WASH CLUSTER TECHNICAL WORKING GROUP: ACUTE WATERY DIARRHOEA

RAKHINE STATE, MYANMAR

2016

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# Introduction

In early 2016, the WASH Cluster created a technical working group to address the topic of ‘acute watery diarrhea’. A small literature review highlighted two previous documents for Rakhine; ‘Rakhine WASH Cluster Acute Watery Diarrhea (AWD) Preparedness and Response Plan, March 2015’ and ‘DFID Consortium AWD Contingency Plan, Rakhine State, July 2014’. In addition, experience from the South Sudan WASH Cluster TWG highlighted two other documents ‘South Sudan WASH Cluster Cholera TWG Technical Recommendations, 2014 and ‘South Sudan WASH Cluster Global Template, 2014’. These four documents were reviewed and information was included in the Rakhine AWD TWG document. The information was adapted to the Rakhine experience and can be found below.

## Purpose of Document

The purpose of this document is to provide tangible and useful information to WASH and no-WASH actors in regards to ‘acute watery diarrhea’. This document is not designed to provide strict recommendations or compulsory activities but is more intended to provide information for the reader to consider and to adapt for their specific area of intervention. The overall WASH response objective remains to reduce the risks of outbreaks occurring but also to reduce the extent and spread of it, if/ when it arrives.

It is advised that individuals/ organizations become familiar with this document as information provided covers both preparedness and response activities. Useful resources can be found in the Annex section.

This document aims to reduce the time, financial and human resource investment into activities which are ineffective. In addition, whilst it is acknowledged that there are times when WASH actors move out of ‘pure’ WASH activities for the benefit of the intervention, this document intends to clearly show which activities WASH actors are automatically responsible for. This document also intends to show that there are some activities which can be completed by WASH actors after discussion and agreement with other partners on the ground as well as after receiving any technical information that the WASH actor may need.

The terms ‘actor’ (such as ‘Health actor’ or ‘WASH actor’) is not intended to differentiate between government and non-government actors, national or international. This term is used to include anyone who is working in that area of intervention.

In the event of an outbreak, it is common to experience increased communication between Government, NGO, UN sectors as well as between sectors such as Health and WASH, particularly at the beginning of an outbreak. In some circumstances, a specific taskforce is created. However this should not be assumed but communication is vital.

It must be noted that actors do not have to wait for an outbreak to be declared before they respond to increased cases of diarrhea and before they decide to implement all or some of the activities outlined in this document.

Throughout this document it is assumed that WASH organizations will respond within their existing areas of intervention and that any new intervention locations would need to be discussed with the relevant agency/ cluster and decided upon on a case by case basis. It is assumed that the existing WASH partners have capacity to respond to an outbreak however, if this is not the case then communication and support from outside that organization will be required which may result in a change in the responsibilities undertaken.

Within this document, there are no distinctions made for activities relevant for rural or urban areas, nor camps or villages. The only distinction made is between health facilities and areas outside of health facilities.

## Timeframe

It is very difficult to propose a timeframe for an outbreak response as there are many variables to consider as well as many different contexts to consider. Attempts have been made to explain priorities below

1. Ensure that you are prepared BEFORE an outbreak is declared

* Equipment, chemicals, items required
  + For example, water treatment, supply and storage at household and communal level
* Consumables are available and have not expired
  + For example, chlorine, soap, detergent, aluminium sulphate
* Contacts are made
  + Who will you need to speak to if an outbreak occurs in your area of intervention? Including other WASH actors, actors responding in the same area, authorities
* Capacity is assessed
  + What are you able to respond to? What are you not able to respond to? Try to highlight the latter at cluster meetings and/ or with partners who are working in the same area as you
* Teams are trained
  + What understanding do they need to be able to assess and respond to an outbreak? Bear in mind that travel restrictions can/ will apply to certain people (i.e. foreigners)
  + Consider if you have trained or experienced people on AWD
  + Consider also if you have enough staff in every area you are working in.

1. Complete a rapid assessment when cases of diarrhea increase significantly and/ or when an outbreak is declared

* What is the current situation?
* What standards do you have to obtain? Sphere standards, organizational standards
* What activities do you need to do to obtain or get as close as possible to these standards?
* What equipment, consumables, finances, knowledge and human resources will you need to do this?
* This assessment may be completed and compiled at cluster/authority level or organizational level. As assessment may not provide all of the information or details that you need for your specific area of intervention
  + Multiple assessments are possible (and are likely). Ensure that good communication continues (inside and outside of your organization and intervention area) to ensure that assessments are not duplicated in their entirety and that all useful information is shared

1. Implement activities as per the rapid assessment outcome
2. Continue to monitor the situation

* Ensure that constant monitoring of activities is continued throughout the response
* Activities and implementation methods may need to be added, stopped or changed as the outbreak and response continue

## Points to remember

* Outbreaks are both an emergency and development issue and the eradication depends on long term development of WASH. Therefore, WASH activities should also be implemented in a non-outbreak setting, they (and the addition of chlorine in some activities) take a higher importance during an outbreak
* Acute watery diarrhea is a water-borne disease and is therefore transmitted the same as diarrhea. Hence, the barriers to the transmission routes are exactly the same and so existing activities and IEC material can be adapted
* If all WASH facilities and good hygiene behaviors are complete and in place then there should not be an AWD outbreak even if someone falls ill. This highlights the importance of continuous monitoring, evaluation and improvement of the WASH situation during outbreaks and non-outbreak situations
* It is important to try to minimize parallel interventions. Enhance understanding at all levels that AWD transmission is the same as normal diarrhea and therefore the community should be encouraged to continue with good basic personal, family, communal hygiene practices such as handwashing with soap.
* The situation will be dynamic in an outbreak with lots of actors involved. Therefore try to ensure that confusion and fear are kept to a minimum by harmonizing information that the population receives
* There are no WASH activities required specifically for malnourished children/ adults than those which are required for nourished children/ adults. However, all standard WASH activities take on higher significance and therefore there needs to be *a higher emphasis to maintain a higher level of hygiene when interacting with a malnourished child/ adult.*
* All WASH activities need to be applied to children too and therefore as soon as possible after the initial cholera response is in place, actors need to ensure that there is a higher emphasis on improving child hygiene
* There is often the replication of activities in the community which are implemented in a health facility or isolation facilities without consideration for their appropriateness. It must be remembered that these health facility activities are implemented in a high risk, highly contaminated area where high levels of bacteria are present. However, WASH actors implement activities in the community where there is less contamination as it is not a certainty that the bacteria will be present. Therefore there are some activities that are relevant and appropriate to the health facilities but which are not appropriate for the community. Do not implement in a blanket way or blindly.
* Rehydration saves lives. This must start as quickly as possible and should continue until medical assistance is received
* Word of caution that in a camp, AWD can spread rapidly because population is denser and in a confined area; therefore immediate action/response is necessary.

## General AWD

* AWD can kill within hours because of dehydration if it is untreated. The symptoms of cholera are severe watery diarrhea sometimes with vomiting. It affects all ages, both children and adults.
* AWD is highly infectious. Direct contact with the faces and/or vomit of a sick person can easily infect another person; this includes clothing, bed-sheets and the skin contaminated by an affected person. AWD can also be transmitted by eating and drinking food and drink contaminated with faeces.
* The bodily fluids of someone who died due to suspected or confirmed AWD are still infectious. If possible, avoid or minimize physical contact with the corpse, but if you have to handle the body the following should be done:
  + Do not handle the corpse without protection. Use gloves or alternatives like plastic or aprons.
  + Do not empty the intestines of the corpse
  + Burn and bury dead person’s clothing and bedding.
  + Wash your hands thoroughly using soap/ash under running water after handling the corpse, the clothing and bedding.
  + Avoid putting your hands into your mouth, touching your face, food, or utensils after touching the corpse
* Funerals of people who have died of AWD or of any other cause during an outbreak can contribute to the spread of the epidemic.
  + If possible, avoid gatherings and preparation and consumption of food at the funeral.
  + All mourners should wash hands thoroughly with soap/ash and under clean running water.
  + Persons preparing food for immediate family members should:
    - Wash their hands thoroughly before preparing food and frequently during food preparation.
    - Use clean water for cooking.
    - Wash all fruits and vegetables in safe boiled or chlorinated water.
    - Cook food thoroughly and avoid re-heating.
    - Serve food while hot discouraging sharing of utensils.
    - Discard leftovers in refuse pit or bin.

# TECHNICAL CONTENT

## Division of Responsibilities

*It is recognized that other sectors such as logistics have roles and responsibilities in cholera response, however, WASH and Health activities often overlap, are similar or can be confused.*

*The aim of this section is to define which roles and responsibilities should primarily lay with each sector however; this does not exclude the possibility of a change in responsibilities between Health and WASH actors if this is agreeable to both parties.*

**Recommendation**

* It is necessary to decide and agree on the division of responsibilities between WASH, Health and Social Mobilization/ Hygiene Promotion actors in collaboration with the Health authorities before there is an AWD outbreak declared.
  + If this is not possible then the division of responsibility needs to be determined in response to the outbreak and prior to the start of interventions
  + This is particularly important given the incredibly high turnover of staff during a cholera response
* The division of responsibility as discussed by the TWG is found below and also in annexe 4.3 Division of Responsibilities Template.
* **Data and Information Sharing**
  + The outbreak is announced by Ministry of Health after clinical verification
  + Health data are shared on a monthly basis by default, on a weekly basis if there is an ongoing concern
* **Overall Considerations**
* **Requests from Health actors (Government or Non-Government) for WASH support (Government or Non-Government)**
  + If a health actor is overwhelmed and/ or does not have the capacity to provide WASH services within a CTC, isolation center or health facility then the request for assistance should be ideally as follows:

Health Actor Health Cluster WASH Cluster WASH Actor

If the WASH and Health actor already know who is working in the same area, then the request can be made directly and the Cluster leads can be informed afterwards.

* + Health Actors should plan to complete health-related WASH facilities or explicitly request support for specific activities. It should not be assumed that a WASH actor will ‘fill the gap’
    - Water supply, storage and treatment
    - Sanitation construction and maintenance
    - Handwashing
    - Wastewater management
    - Waste (including medical) management
    - Hygiene promotion
  + To aid planning of resources and supplies, it is recommended that the discussion of assistance takes place before an outbreak is declared.
* Be aware of any existing WASH, water or other committees in the intervention area and include them in any preparedness and response plans
* Ensure that communication is maintained with all different sectors such as Hygiene Promotion, Social Mobilization and Health to ensure harmonization of messages

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **ACTIVITY** | **WASH ACTORS** | **HEALTH**  **ACTORS** | **DESCRIPTION** | **COMMENTS** |
| CTC, Isolation Centre or Health Facility |  | √ |  | All activities within a CTC/ Isolation Centre are a **HEALTH** actors responsibility unless they have no (more) capacity. WASH can support upon request or as the situation demands and decisions decided between both parties |
| Surveillance |  | √ | Early warning, response and alert system | A **HEALTH** actors responsibility to collect and monitor medical data and alert WASH actors of any high risk areas  It is a **WASH** actor’s responsibility to request this information from the health actors so that WASH can use it.  It is **not** a WASH responsibility to actively collect data during WASH prevention and response activities but a choice, although this information should be shared with health actors.  When they do, must coordinate with the Health Actor in their area of coverage to have a common definition of diarrhea and protocol for service provision for positive response cases. |
| Response at Community Level | √ | √ | Checking households, families and neighbors after a patient has been admitted for signs and symptoms of cholera according to medical criteria | **HEALTH ACTORS** are responsible to look for other cases of AWD (in targeted areas) according tomedical reports, origin of patience and high risk areas  **WASH ACTORS:** First response for WASH actors in high risk/ highlighted areas would include hygiene promotion key messages, any community distributions, checking and improving of water sources etc.  **ALL ACTORS** responding in the area have the responsibility to pass on (the same) key health and hygiene messages |
| Oral Rehydration (ORS) Response |  | √ | Health screening of the population | Oral Rehydration Points (ORPs) are a **HEALTH** responsibility due to simultaneous activity of rehydration whilst also screening affected communities for signs of AWD |
| ORS distribution/ education | √ | √ |  | **WASH and HEALTH** actors can distribute ORS and pass messages to the community regarding its preparation with safe water (for example) but the content of these messages must be agreed with the health actors  *Note: ORS preparation can be prepared sachets or homemade solution depending on the context* |
| Supply of Clean Water to CTC or Health Facility or ORP |  | √ |  | Supply of clean water within a CTC or health facility is a **HEALTH** actor’s responsibility falling within the role of providing a safe environment to provide medical care.  If the health actor’s capacity is exceeded then **WASH** actors can be requested to assist with the initial set up of clean water supply or chlorination areas (for example). They can also assist in training of health staff however the daily management responsibilities for the continuation of activities such as infection control, FRC monitoring, preparing chlorine solution (for example) should remain with the **HEALTH** actor |
| Supply of Clean Water to Communities | √ |  |  | This is a clear **WASH** actors responsibility for existing areas of intervention, where it would be ideally linked to long term aims.  If the decision is made to support a new area with response activities, then the WASH actor can decide if these activities are linked to the response only or to longer term assistance. |
| Infection Control within a CTC or Health Facility |  | √ | Disinfection of the building, beds, laundry, clothing, preparation and use of chlorine solutions, excreta management etc. | Within a health facility this is a **HEALTH** actors responsibility falling within the role of providing a safe environment to provide medical care. |
| Management and disposal of excreta within a CTC or Health Facility |  | √ |  | This is a **HEALTH** actors responsibility as this is infected waste generated within a health facility and must be treated as contaminated medical waste  WASH actors could potentially support regarding transport, treatment and safe disposal of this waste. However this would need to be requested from the **HEALTH** actors and not assumed as the location, distance travelled, capacity and technical aspects would need to be considered  If WASH can, and are willing then assistance can be given, however guaranteed WASH responsibility cannot be assumed |
| Latrine Construction in CTC/ Health facility |  | √ |  | **This is not a recommended immediate cholera response activity within communities**  Within a health facility, latrine construction this is a **HEALTH** actor’s responsibility. However, is the health actors capacity is exceeded then **WASH** actors can agree to support with construction and daily management should remain under the health actor |
| Disinfection at Community Level |  | √ |  | **Household spraying as a disinfection technique is not a recommended cholera response activity within communities**  **WASH and ALL** other actors can pass messages to the community regarding correct cleaning/ disinfection clothing, bedding, and laundry (for example) to the general population but content of these messages must be agreed with the health actors  It is a **HEALTH** actor’s responsibility to raise awareness of basic hygiene messages to the *patient and care giver* including correct cleaning of clothing, bedding, and laundry (for example).  It is also a **HEALTH** actors responsibility to clean the vehicles transporting (suspected) cholera patients and/ or to advise the driver regarding correct cleaning procedures |
| Distribution of Cholera Kit | √ | √ | Provision to patients and caregivers  Community level distribution | It is a **HEALTH** actors responsibility to provide (or not) cholera/ hygiene kits and to explain them to patients and care givers leaving the CTC or health facility  It is a **WASH** actor’s responsibility to complete blanket distributions of hygiene kits to targeted areas depending on information received |
| Targeting Areas within the Community | √ | √ | Cholera response | It is both a **HEALTH** actor’s and a **WASH** actor’s responsibility to cooperate with the other regarding the origin of new cases to allow for specific targeting of community WASH interventions |
| Communication | √ | √ | Cholera response and prevention | It is both a **HEALTH** actor’s and a **WASH** actor’s responsibility to communicate with the other throughout the outbreak to allow for specific targeting of community WASH interventions |

## Health facility and Community Intervention Comparison

|  |  |  |
| --- | --- | --- |
| Activity | CTC/ Health Facility | Community (Camps, villages, anywhere outside a health facility) |
| Feet spraying | REQUIRED  A highly contaminated environment requiring high level infection control  A psychological barrier to remind people that they are entering a controlled area and/ or that they are in a cholera outbreak  Use a good sprayer with high pressure for better efficiency | DEPENDS  Lower contamination environment and so this is not required  However, this can be effective if there is a camp population with controlled exits/ entrances in/ near an area of high risk  Use a good sprayer with high pressure for better efficiency |
| Footbaths  NOT REQUIRED  Footbaths rapidly become dirty and ineffective in comparison to the feet spraying.  Regular solution changes are required to avoid limiting and reducing the effectiveness of the chlorine solution  However, if a footbath is to be used, more than one footbath with a solution is necessary:  -Use two pre-cleaning baths with a ‘door mat’ or something similar to create friction and remove physical dirt before entering into chlorine footbath  - Ensure that there is regular rotation of all three solutions in the footbaths | | |
| Handwashing with chlorinated water | REQUIRED  A highly contaminated environment requiring high level infection control  A psychological barrier to remind people that they are entering a controlled area and/ or that they are in a cholera outbreak | NOT REQUIRED  Lower contamination environment  High need to encourage continued ‘normal’ good hygiene practices of washing with soap/ ash and water  However, this can be effective if there is a camp population with controlled exits/ entrances in/ near an area of high risk  It is not easy to follow up the correct use of the chlorinated solution including mixing the chlorinated solution with soap |
| House and household item cleaning with chlorinated solutions | REQUIRED  A highly contaminated environment requiring high level infection control | NOT REQUIRED  Lower contamination environment and so this is not essential and would not be a pursued WASH activity  However, this practice would not be discouraged if this was an individual/ household/ community initiative as it should not cause harm if the chlorine solution strength is correct |
| Latrine disinfection with chlorinated solutions | REQUIRED  A highly contaminated environment requiring high level infection control | DEPENDS  Disinfection of latrines, especially as household level is not an essential activity. Cleaning with soap and water should be enough to remove physical dirt however, this practice would not be discouraged if this was an individual/ household/ community initiative as it should not cause harm if the chlorine solution strength is correct  A chlorinated cleaning solution will disinfect latrines and so this a potential WASH activity, especially for communal latrines with high use and/ or in/near a high risk area |
| Restrictions of movement | REQUIRED  A highly contaminated environment requiring high level infection control  Restrictions apply moving into and out of the health facility/ CTC/ isolation area, as well as between highly contaminated and ‘clean’ zones within it | This would be very difficult to manage and enforce outside of a defined structure.  Information could be passed advising people to avoid certain areas or to take extra precautions such as at funerals |

## Key Hygiene Messages

### Overall

* Ensure that these messages are agreed with other partners (health, education, social mobilization) in case there is any information specific to that response
* Ensure that AWD messages are not in parallel to messages passed in non-outbreak settings. For example, if the community boils their water at household level normally, continue to encourage this. Heat and chlorine can both kill AWD bacteria
* Ensure that HP messages are capped so there are not too many/ dissimilar messages going out

### Message Objectives

* To respond to a cholera epidemic/outbreak
* To prevent or decrease the likelihood of recurrent epidemics in the long term
* Immediate at community level the objective is to:
  + Reduce the death rate from Acute Watery Diarrhea (AWD) and Cholera
  + Make communities aware of the critical role that they have to prevent infection in the short term
* Longer term at community level (includes long term development actions)
  + Make communities aware of the critical role that they have to break the cycle of recurrent outbreaks
    - The main motivation for hygiene change is fear and so when the cholera goes, the fear also goes, and handwashing practices decrease

### Key Messages

* You can prevent cholera by following the 4 cleans (Myanmar HP strategy).
* Everyone is responsible for cholera prevention and transmission

Myanmar HP strategy is four cleans. Post emergency key messages have been created and so relevant ones can be used for AWD IEC/ 4 cleans as well. Message from Minister of Health in Annex 4.6 MoH AWD related messages.

* Clean Hands
  + Dirt and germs can live on dirty hands and under dirty nails
  + Wash hands and fingernails with soap under running water (from a tap, tippy tap or being poured). Communal washing of hands in one container is extremely dangerous and should not be done.
  + Critical times
    - After going to the toilet
    - After wiping a child’s bottom
    - Before eating
    - Before feeding a child
    - Before preparing food
    - Before handling water
    - After looking after a sick person or a dead body
  + HW is the main prevention of diarrhea and AWD
  + Allow hands to air dry
    - Avoid hand towels especially communal ones as these are likely to be contaminated
* Clean Food
  + Exclusively breastfeeding to babies under 6 months old even if they have diarrhea and sickness
    - Make sure that hands and breasts are cleaned beforehand
    - AWD is not a contraindication for breastfeeding (bacteria is not transmitted via breastmilk) unless otherwise advised by a healthcare provider (due to dehydration).
  + Complementary feeding should be started from 6 months
    - Prepare complementary food with safe water
    - Continue feeding children whilst also giving ORS
  + AWD is transmitted by eating faeces or food contaminated with faeces. This is the same transmission route as ‘normal’ diarrhea
  + Wash and peel all fruits and vegetables with safe water
  + Cook food thoroughly
  + Food should be eaten while it’s hot because the cholera germ cannot survive in very hot and completely cooked food.
  + Make sure to separate raw meat and vegetables from cooked food during preparation. Avoid purchasing peeled or sliced vegetables or fruits
  + Keep food in a clean environment and covered at all times. This prevents the contamination of food with cholera and other germs.
  + Avoid drinking of local brews, fresh juice and ice. This is because they could have been prepared in unhygienic way with unsafe water.
  + All food handling utensils should be kept clean all times. Air dry all utensils and avoid using towels or pieces of cloth to dry your utensils as these may be contaminated.
    - It is possible to leave these in the sun to dry as well, although care must be taken to ensure they don’t get re-contaminated by people, animals or the environment
  + Keep your restaurant or kitchen surroundings clean by disposing of all left over foods. Keep changing your dish-washing water.
  + Provide hand-washing facilities with soap in restaurants and canteens and promote their use
* Clean Latrines
  + Human faeces - even from someone who is not sick - contain germs that cause disease such as AWD and diarrhea, which can lead to sickness and death.
  + Dispose all human faeces in a latrine.
  + Dispose all children’s faeces in the latrine or bury them. Children’s faeces are just as dangerous as the faeces of adults. They carry disease-causing germs such as AWD, can pollute the environment and contaminate water sources and food.
  + Where there are no latrines – bury your faeces– use the “cat method.” This stops flies landing on the faeces and spreading disease.
  + All latrines must be kept clean at all times. This prevents flies from carrying AWD to your food and making you sick.
* Clean Water
  + Water can be contaminated because of AWD and waterborne diseases. These can easily be spread. Therefore only drink safe water (boiled or chlorinated water)
  + All water that people drink and use should come from a safe source or be purified.
  + Containers for carrying and storing water need to be kept clean inside and outside and covered to keep the water safe and clean.
  + To make water safe:
    - Filter water through a cloth and boil until it bubbles strongly for at least 3-5 minutes. This kills all AWD germs in the water and will protect you from getting AWD.
    - If appropriate to your intervention area, households can also use Chlorine tablets or PuR sachets – follow the manufacturer’s instructions.
  + Drinking water should be stored in narrow-mouthed or covered container preferably jerry cans.
  + Never put your hands in drinking water. If water must be dipped out, use a dedicated clean implement, such as a ladle.
* Specific AWD messages
  + If diarrhea occurs then drink ORS
  + Immediate and continued rehydration while seeking medical care saves lives
  + Drink ORS as soon as possible after having diarrhea and continue to drink it even if you are travelling towards a health facility
  + Drink ORS after each loose stool
  + The ORS in the sachets is made up of salt and sugar. If you do not access to ORS sachets or are not given, then make a homemade solution- 1 liter of treated water, 8 teaspoon of sugar, 1 teaspoon of salt.
    - Also consider the 5:3:1 rule – 5 fingers scoop of Sugar : 3 finger pinch Salt : 1 liter water. – When no teaspoons are available.
  + If diarrhea occurs more than 3 times per day, go to the nearest health facility
  + If there is a diarrhea outbreak in your village quickly inform the nearest health facility or the Township Medical Officer
  + If there is a diarrhea outbreak in your camp quickly inform the nearest health facility or the Township Medical Officer
  + Not everybody infected with cholera gets sick but they can still spread the disease in their faeces. Therefore everyone must take care, use the latrines and practice good hygiene behaviors
  + Safe handling of dead bodies and practice good hygiene at funerals and when handling people with AWD
  + It is dangerous for the person, family and community to hide anyone who may be ill.
    - The best way to protect the health and lives of the population is to ensure that anyone who falls sick receives proper treatment
    - If people do not receive proper treatment then they will not get better

### Methods of Passing Messages

* Think about how the information will be passed:
  + IEC, mass media and social mobilization all need to work together
  + Mass media such as radio can create knowledge and build risk perception. This can be used in long term too and not just in response to outbreaks.
  + Use demonstrations
  + Social mobilisers/ Home health promoters/ religious leaders to engage the community
  + Ensure that key members of the community know the messages before wide dissemination to assist with appropriate/ clear messaging
* Be aware of various existing materials:
  + Use commonly approved IEC materials, with clear pictures and appropriate text (quantity and language)
  + ‘The Story of Cholera’- a short cartoon, clearly showing the transmission of bacteria. Available online in limited languages, available from WASH Cluster in ‘Rohingya language’. Add link in Annex
  + SOPO
  + Mr. Than Shint, it’s the Hand washing and WASH in schools mascot. UNICEF has some IEC materials related to him: video, posters and booklet.
* Think about where the messages will be passed (for example):
  + Schools (formal and informal)
  + Religious places
  + Markets
  + Meeting points
  + Transportation hubs (airports, stations, etc.)
  + Local traders especially those serving food and drink
  + Local/ traditional healers/ pharmacies

## Considerations

If you are considering these activities then considerations to be aware of can be found below.

### Handwashing

* Handwashing point locations
  + Highly public areas such as markets, restaurants, transport hubs/ bus stations
  + Consider locating handwashing points near to checkpoints if it would be appropriate
  + In locations such as camps, there can be high visibility and impact by locating handwashing points at entrances and exits
  + Existing hand pump locations
  + Other locations which attract a high level of people
* Handwashing point attendant
  + Consider a HW attendant to pass out key hygiene promotion messages
  + Ensure that the water is used for handwashing only and not for drinking
  + Ensure that soap or ash is available
  + Ensure that children do not drink or play in it
  + Ensure that water is used onsite and not taken for use elsewhere
* Handwashing materials
  + If possible prioritize handwashing with soap/ ash in the AWD response to enforce its normal use and understanding in the community
  + It is possible to add detergent to the water to avoid the issue of soap disappearing, however this not encourage normal handwashing practices to continue in the community. There are also other issues to consider if using detergent such as the possible issues of residual taste (if used before eating), and a second water source would be needed for rinsing to remove the detergent ‘film’ left on the hands
* It is not necessary to use potable water for handwashing however clear water is preferred

### Latrine Cleaning

* Existing latrines, especially communal latrines, need to be kept clean to ensure that the faecal- human contact or faecal- vector contract is minimized.
* This cleaning can be completed with soap and water, ash and water, or detergent and water.
* Once the latrine is physically clean, it is recommended to spray the latrine slab (especially communal latrines) with a 2% chlorine solution.
* It is also possible to spray the superstructure if it is made of non-organic materials

### Latrine Construction

* Latrine construction is not an immediate response to an AWD outbreak
* This is based on the knowledge that once AWD is in the community, the quickest method of transmission is hand-to-hand contact and through eating or drinking contaminated food or water. Therefore, the immediate response must focus on hygiene promotion (cover excreta, safe food preparation, and safe water chain), protecting water (treatment, correct storage, jerrycan cleaning), cleaning of existing latrines and encouraging handwashing. The energy and resources required to construct new latrines will have a lower impact than if these were invested in interrupting the aforementioned main transmission routes.
* If existing latrines become full then it is recommended to decommission the latrines as per normal procedure whilst ensuring that the pit and its contents are well covered and fenced to avoid becoming a new source of contamination.

### The spraying of waste/ garbage is an AWD response activity

* This is not an effective AWD response activity
* This is mainly due to the high organic content of the waste/ garbage which will use up any chlorine solution sprayed onto it and is therefore an activity that requires high impact with no positive outcome.
* Instead, waste collection and management should continue as normal to ensure that the general environment remains clean.
* Ensure that waste collectors are correctly protected and maintain good hygiene levels

### Household Spraying with Chlorine

* It must be recognized that chlorine is often perceived to be the solution to cleaning however, it must be reiterated that chlorine will attack the largest particles first. Therefore if there is physical dirt present then the chlorine will effectively be used up before it has the chance to attack any pathogens present
* Bearing this in mind, chlorine will have a reduced or no effectiveness if it is being sprayed haphazardly in comparison to being sprayed onto a physically clean surface.
* There are question marks over the effectiveness of household disinfection due to the movement of people in and out of households and around the area. By the time a spraying team has arrived, it is highly likely that bacteria and physical dirt will have been moved around thus rendering targeted spraying as ineffective
* Household level spraying requires a very high investment of people, resources, time and finance without producing a positive result
* Household level spraying can also cause a negative impact if there is stigma attached to cholera in the community which will be highlighted and reinforced by household spraying
* Instead of spraying households those affected by AWD or diarrhea should be encouraged to carefully cleanse bedding, soiled clothes, hands, places where the patient has vomited, etc. with dilute sodium hypochlorite (bleach) or other disinfectants (if available), water, and soap and let affected bedding, etc. dry in direct sunlight. It is important that bedding, clothing, and other materials from cholera patients not be washed in open waters.
* The transmission cycle also needs to be addressed through other groups who should be targeted with the disinfection messages - e.g. taxi drivers and tuk tuk riders that have transported cholera patients to CTCs. they need to clean and disinfect their taxis, bikes and themselves. Schools also need to be included sensitization of the risks involved. These groups can also be used to spread cholera prevention messages once they have been targeted and informed themselves.
* Disinfect latrines where present, encourage normal cleaning too
* Highlight the need for disinfection of communal latrines in target areas.
* It is also recommended to distribute soap to the affected communities to encourage good handwashing and personal hygiene.

## Household Water Treatment

* In an outbreak, it is important to ensure that normal safe water treatment practices are encouraged to continue
* Sometimes it is necessary to set up parallel water treatment systems, for example,:
  + Where the community take water from an unprotected or unsafe source such as the river
  + Where the community do not have an existing method of treatment water
  + Where the community are not responding to safe water treatment messages
  + Displaced/ host populations or populations normally dependent on external support
* This parallel system may be necessary to avoid initial high death rate from AWD and/ or to provide support whilst a longer term solution is being created for example:
  + CWF distribution
  + Outbreak response in a location where there is no longer term support planned
  + Borehole, handpump or other water source rehabilitation is underway
* During a WASH response:
  + Keep encouraging normal household treatment processes, provided that they are safe
    - I.e. filtering with a cloth and boiling if there is no PuR or chlorine intervention planned or appropriate
    - Ensure that water is boiled for 3-5 minutes after boiling point is reached i.e. strong bubbles are visible
    - However be aware that firewood may be inaccessible and/ or expensive and so other practices will need to be promoted
  + Use appropriate language (i.e. brand or generic names) when promoting HHWT options depending what the population are most familiar with

Note: CWF does not provide any residual protection (like PuR or Chlorine products). Distribution of CWF as a rapid intervention during an AWD outbreak is not recommended, given their time-consuming nature of procurement and distribution, and the lack of residual protection. But communication should not go against the use of CWF at household level.

### Distribution of HHWT Products

* If household distributions (PuR or chlorine) are considered appropriate then it is important to ensure that:
  + The recipients are properly trained and can demonstrate correct use
  + Any related materials/ items are also distributed at the same time for example, buckets and cloth filters
  + The behavior of the population is understood and this is included in the planning and distribution considerations:
    - Water sources used i.e. PuR distribution should not be required where the population use clear groundwater
    - Size/ type of water container used
    - Household size
    - Ensure that any longer term plans for water treatment are not negatively affected by any outbreak response intervention
    - Number of sachets/ tablets given per household is known and appropriate
  + Ensure that the distribution is adapted to the specific context
  + Ensure that clear messages are given
    - Demonstrations
    - Explanations for the specific quantity to reduce the likelihood that the households will use more or less than what is recommended
    - Be aware that households may keep/ hoard the items and create messages to address this issue
    - Be also aware that households may sell the items and create messages to address this issue
    - Explanations that the distribution is an immediate response activity and not a long term solution.
      * This is especially important if the area will not be covered by longer term WASH support
  + Consider a post-intervention survey to assist with lessons learned but this is not an emergency response activity

### Monitoring and Evaluation

* As soon as the HHWT is set up, start monitoring and evaluation activities:
  + Post Distribution Monitoring
  + Water quality FU at sources and HH level
* Regarding the emergency context, consider increasing the frequency of your regular monitoring on water quality

## AWD and Nutrition

* It is important to note that there are no WASH activities required specifically for malnourished children/ adults than those which are required for nourished children/ adults. However, there needs to be *a higher emphasis to maintain a higher level of hygiene when interacting with a malnourished child/ adult*
  + *For example, a clean environment needs to become a really clean environment, a rinsed cup needs to become a thoroughly cleaned cup*
* Emphasize the known link between WASH and nutrition
* Maintain communication between WASH and Nutrition actors and ensure that these actors are included in the initial discussions once an outbreak is declared or higher than normal levels of AWD are seen
* Ensure that nutrition cluster disseminate all the required messages specific to malnourishment
* As nutrition team are aware on how to disseminate messages, conduct awareness session WASH actors could ask their support in case of need and depending on their wishes and capacities.

## AWD and Children

* It is important to note that the same transmission and prevention routes apply to children and adults. All water-borne disease information states the need to break the Faecal- Oral transmission route. This needs to be applied to children too and therefore as soon as possible after the initial cholera response is in place, actors need to ensure that there is a higher emphasis on improving child hygiene
* It is important to ensure that children are not forgotten and that key messages are adapted for children and their caregivers to understand
  + Baby WASH is an initiative that could be used (or aspects of it) see annex 4.5 Baby WASH.
  + Mr. Than Shint or also famous as ‘Square soap Longyi pants’ is an UNICEF Myanmar mascot to promote hand-washing with soap in order to decrease child mortality and illness, specifically diarrhea and other pathogenic diseases caused by poor hygienic practices. Mr. Than Shint is now widely use in Myanmar for WASH – child related campaign, especially to encourage children and their caregivers to wash their hands at key times during critical time.
* Ensure that children receive suitable messages as soon as possible:
  + Messages transmitted to schools, or children-related clubs
  + Songs and cartoons are used (for example)
  + That posters and leaflets contain clear pictures

## Psychosocial Aspects of AWD

* It is important to acknowledge that AWD cases and/ or an outbreak can be traumatic and frightening for populations. This is especially true where there has been no outbreak before and the understanding of the population is low.
* Fear is the most significant challenge that must be dealt with during a response. The importance of sharing good and clear information cannot be underestimated in reducing the fear and encouraging correct formal and informal response.
  + Be aware that the reaction of some people will be to hide anyone who may be sick
    - Ensure that WASH activities do not encourage this
    - The best way to protect the health and lives of the population is to ensure that anyone who falls sick receives proper treatment
    - If people do not receive proper treatment then they will not get better
* During a WASH response:
  + Share clear information about AWD to key people such as staff, authorities, local religious leaders, and the population in general
    - Make sure that all information is checked to avoid increasing the false information/ rumors which will be circulating
  + Avoid activities or discussions that lead to finger pointing, blame or stigma towards individuals or geographical locations
    - Encourage productive discussions with correct messages; possibly in a fun way using song or drama this can help to relief some psychosocial pressure during HP activities.
  + Be aware that response staff may be personally affected by AWD and may face increased pressure from themselves or others because of their position in the response or in the outbreak itself
  + Be aware that people involved in the response and caregivers may also be scared
    - Ensure that they have receive information and support

## Desludging

* In areas where desludging of latrines is not common practice, then it is not recommended to start desludging latrines
* In areas where desludging of latrines is common practice then desludging during an AWD outbreak can be continued but care must be taken
  + Note: This does not include AWD treatment facilities
* In community latrines (household or communal), the latrines may well contain the cholera bacteria, however in general they will be less contaminated than in an AWD treatment facility
* Therefore there is a need to take into account the following considerations:
  + Increase the physical protection for the desludging team
    - Like glasses, boiling suit, gloves, boots, etc.
    - Clean desludging items with chlorinated solutions, as opposed to with laundry detergent in a non-outbreak setting
      * 0.05% for handwashing and 0.2% for cleaning clothes
  + After desludging, ensure that the pit manhole cover and the latrine (inside and out) are clean as normal. If there is a high risk that is contaminated disinfect with a 2% chlorine solution
    - Note: If there is excess waste on the ground surrounding the latrine pit, this must be removed (back into the pit, into the barrels). Chlorine solutions are ineffective on such a highly organic surface such as the ground
  + Be more careful about the surroundings of the latrine, ensure that there is no waste lying around and any cases of open defecation are put into the latrines
  + Ensure that latrines are safe to use by ensuring that the covers are sealed, that there are no leaks
  + Ensure that all desludging materials (including barrels, tractors, pump, pipes, boots, and any mixing tools) are sprayed with a 0.2% chlorinated solution.
  + More care should be taken during an outbreak to avoid any spillages during transportation
    - Ensure that lids are fastened tightly
    - That the outsides of any barrels and the tractors are sprayed before movement with a 0.2% chlorinated solution
    - If the pump and pipes are to be moved (even to another latrines), ensure that the pipes are flushed with a 0.2% chlorinated solution to avoid spillages exiting the pipe
* In any AWD treatment facilities (CTC, isolation centers, etc.)
  + The treatment of human waste will be a very contentious issue between Health and WASH actors.
  + In a CTC the latrine waste is a health responsibility however as soon as WASH actors remove the waste it becomes a WASH responsibility.
  + Therefore, before any waste is removed from latrines, the WASH actor must be 100% certain that final disposal site is appropriate to receive highly contaminated AWD waste
    - Note: it is dangerous to allow contaminated waste to enter water sources or an inadequate waste treatment site. Therefore it may be necessary to store the waste on site whilst an appropriate solution is found. Care must be taken if this option is chosen. (Annexe 4.1 Household Disinfection- Position Paper)
  + All the above recommendations for the community latrine desludging also have to be considered for the AWD treatment facility waste but with a higher level of attention as the AWD waste will be much more highly contaminated

## Chlorine

* Correct use of chlorine and heat/ boiling water can both kill the cholera bacteria
* It is important that chlorine is used correctly and safely to ensure that:
  + Effective and appropriate solutions are prepared
  + Reduced unnecessary consumption of chlorine products, which will be in high demand during an outbreak
* If there is a need to chlorinate drinking or disinfection solutions:
  + Then chlorine should be handled by trained personnel and not distributed randomly
    - Demonstrations and practical attempts are more effective than only explanations
  + Those responsible must be provided with (and wearing) full protective clothing (masks, goggles, gloves, apron, overalls, etc.)
  + Ensure that expired chlorine is not used and that storage conditions allow the prolonged life of the product.
  + Ensure that the strength of the chlorine product is checked (i.e. 65% or 70%, etc.) and this is used when calculating ratios of chlorine to water, i.e. follow the manufacturer’s instructions for preparation.
    - Note: it is easier to ensure that one brand/ strength of chlorine is used in an area of intervention (preferably including all actors) to ensure that chlorine preparation confusion does not occur
  + Ensure that the different strengths of chlorine solutions are clearly marked, are thrown out at the end of each day and that new batches of solutions are made, (do not ‘top up’ existing chlorine solutions)
* Chlorinated Drinking solution:
  + People will not drink a chlorinated solution if the free residual chlorine is too high. However this may result in them using an unsafe water sources which is even more dangerous during an AWD outbreak
  + If it is considered appropriate to distribute chlorine products (tablets or powder) to the community then this will require clear demonstration, messages to ensure safe and correct use and strong follow-up on the use.
  + It is also necessary to give clear information about:
    - Why chlorine is necessary during an outbreak but that the community will not receive it in a non-outbreak setting. Be aware that this message (or when the distribution stops) could cause confusion, mistrust or fear.
    - How long they will receive it for
    - What they should use the chlorine for
  + The aim should be to maintain a Free Residual Chlorine minimum level of 0.5mg/l (if the pH is less than 8) or 1mg/ l (if the pH is more than 8)
    - It is recommended that FRC remains at the higher end of the required range at the point of collection (i.e. 0.5 mg/l if pH is less than 8 or 1mg/ l if pH is more than 8). This, in addition to water container cleaning (such as jerrycans) can greatly assist with a longer period of protection for the water quality
* Chlorine Solutions for Disinfection
  + Chlorine is required in different strengths for different purposes
  + Starting with the weakest to strongest, here are the recommended chlorine solutions:
    - Chlorinated handwashing water (0.05%)
    - Disinfection solution for items (0.2%)
    - Disinfection solution for highly contaminated body fluids (2%)
      * *Note it is also recommended that communal latrines are cleaned with a 2% chlorine solution*
  + There are specific amounts of chlorine to be used to achieve certain strengths of disinfection solution. It is possible to use more chlorine than recommended however this will not make the solution any more effective and will just use up more of the chlorine product
  + These chlorine disinfection solutions are normally found in a health facility (CTC, clinic).
  + These solutions can be used at community level but if this is occurring then this practice will not be discouraged but it is not recommended, because:
    - It is very difficult to ensure that the correct dose of chlorine is being used, the different quantities/ ratios of water and chlorine can be confusing
    - It takes the focus away from maintaining/ improving non-outbreak good hygiene practices and increases the belief that chlorine is the unique solution to the problem
    - In general, the community will face a lower level of contamination in comparison to a health/ treatment center and so good household and individual hygiene practices should be sufficient.
    - It is an unnecessary and high expense for organizations to provide chlorine to the population and it is difficult to maintain over a prolonged period of time. It is also difficult to stop distributions once they are started, especially if the outbreak is ongoing elsewhere.

## AWD Contingency Stock list

It is difficult to provide details of recommended stick lists due to the different intervention activities in different locations and with the intention to cover an unknown period of time. This also applies to the quantities required.

### Activities

Therefore, there are some activities to consider:

* Is this a response at community level?
* Are health facilities requiring any additional support?
* Will there be any distributions planned to the community?

### Possible Items for Blanket Distribution in the Community

*Note: This is for general distribution to the whole community. These may be different to the items given by health actors to patients who are being discharged*

*The items below will be as per international standards or alternatively according to what is standard in the area of intervention*

**Recommended Items:**

* Bucket/ jerrycan/ container (preferably 20 liters) for water collection and water treatment
  + SPHERE standard: 3-5 liters of drinking water per person per day
* Bucket/ jerrycan/ container (preferably 20 liters) for water storage
* Handwashing soap
  + SPHERE standard: 250 g per person per month
* Laundry Soap
  + SPHERE standard: 200 g per person per month
* Nail clippers (especially if the hygiene messages is regarding clean nails)
* Instructions for creating homemade ORS (if this is received/ checked by health actors)

**Other Items:**

*These items need to be considered but will not be appropriate in all areas of intervention*

* Aquatabs/ chlorine product for household level use
  + SPHERE standard: 3-5 liters of drinking water per person per day
  + *Only recommended in specific contexts and where a comprehensive IEC campaign and demonstrations are conducted in support of the distribution*
* PuR for household level use
  + SPHERE standard: 3-5 liters of drinking water per person per day
  + *Only recommended in specific contexts and where a comprehensive IEC campaign and demonstrations are conducted in support of the distribution*
* Filter cloth for filtering after the use of PuR
* Potty for children

### Bucket Chlorination

*The quantities will depend on how many bucket chlorination points are planned*

Community will need:

* Safe water collection container (preferably clean and closed/ with a lid)
* Soap for handwashing

Bucket Chlorinator will need:

* 1% mother solution in a container with a lid
  + Quantity will depend on planned duration of use; A new solution must be made each morning
* Syringe
  + Size appropriate for the amount to be added to the water i.e. 5ml
* Rubber/ plastic gloves
  + Possibly one per day is disposable, or longer if they are stronger
* Sign/ IEC materials
  + Explaining key messages including why the chlorination is necessary
* Shade
  + For the chlorinator and the chlorine
* Protective equipment (especially when preparing the mother solution)
  + Goggles, apron, gloves, mask
* Paper and pen
  + For marking how many buckets are chlorinated
* Knowledge
  + How much chlorine to put in each container. The will depend on results of the bucket test and the size of the receiving container
  + Checking of the receiving container for cleanliness

# RESPONSE

## Response Trigger

* FOLLOW UP WITH HEALTH ACTORS

Need to change to Rakhine, also in view of no health actor

Also acknowledge that if an outbreak is not declared, WASH actors can still intervene based on increased diarrhea

In case of appearance of one suspected case of cholera:

* The Health Focal Point liaises with the WASH Focal Point and requests a standby or the implementation of aspects of the WASH Cholera Response Plan

In case of appearance of one confirmed case of cholera:

* The Health Focal Point liaises with the WASH Focal Point and requests the implementation of the WASH Cholera Response Plan
* The WASH Response Plan cannot be applied without clear instruction only given by the Health Focal Point (Health State Department)
* A joint assessment can be proposed by Health Focal Point to the WASH Focal Point
  + Alternatively the Health Focal Point can share information regarding high risk areas and WASH Focal Point can share their findings
  + Other WASH agencies/partners can be proposed to participate in the assessment stage
* The environmental, led by WASH, assessment will aim to identify potential contamination sources, response activities and a basis for planning future activities
* The Health Focal Point provides the WASH Focal Point with all necessary and relevant information in order to allow him having a comprehensive view of the situation and facilitate the definition of adequate WASH response measures.
  + Epidemiological data
  + Affected shelters/areas
  + Contact tracing information such as sources of food and water in their recent history

## WASH Response Definition

* It is assumed that each WASH actor will respond in their existing areas of intervention, requesting further support or increased actors if their capacity is overwhelmed.
* WASH actors can respond in areas outside of their ongoing intervention areas, however this should be coordinated with the WASH cluster to ensure that there is no duplication and priority areas are targeted
* Each WASH actor should define the adequate WASH response measures to be implemented during their response
  + Note: Ensure that there is coordination with the WASH Cluster/ other actors so that the same messages are being passed and to avoid investment into ineffective activities such as household spraying
* Each WASH actor should coordinate with other actors in their area of intervention specifically including health, nutrition, authorities etc.
* It is recommended to decide and agree on the division of responsibilities between WASH, Health and Social Mobilization/ Hygiene Promotion actors in collaboration with the Authorities before there is an outbreak declared.
  + If this is not possible then the division of responsibility needs to be determined in response to the outbreak and prior to the start of intervention
  + This is particularly important given the high turnover of staff during a cholera response
  + Annex ??? can be used to assist with the division of responsibilities
* Ensure that there is two-way communication with the WASH Cluster

## Surveillance And Rapid Assessment

*Questions for health actor about data collection- add the answers in here*

* Surveillance systems should be able to rapidly detect an increase in reported cases of acute watery diarrhea
* Such an increase should trigger efforts to determine the source of transmission and ensure implementation of control measures in the affected area.
* It is a Health responsibility to collect this information before and during an outbreak however, it is a WASH responsibility to request this information from the health actors so that it can be uses it to target WASH activities to the high risk locations.
  + Note: The mapping of suspected and/ or confirmed cases should be completed by the health actors. However data from WASH actors can be fed into this and the resulting map used to target WASH activities
  + It is not a WASH responsibility to actively collect this information but they are obliged to pass on any information found out in the course of the prevention and response activities.
* Rapid assessments can be undertaken by any actor in any area however communication is required to ensure that efforts are not duplicated in the same location
* See annex 4.7 Diarrhea tracking for a possible assessment resource and diarrhea tracking
* Potential locations for outbreaks include:
  + Locations of previous outbreaks (hot spots)
  + Area where sanitation facilities are located within 20 m of water sources
  + An environment with availability of water and poor food handling practices
  + Inadequate sanitation
  + A population living in crowded conditions
  + Where people use drinking water of poor quality
  + High poverty and malnutrition
  + Coastal areas, areas around water bodies and around transport links.

## Contact Tracing

* Once someone presents at a health facility the symptoms of AWD. It is the health actors responsibility to follow up the movements during the incubation period as well as checking any high risk individuals such as family members, neighbors, schools/ institutions, location of employment/ livelihood such as markets
  + **Mobile Team Deployment** focuses on checking at household level once a patient has been admitted to check family and neighbors for signs and symptoms of cholera according to medical criteria. This is therefore a health activity

## Oral Rehydration Points (ORPs)

* These are a health responsibility and therefore the distribution of ORS into communities is also a health responsibility.
* WASH actors can pass messages to the community regarding ORS preparation with safe water but the content of these messages must be received from the health actors.
  + For example, messages regarding homemade ORS are also disseminated possibly using the 5:3:1 rule (5 finger scoops of sugar, 3 finger pinch of salt, 1 liter of water)
* The use of ORS in saving lives must be promoted.
  + If they wish, WASH actors can support or lead in the distribution of ORS but this is best to be undertaken after discussion with the health actors and after consideration of existing capacity such as logistics, procurement etc.
* WASH actors can assist with the provision of safe drinking water if the health actor requests extra support
  + Note: In this case, the responsibility of the ORP still rests with the health actor

## Individual donations to discharged patients

*Note: This is different to a general distribution of hygiene kits to communities*

* Sometimes cleaning and/ or hygiene materials are given to patients during their discharge process from the health facility after recovery from AWD
  + These materials are given with explanations to the patients and care givers by the health actor
  + However, WASH actors can assist with the provision of materials if this is agreed by the two actors involved

## WASH Response

* Each actor should decide on their response activities based on the characteristics and existing services/ sources in their area of intervention.
* See annex 4.8 Assessment for a possible assessment

# ANNEXES

## Household Disinfection- Position Paper

**Draft document for a position paper against chlorine spraying at households of cholera patients**

*Developed by UNICEF, CDC and MSF in 2011*

For over a century, authorities have recommended disinfecting the homes of cholera patients as a measure to prevent further cholera transmission. However, a thorough search of the published scientific literature has not identified any studies on the impact of chlorine spraying of households of cholera patients on disease spread.

Vibrio cholerae, the bacterial cause of cholera does not survive in dry conditions, and chlorine solution is rapidly inactivated by contact with organic material and by sunlight. Therefore, in the typical home of a cholera patient, which may have a dirt floor and a thatch roof, there could be little benefit in spraying chlorine solution.

The cholera vibrio load in excreta of severely symptomatic cases is particularly high, and there is no question that in cholera treatment centers good hygiene practices, including environmental disinfection, are essential to protect the health of providers, patients, and their families. However, especially in the epidemic setting, it rapidly becomes impractical to send teams to the homes of each cholera patient to conduct “one-off” environmental disinfection. Typically, the spraying team only reaches the household several days after the onset of cholera in the index case, by which time other members of the household have likely already been exposed either to the primary source of contamination or to secondary transmission from the index case.

One-off disinfection will not prevent subsequent recontamination of the household environment in the following days as the chlorine solution sprayed on surfaces like bedding, soil, and kitchen utensils reacts quickly with the surface sprayed and does not have any residual effect.

Excreta from mildly ill, asymptomatic (subclinical), and convalescent patients also contains cholera vibrios, and a single household visit for disinfection will not prevent recontamination from these sources. Household members will remain vulnerable to infection from exposure to drinking water from unprotected sources or foods that have been contaminated outside the home, regardless of the effects of household spraying, and may thus re-introduce Vibrio cholerae into the household environment.

In addition to requiring considerable logistical resources and staff time, household spraying runs the risk of stigmatizing patients and their families, and being such an ordeal for the households affected that other households become reluctant to report their cases.

Instead of spraying households affected by cholera or diarrhea should be encouraged to carefully cleanse bedding, soiled clothes, hands, places where the patient has vomited, etc. with dilute sodium hypochlorite (bleach) or other disinfectants (if available), water, and soap and let affected bedding, etc. dry in direct sunlight. It is important that bedding, clothing, and other materials from cholera patients not be washed in open waters. If resources are available and there is interest in household disinfection activities, it is advisable to provide households with the means and knowledge to do proper home disinfection for several weeks (as opposed to a one-off event). This can be done in conjunction with efforts to provide households with products and education for household drinking water treatment, safe food preparation, and handwashing, which are typical prevention measures in cholera response in the epidemic and endemic setting.

**In light of these concerns, we suggest that scarce resources, including vehicles and staff, not be directed to household spraying with chlorine or other disinfectants during a cholera response campaign. Instead, resources should be focused on interventions like provision of sufficient quantity of water, chlorination of drinking water and hygiene behavior change.**

*END OF POSITION PAPER*

## What is Acute Watery Diarrhea?

AWD information for the public

* 1. What is AWD?
* It is a human disease, starting with a sudden onset of numerous watery stools, often combined with vomiting from 6 hours to 5 days after exposure to the bacterium.
* In these cases, the loss of large amounts of fluids can rapidly lead to severe dehydration.
* In the absence of adequate treatment, death can occur within hours.
* People with low immunity, such as malnourished children or people living with HIV, are at a greater risk of death if infected
  1. What do you have to know about AWD?
* It’s a very contagious disease, but can be treated easily and quickly
* Of those who develop the disease, 80% will have illness with diarrhea, which can be treated with Oral Rehydration Solution (ORS)
* Of the people who develop typical AWD normally less than 20% will suffer from dehydration. These cases should be taken to a health facility. EARLY TREATMENT IS ESSENTIAL
* Both children and adults can become ill with AWD
  1. When do you suspect AWD?
* As soon as you have watery diarrhea or watery stools
  1. How can you get AWD?
* By drinking water contaminated with faeces from unsafe sources – rivers, open wells, water pans – which has not been treated
* By drinking water that has become contaminated during transport, storage or consumption.
* By eating food contaminated with faeces during or after preparation including food that has not been peeled, washed or cooked thoroughly
* Dirty hands can pass AWD from hand contact into the mouth, onto food and/ or with other people during handshaking etc.
* Touching dead bodies of people who have died from AWD
  1. How is AWD transmitted?
* AWD is transmitted via the faecal-oral transmission routes
* The main mode of transmission is through contaminated food or drinking water or hands.
* Faeces and vomit are very infectious and so can easily be transmitted from person to person in areas of dense populations and poor sanitation and hygiene, such as poor urban areas and IDP camps
* People with no symptoms can still transmit AWD without that person becoming ill
  1. What to do in case of suspected AWD?
* If diarrhea occurs then drink ORS
* Immediate and continued rehydration while seeking medical care saves lives
* Drink ORS as soon as possible after having diarrhea and continue to drink it even if you are travelling towards a health facility

## Division Of Responsibilities Template

*Use the table below to collect key contact details for the area of intervention. Remember to ask the WASH Cluster for the most updated list in your area*

|  |  |  |  |
| --- | --- | --- | --- |
| **ACTIVITY** | **RESPONSIBLE ORGANISATION AND**  **CONTACT DETAILS** | **LOCATION** | **COMMENTS** |
| CTC, Isolation Centre or Health Facility |  |  |  |
| Surveillance  *Early warning, response and alert system* |  |  |  |
| Response at Community Level  *Checking at household level once a patient has been admitted to check family and neighbors for signs and symptoms of cholera according to medical criteria* |  |  |  |
| Oral Rehydration (ORS) Response |  |  |  |
| Supply of Clean Water to CTC or Health Facility |  |  |  |
| Supply of Clean Water to Communities |  |  |  |
| Infection Control within a CTC or Health Facility  *Disinfection of the building, beds, laundry, clothing; Preparation of chlorine solutions; Excreta management* |  |  |  |
| Desludging of latrines within a CTC or Health Facility |  |  |  |
| Latrine Construction |  |  | **This is not a recommended immediate cholera response activity within communities** |
| Disinfection at Community Level |  |  | **Household spraying as a disinfection technique is not a recommended cholera response activity within communities** |
| Distribution of Cholera Kit  *To patients* |  |  |  |
| Targeting Areas within the Community  *Cholera response* |  |  |  |
| Communication  *Cholera response and prevention* |  |  |  |
| Refugee, IDP and Spontaneous Settlements |  |  |  |

## IEC materials available

* There are some IEC materials already available (see below for examples)
* Check with the WASH Cluster and WASH partners for available materials as part of AWD preparedness



## Baby WASH

**BABY WASH**

**A new way of thinking about WASH in the first 1000 days**

* Protective play space, to protect developing child from contaminated soil and animal faeces (especially chickens)
* Infant hand washing with soap, when outside of protective play space.
* Caregiver hand washing with soap after faecal contact and before preparing/ serving food
* Safe disposal of faeces especially of children’s faeces
* Water treatment
* Avoid feeding leftovers, or reheating food *Baby WASH from UNICEF*

Note:

* Creating a playing space that could also be a feeding place for example free from animal and human defecation
* The care giver must wash their hands, but so should the infant or child who is receiving the food
* Construction of child friendly latrines is recommended as a cholera ***preparedness and prevention*** activity not as a response activity

## MoH AWD related messages

* Chlorination





* Diarrhea



## Chlorine Solutions and Their Uses

A chlorine calculator can be found below, it is a very useful tool as it allows different parameters to be changed including:

* Strength of the chlorine used
* Percentage solution required
* Quantity of solution required



|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Chlorine Product | 0.05%  Chlorine Solution | 0.2%  Chlorine Solution | 1%  Mother Solution | 2%  Chlorine Solution |
| Calcium Hypochlorite  (HTH)  65% active chlorine | 1 g of HTH per  1 liter of water  **Or,**  10 g of HTH per  10 liters of water  **Or,**  20g of HTH (65%) in  20 liters of water | 4g of HTH per  1 liter of water  **Or,**  40g of HTH per  10 liters of water  **Or,**  80g of HTH (65%) in  20 liters of water | 20g of HTH (65%) in  1 liter of water  **Or,**  200g of HTH (65%) in  10 liters of water  **Or,**  400g of HTH (65%) in  20 liters of water | 40g of HTH (65%) in  1 liter of water  **Or,**  400g of HTH (65%) in  10 liters of water  **Or,**  800g of HTH (65%) in  20 liters of water |
| ‘Aquatabs’  Sodium Dichlorcyanurate (NaDCC)  1g active chlorine per tablet | ½ tablet in  1 liter of water  **Or,**  5 tablets in  10 liters of water  **Or,**  10 tablets in  20 liters of water  r | 2 tablets in  1 liter of water  **Or,**  20 tablets in  10 liters of water  **Or,**  40 tablets in  20 liters of water | 10 tablets in  1 liter of water  **Or,**  100 tablets in  10 liters of water  **Or,**  200 tablets in  20 liters of water | 20 tablets in  1 liter of water  **Or**,  200 tablets in  10 liters of water  **Or**,  400 tablets in  20 liters of water |

*Note that often there are spoons provided with chlorine powder products and these will allow measurement in grams*

**Chlorine Solutions for Cleaning**

***(Note: These are cleaning solutions in a health centre and are NOT drinking water solutions)***

*Information taken from ‘Public Health Engineering in Precarious Situations’ MSF, 2010*

|  |  |  |
| --- | --- | --- |
| **Chlorine Solution** | **Use** | **Situation** |
| 2% | * Disinfection *during a cholera outbreak:* * vomit * excreta/ faeces * dead bodies/ corpses | * Cholera/ Cholera Treatment Centre (CTC) |
| 1% | * Mother solution   *Add a small quantity of the mother solution for*:   * Drinking water * Cleaning and disinfection of wells and flexible reservoirs | * Normal *(non epidemic)* |
| 0.5% | * Disinfection of dead bodies *during an Viral Hemorrhagic Fever (VHF) outbreak* *(Ebola, Marburg, SARS)* * Disinfection  *during an Viral Hemorrhagic Fever (VHF) outbreak* *(Ebola, Marburg):* * Vomit, excreta/ faeces, urine, bodily fluids | * Specific epidemics/ outbreaks |
| 0.2% | * Disinfection *during a cholera outbreak*: * floors * walls * surfaces * beds * objects * latrines and showers * feet spraying * Disinfection and cleaning of floors during an epidemic of illnesses associated with vectors and/ or body lice | * Cholera/ Cholera Treatment Centre (CTC) * Specific epidemics/ outbreaks |
| 0.1% | * Disinfection and cleaning: * Water trucks, pipe, pumps * showers * washing facilities (laundry areas) * waste bins and buckets for soft/ combustible waste and organic waste * reusable sharps containers * sharps pits including the slab and the entry pipe | * Normal *(non epidemic)* |
| 0.05% | * Well cleaning * Disinfection and cleaning of: * The lower section of the water filters * Open reservoirs * Solid waste trucks * Cups * Disinfection *during a cholera outbreak:* * Hands/ skin * Clothes * Bed covers * Washing buckets * Disinfection of household items: * gloves * aprons * glasses/ goggles * clothes * bedcovers | * Cholera/ Cholera Treatment Centre (CTC) * Normal |

## Diarrhea tracking

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  | | --- | | **Diarrhea Tracking Survey** | | | | | | | | | | |
| **Camp Name-** | | | |  | **Camp Total Population-** | | | | |
| **Hygiene Promoter Name -** | |  | | |  | **Date-** | | | |
| **Is there someone in your family who has some diarrhea?** | | | | | | | | **Yes / No** | |
| **Sr.No** | **Camp** | **Sector** | **Family Size** | | **Under 5 years** | | | **Over 5 years** | |
| **M** | | **F** | **M** | **F** |
| 1 |  |  |  | |  | |  |  |  |
| 2 |  |  |  | |  | |  |  |  |
| 3 |  |  |  | |  | |  |  |  |
| 4 |  |  |  | |  | |  |  |  |
| 5 |  |  |  | |  | |  |  |  |
| 6 |  |  |  | |  | |  |  |  |
| 7 |  |  |  | |  | |  |  |  |
| 8 |  |  |  | |  | |  |  |  |
| 9 |  |  |  | |  | |  |  |  |
| 10 |  |  |  | |  | |  |  |  |
| 11 |  |  |  | |  | |  |  |  |
| 12 |  |  |  | |  | |  |  |  |
| 13 |  |  |  | |  | |  |  |  |
| 14 |  |  |  | |  | |  |  |  |
| 15 |  |  |  | |  | |  |  |  |
| 16 |  |  |  | |  | |  |  |  |
| 17 |  |  |  | |  | |  |  |  |
| 18 |  |  |  | |  | |  |  |  |
| 19 |  |  |  | |  | |  |  |  |
| 20 |  |  |  | |  | |  |  |  |

## Assessment

The questions (*in italics*) are included *to prompt the user* regarding useful information however these questions are not relevant in all contexts and so the user needs to be selective in excluding some of the information but also including other information which is more relevant and useful to that specific context. This tool to be jointly used by WASH and Health actors

### Water Source Quantity and Quality

* Once an AWD outbreak is suspected or declared the WASH actors must ensure that the water quality in used water sources is checked. It is preferable that this is already checked prior to the declaration of an outbreak.
* The WASH actors must monitor the water sources regularly and remain aware of any changes
* Things to consider:
  + *What water sources are currently used?*
    - *Groundwater- borehole? Hand dug well? Are these protected?*
    - *Surface water- where?*
    - *Rainwater- is this used?*
  + *What parameters are being checked? Faecal coliforms? pH? Turbidity? Conductivity?*
  + *What are the needs (or potential needs) for treatment?*
    - *Any there any concerns related to the water source? i.e. access, fencing*
  + *Is there enough water available to meet all needs?*
  + *If not, what can be done to increase the water quantity available?*
* *What activities will be implemented in response to this situation?*
* Note: Unless requested, the health actor should be providing safe water for any response facility. However, ensure that their use is understood as well as any impacts on the sources being used by the community
  + If the WASH actor is supporting the health team with the provision of water, ensure that community and facility needs are both considered

### Water Treatment/ Chlorination

*Note: Chlorine solution strength reduces according to time and exposure to sunlight. Store solutions in a cool, dry and well ventilated location and prepare a fresh solution every day*

*Note: It is not recommended to distribute chlorine products to the community*

* *What water treatment activities are required?*

*Note: The treatment required may change for different water sources*

* + *What is the current method of treating water in the community/ household?*
    - *Can this be continued?*
    - *Can this be improved/ supported?*
  + *If a parallel system is required:*
    - *Will this be for the long term or short term?*
    - *Is bucket chlorination necessary?*
    - *Is the WASH actor conducting Batch chlorination at the point of collection?*
      * *Which locations?*
    - *Quantity of water supplied?*
    - *Distribution network? Multiple tap stands? Tanks?*
    - *FRC to be obtained?*
    - *Distribution of PUR (short term response whilst setting up other water treatment) or filter cloth?*
  + *After treatment (household/ community or WASH actor), what is the quality of the water provided?*
    - *FRC? pH? Turbidity? Conductivity? Faecal coliforms?*
* *What activities will be implemented in response to the water situation?*

### Safe Excreta Disposal

Safe disposal of excreta must be encouraged but is of higher importance during a cholera outbreak.

* Are there latrines in the community?
  + *If there are no latrines present:*
    - *What methods of excreta disposal are in place? Burial (cat method)?*
  + *Note: if there are no latrines, it is not recommended to construct new latrines as an outbreak response activity, however the community must be encouraged to take care with excreta such as burying it or create a managed open defecation area/ field*
* *What is the existing provision of latrines?*
  + *Household latrines? Communal latrines?*
  + *What type of latrines? Simple pit latrines? Pour flush? etc.*
* *Are the latrines being maintained?* 
  + *By who?*
  + *Are cleaning materials required to assist with normal cleaning?*
  + *Will the latrines be sprayed with a chlorine solution? What strength? How often?*
* *Are there any handwashing facilities available?*
  + *Are any repairs needed?*
  + *Does the community have access to soap and water?*
* *Are the latrines de-sludgeable?* 
  + *Who does this? Can this existing management be supported or improved?*
  + *Where will any latrine waste be disposed of?*
* *Is there the high presence of flies in the latrines and/ or the area surrounding them?*
* *Any latrines require decommissioning? Where? How will they be decommissioned?*
* *What activities will be implemented in response to the excreta disposal situation?*

### Community Handwashing and Feet spraying Activities

*Note: This is only recommended in community locations where there is controlled access and a clearly demarcated area such as the entrance and exits to IDP sites, schools etc.*

* *Is this a required or appropriate activity?*
* *Which locations will be targeted? Markets? Religious centers? Schools? Bus stations? Entrances and exits of controlled locations (i.e. camps)*
* *How long will the handwashing and feet spraying activities be implemented?*
* *For handwashing, will soap be provided?*
* *Will any messages be passed to the community during these activities?*
  + *What method will be used to pass the messages?*
  + *How often will messages be passed?*

### Hygiene Promotion

*Note: Awareness rising should be implemented at all levels such as at the water collection point, household and community levels*

* *Awareness raising regarding the transmission, prevention and response to AWD*
  + *What messages will be included?*
  + *How are these messages going to be transmitted? How often?*
  + *Which locations will be targeted? Markets? Religious centers? Schools?*
  + *What key messages will be shared?*
  + *What method will be used to pass the messages?*
  + *How often will messages be passed?*
* *Clean Water*
  + *How can the activities below be encouraged, supported or improved?*
  + *What safe water promotion activities currently exist?*
  + *Where are the safe water sources?*
  + *What are the current collection methods used by the community?*
  + *What are the current storage methods used by the community?*
  + *What are the treatment options or household or community level?*
    - *What external materials are required and are these available?* 
      * *Ceramic water filters, wood for fuel, cloth for filtering etc.*
  + *What are the current safe water chain activities?*
    - *Is water collection container cleaning required?* 
      * *Which locations? At household or community level?*
      * *How often? Regular or one-off?*
      * *Which cleaning materials will be needed? Chlorine, soap, stones, ash etc.*
      * *Who supervises/ manages this activity? WASH Staff? Hygiene Promoters? Community Members?*
      * *Is soap provided? Or using detergent? Or stones?*
      * *What hygiene promotion/ messages will be given out?*
      * *Will demonstrations be completed?*
      * *Which collection reservoirs are being used by the population?*
* *Clean Hands*
  + *How can the activities below be encouraged, supported or improved?*
  + *Do hand washing activities currently exist? Household level? Community level?*
  + *Where are the water sources for hand washing?*
  + *Is soap available?*
* *Clean Food*
  + *How can the activities below be encouraged, supported or improved?*
  + *Does people covering their food?*
  + *Is there any evidence of flies in food preparation/dining table area?*
  + *Is the raw vegetable and fruits are cleaned and washed with safe water?*
  + *Is the food utensils are cleaned?*
* *Clean Latrines*
  + *How can the activities below be encouraged, supported or improved?*
  + *What are the current sanitation practices at community? OD/shared latrines/cat method*
  + *If community using shared latrines, who is in charge for cleaning? how often?*
  + *Is there any evidence of faeces scattered in latrines area?*
  + *Does water available for latrine cleaning*
  + *Are materials for anal cleaning available? (e.g. water, paper, etc.)*

### Hygiene Kit Distribution To Targeted Areas

It is a WASH responsibility to complete blanket distributions of hygiene items to targeted areas. These areas could be based on the information received from health or WASH or other actors.

*Note: This hygiene kit is for general distribution to the whole community. These may be different to the items given by health actors to discharged patients*

*Note, unless otherwise stated during the outbreak, ‘standard’ distributions can take place where the community go to the distribution area. However, handwashing and feet spraying activates can be implemented here to reinforce the message that there is an outbreak and to reduce transmission*

* *Which locations will be targeted for distribution?*
* *Is it a one- off distribution?*
* *Which items will be given?*
* *What hygiene messages will be disseminated during the distribution?*
* *What method will be used to pass the messages?*
* *Will there be any post-distribution monitoring?*

### Ongoing Monitoring Of Activities

* Once response activities have started, all response activities have to be monitored daily at the minimum due to:
  + The high transmission rate of cholera
  + The fragility of chlorine
  + The implementation of new WASH activities
  + The dynamic situation during an AWD response requires ongoing monitoring to allow resources (people, materials, time etc.) to be directed to the high risk locations
* What is the existing situation for monitoring the WASH situation in the village?
  + If there is no change in the WASH activities in each location then there is no need to disrupt the normal monitoring activities, enable them to continue during the outbreak
  + Could the WASH committee or village committee do this?
  + WASH actors could provide basic guidelines
* Monitor all used water sources for quality as well as any changes
* All chlorination (FRC) at storage or distribution must be tracked and recorded by the agency responsible
* FRC at household level should also be monitored (the context will determine the regularity and the sample numbers)
* Promotion of safe water practices messages must be monitored to ensure they are relevant to the changing situation
* Container cleaning campaigns must be monitored to reduce the likelihood of ‘response fatigue’ by the population
* Monitoring of the content and method of hygiene promotion messages is important to try to avoid ‘response fatigue’
* Monitor the effectiveness of handwashing points, changing their location in order to target more people or to achieve higher visibility
* Monitor any chlorine solutions used for feet spraying
* Ensure that all distributions are combined with targeted key cholera messages
* Monitor that excreta is being disposed of safely
* Monitor that latrines, especially communal latrines, are being cleaned regularly and correctly
* Monitor any ongoing desludging activities and the safe disposal

# Recommended resources

Need to check to see if there is an Asian version

* + Mr. Than Shint (link are not available but we can added in annex for video, poster and sticker)
  + Choose Soap
    - <http://www.choosesoap.org>
    - This is a whole training and video package for promoting Handwashing with Soap - it has a South Asia bias but it has been useful in African contexts
  + ‘F’ Diagram Animations
    - <http://vimeo.com/album/2870771>
  + Handwashing Promotion Comedy from Namibia
    - <http://vimeo.com/album/2870767>
  + The Story of Cholera
    - <http://globalhealthmedia.org/story-of-cholera/videos/>
  + WASH in Schools in Emergencies.
    - This is a complete set, freely available from UNICEF

<http://www.unicef.org/wash/files/WASH_in__Schools_in_Emergencies_Guidebook_for_teachers_.pdf>

<http://www.unicef.org/wash/files/WinS_in_Emergencies_flashcards__Africa.pdf>

The Global Burden of Cholera, The World Health Organization,

<http://www.who.int/bulletin/volumes/90/3/11-093427/en/>

Oxfam cholera guidelines http://www.unicef.org/cholera/Annexes/Supporting\_Resources/Annex\_6B/OXFAM\_Cholera\_guidelines.pdf

UNICEF cholera guidelines <http://www.unicef.org/cholera_toolkit/>

Cholera UNICEF advocacy video: https://youtu.be/T3p8qmdd4ww

Medecins Sans Frontier (2004), ‘Cholera Guidelines’ 2004 http://www.unicef.org/cholera/Chapter\_2\_basics/04\_MSF\_cholera\_guidelines.pdf

Documents used as a basis for this document:

* Rakhine WASH Cluster Acute Watery Diarrhea (AWD) Preparedness and Response Plan , March 2015
* DFID Consortium AWD Contingency Plan, Rakhine State, July 2014
* South Sudan WASH Cluster Cholera TWG Technical Recommendations, 2014
* South Sudan WASH Cluster Global Template, 2014