

Oxfam GB Nias Child-to-Child Activities

1.0 Implementation

During September-October 2007, a Child-to-Child (C-to-C) component was introduced into the Oxfam GB Nias Water and Sanitation programme. The objective of the activity was to increase children's awareness on public health and hygiene issues.¹ 224 children (99 girls and 125 boys) were trained as Child Facilitators and provided direct promotion to their peers and families (*Table 1*). In the villages, children were selected by the village leaders and programme was implemented for 6 weeks. In the locations where Oxfam GB was constructing sanitation facilities for schools, sessions were held for 8 weeks and children were selected by the head of the school.

Table 1: Child-to-Child Facilitators Trained

No	Location	Girls	Boys	Total
1	Satelit Village	22	23	45
2	Lauri Village	16	30	46
3	Maliwa'a Village	32	41	73
Village Sub-total		70	94	164
4	Biouti Primary School	11	13	24
5	Siofabanua Junior School	6	6	12
6	Siofabanua Primary School	12	12	24
School Sub-Total		29	31	60
Total		99	125	224

Modules and handouts were developed by the Oxfam GB PH Team and prior to each session, the modules were reviewed by the Community Health Volunteers (CHVs) or teachers to enable them to either lead or co-facilitate the session (see *Annex 1* for a sample module and handout). The traditional zig-zag approach² was used in training the team and in developing the children's modules.

1. Choosing the right idea
2. Finding out more
3. Discussing what we have found out and planning the action
4. Taking action
5. Discussing results
6. Doing it better and sustaining the action

1. Choosing the right idea

To identify a water and sanitation related issue, a survey was done with all the Child Facilitators during the first week of the programme. The survey asked questions about their knowledge of sanitation practices (operation and maintenance of latrines and open defecation), water-handling practices, handwashing, and diarrhea transmission and prevention. The results were analysed (see section 2.1 for methodology) and the areas in which children had less knowledge were identified as priorities. Then based on the children's review and input, one topic was selected. In the villages children selected open defecation and in the schools children focused on latrine operation and maintenance. In all areas, diarrhea transmission routes and prevention behaviours were the underlying themes.



Maliwa'a Village

¹ See IDSB27 Log-Frame

² Child-to-Child: A Resource Book, 2nd ed. Editors: Hugh Hawes, Donna Bailey and Grazyna Bonati. 2007. Oxfam GB Nias Child-to-Child Activities 2007
afleischer@oxfam.org.uk



Lauri Village

2. Finding out more

After the children selected their topic of interest, they collected data to document the related hygiene behaviours in their community to determine the current knowledge among their peers and families. Data was collected through a variety of methods, including key informant interviews with family members or classmates, observation of handwashing practice, and mapping exercises to identify open defecation locations. During this session, the children discussed key hygiene concepts, including diarrhea transmission routes and prevention behaviours.

3. Discussing what we found out and planning action

After data collection, the children presented their findings to one another. Then incorporating the hygiene information they had learned in the previous two sessions, they analysed possible reasons for people's current behaviour and gaps in hygiene knowledge and practice. After this process, the children identified an objective for a community or school-based activity. Some of the objectives included increasing their peer's knowledge of proper latrine usage in schools, increasing knowledge of the risks of open defecation, and the importance of handwashing. In order to implement their activity, the children developed an action plan based on the following questions:

- **Who** will the audience be?
- **What** will the message be?
- **Where** will we share the message?
- **When** will we share the message?
- **How** will we share the message?



Maliwa'a Village

4. Taking Action

After developing their action plans, the Child Facilitators worked together with the CHVs, teachers, and Oxfam GB staff to further develop the events. This process required children to use their creativity to develop an engaging activity their peers would enjoy and to assume leadership roles to ask the village and school leaders for approval as well as mobilize their family and friends to attend the event. The events they developed included:

- Dramas on the prevention of diarrheal diseases and latrine operation and maintenance.
- Original songs composed by children on the cat method, handwashing, and latrine operation.
- Integration of hygiene practices into common children's games (sack races and handwashing; tug-of-war and handwashing).
- Discussions with female classmates on what menstruation is and menstrual hygiene at school.
- Latrine cleaning demonstrations.
- Household visits with families that did not own latrines.



Satelit Village



In Biuti Primary School, Child Facilitators act out a scene in their drama which communicated the importance of washing hands after using the newly constructed school latrines. The drama was written by the children and their teachers; they were extremely motivated in preparing and sewed a curtain for their “stage” and rehearsed on Sundays (left).



Children in Maliwa’a and Satelit Village adapted children’s games to focus on handwashing (left), and latrine usage (below).



Not only did children develop the community events, they also implemented the entire activity including a review of key hygiene messages at the end of the event. (above left – Diarrhea transmission and prevention in Biuti Primary School, above right- Handwashing in Satelit Village)



Singing and dancing are an important part of the culture in Nias. Children in all locations wrote original songs on hygiene throughout the programme and then performed them for their peers during their activity. In addition to making the events more fun, the songs were one way that Child Facilitators and community members remembered hygiene messages. (above – Satelit Village)

5. Discussing Our Results



Lauri Village

11 events were held at the village and school level, with 1,756 children (877 girls and 879 boys) participating in activities (see Table 2). After the event, Child Facilitators followed up with their target audience to collect feedback about the activity. They identified what participants learned from the event and what they could do differently to make future activities more effective in communicating hygiene messages. They also observed their peers and families for behaviour changes, for example handwashing. While it is ambitious to expect change after a one-time event, the introduction of the monitoring concept helped to emphasize the need for continuing activities. While it was not possible to measure the change in the children who were targeted in the events, the opportunity to see their peers leading an activity was commonly cited as the most important result reported by the participants. Children and adults also remembered the songs composed by the children. In addition, the children who led the C-to-C activities showed significant increases in their hygiene related knowledge and qualitative data showed a change in the children’s behaviour (see Section 2.2).

Table 2: Participants in Child-to-Child Events

Location	Girls	Boys	Total
Village	396	391	787
School	481	488	969
Total	877	879	1,756

In the schools, the programme continued for an additional 2 weeks. During this time, the Child Facilitators continued daily monitoring of the use of school sanitation facilities and provided daily feedback to classmates to encourage proper operation and maintenance.



6. Doing it better next time

Oxfam GB Nias public health programme closed in November 2007, therefore it is not possible to determine whether or not the Child-to-Child Approach will be implemented again by the CHVs or teachers. This was the first opportunity for children in Nias to actively engage in a process of information collection and reflection and to design and implement an activity for their community. The activity introduced a different model for adult's interaction with children and the interaction of children among themselves. While there is limited experience with the Child-to-Child Approach in Nias, the involvement of teachers and CHVs in the

implementation of C-to-C activities has created a pool of community members who have the potential to continue working with children using the Child-to-Child Approach. It also expanded Oxfam GB staff's knowledge of working with children. Previously children's activities were planned in a top-down model by Oxfam GB staff, CHVs, and teachers. After using the Child-to-Child Approach staff have had the opportunity to work in a different way, using a bottom-up model where activities are planned and implemented by the children themselves. Therefore, not only does the community have the skills to implement a similar activity again, Oxfam GB staff will be able to apply this experience in other Oxfam projects or with other agencies.

2.0 Child-to-Child Key Indicators

2.1 Survey Methodology

A knowledge and practice survey was implemented prior to beginning C-to-C activities to determine the Child Facilitators' baseline and to identify the hygiene domains to focus on during the programme. Given the short period for implementation (effectively 2 months), the number of children, and limited surveyors it was not possible to complete individual surveys with each child. Therefore, small groups were formed and the surveyors asked groups of children each question. The number of different responses for each question was recorded and is used as the denominator for calculating the percentages. As shown below, the denominators for some of the questions varies; this is attributed to a different number of responses for each question. Percentages were calculated for each response and this data served as the baseline. The same survey was completed after the programme ended and analysed using the same method.

2.2 Findings

Handwashing

- There was a **significant increase** in children's ability to identify key times for handwashing. At baseline, only 67% could identify 2 or more times for handwashing. In the final survey, 100% of children could identify 2 or more times (see *Annex 2, Table A*).
- There was also a **significant increase** in children's ability to identify key times for handwashing. In the follow-up survey, children were able to identify 60% (4/6) of the times for handwashing. This is compared to the baseline survey when only 33% (2/6) times were identified (see *Table 3*).

Table 3: Key Times for Handwashing

Key Times for Handwashing	Baseline % (n)	Follow-up % (n)
Before preparing food or cooking	0% (0/33)	75% (15/20)
Before eating	94% (31/33)	100% (20/20)
Before feeding children	0% (0/33)	10% (2/20)
After defecation	70% (23/33)	100% (20/20)
After helping children defecate	0% (0/33)	0% (0/33)
After touching animals	0% (0/33)	0% (0/33)

Based on the data, handwashing after helping children defecate and after touching animals should be emphasized in future activities. This is particularly important given the informal poultry market in Nias and the risk of Avian Flu in Indonesia. Also, for many children they are the primary care-giver for their younger siblings and there is the potential to transmit diarrheal disease.

- Other findings show **significant increases**. At baseline only 38% (9/24) of children reported washing their hands with soap and water. In the follow-up survey, 100% (24/24) reported using soap. At baseline, 18% (4/23) of children knew that washing hands with soap was the most effective behaviour to prevent diarrhea. In the follow-up survey, 73% (17/23) knew that washing hands with soap was the most effective behaviour to prevent diarrhea (see *Annex 2, Table B*).

Diarrhea Transmission

- There was a **significant increase** in the number of children who were able to identify 2 or more routes for diarrhea transmission. At baseline, 0% (0/35) of children could identify more than 2 transmission routes. In the follow-up survey, 95% (19/20) could identify 2 or more routes (see *Annex 2, Table C*).
- There was also a **significant increase** in the number of children who were able to identify each of the diarrhea transmission routes. For example, at baseline only 11% (4/35) of children knew that unwashed hands could cause diarrhea. However, in the final survey, 95% (19/20) knew that unwashed hands could cause diarrhea (see *Table 4*).

Table 4: Diarrhea Transmission Routes

Routes	Baseline % (n)	Follow-up % (n)
Water	3% (1/35)	65% (13/20)
Hands	11% (4/35)	95% (19/20)
Food (including uncovered food)	23% (8/35)	90% (18/20)
Open Defecation	0% (0/35)	25% (5/20)
Flies	0% (0/35)	0% (0/20)

After the programme children still did not spontaneously identify flies as a potential transmission route of diarrhea which indicates the need to emphasize this transmission route in future activities.

Diarrhea Prevention

- There was a **significant increase** in the number of children who could identify 2 or more behaviours to prevent diarrhea. At baseline 0% (0/35) could identify any of the behaviours. In the final survey, 85% (17/20) of children could identify 2 or more behaviours (see *Annex 2, Table D*).
- There was also a **significant increase** in the children who could identify each of the key prevention behaviours. Subsequent promotion should focus on safe defecation as a behaviour to prevent diarrheal diseases, as it was the least frequently reported (see *Table 5*).

Table 5: Diarrhea Prevention Behaviours

Behaviour	Baseline % (n)	Follow-up % (n)
Boil Water	3% (1/35)	60% (12/20)
Handwashing	3% (1/35)	80% (16/20)
Covering Food	0% (0/35)	55% (11/20)
Safe Defecation	0% (0/35)	25% (5/20)

Safe Defecation

Safe defecation (utilizing the cat method) for those households who do not have a latrine was identified as a need during the baseline survey with children. In the first survey, 60% (34/57) reported using a latrine and nearly 40% (23/57) reported defecating in the open including the river, drainage channel or in fields. 0% (57/57) knew about safe defecation practices. Therefore, children were taught about the cat method and the safe location for defecation (distance from wells and households). In the final survey, there was a **significant increase** and 82% (18/22) of children could properly describe safe defecation using the cat method.

Participation

Children's attendance at the weekly sessions was consistently greater than 90%, this level of participation allowed children to fully engage in C-to-C activities and was important for continuity. It was also a proxy indicator for the children's interest in the activity.

Qualitative Findings

Observations during the Child-to-Child weekly meetings and feedback from community members indicate that children changed in the following ways:

- Increase in self-confidence
- Increase in willingness to ask questions
- Spontaneously offer more suggestions for solving problems
- More willing to engage with older family members or teachers in making plans
- More frequently discuss hygiene issues at home and with their peers (for example some older children report that their younger siblings ask them if they have washed their hands before preparing their food).

Considering the didactic teaching methods common in the education system in Nias and the hierarchical nature of the community which limits children's ability ask questions or express their opinions, these are perhaps the most important outcomes of the Child-to-Child programme.

3.0 Lessons Learned

- While a significant amount of data was collected from children about **why** they engaged in certain behaviours, it was challenging for staff to incorporate the behavioural motivations into the hygiene promotion activities. It was easier for them to focus only on the provision of information and not include messaging or information that addressed barriers to change or factors which would facilitate change. It is therefore important to support staff in moving beyond simply "giving" information and to begin to look at personal, social/cultural, environmental, and political factors which contribute to behaviour change.
- When Child-to-Child activities are linked to construction of water and sanitation facilities (as in the schools in Nias), it is helpful to develop an alternate plan in case construction activities are delayed.
- In Nias, there were on average 2 facilitators (1 Oxfam and 1 CHV/teacher) for 25 children which was acceptable; however, if there are sufficient financial and human resources (paid or volunteers) additional facilitators would increase the children's participation.
- A longer implementation period would allow for monitoring change over time, spending more time on each step, and/or implementing the zig-zag cycle again.
- The Child Facilitator selection process needs to be clearly communicated to the community prior to beginning activities, as a limited number of children can benefit in an intensive programme and community jealousy can develop if there is not a transparent process.
- The modules developed in Nias could be used by semi-literate children but future materials should be developed for illiterate populations to ensure that children are not excluded from activities.
- A mid-programme survey would have shown areas where children were not increasing their knowledge (such as flies as a diarrhea transmission route) and allowed programme activities to focus on areas where knowledge was still limited.
- Some people have a natural ability to work with children, others may learn through training and experience; however, there are some staff who even with modeling and mentoring find work with children challenging and their energies should be focused in areas they are more skilled in.
- Working with children was rewarding for the staff; children brought a sense of fun and creativity to activities which was energizing for the staff.

4.0 Conclusion

The Child-to-Child Approach was effective in increasing hygiene knowledge among Child Facilitators in a short period of time (approximately 2 months). Significant changes were seen in children's knowledge and anecdotal reports indicate positive changes in children's confidence to engage with their village and school communities. However, observations and key informant interviews do not indicate a change in community or school health at a broader level within the 2 month implementation period.

Acknowledgements: Oxfam GB staff: Nina Soares, Adil Maulufati Hulu, Ibeno Hulu, Jeffryka Farid, Rista Vita Imelda Zebua, Trisna Sertawati Gulo, and Yusharni Zebua. Community Health Volunteers in Lauri, Maliwa'a, and Satelit Villages. Teachers at Biouti Primary School and Siofabanua Primary and Secondary Schools.

Photos by: Jeffryka Farid, Rista Vita Imelda Zebua, and Angelica Fleischer.

Annex 1: Sample Module and Handouts

This is an example from the Safe Defecation module and focused on promoting the cat method for families without access to a latrine.

Week 3

Materials:

- General Materials
- Pictures of Safe Defecation
- Safe Defecation Survey Form

To do before session:

- Prepare Flipchart before activity.
- Distribute children hygiene kits from warehouse.

Step 2 : Finding out more

Have the children share what they found at home regarding where people go to the bathroom.

Activity

1. Make a flipchart as shown below.
2. Ask 3 children to give report about when each person defecates. Ask them to say whether or not people cover. A completed table should look like table 1.
3. After hearing what the children report, ask them when they think about defecating in these locations. Is there one location that is better than another?
4. After their response, show the best method (safe location and covering).
5. Ask why it would be important to defecate in these places?
6. Explain that it is important because it is far away from water. Secondly covering feces prevents flies from landing on feces (*Remember diarrhea transmission route – Feces-Flies-Food).
7. Review that the best way to prevent diarrhea is handwashing with soap. Another way to prevent diarrhea is to defecate in a safe location (WC or cat method).
8. Review the Safe Defecation Survey Form.

Before next week

Have the children to ask 1 person in their family or 1 of their friends what they think about the picture of the person covering their feces.

Would this behaviour be hard? Why or why not?

Share what they have learned about the cat method with their family.

Distribute

- Pictures of safe defecation.
- Hygiene Kits
- Safe Defecation Survey Form

CHV Support

- Assist children in doing a survey with 1 person or child.

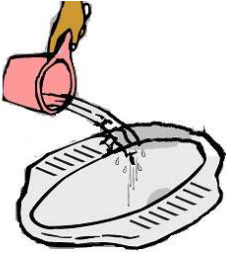
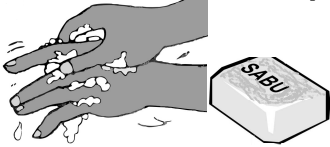
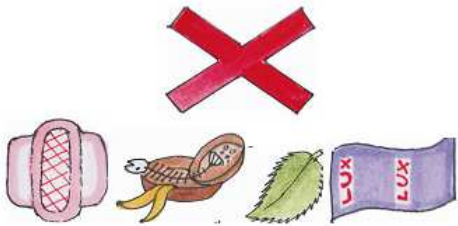
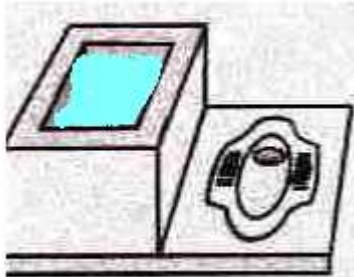
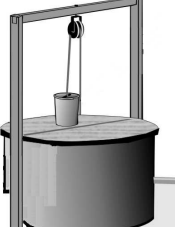
Locations for defecation	Mother	Father	Older Children	Younger Children

Table 1: Example - Completed chart for defecation location

Locations for defecation	<i>Mother</i>	<i>Father</i>	<i>Older Children</i>	<i>Younger Children</i>
River	<i>3 – no cover</i>	<i>3 – no cover</i>	<i>3 – no cover</i>	<i>3 – no cover</i>
Behind the house	<i>3 – cover</i>	<i>3 – cover</i>	<i>3 – No cover</i>	<i>3 – No cover</i>
Far from the house	<i>3 – no cover</i>	<i>3 – no cover</i>	<i>3 – no cover</i>	---
Anywhere	----	----	---	<i>3 – No cover</i>

This is an example of a handout used for the school Child-to-Child module on latrine operation and maintenance. These surveys were done to determine which behaviour children thought would be the hardest and then the Child Facilitators incorporated this into the school event they designed.

Directions: Ask 1 person in your class whether these behaviours would be easy or hard. Circle the answer. Why is that their answer?

Using the WC, Wells, and Handwashing	Easy or Hard	Why
<p>Flushing latrine</p> 	<p>Easy</p> <p>Hard</p>	
<p>Wash hands with soap.</p> 	<p>Easy</p> <p>Hard</p>	
<p>Only water and excreta into Septic Tank</p> 	<p>Easy</p> <p>Hard</p>	
<p>Keep bak full with water.</p> 	<p>Easy</p> <p>Hard</p>	
<p>Keep the well covered. Do not throw things in well.</p> 	<p>Easy</p> <p>Hard</p>	

Annex 2: Data Tables

Table A: Handwashing: Number of Key Times

Number of Key Times	Baseline % (n)	Follow-up % (n)
0 Times	3% (1/33)	0% (0/14)
1 Time	30% (10/33)	0% (0/14)
2 Times	67% (22/33)	29% (4/14)
3 Times	0% (0/33)	50% (7/14)
> 3 times	0% (0/33)	21% (3/14)

Table B: Summary of Progress Against Key Indicators

Key Indicator	Baseline % (n)	Follow-up % (n)
Handwashing with soap	38% (9/24)	100% (24/24)
Wash hands to prevent diarrhea	18% (4/23)	73% (17/23)

Table C: Diarrhea Transmission: Number of Routes

Number of Routes	Baseline % (n)	Follow-up % (n)
0 Routes	63% (22/35)	0% (0/20)
1 Route	37% (13/35)	5% (1/20)
2 Routes	0% (0/35)	20% (4/20)
3 Routes	0% (0/35)	70% (14/20)
4 Routes	0% (0/35)	5% (1/20)
5 Routes	0% (0/35)	0% (0/20)

Table D: Diarrhea Prevention: Number of Behaviours

Number of Behaviours	Baseline % (n)	Follow-up % (n)
0 Behaviours	91% (32/35)	0% (0/20)
1 Behaviour	9% (3/35)	15% (3/20)
2 Behaviours	0% (0/35)	20% (4/20)
3 Behaviours	0% (0/35)	15% (3/20)
4 Behaviours	0% (0/35)	50% (10/20)
5 Behaviours	0% (0/35)	0% (0/20)