WEDC have developed some useful materials that use this model in the WASH sector and could be adapted for use in emergencies. Christian Blind Mission (CBM 2012) has also produced a useful manual called 'Inclusion Made Easy' that provides information on disability and children's rights, disaster response and water and sanitation.

Summary Box: Children's Participation in Emergency WASH

Good Practice

1. Consider the different dimensions of children's lives separately, when carrying out assessments or involving children in implementation e.g. gender, age or disability
2. Recruit and train both male and female WASH staff who buy into the participation concept and who are able to relate to boys and girls, supporting identification of their WASH needs and participation
3. Make use of and adapt existing WASH tools such as the WEDC accessibility audit, and referring to UNICEF or Save the Children guidelines.

Recommendations

1. Adapt proposal writers' checklists to ensure that children are included before sign off and consider advocacy for changes to the Gender marker to lobby for inclusion of project methodologies that include working with children of different ages.
2. Incorporate more sessions on working with children into existing training for WASH practitioners and provide practical examples of participation relating to WASH
3. Collate existing activities from manuals on child participation and adapt for use in the WASH sector (see resources section)
4. Identify at least two emergency responses where the WASH cluster is active, and trial a participatory approach for children; providing resources to guide and support a greater focus on working with children of different ages and children's participation.
5. WASH agencies should develop leaflets or booklets that describe how children of different age groups can participate in a WASH response

Knowledge Gaps

1. There are very few examples of how WASH programmes have enabled child participation beyond simple assigned activities

6.4 Sanitation

There appear to be few studies available on child defecation practices in different countries and cultures. However it is apparent that children of different ages have different requirements for excreta management, and most lessons around how to adapt emergency sanitation interventions to meet the needs of children revolve around the need to find appropriate solutions for different age groups.

Children and Sanitation
"Children especially, have needs and concerns that should be taken into account when creating sanitation interventions to be used by them. In primary schools, toilets are often inadequate to serve the needs of girls, resulting in non-attendance during menses. Conversely, school enrolment and retention of girls, increases where there are water and sanitation services.
Women, men and children increasingly share roles in sanitation uptake and sustaining hygiene behaviour change. Stereotypes are being dashed as women become more engaged in economic endeavours outside the home, and children increasingly shape the behaviour trends of current and future generations. In line with this, sector agencies need to invest in research to inform communication and maximize behaviour change through the abilities of different target groups."
Source: WSP Working Paper 2010

6.4.1 Excreta management for babies and infants

Children under 12 months have no bowel or bladder control and are usually only able to exert some control by the age of 18 months to 2 years. Some children are only ready for potty or toilet training at 3 years. Stress within the home can make potty training particularly difficult and the process can take weeks or months to complete. The stress of the emergency context may make it a particularly difficult time to start potty training. A review of existing research from a variety of countries, conducted by the Hygiene Improvement Project (HIP 2004) found that latrines were rarely used by children under three and by no more than 25% of children under five. A common misconception is that children's faeces are not a health hazard even if inappropriately disposed of and therefore neither is the wastewater used to clean potties or nappies (HIP 2004).

Studies that do exist on this subject outline a variety of practices from the use of nappies or cloth in very young children to the use of potties, defecation onto soil in the bushes around the house or in open fields or onto pieces of paper or board. Cloth nappies are usually washed and the wastewater thrown onto the compound or down the latrine.

Table 5: Prevalence of nappy use by region (HIP 2004)

Region	Percentage use	Up to:
Africa (Burkina Faso)	6- 52%	20 months
Asia (Philippines)	Approx 30%	Data not available
Latin America (Nicaragua, Mexico and Peru)	11 - 100%	35-40 months

The time, effort and resources required for managing infants faeces can be a strong motivation for commencing potty training as early as possible and carers in many contexts will often claim to have 'potty trained' infants when in fact they have just become expert at catching the time when their infants will defecate e.g. after meals. Studies in Burkina Faso and Peru found that mothers claimed to have potty trained their infants at between 6 -12 months when in fact they were holding the children over the potty at specific times during the day. Training too early was found to be associated with rejection of the potties by the children and made potty training much harder.

The contents of potties are usually thrown into a latrine if available or behind bushes and the potty may or may not then be washed.

Table 6: Prevalence of potty use by region (HIP 2004)

Region	Percentage use	From:	Up to:
Africa (Burkina Faso)	66 – 82%	18 months	20 – 25 months
Asia (Philippines)	Approx 30%	Data not available	Data not available
Latin America (Mexico and Peru)	2 -27 %	0 months	40 months

According to the HIP study, children over the age of 40 months were more likely to subsequently defecate in the open around the compound until they were old enough to use the latrine. The study found that a lack of data meant they were unable to conclude very much about regional variations in latrine usage.

A little-considered option to emerge from this study is the possibility to link sanitation, nutrition and health issues for babies and infants, so that an integrated package of WASH, health and nutrition services could be provided to the group most at risk: the under two age group, in collaboration with mothers. Combining advice on breastfeeding (IYCF), hygiene messages, and coupling this with appropriate sanitation (such as well-managed distribution of washable nappies with provision of spaces to wash them, or responsible potty distribution) and access to appropriate health interventions, would surely make a significant contribution to the survival chances of infants and young children.

6.4.2 Child-friendly latrines and toilets

Reasons given by children for not using a toilet include:

- Fear of the dark
- Squatting hole too big
- Fear of snakes, insects or rats
- Fear of falling into the pit
- Not enough toilets so forced to queue
- Too smelly
- Parents prevent them because of mess, they can't keep an eye on them or they feel they are contaminated with adults faeces or evil spirits

The need for privacy when using the toilet is linked to the development of a sense of self, separate from others and will become apparent at different ages. It should not be assumed that all young children are happy to defecate in public.

The provision of facilities that are acceptable to children with disabilities is also important. WEDC has produced useful materials that discuss possible modifications for WASH facilities. In the recent field visits to Bangladesh, which were done as a part of this current research, young children were asked to draw pictures of the perfect latrine. Many of the pictures included torches or candles and sandals for use in the latrine.

General principles and considerations when designing toilets for children (UNICEF 2003, Zomerplaag and Mooijman, 2005, Jones 2011) include:

- Children are often not prepared to wait (or do not have sufficient bowel or bladder control) – and more toilets will be needed so that they do not have to queue.
- Space for carers taking young children to the toilet should be included in toilet designs (this is also useful for people with disabilities)
- Children of different ages and abilities should be involved in helping to design facilities that are suitable and that they will be happy to use and also in the siting of facilities.
- Use appropriate dimensions for squatting plates, height of locks and handwashing facilities
- For communal toilets ensure that systems for maintenance and cleaning are in place that do not exploit children or discriminate against girls
- For communal toilets ensure that facilities for managing menstrual hygiene are provided

- Ensure modifications for children with disabilities e.g. turning circle for wheelchair, handrails, seats, accessible locks and handles etc.
- In communal latrines, ensure path is wide enough for two people to pass each other

These design constraints should also be taken within the local context. According to UNICEF (2012) "It is impossible to set international standards for dimensions of facilities because the height and size of children may vary per region. A participatory mathematics exercise, in which children measure their height and size while standing, squatting or sitting, provides good information for determining dimensions."

6.4.3 Appropriate solutions for children of different ages

Table 7, below, summarises some of the possible excreta disposal options for children of different ages (cut off points may be context specific and will depend on wishes of parents and children):

Table 7: Excreta disposal options for young children in emergencies

Excreta disposal options			Comments
Babies under 18 months	Cloth nappies or cloth inserts	Disposable nappies	Biodegradable or compostable nappies or nappy liners are available but from limited suppliers Discuss requirements with carers e.g. numbers required, laundering or disposal – may need to provide bucket with lid or detergent for cloth nappies etc.
Children 18 months to 5 years	Potties with lids	Open air infant friendly toilet or adapted adult toilet e.g. use potty over squat hole or provide scoop /trowel or combined adult and child toilet with 2 squat holes	Disposal of faeces still required and Washing of potties Extra space needed for carers in toilets, Possible use of Peepoo bags. Attention to height of handwashing facilities
Children 5 years to 11 years	Child friendly toilets	Adapted adult toilets	Modifications for children with disabilities. Include and promote handwashing Attn. to size of hole, height of handwashing facilities, lighting, handrails
Children over 12 years	Adult toilets	Child friendly toilets in schools	MHM for adolescent girls Modifications for children with disabilities Include and promote handwashing

All of the options above will require hygiene promotion to ensure effective use and maintenance of the facilities or items provided such as subsequent disposal following use of potty, the laundering process following use of nappies, disposal of wastewater.

6.4.4 Management and maintenance of toilets

In many situations where toilets are provided for children, such as in schools, the maintenance of facilities is not adequately addressed. This needs to be considered prior to construction and

agreements signed with all the involved parties. Whilst it will sometimes be possible to involve children in the care of the toilets, it is also important to ensure that this does not interfere with their schooling and does not place an undue burden on particular groups such as girls or younger children or particular castes.

Latrines may fill up quicker than expected because children have been dropping items down the hole. Where latrine covers are not attached to the slab and are quite small, they are often dropped down the hole. There appears to be no IEC material that explores this issue but it is important to discuss this with children and parents and to design materials that are specific to the issue and context.

In the fieldwork conducted as a part of this research, school toilets were often observed to be unclean or locked (and therefore not accessible).

Handwashing facilities, also, were either not constructed or not functioning. Frequently, no system was in place for cleaning the toilets or filling up the water reservoir (for handwashing) and soap or an alternative was rarely available.

6.4.5 What is the risk of children's faeces in the environment?

As previously stated, children's faeces are believed to be more harmful than adult faeces although mothers often think otherwise. There are few studies available that document the way that babies' and young children's faeces are disposed of however and even fewer have investigated the relationship of those practices to diarrhoea. A meta-analysis of existing research from 1986 to 2002, found that risky behaviours relating to the disposal of infant faeces were associated with a significant increased risk of diarrhoea in the household (HIP 2004).

It has also been suggested that significant public health outcomes can only be achieved where the area is 100% open defecation free (WSP 2007) although there is debate about the basis for this claim and more evidence is required. It is thought that even if a small segment of the population continues to practice open defecation, the risk of bacteriological contamination and disease transmission may continue to be high:

> **"This means that if villages or urban districts switch from open defection to some form of improved sanitation technology, the health improvement for the children is larger than the sum of the individual household effects." (WSP 2007)**

The above claims (represented in Table 8, below) do not make it clear if this includes the disposal of children's and babies' excreta or if this effect can be achieved without a specific focus on children.

Table 8: Relationship between the degree of Open-Defecation and the Prevalence of Diarrhoea in villages in Himachal Pradesh, India, 2004 (Sanan and Moulik 2007)

Category	Users of toilets [%]	Prevalence of diarrhoea [%]
Open defecation–prevalent	29	38
Almost open defecation-free villages	95	26
Open defecation-free villages	100	7

6.4.6 Menstrual Hygiene Management (MHM)

A recent study conducted by UNICEF in Somalia found that less that 5% of girls could afford sanitary materials and that girls in grades 6-8 would often miss up to five days school each month because they preferred to deal with menstruation at home. Similar findings have been documented for other countries (Somer et al 2013).

Education about menstruation and the provision of facilities such as laundry areas, additional privacy and disposal facilities for sanitary towels should be age orientated rather than only aimed at secondary school children. Many children start school late and repeat grades and adolescence can begin in lower primary school.

The provision of privacy areas for girls at schools could make managing their periods easier as well as provide a venue for discussion/education on menstrual hygiene and safety. More and more booklets on growing up and menstruation are being developed on a national level for use with boys and girls and could be used in emergency programmes (Sommer 2013).

Resources for responding to MHM in emergencies have recently been developed and the recent publication 'Menstrual Hygiene Matters' (House et al 2012) outlines the problems that girls often face in managing periods both at home and at school.

It should also be remembered that female teachers at school would need to have provision for MHM and some construction manuals fail to identify this need (Government of Ethiopia 2012). If female teachers are deterred from coming to school during menstruation because there is no privacy or MHM provision this will affect children's education.

6.4.7 Vector control

Vector control takes many forms such as indoor residual spraying for mosquitoes, spraying toilets to control flies, setting traps for flies or rodents. Children need to be considered in relation to all of these activities especially in ensuring safety.

The distribution of bed-nets (Long lasting insecticide treated nets - LLINs) can also be the responsibility of some WASH programmes. If such programmes are to be successful, it is important to find out whether young children are actually using the nets. One respondent for this study mentioned that middle children were often left out when only 2 bed-nets were distributed with babies with parents and older children being prioritized.

Summary Box: Children and Emergency Sanitation

Good practice

1. Careful consideration of the options for children's excreta management are needed – this involves talking to mothers, carers and children of different ages, to match constraints against child-friendly design options for specific locations.
2. When washable nappies are distributed, or used, specific measures to contain and treat washing water must be put in place.
3. Where potties are distributed, providing information on the dangers of children's faeces and on how best to use and clean potties is also be necessary.
4. Work closely with community members, school management and WASH committees to identify maintenance issues and to enable them to provide consistent water supply and access to soap, and to avoid the breakdown of facilities.
5. Promote the construction of gender specific (boy- and girl-friendly) facilities within communal latrine blocks in schools and communities.
6. Include MHM provision in sanitation work, as well as providing information booklets on puberty if possible.
7. Consider including torches and sandals, for children's use in latrines, within hygiene kits

Recommendations

1. Develop a technical training brief on sanitation options for children of different ages
2. Adapt and use the WEDC accessibility tools to ensure that children's sanitation needs are addressed.
3. Incorporate greater focus on children's sanitation in existing training modules and guides

Knowledge Gaps

1. Little is known about how mothers and carers actually manage babies and young children's faeces in emergencies and it is thus difficult to identify the best solutions.
2. A clear gap exists in planning how WASH, Health and Nutrition teams can work together to deliver an effective package of services for babies, infants and young children, so that sanitation, hygiene, IYCF and healthcare approaches can work together.
3. More data is needed to provide firm evidence for the assertion that "significant improvements in public health outcomes depend on an area being 100% open defecation free" and whether this includes babies and infants' excreta.
4. The provision and maintenance of handwashing facilities at latrines is often problematic (especially in water scarce areas) and not enough is known about how to manage handwashing facilities for children in schools and the community, given the wide range of technical options available.
5. Few case studies exist of sanitation provision for children in emergencies: more would increase sectoral knowledge of the appropriate options and designs available.

6.5 Water

6.5.1 Modifications of facilities

In emergencies there have been various attempts to modify facilities to ensure that they are accessible for children. For example the Oxfam bucket, tapstands and taps have all been developed partly with children in mind: the bucket is 15 litres rather than 20, tapstands are the appropriate height for children to use and taps are made so that they are self-closing (Oxfam personal communication). Clearly robust taps that are difficult to remove are also friendly in adding to the resilience of a system, contributing longer term water provision.

Field visits in Bangladesh, for this study, especially suggest that children's needs are not always taken into consideration and that there are numerous modifications that could be made to the design and siting of hand pumps to make them easier to use. One girl remarked that, "the well is good, but the steps are high. When I am at the pump I stand here and am afraid as the handle is the corner-side" [near the edge of the platform with a steep drop]. The depth of the well or borehole will also have an impact on the ease of pumping.

The provision of hot water is a consideration in winterised programmes, as children are more likely to WASH their hands, or bathe properly if they will not get cold during or after washing (WEDC 2004).

6.5.2 Management and maintenance of water facilities

It is frequently the case, that young children are found playing on tapstands and this often leads to damage or wastage of water. In addition to using more substantial taps (using ¾ inch as standard instead of ½ inch) the problem of broken taps could be partly addressed by discussing maintenance issues more with children and encouraging older children to supervise their younger siblings or health clubs to work on solving this issue. Older children could also be part of the WASH committees and serve as children's representatives as well as being involved in the maintenance of facilities.

Some engineers have tried to design facilities where children are encouraged to play in order help to pump water such as roundabouts attached to pumps. However these appear to have had limited success.

Summary Box: Child-focused Emergency Water Supply

Good Practice

1. Involve children (users) in the design and siting of water points and ensure that their views are incorporated into programme planning and that the hardware selected is appropriate to the needs of children.
2. Use robust, difficult to break taps wherever possible.
3. Consider including older children on WASH committees and involve children more in discussions about maintenance, and through their involvement in hygiene clubs.

Recommendations

1. Develop a technical briefing paper on water issues for children (include GBV and health and safety issues)
2. Work on improving tap designs that are both child friendly but that also do not break easily.
3. Adapt the WEDC accessibility audit to incorporate safety and use this with the children that use the water points.

Knowledge Gaps

1. Lack of case studies describing children's involvement in WASH

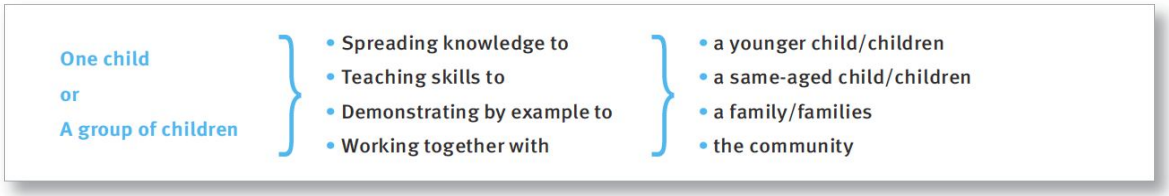
6.6 Hygiene Promotion

Hygiene promotion or communication is a vital part of the assessment, design and provision of water and sanitation facilities and most WASH interventions that do work with children recognize their capacity to be agents of change in their community and not just participants in hygiene education sessions.

Child focused HP approaches that have been used in emergencies include:

- Child to Child (and child to community)
- CHAST (Children's hygiene and sanitation for transformation) - Somalia
- School health clubs – various countries
- Community health clubs (can include children but also children only clubs) – examples of use in Uganda IDP camps and Darfur
- Peer education

Figure 6: Child to child matrix: source WSSCC (2010) in WaterAid Hygiene framework 2012



In addition, a variety of different methods and activities have also been used with children in emergencies.
Other approaches that could be adapted for use in emergencies are:

- School Led Total Sanitation (similar to CLTS but working with school children)
- Social marketing

However, activities aimed at children tend to focus on younger (primary school age) children or work through mothers and children's carers. Once again, children are often seen as a homogenous group or the age range is unspecified.

Fieldwork connected with this study found that hygiene promotion activities with children often appeared to be disconnected from WASH hardware provision. For example education activities on the importance of handwashing were done in school but there were no facilities for handwashing at the school toilets and not enough work had been done on ensuring the cleaning and maintenance of facilities.

Indicators relevant to WASH outputs and outcomes for children are rarely provided in project documentation and monitoring of such outcomes is therefore non-existent. The exception is in WASH for schools where monitoring could often be strengthened. UNICEF has produced some useful frameworks and guides for monitoring school WASH and has produced a variety of case studies – 'soap stories' on handwashing with children.

Another important issue is ensuring that interventions keep a focus on specific outcomes rather than just having fun and entertaining children. As in many areas of WASH, monitoring is not always carried out systematically.

Tearfund children's health clubs in Darfur

When Tearfund initially came to work in Darfur they visited communities South West of Geneina to identify what would be the best way to support them. Many community members requested that the programme be aimed at the children. Community leaders including Headmasters and mothers explained some children were in school but many were not and so they suggested an out of schools program open to all. They also suggested the programme take place in the cool of the early evening and that it should be fun as well as educational. They were keen that many local people were involved in running the programme.
After the programme had been running for some time club members complained that too many of their mothers were also coming to their clubs. When Tearfund spoke to the women they requested their own clubs, as they were very keen to learn what their children were learning. These mothers then started their own clubs with support from Tearfund.

Source: Tearfund 2008

The WASH Cluster hygiene promotion materials including the visual aids library include activities and picture sets that can be used with children. There is also an introductory training session on working with children and training sessions that introduce child-to-child, working with puppets and working in schools. However, the materials lack detailed information on how to work with children and there is a limited amount of information on working with children of different ages and on how to encourage greater participation. There is nothing on working with children on operation and maintenance of facilities and no information on how to involve children in decision-making.

Additional resources available include:

- UNICEF has recently produced a guidebook for teachers working on WASH for schoolchildren in emergencies. This is accompanied by three sets of flashcards designed for Asia, Africa and Latin America.
- IFRC has developed a hygiene promotion box that contains picture sets for different regions and materials for making puppets along with other useful materials and equipment for setting up hygiene promotion activities in emergencies.
- Oxfam has recently produced a briefing paper called 'Working with Children in Humanitarian WASH Programmes'. This provides a matrix of WASH activities for children of different ages as well as ideas about how to include children in WASH programmes at different stages of the project cycle (see appendix).
- Tear Fund has produced a children's health club training guide (Tearfund 2008), which was developed for use in Darfur and is accompanied by a set of picture cards. Information is provided on how to initiate the clubs, child protection, how to manage children's behaviour as well as a variety of activities that can be carried out with children. However, there is no

information or activity sessions that focus on preventing damage to facilities such as pumps, tapstands or toilets.
- Caritas (2004) have also produced a practical guide for children's hygiene and sanitation training (CHAST) based on the PHAST materials.
- Save the Children (2010b) has recently produced a health education manual to support their school health and nutrition programmes. The manual has a section on WASH and a section on (predominantly) WASH related diseases with ideas for lessons aimed at 8-10 year olds. A session on WASH in schools is included.

In Zimbabwe UNICEF and ZimAHEAD have produced a series of manuals for WASH in Schools that have activities and provide homework practicals to apply the knowledge gained during lessons. This also includes material on disaster risk reduction. The manuals are targeted at different age groups and provide age appropriate materials.

Hygiene Central and LSHTM have developed a 'Tools for Schools' kit focusing on handwashing. This contains useful ideas for working with children that could be adapted to different age groups for use in emergencies. The 'Handy Little Book on Schools Research' provides some good ideas for assessing hygiene in schools (see resources section for an overview of these) as well as information on psychosocial development and behaviour change in children.

During the current research WASH practitioners identified the following gaps in IEC materials:
- Materials for use with children in pastoralist communities (Ethiopia)
- Materials that focus on the maintenance or management of WASH facilities (for use with children)
- More variety in materials (programmes tended to use one set all the time and children got bored of this)
- Materials for teenagers and young adults (the MHM information books and some DRR materials are an exception to this)

A long-standing gap within HP provision seems to be accessing and sharing IEC materials. The Visual Aids Library developed by the WASH Cluster HP project aimed to address this gap. However, the materials that were developed are not aimed specifically at children, and are only available on a DVD and the IFRC wikispaces website, where they are not easy to find. A separate section on working with children would be useful.

A longer-term WASH programme in Laos (NEHWSC 2007) has worked with community members, including children to get them to design their own IEC materials and this approach could be adapted for use in some emergency programming with children.

6.6.1 The use of new technology in HP with children

Recent emergency interventions that have made use of mobile phones for hygiene promotion have found that where children have access to mobile phones, young people are not surprisingly, more likely than adults to favour the use of and trust the new technology (EEHF 2012 Workshop report). Healthphone is an organization that has developed preloaded short health films onto smart phones. These cover a variety of topics from handwashing to diarrhoea management to preventing domestic violence. Most videos currently appear to target adults. There are opportunities for developing HP materials focused on older children that make use of new technology – although of course this will not be applicable in all situations.

In the camps in Ethiopia IMC had a multimedia station for use in promotion activities, which is another example of appropriate innovative thinking in hygiene promotion which is likely to appeal to a young audience and users.

6.6.2 Hygiene items and kits

Where hygiene kits have been distributed in schools, directly to children there have been complaints that this led to duplication as households were receiving similar items in the general distribution. However, there is scope for developing children's hygiene kits through consultation and to include handwashing diaries, hygiene colouring books or comics or other items that could stimulate an interest in hygiene issues, remind children about specific hygiene actions or that they could use to inform their parents about hygiene.

6.6.3 Handwashing

Fieldwork as part of this study showed that handwashing facilities in schools were often not constructed or not functioning. Frequently, no system was in place for cleaning the toilets or filling up the water reservoir (for handwashing) and soap or an alternative was rarely available. In cold climates, the absence of hot water for handwashing may deter children especially from Washing hands and bathing (WEDC 2004).

Promoting handwashing is possibly the easiest single activity that a HP team can implement with children, and yet without access to sustainably managed handwashing facilities and soap the activity may represent wasted energy. The balance between handwashing training activities and other HP activities such as safe water storage, personal hygiene, food hygiene and others also needs to be examined to make sure the balance is maintained.

Summary Box: Hygiene promotion for children in emergencies

Good practice

1. Identify at least one or two indicators for monitoring project outputs and outcomes for children
2. Make use of existing established child to child, CHAST and SLTS methodologies.
3. Consider the involvement of older children on WASH committees, hygiene clubs.
4. Involve children in monitoring the use and maintenance of facilities (e.g. get them to take photographs, draw the good and bad facilities, hold discussions etc.)
5. Ensure that software and hardware are integrated so that children are enabled to have better hygiene rather than simply learning messages about hygiene.
6. Making learning fun is a useful way of giving messages to children (however remember that the objective is not *just* to have fun with children but more importantly to promote hygiene including use and maintenance of WASH facilities).

Recommendations

1. Identify the WASH needs of children of different ages in the initial assessment.
2. Involve older children in carrying out further assessment of needs and monitoring interventions.
3. Identify ways to promote more effective sharing of IEC materials for use with children, for example by creating a library of workable materials linked to the WASH cluster website.
4. Develop hygiene promotion materials for mothers that link best practice and appropriate messages in infant and small child health and nutrition, with hygiene messages. For example include the message that babies under 6 months should not drink the water we provide, because they should be exclusively breast fed.
5. In consultation with target groups, develop WASH materials for use with teenagers in key emergency contexts (include pictures and activities on the maintenance of tapstands and toilets).
6. Develop IEC for pastoralist communities in key emergency countries and share with other agencies (development should be done with representatives from government and various agencies and children themselves).
7. Consider asking IFRC to include a section on working with children on the wikispaces website.

8. Consider the ways that new technology can be used to reach children.

Knowledge Gaps

1. There is very little evidence about what approaches and methods work best with different age groups of children and disaggregated data from monitoring is very limited.
2. The extent to which children can influence parents' and younger siblings' behaviour in an emergency has not been formally researched and no evidence for this currently exists.

6.7 WASH in Schools in emergencies

Although there is a dearth of material on working with children in the WASH sector, the exception to this is WASH in Schools where significant work has been done by UNICEF and others to inform interventions, make toilets and facilities more child friendly and improve both policy and practice. There are numerous documents and websites available that provide information on WASH in Schools (Zomerplaag and Mooijman, 2005; www.schoolsanitation.org; www.WASHinschools.info).

The WASH in Schools website has mapped the available resources for different countries and a variety of materials can be downloaded including technical designs, hygiene education manuals and visual aids.

According to WSSCC (2010) an effective WASH in schools programme usually focuses on:

1. Training of Trainers or orientation of community and parent groups such as the school management committee, parent teacher association leaders and self-help groups;
2. Parents (rich and poor), teachers and community groups decide on the technology, designs and payments using participatory tools;
3. Baseline survey or school study;
4. Preparation of water and sanitation (WATSAN) plan and community contribution;
5. Training of teachers and head teachers, providing lesson plans and materials;
6. Classroom teaching, for example, one hour a week;
7. Active school clubs with children in school, home and community;
8. Construction of water points, toilets and urinals, handwashing and water storage;
9. Continued use, maintenance of facilities and monitoring in the school.

This comprehensive list of activities is often adapted in emergencies and depending on the time frame and the urgency of the situation activities may be reduced in scope. It is notable that point 2 in the above list seems to neglect the input that children themselves can have on the design of facilities.

UNICEF have recently produced two useful documents relating to WASH in Schools in emergencies – one that provides guidance on a variety of technical designs and the other a guidebook for teachers. However, neither manual addresses the issue of preventing children from playing on tapstands or throwing latrine covers, bottles or other items into the latrine. The guidebook for teachers provides information on the maintenance of latrines in schools but has little information on the maintenance of water points or latrines in the community. Information is also available on monitoring school WASH that could be adapted for use in emergencies.

Guidance is also available for monitoring school WASH and case studies on school WASH and handwashing have been produced. The UNICEF compendium of WASH in Schools facilities (2012) also provides examples of handwashing facilities and how maintenance is carried out in emergency responses. However, there is little reference to how schoolchildren have been involved in the design and siting of facilities. Environmental sanitation kits and latrine cleaning kits are often distributed to children's sanitation committees and hygiene kits have also been distributed directly to children.

This study was unable to spend much time researching the situation in schools but observations of a few schools did indicate significant gaps in the response with the lack of child friendly facilities, the

absence of real participation of children and a failure to integrate hardware and software issues. The provision of handwashing facilities seemed particularly problematic and there was also little provision to support MHM either for children or for female teachers. In Ethiopia, recent guidelines on design and construction of School WASH fail to include the provision of MHM for female teachers or acknowledge that secondary school age girls may also be forced to resit their primary education. Whilst some programmes were using UNICEF's recently developed materials, others lacked a variety of IEC. Some key informants suggested that the main problem was a lack of emergency funding for School WASH. The issue of MHM is gradually being addressed, by many actors, now that guidance documents are available (House et al., 2012)

Summary Box: WASH in schools

Good Practice

1. Make use of UNICEF's materials on School WASH in emergencies, and other existing advice.
2. Encourage greater participation of schoolchildren in the design of the intervention and in making decisions about how best to improve WASH in the school and community
3. Ensure that interventions integrate hardware and software issues, so that they complement each other, and so that handwashing and MHM are part of the initial programme design.
4. Work with parents, teachers and school children to ensure that the use, cleaning and maintenance of facilities is addressed, preferably before construction commences.
5. Where school health clubs are initiated consider how they can influence others in the school and produce concrete improvements in hygiene. Do not limit membership
6. Ensure that regular monitoring and feedback from users is used to identify and address weaknesses in the response

Recommendations

1. Lobby donors for funding to intervene in schools during emergency WASH responses as this is an important opportunity to influence key change agents
2. Produce a short briefing paper on handwashing designs for schools and disseminate amongst WASH staff working on school WASH (e.g. tippy tap, handyWASH and metal scoops)

Knowledge Gaps

1. Not enough is known about the outcomes of School WASH projects in Emergency contexts

6.8 Disaster Risk Reduction

There are numerous examples of how children have been involved in DRR (disaster risk reduction) programmes although there is a limited amount of information on their involvement in WASH specific activities. WASH programmes and especially hygiene promotion personnel can learn important lessons from these examples that promote children's participation and community resilience.

Philippines: The power of children's voice in coping with extreme weather

Heavy rain early in 2007 caused several landslides in the Philippines. One village was buried with terrible loss of life. Subsequently the Philippines Mines and Geosciences Bureau conducted a risk assessment of potential landslides in Southern Leyte province in 2006, determining that eight barangays were at high risk within the Municipality of San Francisco. These included Santa Paz Sur and Santa Paz Norte, with recommendations to relocate affected houses. These two barangays were home to a high school and an elementary school, both of which were considered to be extremely exposed to landslides.

Following debates about whether and how to relocate the school, the headmaster opened the decision to a community-wide referendum, with a vote for each of the children of the school. Broadly the children were in favour of the relocation. But their parents were opposed because they did not want their children to travel to school located in a different community and local shops feared loss of business.

The children's organisations in the school embarked on an education campaign about the physical processes of landslides and a great many students wrote to the local government expressing their desire to relocate.

The student's proposal won the vote by 101 to 49. Due to concern from the Provincial authorities, the schedule for relocation was shortened to just two days following more heavy rains. A temporary tent school was erected over one weekend with children and parents helping to put up the tents and children digging drainage channels.

The children were very pleased that they had influenced this important decision and said they had no regrets about the decision to move. The new school was opened in July 2007 in Pasanon, a safer location a few hundred meters from the temporary school, with co-financing from Plan. The school is safe from landslide and flood and also includes earthquake mitigation measures such as steel ties on the roof.

Figure 7: Philippines case study

Save the Children states: "Children who participate in CLDRR (child led disaster risk reduction) have a greater capacity to cope with disasters; their sense of security is increased; their knowledge of the risks is developed; and their sense of control and survival potential is enhanced by knowing how to respond to disasters". (Save the Children 2007)
Source: Children in a changing climate (wwwchildreninachangingclimate.org)

Ideally DRR should be integrated into the school curriculum. Cuba, Nicaragua and Peru provide examples of where this has worked well. A useful training manual on DRR developed by Save the Children Sweden (2007) details how children can be involved in producing community maps and in designing an information campaign. However, there have also been useful interventions with youth groups, girl guides and other clubs for young people (Save the Children 2007).

Children and DRR: Why children?

"…during disaster we are the most affected in the society and should be prioritized. The children have the right to participate in any community capacity development. And we too can easily understand that which can harm us and use our talent to influence duty bearers to protect children against the risk of disaster. " Mark, 14, child leader from Easter Samar, The Philippines.

Source: UNISDR/Plan (2012)

In Jamaica, the Office of Disaster Preparedness and Emergency Management, (ODPEM) has identified key areas where children are particularly vulnerable during disasters including health and water and sanitation amongst others, and these could be included in approaches to disaster risk reduction:

WATER AND SANITATION

- The faecal-oral transmission of water-borne disease threatens children in particular.
- Location of water points and latrines are often inconvenient for children.
- Water points pose potential hazards to children (e.g., unprotected wells, heavy pump handles).
- Both children and caregivers lack hygiene and water resource management information.
- Children tend to have easy contact with solid waste (trash) in and around shelters.

HEALTH ISSUES

- Health status of children is most precarious in emergencies.
- Acute respiratory infections and diarrheal disease are the chief threats.
- Children and caregivers lack health and hygiene information.
- Reproductive health of young girls and adolescents is especially affected during disasters.
- Psychosocial needs increase, for children and parents; response should emphasize family and community rather than individual clinical care.

Source: Save the Children (2007)

During the current research project, few observations were made of DRR programmes, although both Bangladesh and Ethiopia have examples of such interventions. Hygiene issues and the prevention of diarrhoea are often neglected in such programmes. Even very young children can often be carers for younger siblings and should be aware of how to prevent and manage diarrhoea, using ORS.

An interesting finding from Ethiopia however, showed how the dropout rate from schools was used as an indicator to determine when to start water trucking. As families attempt to adapt to an increasingly severe drought children may be needed to help fetch water or families may migrate to find pasture and water and consequently children are withdrawn from school.

Summary Box: Children and DRR

Recommendations

1. Ensure that DRR programmes focus on children of different ages and include information on the prevention and management of diarrhoea and access to WASH facilities.

Knowledge Gaps

1. Little is known about the extent to which WASH for children is incorporated into DRR programmes in different countries

7. Conclusions and recommendations

From the completed scoping study on Emergency WASH for Children, it is clear that WASH provision for children in emergencies is not done consistently or systematically and there are only a few examples of good practice. Given that young children are usually more vulnerable to WASH related diseases and that children under the age of 18 can represent over half of the population, the WASH sector could significantly improve the quality and effectiveness of interventions by considering how it can better meet the needs of children. Fears that this might lead to vertical programming are unfounded and it is important to explore the issue in more depth, in order to understand both the problem and the opportunities and to identify the best approaches to use. WASH for children should not be considered as an optional extra but as a crucial intervention that could significantly contribute to improving the effectiveness of WASH in emergencies. WASH for children is not just a concern for hygiene promoters but for engineers also and must be given a higher priority than is currently the case.

It is important to remember that the WASH sector could also improve its response to people with disabilities, older people, religious or ethnic minorities, people living with HIV, and other groups that are often marginalized. Improving accessibility and social inclusion should be a goal of all WASH interventions and solutions found for children may also be adaptable to other vulnerable groups. Consideration of adaptability of the solutions may help reduce the number of toolkits needed to address the varied needs of far from homogenous communities in crisis.

Key good practice recommendations from this research as well as some of the knowledge gaps that require further research are listed below, and promoting the use of operational research as a means to address these knowledge gaps is recommended.

Recommendation 1: More evidence is needed to explore how Emergency WASH can contribute to children's health and nutritional status; however defining a combined WASH, nutrition and health programming methodology for infants and very young children seems to present a real opportunity to have a significant impact.

A combined approach involving WASH, Health and Nutrition would allow the exploration of the knowledge gaps and questions previously outlined:

1. Despite studies that show that children's faeces could contain up to six times the pathogen levels of adults', the level of risk of very young babies' faeces is not fully understood and it is therefore difficult to prioritize excreta management for children of different ages e.g. should we give greater importance from infancy onwards as opposed to focusing on young babies' excreta?
2. Agencies and programmes that provide humanitarian WASH, health and nutrition interventions could better integrate their programmes by a focus on those children most at risk from diarrhoeal disease i.e. those under two years of age. This would include hygiene promotion with mothers including practical support for excreta management, improved handwashing and management of diarrhoea as well as food hygiene.
3. Whilst neonatal death contributes significantly to under-five mortality, it is not clear whether hygiene promotion work with mothers and new-borns can contribute to a significant reduction in mortality.
4. Emergency sanitation practices for infants and young children, for example the use of washable or disposable nappies, and potties and what carers do if these are not available, is very poorly understood.

Other opportunities to maximise the health and nutrition outcomes from a combined approach could include:

5. More evidence is needed on the extent to which poor food hygiene contributes to diarrhoea in children and on the effectiveness of behaviour change interventions aimed at improving food hygiene during weaning.
6. More evidence is needed to confirm the suggestion that 'environmental enteropathy' contributes significantly to malnutrition in young children, and to design WASH interventions specifically around this causal pathway.
7. A basic awareness of what psychosocial first aid is should be provided to all WASH staff working in emergencies.

Recommendation 2: Children's participation in Emergency WASH programmes can and must be improved

At the moment there are few good practice example of how children have been actively involved in Humanitarian WASH programmes, other than in completing specific activities, mostly hygiene promotion related. It would be good practice to consider the following

1. Recruit and train both male and female WASH staff who buy into the participation concept and who are able to relate to boys and girls, supporting identification of their WASH needs and participation
2. Make use of and adapt existing WASH tools such as the WEDC accessibility audit; refer to UNICEF or Save the Children guidelines; and incorporate the participation ladder into discussions on how to include different age groups.
3. Consider the different dimensions of children's lives separately, when carrying out assessments or involving children in implementation e.g. gender, age or disability

In addition, the following would also lead to improvements in the participation of children

4. Adapt proposal checklists to ensure that children are included before sign off and consider advocacy for changes to the Gender marker to lobby for inclusion of children of different ages.
5. Incorporate more sessions on working with children into existing training for WASH practitioners and provide practical examples of participation relating to WASH
6. Further work to collate existing activities from manuals on child participation and adapt for use in the WASH sector
7. Identify at least two emergency responses where the WASH cluster is active, and trial a participatory approach for children; providing resources to guide and support a greater focus on working with children of different ages and children's participation.
8. WASH agencies should develop leaflets or booklets that describe how children of different age groups can participate in a WASH response
9. Collect further examples of how WASH programmes have enabled child participation beyond simple assigned activities: at the moment there are few examples.

Recommendation 3: Protection of children is implemented sporadically, and in general children are under-protected due to lack of time and knowledge on the part of WASH teams.

Good practice in protecting children participating in or involved in the supply chain for emergency WASH programmes would include:

1. WASH teams should work more closely with the protection sector and others (e.g. Ministry of Social Welfare, Education cluster etc.) that have expertise in working with children and safeguarding
2. Ensure that a child protection policy is provided and that all staff working with children are made aware of this and the practical steps they can take to protect children from harm (e.g. during recruitment, seeking permission from parents, working in pairs etc.)
3. Ensure that key child protection documents are translated where required

4. Ensure that the siting of WASH facilities is carried out with groups of women and adolescent girls and that safety is considered
5. Consider children involved in the supply chain for WASH programmes as well as those directly participating. Procurement contracts should explicitly mention what we expect from our own suppliers and their suppliers as well.
6. Police checks should be carried out wherever possible for all international WASH staff that will be working with children, and consult local human resources people to investigate how best to do background checks on national staff.

The following should also be considered as possible follow up actions:

7. WASH agencies should develop a practical and concise training module and/or film on child protection for WASH practitioners (to also cover child labour and health and safety issues)
8. Consider asking the WASH or Protection sectors to collect and disseminate disaggregated data on accidents or incidents involving children in WASH sector

Recommendation 4: Emergency sanitation for children can be improved: in particular through the consideration of children of different age groups.

Good practice in providing emergency sanitation to children of different age groups, would include:

1. Careful consideration of the options for children's excreta management: talking to mothers, carers and children of different ages, to match constraints against child-friendly design options for specific locations.
2. When washable nappies are distributed, or used, specific measures to contain and treat washing water must be put in place.
3. Where potties are distributed, providing information on the dangers of children's faeces and on how best to use and clean potties is also be necessary.
4. Promote the construction of gender-specific, child-friendly facilities within communal latrine blocks in schools and communities.
5. Include MHM provision in sanitation work, as well as providing information booklets on puberty if possible.

General good practice in providing emergency sanitation for children would include:

6. Work closely with community members, school management and WASH committees to identify maintenance issues and to enable them to provide consistent water supply and access to soap, and to avoid the breakdown of facilities.
7. Consider including torches and sandals, for children's use in latrines, within hygiene kits

The provision of emergency sanitation for children could be improved by consideration of the following:

8. Develop more detailed guidance/briefing papers on sanitation options and water issues for children of different ages, in the community especially (including MHM, GBV and safety issues).
9. Adapt and use the WEDC accessibility tools to ensure that children's sanitation needs are addressed
10. Incorporate greater focus on children's sanitation in existing training modules and guides
11. Little is known about how mothers and carers actually manage babies and young children's faeces in emergencies and it is thus difficult to identify the best solutions.
12. A clear gap exists in planning how WASH, Health and Nutrition teams can work together to deliver an effective package of services for babies, infants and young children, so that sanitation, hygiene, IYCF and healthcare approaches can work together.
13. More data is needed to provide firm evidence for the assertion that "significant improvements in public health outcomes depend on an area being 100% open defecation free" and whether this includes babies and infants' excreta.
14. The provision and maintenance of handwashing facilities at latrines is often problematic (especially in water scarce areas) and not enough is known about how to manage

handwashing facilities for children in schools and the community, given the wide range of technical options available.

15. Few case studies exist of sanitation provision for children in emergencies: more case studies would positively affect knowledge of the appropriate options and designs available.

Recommendation 5: Child-focused Emergency Water Supply has been investigated already, to a certain extent. However efforts to improve tap designs, and improving awareness of good practice in relation to child protection and children's participation in WASH should continue.

Good Practice when considering emergency Water Supply for children would include:

1. Involve children (users) in the design and siting of water points and ensure that their views are incorporated into programme planning and that the hardware selected is appropriate to the needs of children.
2. Use robust, difficult to break taps wherever possible; and use moderately sized buckets.
3. Consider including older children on WASH committees and involve children more in discussions about maintenance, and through their involvement in hygiene clubs.

Follow-up actions that could contribute to good practice, would include:

4. Develop a technical briefing paper on water issues for children (include GBV and health and safety issues)
5. Work should continue on improving tap designs that are both child friendly but that also do not break easily.
6. Adapt the WEDC accessibility audit to incorporate safety and use this with the children that use the water points.

Recommendation 6: There are excellent opportunities for the involvement of children in emergency hygiene promotion, especially teenagers, and to make suitable IECs for working with children more accessible to WASH actors.

Good practice in adapting emergency hygiene promotion for children's needs would include:

1. Make use of existing established child to child, CHAST and SLTS methodologies.
2. Consider the involvement of older children on WASH committees, hygiene clubs.
3. Involve children in monitoring the use and maintenance of facilities (e.g. get them to take photographs, draw the good and bad facilities, hold discussions etc.)
4. Ensure that software and hardware are integrated so that children are enabled to have better hygiene rather than simply learning messages about hygiene.
5. Making learning fun is a useful way of giving messages to children (however remember that the objective is not *just* to have fun with children but more importantly to promote hygiene including use and maintenance of WASH facilities).

Recommendations to improve the delivery of hygiene promotion to children in emergencies would include:

9. Adapt assessments so that we can identify the WASH needs of children of different ages during that initial assessment.
10. Involve older children in actually carrying out assessments of needs and monitoring interventions.
11. Develop hygiene promotion materials for mothers that link best practice and appropriate messages in infant and small child health and nutrition, with hygiene messages. For example include the message that babies under 6 months should not drink the water we provide, because they should be exclusively breast fed.
12. In consultation with target groups, develop WASH materials for use with teenagers in key emergency contexts (include pictures and activities on the maintenance of tapstands and toilets). Materials are mostly aimed at younger children at present.

13. Consider the ways that new technology can be used to reach children.
14. Consider asking IFRC to include a section on working with children on the wikispaces website.
15. Identify ways to promote more effective sharing of IEC materials for use with children, for example by creating a library of workable materials linked to the WASH cluster website.
16. There is very little evidence about what approaches and methods work best with different age groups of children and disaggregated data from monitoring is very limited.
17. The extent to which children can influence parents' and younger siblings' behaviour in an emergency has not been formally researched and no evidence for this currently exists.

Recommendation 7: WASH in schools, in emergencies should include better planning of operation and maintenance, especially of hand washing facilities, and greater consideration of MHM.

When implementing WASH in schools in emergency situations, good practice would involve the following:

1. Make full use of UNICEF's materials on school WASH in emergencies, and other existing advice.
2. Work with parents, teachers and school children to ensure that the use, cleaning and maintenance of facilities is addressed, preferably before construction commences.
3. Encourage greater participation of schoolchildren in the design of the intervention and in making decisions about how best to improve WASH in the school and community
4. Ensure that interventions integrate hardware and software issues, so that handwashing and MHM solutions are part of the initial programme design.
5. Where school health clubs are initiated, consider how they can influence others in the school and produce concrete improvements in hygiene. Do not limit membership.

Current practice could also be improved as follows:

6. Produce a short briefing paper on handwashing for schools and disseminate amongst WASH teams working in schools. This could include technology choices such as tippy taps, handyWASH and metal scoops, but could also include hygiene promotion and tips on the operation and maintenance of latrines and handwashing facilities.
7. Advocate to donors for funding to intervene in schools during emergencies, partly as continuing children's education at a time of crisis should be a priority, but also because implementing WASH in schools is an important opportunity to influence key change agents, i.e. children.
8. There is insufficient data on the outcomes of school WASH projects in emergency contexts, therefore additional study would help give clarity.

7.1.1 Additional Recommendations

At national and international organisational levels it would be useful to:

- Identify male and female children's WASH champions (or 'inclusion advocates') to promote greater awareness of vulnerability and exclusion and ensure integration of children's issues into WASH programmes – at headquarter and programme level.
- Enable more in depth learning on WASH for children for both engineers and hygiene promoters (e.g. use e-learning, short films etc.) and include child protection issues

Programme design recommendations would include:

- Work with MEAL teams (where available) to ensure that child centred WASH indicators are included in monitoring and evaluation frameworks
- Include a question on working with children in the proposal checklist to remind staff of its importance and ensure that children have been consulted as part of the planning process and that child sensitive indicators identify outputs and outcomes for children
- Include a 'working with children' budget line in all WASH proposals (this should include both software and hardware if not covered elsewhere, such as staffing, child friendly latrines, Nfls and IEC materials for different age groups)
- Amend WASH assessment checklists to include questions about children and information on how to involve children in the assessment process
- Little is known about the extent to which WASH for children is incorporated into DRR programmes in different countries, however it would be good to ensure that DRR programmes consider children of different ages and include information on the prevention and management of diarrhoea and access to WASH facilities.

7.1.2 Dissemination

A practical strategy is necessary for sharing the outputs and recommendations of this research: this will include

- Work with the Global WASH cluster to ask for space on the GWC website, which can be further developed alongside additional resources;
- Present results to the Global WASH Cluster to ensure that work with children is seen as a cross cutting issue and continue to speak on behalf of children at international and cluster level;
- Work with cluster members to discuss the use of the IASC Gender and Age Markers to advocate for the inclusion of children of different ages in humanitarian WASH proposals ;
- Seek funding for pilot projects working with children of different ages on integrated WASH and ensure that these projects are provided with adequate resources and support in order to explore and document best practice.

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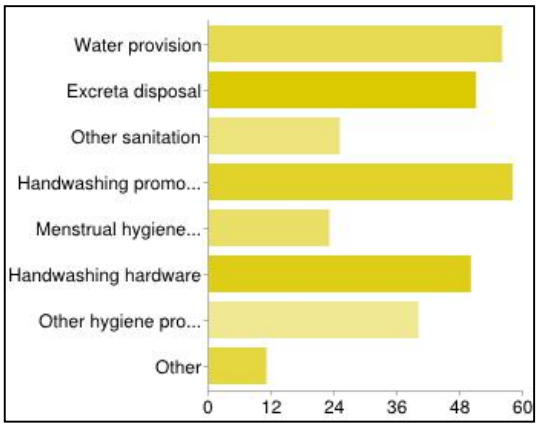
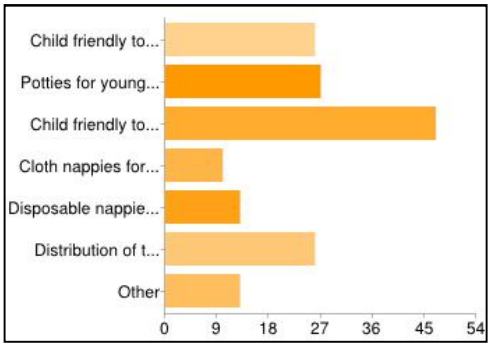
9. Annex A: Results from the questionnaire to practitioners

Have you or your agency been involved in providing the following emergency WASH in Schools?



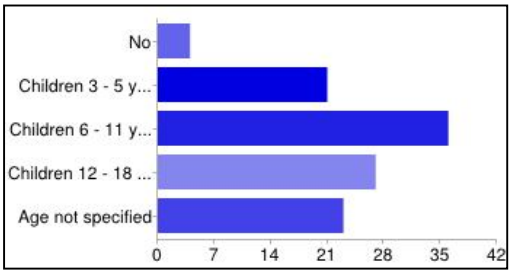
Water provision	56	18%
Excreta disposal	51	16%
Other sanitation	25	8%
Handwashing promotion	58	18%
Menstrual hygiene management	23	7%
Handwashing hardware	50	16%
Other hygiene promotion	40	13%
Other	11	4%

Have you provided any of the following excreta disposal methods aimed at children?



Child friendly toilets in community	26	16%
Potties for young children	27	17%
Child friendly toilets in schools	47	29%
Cloth nappies for babies	10	6%
Disposable nappies for babies	13	8%
Distribution of tools/trowels for burying children's faeces	26	16%
Other	13	8%

Have you been involved with child focused hygiene promotion activities in emergencies?



No	**4**	4%
Children 3 - 5 years age	**21**	19%
Children 6 - 11 years age	**36**	32%
Children 12 - 18 years age	**27**	24%
Age not specified	**23**	21%

9.1 Quotes from practitioners responding to the questionnaire survey

"Have no fear, kids are very capable, (they) have the time and energy to engage and with support can fully engage in WASH/HP, even in emergencies"

"Child friendly facilities are on paper but many times not in practice and at the same time child friendly facilities are designed by adults, not with children hence may not be as friendly as we think". Ritva

"Also many HPs did not feel comfortable working with children and I many times thought we are really missing an opportunity here.....generally the feeling was that we did not really know what to do with children, how to engage them etc."

"We would need HP who knows how to engage children".

"In the camps we are only focusing on the adults rather than children and put all the responsibility on the mother for excreta disposal and hygiene"

"Intervention not equally effective in all situations because of the influence of the context i.e. beliefs, values, social norms, socio-economic factors etc."

"Information on time savings is often substantial but not factored into evaluations"

"We need to have a specific staff focused on facilitating HP with children. Our staff were on multi tasking."

"There has not been a strong child focus in most country programmes."

"It is usually only considered to be a second phase activity."

"Hygiene promotion activities are a good way to distract children in times of distress."

"Psychological support is also key to promoting certain behaviours as children are also traumatised although some may not show it vividly."

"Child-focused health clubs have been key interventions in Darfur and Haiti. CHAST and CLTS have been programmed more recently"

"Disposable nappies or cloth nappies should be part of the NFI kit for families"

"Agencies need to be careful not to demand too much time from teachers for training. This should be better coordinated."

"Potties should not be encouraged they are unhygienic if not well taken care of and are a disease-transmitting item."

"This is a significantly important area that agencies ought to focus on better than it has been done in the past."

"In the camps we are only focusing on the adults rather than children and put all the responsibility on the mother for excreta disposal and hygiene."

"More innovation is required. Working with children requires knowledge and skills but at the same time it is rewarding and can promote sustainable behaviour change."

10. Annex B: Agencies and individuals contacted

Name	Organization	Steering Group	Meeting	Survey Question-naire	Fieldwork	Interview
Mark Buttle	SCUK	X	X	X		X
Kate Brogan	IMC	X	X			
Marion O'Reilly	Oxfam	X	X			X
Jonathan Barden	DFID		X			
Joanne Beale	WaterAid		X			
Aneeta Williams	Tearfund		X			
Thomas Wilson	SCUK		X			
Hilde Neels	SCUK		X			
Therese Dooley	UNICEF	X	X			
Andrew Parker	UNICEF	X				
Hazel Jones	WEDC					X
Peter Egesa	SCUK			X		
Paul O'Sullivan	Independent			X		
Md Mostak Hussain	Save the Children			X	X	
Mohammad Shamsuzzaman	Save the Children				X	
Nayyar Iqbal	Save the Children				X	
Ranajit Das	Oxfam				X	
Iqbal Mahmood	ACF				X	
Arnost Gasker	Christian Aid				X	
Md. Mohiuddin	SCiB				X	
Saleha Khatun	ECB				X	
S.M. Ahsan	SCiB				X	
Abdur Rahim	SCiB				X	
Ranadhir K Das	SCiB				X	
Abdul Mannan	Muslim Aid				X	
S. M. Rajiv Ahson	Shushilan				X	
Arif Iqbal	Shushilan				X	
Md Abduramman (Doble)	Uttaran				X	
Md. Haider Ali	Save the Children				X	
Md. Rafiqul Islam	Muslim Aid				X	
Arnost Gasker	Christian Aid				X	
S. M. Rajiv Ahson	Shushilan				X	
Arif Iqbal	Shushilan				X	
Md Abduramman (Doble)	Uttaran[5]				X	
Md. Haider Ali	Save the Children				X	
Md. Rafiqul Islam	Muslim Aid				X	
A.K. M. Rezaul Haque Khan	Save the Children				X	
Iftekhar Alam	Save the children				X	
Md. Gaziur Rahman	Save the Children				X	
Hasina Parvin	Uttaran (local NGO)				X	

[5] local organization – SC partner organisation

Engr Noor Ahmed	Govt (Satkhira District)				X	
Richard Doby	Christian Commission Development in Bangladesh				X	
Nirmal Tudu	Christian Commission Development in Bangladesh				X	
Ali Mohamed	Oxfam				X	
Iqbal Mahmood	ACF				X	
Md. Zahangir Alam	DCA				X	
Arnest Aninda Sarkar	CA- CCDB				X	
Md. Riazul Islam	Plan Bangladesh				X	
Md. Helal Uddin Faras	Islamic Relief Bangladesh				X	
A. K. M. Rezaul Haque Khan	Save the Children International				X	
Mohammad Ali	Oxfam				X	
Md. Gazior Rahman	SCI				X	
Md. Iftekhar Alam	SCI				X	
Mahifuga	SCI				X	
Hamidou Maiga	UNICEF				X	
Md. Mohiuddin	SCI				X	
Kawran Jacab	SCI				X	
Ciara Rivera	UNICEF				X	
Henri Markus Stalder	UNDP				X	
Shamsuzzamen	SCI				X	
S M Ahsan	SCI				X	
Golam Morsehd	Oxfam				X	
Mahfuzur Rahman Chowdhury	Muslim Aid – UK, Bangladesh Office				X	
Sumn Chandra SII	IFRC				X	
Mohamed Muhumed	MEAL Adviser, Save the Children				X	
Ewan Chainey	UNICEF Emergency WASH /Coordinator				X	
Hiwot Zewdu	Public Health Promotion Adviser				X	
Ketema Wogari	SCI WASH Advisor				X	
Sisay Dejene	Accountability & child participation Save the Children				X	
Mesfin Sahele	Senior Project Manager Save the Children				X	
Tesfaye Mekonnen	International Medical Corps				X	
Sisay Seyoum	Deputy Country Director, IMC				X	
Mohamed Yusuf	WASH engineer				X	
Haji Mohamoud	WASH – MEL coordinator				X	

Ahmed Abib	WASH sanitation & hygiene promotion coordinator				X	
Tawfik Aden	WASH programme manager				X	
Manish Kumar Agrawal	Oxfam GV, Siti Zone, Dire Dawa PM Siti Zone programme				X	
Ayanle Hajiomer	OGB WASH TTL				X	
Mesfin Bekele Andargie	OGB PHP TL				X	
Nimo Abdilali	Instrument for Stability Gender officer				X	
Zeyad Ahmed	SC Jijiga Field Office Manager				X	
Abdicadir Mohamed	SC Project manager Nutrition (CMAM), Harshin and Meiso				X	
Abdurazak Hussein	IRC WASH manager, Somali region				X	
Kelif Musse	IRC Senior Water tech				X	
Mohamed Muhumed	IRC Hygiene Promotion Officer				X	
Ahmednur Abdulali	NGO Coordinator				X	
Tilahun Disasa and his team!	WASH coordinator, Harar				X	
Hilina Mikrie	Deputy Programme Director, ECC-SDCOH				X	
Katy Webley	SC Deputy CD PDQ				X	
Cherkos Tefera	SC Head of WASH				X	
Paul Eames					X	
Graham Henderson	Independent			X		
Andy Bastable	Oxfam					X
Melchizedek Malile	NRC			X		
Eric Fewster	Independent			X		
Jan Heeger	Netherlands Red Cross			X		
Jean McCluskey	Independent			X		
Ross Tomlinson	CRS			X		
Tanaji Sen	RedR India			X		
K.Y. Babu	Independent			X		
Ritva Jantti	Independent			X		
Peninah Mathenge	IRC			X		
Frank Greaves	Tearfund			X		
Abdus Sobhan	Oxfam			X		
Batundi Wabo	Independent			X		
Jeffrey Silverman	Oxfam			X		
Bibi Lamond	Oxfam			X		

Trish Morrow	ACF			X		
Martine Haentjens	Protosh20			X		
Sarah Dinas	Oxfam			X		
Rabia Syed	Independent			X		
Monica Ramos	CARE			X		
Shamima Akhtar	PLAN			X		
Yasmin Al Kourdi	MSF Belgium			X		
Evalyne Nyasani	Independent			X		
Hanna Mekonnen	Independent			X		
Abdalrassoul Abdallah	Independent			X		
David Njuguna	Oxfam			X		
Mary Ayalo	Independent			X		
Julia Moore	Independent			X		
Gladys Inzofu	Independent			X		
Ramya Jesmi Ratnakumar	Independent			X		
Jean Marie Bofio	Independent			X		
Rana Offman Hirbawi	Independent			X		
Jonathan Valdez	SCUK			X		
Hanna Taylor	Independent			X		
Kerine Deniel	Oxfam			X		
Rafi Aziz	Save the Children			X		
Nirali Mehta	Save the Children			X		
Jorge Bica	Save the Children			X		
Faruque Azam	Save the Children			X		
Bi Tizie Tre	Save the Children			X		
Jackson Musomba	Independent			X		
Mohammed Bedri	Save the Children			X		
Rania Ali	Save the Children			X		
Peter Lukwiya	Save the Children			X		
Norsalam Bago	Independent			X		
Maoundonodji Djerade	Independent			X		
Maryline Renault	Independent			X		
Ehtemanchi Chane	Independent			X		
Niall Roche	Independent			X		

Save the Children works in more than 120 countries. We save children's lives. We fight for their rights. We help them achieve their potential.

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