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**INTEGRATED INDUCTION, PHAST AND CLTS TOT TRAINING FOR COMMUNITY HEALTH  
VOLUNTEERS HELD AT THE GREENHOTEL HOTEL IN SIMBU ON 6<sup>TH</sup> – 12<sup>TH</sup> DEC 2015**



## **Integrated Induction, PHAST and CLTS ToT training for Community Health Volunteers**

The ongoing El Nino associated drought means that people are unable to partake in good hygiene and sanitation practices. Through a broad framework of Disaster Risk Reduction (DRR), IOM aims to mitigate the increased risk of disease due to the lack of accessible water. In response to this, IOM's AGWA project organized a 5 day training workshop on integrated induction, Participatory Hygiene and Sanitation Transformation (PHAST) and Community-Led Total Sanitation (CLTS) for Community Health Volunteers (CHVs). This residential workshop was held at Greenland Hotel in Simbu province. The workshop was attended by 29 CHVs drawn from Gumine and Saltnomane-Karamui districts. *(See participants list in annexure)*

### **Structure**

Trainings were conducted from 6<sup>th</sup> to 12<sup>th</sup> December, 2015. Lessons were characterized by three (3) two-hour interactive and participatory sessions spanning the whole day from 8:30 am in the morning to 4:30 pm in the afternoon. Training was organised and conducted by the International Organization for Migration, in Papua New Guinea. The sessions were facilitated by the Water, Sanitation and Hygiene (WASH) Officer, Mr. Benson Mwarongo. Topics covered included maternal and newborn child health (MNCH), management of common illnesses such as diarrhoea, respiratory ailments (TB), malaria and HIV/AIDS, sexual and gender based violence, Participatory Hygiene and Sanitation Transformation (PHAST), Community-Led Total Sanitation (CLTS), and use of information tools for monitoring and evaluation of their activities at the village level. *(See training programme annexed)*

### **Training Objectives**

The training was meant to;

- To introduce participants to concepts on health, development, disaster risk reduction and their relationships
- Equip learners with skills on community governance, good leadership and problem solving techniques
- To enable participants understand their roles, responsibilities and their relationship with community health committees (CHCs) and other partners in health

- To build the capacity of trainees to impart knowledge to their community on prevention of diarrhoeal and water-related diseases
- To equip trainees with practical hygiene promotion facilitation skills
- To orientate learners on basic health care and life saving skills
- To provide trainees with tools for community mobilization and planning in order to address existing hygiene and sanitation problems
- To discuss factors that affect behaviours and how they can be altered in order to bring about positive hygiene behaviours

## **DAY 1**

### **Introductions, norms, expectations, and objectives of the workshop**

All present were welcomed by the DRR Assistant, Ian Gore. The session was started with a prayer after which all members were given a chance to give an introductory statement of their names, their locations, any positions held and to share their most memorable events.

### **Opening Remarks**

The workshop was officially opened by the Principal Health Advisor, Mrs. Margaret Kaile. She thanked all the participants for volunteering for community work and further acknowledged IOM for being the first organization to come to the aid of the province during the drought that was being experienced and which had seriously affected the communities. The provision of safe and adequate water complimented by hygiene promotion and capacity building on conservation agriculture, she said, will go a long way in building the resilience of the communities for the future. The PHA further made a pledge and willingness of her department (Department of Health) to always support the partner with whatever assistance they would require from her office.

Responsibilities were allocated to identified participants for the smooth running of the sessions. The need for the following roles was felt and allocated such individuals in Simbu as;

1. Chairman – Raphael Sipa
2. Spiritual leader - Daniel Gellia/Rose Gari

3. Time Keeper – John Kaupa
4. Welfare persons – Peter Yobale
5. Energizer – Grace Kaupa



**Mrs. Margaret Kaile, Health officer from Jiwaka province opening the workshop**

### **Training methodology**

A participatory approach entailing interactive lectures, brainstorming, role plays, facilitated group discussions and feedback, experience sharing and plenary sessions was used for content delivery. The medium of expression chosen by the participants was Pidgin and English. Presentations and notes taking was done using such resources as flip charts, felt pens, biro pens, note books and masking tapes.

## **Enhancing Climate-Resilient Agriculture and Water supply in Drought-affected communities in Papua New Guinea (AGWA) project overview**

Done by the DRR Assistant, it was meant to describe the project, that is, its objectives and activities, and how the roles of the CHVs to be trained were tied up to achievement of the ultimate goal of the project.



**The IOM DRR Assistant giving a project brief**

This six (6) months AGWA project is funded by USAID and EU through OFDA and ECHO aims at stabilizing the highland communities worst affected by El~Niño induced drought and frost in Papua New Guinea.

The projects' goal of increasing resilience of communities to drought through provision of immediate WASH assistance while encouraging the use of effective and locally developed hybrid varieties of crops and vegetables in highland provinces of Enga, Jiwaka, and Simbu will be realized through the following summarized objectives;

- Train and mentor communities and relevant authorities to promote the dissemination and adoption of Participatory Health and Hygiene practices (PHHE);

- Support on-going PHHE efforts with provision of NFI kits comprising of one (1) collapsible 15 litre water container and two (2) bars of soap;
- Improve access to safe water through drilling and/or repair of boreholes in schools and hospitals and training of their committees for operation and maintenance; and
- Training of master farmers on conservation agriculture and farming and distribute agricultural kits consisting of fast growing seeds, tools, tubers and vines to affected households.

The roles of the CHVs he further explained will be largely restricted to hygiene promotion at the household level through such activities as mapping the households in the initial stages to obtain baseline information in the targeted intervention areas, improving access to, storage and usage of safe water through drilling of boreholes and provision of water containers, promotion of good hygiene behaviours through community dialogue sessions, and drama, songs, and dances through community open sanitation days and soaps provision.

### **Concept of Health, Development and Disaster Risk Reduction**

Health was defined both locally and according to the WHO definition. DRR on the other hand was described as a conceptual framework of reducing the risk of disasters encompassing three main pillars that include: Prevention; Mitigation and Preparedness.

### **Relationship between Health, Development, and Disaster Risk Reduction**

Better health makes an important contribution to economic progress, as healthy populations live longer, are more productive and save more. The importance of health under the framework of DRR was discussed: economic status, education, religion, culture, traditions and attitudes, infrastructure, political instability, leadership and policies, corruption, transparency accountability, dependency and insecurity, food and water. For a community to actively engage in reducing their risk and increasing their resilience to disasters, all of these factors must be considered and thus the relationship between these variables were discussed.

### **Participatory assessment, planning and implementation of DRR plans**

Community assessment is an evaluative study that uses objective data to assess the current social conditions of a specified community or targeted area. They were taught the steps of community assessment: to plan and organize, design the data collection, gather review and analyse the data, make decisions and be introduced to community assessment tools, including a survey, asset inventory, community mapping, daily activities schedule, seasonal calendar, focus group and panel discussion.

### **Governance structure of community health strategy**

Governance, management and coordination were defined and discussed. The structures of health in relation to level 1 - the Community Health Committee (CHC), Hygiene promoters and Community Health Volunteers (CHVs) - were discussed, detailing the criteria/eligibility for election/selection and the characteristics of each. The linkage between the community-level health workforce and the link facility was outlined. Moreover, steps and guiding principles in resource mobilization were summarized. Trainees were also taught financial management in relation to community governance.

### **Community Involvement and Participation**

Community participation is a process by which the communities are actively involved in all stages of project or programme implementation. Trainees were taught the steps in community participation, the importance of community participation, factors hindering community participation, how to promote community participation through partnership and what community participation involves.

## DAY 2

### **Basic principles of health promotion**

Health promotion was defined as the process of enabling people to increase control over their health and its determinants and thereby improve their health. The concepts and principles of health promotion, priority interventions, basic strategies and action areas of health promotion were discussed.

### **Socio-cultural practices and the associated outcomes**

Social and cultural factors influence health by affecting exposure and vulnerability to disease, risk-taking behaviours, the effectiveness of health promotion efforts and access to, availability of and quality of

health care. In addition, such factors contribute to understanding societal and population processes such as current and changing rates of morbidity, survival and mortality. Among the factors discussed were child



rights, care for development, child abuse, exploitation and neglect, early marriage, spouse battering, violence against children, post-rape and defilement care and incest.

### **Nutrition and health**

The CHVs were introduced to nutrition and malnutrition. They were taught about what constitutes a balanced diet and what factors can lead to malnutrition. Common cases of malnutrition were discussed and ways of curbing the same suggested.

### **Antenatal care, breast feeding and care of the baby**

They were introduced to those immunizations required for children and pregnant women. All the immunizations were discussed and their importance stressed. Basic oral hygiene and eye care of the baby and the importance of exclusive breastfeeding were also discussed.

### **Reproductive health and gender based violence**

The CHVs were introduced to gender and health and taken through the reproductive system. Sexual and reproductive health was discussed, together with gender role analysis and its implication for health. Sexual and gender based violence was defined as any harmful act done to a person against his/her will and is based on the society's view of what men or women should be, or should do. The different forms, contributing factors, as well as their effects and



**A participant leading a plenary session Family Planning methods**

reporting for the care (at hospital, police station, and community) of the victim was well explained.

### **Drug and substance abuse**

It was defined as misuse of such substances as drugs, alcohol, and/or chemicals that can change a person's behaviour or make them addicted. The contributing factors, signs, and the roles of CHVs in reducing this vice were discussed in details.

### **DAY 3**

### **Communicable diseases prevention**

Disease prevention was defined and the CHVs introduced. Trainees were introduced to the common communicable diseases, their modes of transmission and preventive measures that can be taken to forestall their occurrences. Among the priority diseases for prevention discussed were: high morbidity and mortality diseases - STIs, HIV/AIDS, TB, malaria; under-five childhood illnesses - diarrhoea, pneumonia, malnutrition; outbreak/epidemics and notifiable diseases, e.g., cholera, dysentery, yellow fever, plague, typhoid fever, meningococcal meningitis, measles and viral haemorrhagic fever.

Among the priority diseases of public health importance discussed were malaria, tuberculosis, new AIDS cases, childhood pneumonia, childhood diarrhoea, cholera, dysentery, meningitis, typhoid fever, plague, measles and H1N1

### **Case identification, diseases for eradication, disability and rehabilitation**

Among the diseases earmarked for eradication/elimination discussed were polio, neonatal tetanus, guinea worm, and leprosy. Trainees were introduced to disability, types of disability, a few common disabilities and possible causes, and ways of preventing disability. The CHVs were also introduced to rehabilitation - especially community-based rehabilitation (CBR) - the purpose of rehabilitation and the role of CHVs in rehabilitation

### **Health promotion in schools**

Trainees were introduced to this component and to the importance of having school health programmes. Among the activities looked at were: Vitamin A supplementation, de-worming, hand-washing with soap, safe faecal disposal, peer education and information on growth and development.

### **Lifesaving skills and demonstrations**

The CHVs were introduced to the life-saving skills for infants, children and adults. They were also shown how to conduct cardiopulmonary resuscitation for infants/child and adults, and first aid procedure for choking. They were shown basic skills of conducting first aid: opening the airway, checking breathing and circulation, counting breaths per minute, taking of pulse and placing the victim in recovery position.

### **Referral**

CHVs were shown the importance of directing those from the community with health needs to nearby hospitals for appropriate services. A few cases requiring referral were discussed, to provide an insight into the importance of timely and appropriate referrals.

### **Introduction to Community health information management**

Data, information and health information were defined. The importance of community health information management, methods/techniques of information collection, types of information/data to be collected at the household level, sources of information and the tools used were all discussed.

The processes of data collation, data analysis techniques, the presentation of information, information dissemination and the use of data for community health planning and action were elaborated.

### **Performance-based reward system for hygiene promoters**

Performance-based reward was discussed, its purpose being to encourage behaviours that strengthen the community unit and create an environment that can enable CHVs to achieve

their targets. The benefits of performance based rewards and the steps to successful performance-based rewards were highlighted, as well.

#### DAY 4

##### **Concepts in hygiene promotion**

The different concepts used in hygiene promotion such as community participation, sustainability, factors affecting sustainability, hygiene, sanitation, health and hygiene promotion were explained. The different models for hygiene and sanitation promotion such as the BASNEF and behaviour change ladder as well as such tools as PHAST, CHAST, CLTS, and SLTS were exploited in details.

##### **Hygiene domains and F-Diagram**

The five (5) domains of hygiene encompassing personal, safe disposal of excreta, water, food, and household and domestic hygiene were well defined as well the measures of ensuring their achievement covered in details.

The F-diagram comprising of 5Fs (fingers, flies, fluids, faeces, and fields) representing the various transmission routes of how faecal matter from the host ends into a new host were also explained and their blocking routes entailing latrine use, protection of food and water sources, handwashing at key times, safe eating and protection of water in transit and storage amongst other means.

## Demonstrations

Hand washing with soap was shown to be the most effective tool in breaking the faeco-oral contamination routes as it prevents



faeces, germs and dirt getting into contact with the food and the water consumed. Participants were also shown the proper hand washing technique to enhance hygiene practices. These activities were to be incorporated in the action plan to be developed by the end of the training and follow up done in two weeks' time by the facilitators to check on progress made.

CHVs were shown the techniques in use of Point of Use water treatment products (POUs). PUR and Aqua tabs were shown and their usage described, that is, 1 sachet of PUR is supposed to be used on turbid waters preferably water from open sources (ponds) while aqua tabs should be used on clear water waters from shallow wells, rivers, and streams. The mixing ratios were 1 sachet: 10 liters and 1 tab: 20 litres for PUR and aqua tabs respectively.

### **Hygiene improvement framework (HIF)**

Hygiene promotion aims at preventing diseases through linking good health and hygiene practices with sanitation facilities. The hygiene improvement framework shows how all the pillars work together and how are interlinked to prevent diarrheal diseases. The pillars are access to hardware (community water systems, sanitation facilities and household level

materials), and hygiene promotion (community mobilization, school programs, and social marketing) complimented by an enabling environment (policy improvement, community organization, Public Private Partnership (PPP), and institutional strengthening). All the pillars as discussed with the participants are necessary and must be present for hygiene improvement resulting to diarrheal and related diseases prevention.

### **Integrated PHAST and CLTS approach**

Participants were given a short brief on the step-by-step framework of the integrated PHAST and CLTS approach. The steps were;

1. Community entry and pre-triggering where the participants were led in identifying a community for hygiene



**Trainees enacting the river crossing role play during community entry**

promotion using community diagnosis and river crossing roleplay;

2. Problem identification in the community using a seasonal calendar;
3. Problem analysis and triggering of good and bad hygiene behaviours, community practices, mapping water and sanitation facilities, shit and medical expenses calculation, walk of shame, role of flies in water and water and food contamination, and how diseases spread;
4. Identification of solutions entailing blocking spread of disease, selecting the barriers, choosing water and sanitation improvements, choosing improved hygiene behaviours and allowing for questions from communities;

5. Planning for implementation and change in mind of gender roles, natural leaders, developing a community action plan, and planning for what may go wrong;
6. Monitoring for implementation progress using a checking chart to check for progress; and,
7. Participatory evaluation for progress achieved.

## DAY 5

### Field exercise

This activity was done in Kuu village, because of its proximity to the training venue and the myriad of health challenges it faces.



**A practical hygiene session in Kuu village**

The aim of this activity attended by all the CHVs being trained as ToTs was to contextualize the theory and put into practice the knowledge and skills gained for hygiene promotion. The community members were mobilized the day preceding the activity with more being mobilized during the occasion by the participants doing door-to-door visits. Topics majorly covered on hygiene domains ranged from personal, domestic and household, environmental, food and

water hygiene to communicable and diarrheal diseases with special emphasis on increasing access to safe water, storage, and point of use treatment.

During the field visits, participants collected information from the households and community on their health and hygiene practices. This information was presented for a plenary session and review after participants returned to the training venue from the field activity. More information was presented from the positive criticism that ensued enabling all to learn from the process. Over 136 community members (70 females and 66 males) graced the hygiene promotion session. The exercise was designed to enable them to develop the practical skills and techniques for data collection and utilization for hygiene promotion at the real field context.

### **Monitoring and evaluation**

Monitoring was defined, and the importance of monitoring, key indicators in health monitoring and evaluation and the characteristics of good indicators: (e.g., SMART, i.e., Specific, measurable, accurate, reliable and time bound) with examples of other monitoring indicators being cited. The CHVs were also introduced to the evaluation process, within which the types and the importance of evaluation were elaborated. Monitoring and evaluation methods and tools and the importance of basic monitoring and evaluation were also discussed. Action plans were developed site wise according to the villages after group discussions. They will be used for follow up of the ear marked activities.

### **Way forward/next steps**

The first two weeks after the training, the newly trained CHVs will have a familiarization meeting, when they will all come together to get to know each other and to discuss how best to divide the number of households they will be serving (minimum of twenty (20) for each). IOM will play a key role in facilitating these meetings, together with the Department of Health, and CHWs working in these sites.

Thereafter, IOM and the Health officers from the DoH will start a thorough follow up of the developed action plans; share the progress with stakeholders; identify sources of strengths and

weaknesses; brainstorm on indicators and timelines; identify unforeseen challenges and possible solutions; plan weekly meetings to review progress; and start work on social mobilization to get everyone involved. The CHVs will then embark on a mapping of all the households in the project sites and identification of hygiene promoters who will consequently be trained by them (ToTs) for further hygiene promotion impact at the village level.

### **Closing remarks**

The workshop was closed by Mrs. Regina Nua, the Nutritional Advisor. She reiterated on the importance for follow for developed action plans and more support from IOM on training of hygiene promoters at the community level for more impact of hygiene promotion as envisaged. She urged the participants to implement the work plan that they drafted and seek assistance where necessary from the government departments and IOM.

The WASH Officer thanked the team for their full participation in the training workshop and called on their commitment to realizing their action plans and beyond for ownership and sustainability of projects. He promised to offer certificates of participation in January 2016 after work plans had been implemented.

Mr. Peter Yobale gave a vote of thanks to the facilitators and IOM on behalf of other participants.

Annex 1: Participants list

	<b>NAME</b>	<b>SEX</b>	<b>Province/Area</b>	<b>Designation</b>
1.	Betty Aiwa	F	Simbu/Gumine	Community Health Worker
2.	John Kaupa Kiriwai	M	Simbu/Gumine	Nutrition Officer
3.	John Yule	M	Simbu/Karamui	Nursing Officer
4.	Rose Gari	F	Simbu/Gumine	Community Health Worker
5.	Grace Kaupa	F	Simbu/Gumine	Community Health Worker
6.	Koma Tabie	M	Simbu/Gumine	Community Health Worker
7.	Wai To	M	Simbu/Karamui	Religious leader
8.	Daniel Gellia	M	Simbu/Gumine	Religious leader
9.	Steven Dama	M	Simbu/Gumine	Community Health Worker
10.	Becka Tivo	F	Simbu/Karamui	Community Health Worker
11.	Alois Gube	M	Simbu/Gumine	Community Health Worker
12.	Kaupa Koy	M	Simbu/Gumine	Community Health Worker
13.	Ubane Aina	F	Simbu/Gumine	Community Health Worker
14.	John Nuls	M	Simbu/Karamui	Community Health Worker
15.	Benson Bomai	M	Simbu/Gumine	Community Health Worker
16.	Peter Yobale	M	Simbu/Gumine	VCT Counselor
17.	Mathew Tandime	M	Simbu/Karamui	Community Health Worker
18.	John Jonathan	M	Simbu/Karamui	Community Health Worker
19.	Raphael Sipa	M	Simbu/Karamui	Community Health Worker
20.	Moses Mol Gore	M	Simbu/Gumine	Community Health Worker
21.	Jonathan Kenny	M	Simbu/Karamui	Community Health Worker
22.	Nancy Chris	M	Simbu/Karamui	Community Health Worker
23.	Peter Maima	M	Simbu/Karamui	Community Health Worker
24.	Jennifer Kulu	F	Simbu/Karamui	Nursing Officer
25.	Samuel Hincho	M	Simbu/Karamui	Community Health Worker

26.	Jack Waitao	M	Simbu/Karamui	Community Health Worker
27.	Peter Sine	M	Simbu/Gumine	Environmental Health Officer
28.	Mathias Ku	M	Simbu/Karamui	Community Health Worker
29.	Bu Bal	M	Simbu/Karamui	Community Health Worker

## Annex 2: Timetable

Time	Day 1	Day 2	Day 3	Day 4	Day 5
Morning (8:30 – 10:00 am)	<ul style="list-style-type: none"> <li>- Introduction</li> <li>- Learning environment</li> <li>- Workshop objectives and schedule</li> <li>- Background on IOM and projects</li> <li>- Pre-test and experience sharing</li> </ul>	<ul style="list-style-type: none"> <li>- Recap day 1</li> <li>- Importance of health promotion</li> <li>- Roles of CHVs in health promotion</li> <li>- Concepts in MNCH (ANC &amp;PNC)</li> </ul>	<ul style="list-style-type: none"> <li>- Recap day 2</li> <li>- Preventable diseases</li> <li>- Common conditions at HH level</li> <li>- Lifestyle diseases</li> </ul>	<ul style="list-style-type: none"> <li>- Recap day 3</li> <li>- Concepts and models</li> <li>- Hygiene domains</li> <li>- Common health practices and challenges</li> <li>- Water cycle/related diseases (traditional beliefs &amp; F-diagram)</li> <li>- Components of hygiene promotion</li> </ul>	<ul style="list-style-type: none"> <li>- Recap day 4</li> <li>- Step 4: Identification of common hygiene and sanitation solutions in relation to various hygiene domains <ul style="list-style-type: none"> <li>- <i>Three pile sorting</i></li> </ul> </li> <li>- Step 5: Planning for implementation and change – <i>Pocket Chart, Gender role analysis</i></li> </ul>
<b>15 min</b>	<b>Break</b>	<b>Break</b>	<b>Break</b>	<b>Break</b>	<b>Break</b>
Mid-morning (10: 15 – 12:00 pm)	<ul style="list-style-type: none"> <li>- Importance of health</li> <li>- Relationship between health and development</li> <li>- Participatory approaches to community health and development</li> <li>- Age cohorts and life services</li> </ul>	<ul style="list-style-type: none"> <li>- Risk factors for women</li> <li>- FP, MNC nutrition and malnutrition</li> <li>- Growth monitoring and assessment</li> </ul>	<ul style="list-style-type: none"> <li>- Promotion of healthy lifestyles</li> <li>- Drug and substance abuse</li> <li>- S&amp;GBV (forms, contributing factors, effects, reporting)</li> </ul>	<ul style="list-style-type: none"> <li>- Integrated PHAST and CLTS approach</li> <li>- Step 1: Community entry and pre-triggering – <i>River crossing role play</i></li> <li>- Step 2: Problem Identification – <i>Seasonal Calendar</i></li> </ul>	<ul style="list-style-type: none"> <li>- Step 6: Monitoring implementation progress and evaluation <ul style="list-style-type: none"> <li>- <i>Monitoring chart</i></li> </ul> </li> <li>- Action planning</li> <li>- Post evaluation test</li> <li>- Questionnaires for filling at HH level</li> </ul>
<b>1 hour</b>	<b>Lunch</b>	<b>Lunch</b>	<b>Lunch</b>	<b>Lunch</b>	<b>Lunch</b>
Afternoon (2:00 – 4:30pm)	<ul style="list-style-type: none"> <li>- Community health strategy</li> <li>- Life cycle approach in CHS</li> <li>- CHVs roles and responsibilities at community tiers</li> </ul>	<ul style="list-style-type: none"> <li>- Immunizations</li> <li>- Danger signs in under-fives, pregnancy and delivery</li> </ul>	<ul style="list-style-type: none"> <li>- Basic lifesaving skills</li> <li>- Basic life skills on specific conditions</li> <li>- Referrals</li> <li>- Community health information and disease surveillance</li> </ul>	<ul style="list-style-type: none"> <li>- Step 3: Problem analysis and triggering <ul style="list-style-type: none"> <li>- <i>Community sanitation mapping</i></li> <li>- <i>Transect walk</i></li> <li>- <i>Glass of water</i></li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>- Field activity</li> <li>- Closing of training</li> </ul>
<b>Departure</b>	<b>Departure</b>	<b>Departure</b>	<b>Departure</b>	<b>Departure</b>	<b>Departure</b>

Annex 3: Harmonized action plan

S/No.	Activity	Baseline	Target	Actions to be taken	Who	When	Resources
1.	Construction and proper use of latrines	30%	90%	Sensitization on need for latrines, building demonstrations, and their proper use Community triggering	CHVs, CHWs, chief, teachers, leaders	20/02/16	Ashes, soap, water, local materials (kunai, pandanus leaves, bamboo, tools and nails etc.)
2.	Improve environmental cleanliness	20%	100%	Awareness, health education, and demonstrations on need for clean homes	CHVs, CHW, chief, teachers, leader	18/12/15	Cleaning equipment, fencing materials, soap, sponges, buckets etc.
3.	Cleaning and protecting water sources	20%	100%	Awareness creation on the importance of cleaning and protecting water sources	Religious leaders, CHVs, teachers, CHWs, chiefs	15/01/15	Fencing materials, gloves, brooms, brushes, flowers for planting
4.	Proper hand washing (with soap) practices	5%	100%	Awareness on need and the benefits of hand washing at critical times through drama, discussions, posters and demonstrations	CHC, CHWs, chief, teachers, leaders	25/01/16	Soap, ashes, water, bucket, and containers

5.	Dialogue days	10%	40%	Promotion of the need for dialogue days and its importance	CHWs, CHVs, chiefs, teachers	05/02/16	Time, refreshments and working tools
6.	Proper food cooking, storage and nutrition	30%	100%	Health education and demonstrations on proper food cooking, storage methods for human consumption	CHVs, CHWs, chiefs, teachers, leaders	15/02/16	Different foods from food groups, vegetables, storage containers, water, covering utensils, trays, and screening materials
7.	Action day	5%	50%	Health education on the need for and the importance of the action	CHW, chiefs, CHVs	21 <sup>st</sup> day of every month	Time, refreshments, cleaning tools (brooms, brushes, gloves, rakes), wheel barrows, etc.