



## Hygiene Education for Afghanistan

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THE PAPER WILL describe a multi-sectoral initiative to rebuild hygiene education in Afghanistan. National Policy Guidelines were produced aiming to provide a set of essential messages on hygiene and guidelines on good practice in delivering them.

### Afghanistan

Afghanistan is a land locked country in the heart of Asia that has been devastated by war. Most of the water supply and sanitation has been heavily damaged by war. Public health activities are limited and basic indicators of health and development are poor, as shown in Table 1.

The Ministry of Public Health (MoPH) estimate that more than 50% of hospital beds are occupied by patients suffering from waterborne and related diseases. There is no sewerage system in any cities, even in the capital Kabul. Public awareness about hygiene is low. Traditionally, 70-80% of the population has been dependent on springs, *qarez* (underground water channels) and shallow wells.

### Hygiene education pre-war

Before the 1980s, hygiene education was in the school curriculum, and government programmes included health education in all clinics, hospitals and in other gathering places. Health inspectors regularly visited schools, and were responsible for hygiene messages. Literacy was low in rural areas, but higher than now in urban areas.

### Hygiene education during wartime

During wartime, there was limited hygiene education as part of health education programmes for secure areas,

refugee camps, and Internally Displaced Persons centres. These were supported by WHO, UNICEF, and humanitarian non-governmental organisations (NGOs). The coverage was low with few people benefiting. In Kabul city, the MoPH have had chlorination and hygiene education projects for cholera control annually since 1993. They employed women to do home visiting, and to pass necessary messages regarding water supply and sanitation. The messages were short and focused on emergency issues, such as chlorination of household wells. The coverage was low. All these programmes were run by different agencies without coordination.

### Hygiene education after war

The war is now over in much of Afghanistan, and the MoPH has started reactivation of the health system based on Primary Health Care policy. It has established new health institutions and refocused its attention on health education and hygiene education. UN agencies and NGOs providing water and sanitation to meet basic needs have also realised that a lack of effective hygiene education has been undermining their efforts. Up to 2000, there was no body responsible for health education nationwide, which was therefore not well coordinated, nor focused on priority needs. NGOs and UN agencies active within Afghanistan had set up various Sector Groups to try and improve coordination of development programmes, and in 2000 the Water and Sanitation Sector Group proposed action on hygiene education. The Group was joined by representatives of the MoPH, and by national and international

**Table 1. Basic Indicators for Afghanistan**

|                               |   |
|-------------------------------|---|
| Access to safe water          | Urban 16% rural 3%  |
| Access to adequate sanitation | Urban 23% rural 7%  |
| Adult literacy rates (1995)   | Men 46% women 16%   |
| Under-5 mortality rate        | 257/1000 live births (4 <sup>th</sup> highest in the world) |
| Life expectancy               | 46 years  |

Source: UNICEF 2001

NGOs active in health education, to form a Hygiene Education Working Group (HEWG).

Coordination of development programmes in Afghanistan has many obstacles to overcome. First, there is severe shortage of local and foreign aid resources relative to need, due to the effects of war and international political isolation. This means that agencies are working under extreme pressure and find it hard to give time to coordination. Second, communication is difficult and geographical spread is large. Afghanistan's development work is managed from both Pakistan and Afghanistan due to lack of Afghan infrastructure. Third, there is the common problem of agencies with different aims and cultures finding it hard to work together. To overcome these difficulties, the Hygiene Education initiative was able to use the experience, administrative support and communication systems of ACBAR, an NGO coordinating body, in establishing a Working Group. ACBAR has provided a forum for NGOs and UN agencies in Peshawar and Afghanistan since 1991.

### **The Hygiene Education Working Group**

This Group was set up with multi-sectoral membership including the health authorities, two UN agencies and seven NGOs (local and international) covering projects in water supply and sanitation, education, health and health education in Afghanistan. The problems identified were high levels of diarrhoeal disease, provision of water and sanitation without good information on their use, little information on existing hygiene education materials and delivery, and lack of consensus (and potential confusion) on the best messages for good hygiene in ravaged Afghanistan. The Working Group therefore aimed to strengthen the knowledge and practice of good hygiene in a way that would be realistic for Afghan people. It was agreed that Policy Guidelines for Hygiene Education, including basic messages, would be produced through a consultative process and would be aimed at programme planners and managers in the water, health, education and community development sectors, in both urban and rural areas. It was also agreed that the Guidelines would focus narrowly on the prevention of oral-faecal transmission of disease, and on the promotion of a few (rather than many) healthy

behaviours consistent with local custom, in accordance with tested principles of good hygiene education (Almedom, Blumenthal & Manderson 1997). The process of developing the Guidelines took nine months.

Two workshops, one in Peshawar and one in Kabul, took place for project managers and senior officials from all major concerned agencies, at which the principles and the detailed wording of the Guidelines were thrashed out. The workshops raised awareness of the practice of hygiene education, achieved broad consensus on the need for action, highlighted issues of concern and proposed "Next Steps" for action in the coming year. Community participation was one of the issues discussed and is high on the international agenda for improving effectiveness of hygiene education (WHO 1997). Community participation in Afghanistan is possible subject to prevailing economic constraints and the social, religious and political norms, as discussed below.

The document produced from the workshop discussions is now being disseminated by UNICEF Afghanistan, and includes 25 agreed priority messages and 19 secondary messages on five areas: safe drinking water, environmental sanitation, personal hygiene, safe food and oral rehydration therapy (HEWG/ UNICEF 2001).

### **Issues in coordinating hygiene education for Afghanistan**

#### **The role of religion in hygiene education**

Afghanistan is an Islamic country in which the law of Islam is applicable in all daily private and public activities. In Islam, hygiene is an important religious obligation. There are many sayings and instructions from the Holy Quran and Hadith emphasising, for example, the importance of cleanliness, the need to keep the environment clean, and the "three damnations" of defecating in water sources, streets and the shade (Al Azhar University & UNICEF, 1405/1985).

Religious leaders in Afghanistan support hygiene messages and have a crucial role in educating and leading changes to improve health and hygiene practices. War and displacement of communities have disrupted this role, and

**Table 2. Key points in relation to religious leaders**

- Religious leaders need to be consulted in the planning of hygiene education activities
- They should have access to good information on preventing waterborne diseases in the prevailing conditions in their areas.
- The channels of communication between religious leaders and women in communities need to be identified.

**Table 1. Examples of segregated channels (HE policy guidelines)**

| Target Audience | Taught by whom and where  |
|-----------------|---|
| Adult women     | Women over 25 yrs of age. In the home, hospitals & health centres, water sources, bakeries, family gatherings   |
| Adult men       | Men over 25 yrs of age. At the Mosque, fields, hujra, clinic, home, garden, pharmacy, markets, factories, sports clubs, schools, Madrasas, offices, military bases, hostels, jails, public transport. |

the awareness of the population is very low as a result. The displacement of families and the destruction of traditional water supplies have also meant that many people are in unfamiliar surroundings, without the water sources they know, and need help. The importance of religious leaders as hygiene educators has been recognised by all agencies in the HE initiative, and has been detailed in the Policy Guidelines. Source materials are available on health education in the Islamic context which need to be translated and adapted for Afghanistan (WHO 1996).

### Gender Issues

Within the many agencies working in Afghanistan there is a range of approaches to working with women. For this initiative, it was agreed that it was essential for women to be included for hygiene education to be effective. The health authorities support the role of women as hygiene educators. However, the authorities have ruled that, due to security and resource problems, women's employment in all sectors except health is temporarily stopped. This means that female hygiene education staff can work in hospitals, clinics and home visiting programmes, while male staff work in water supply, sanitation and education, for example.

Important gender issues are first that women are the main hygiene educators in the family; second that female educators are needed to reach women in the community, and third that men and women have highly segregated lives. Children can mix up to the age of about 9, after which girls and boys are segregated. Identifying acceptable, functioning and segregated channels for communicating hygiene messages is vital in this situation.

In summary, all programmes in Afghanistan should plan for men to pass messages to men and boys, and women to pass messages to women and girls. Women can work and travel with close male relatives, so employing family pairs as "bridges" between the sexes is one way that agencies can improve their programmes.

### Coordination

The HEWG will continue to act as a coordinating body with the remit of facilitating the "Next Steps" that have been proposed. As the HEWG does not have resources or formal authority, the commitment and action of the participating agencies, UN, NGO and health authorities, will be essential for success. One of the "Next Steps" will be a core set of materials for hygiene education and training to improve the quality of education and consistency across sectors. The HEWG will oversee the quality of the set.

Good information is essential for coordination. Data on what organisations active in hygiene education for Afghans are presently doing was collected in August 2000. These data were circulated to all organisations that participated in the survey, and are available freely from ACBAR Resource Information Centre (HEWG 2000). The data were used in the workshops and in preparing the Guidelines. At the end of 2001 another similar survey is planned to see what progress has been made. One finding was that some organisations are able and willing to assist others in training hygiene educators and/or trainers.

### Constraints and hopes for the future

The constraints facing Afghans and development agencies in Afghanistan in 2001 are formidable. Improvements in literacy, access to basic services, food, shelter, roads and communication systems are proceeding slowly, if at all. There is a lack of trained personnel and little experience of peaceful development. In this situation, joint coordinated action is vital. The Hygiene Education initiative has shown that systematic, unrushed consultation and debate can improve multi-sectoral cooperation and tackle the sensitive issues of religion and gender in a constructive way. There is now the chance that the prevention of waterborne diseases can be dealt with in a more planned way, with the combined resources and experience of the agencies weighing in behind a single policy.

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