40th WEDC International Conference, Loughborough, UK, 2017

LOCAL ACTION WITH INTERNATIONAL COOPERATION TO IMPROVE AND SUSTAIN WATER, SANITATION AND HYGIENE SERVICES

Effectiveness of community dialogue in promoting hygiene and sanitation in Afghanistan

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PAPER 2793

Poor hygiene and sanitation practices lead to increased burden of diarrhoeal diseases which is a leading cause of death among children under five years of age. According to the Afghanistan Demographic and Health Survey the under-five mortality rate is 55 deaths per 1,000 live births in Afghanistan and diarrhoea prevalence rate is 29% among children under age of five. Considering the importance of sustained hygiene and sanitation in reduction of diarrhoea, community dialogue approach was designed and implemented in six districts of three provinces in Afghanistan. This study revealed that installation of hand washing facilities, availability of soap and safe storage of water are improved 71.6, 75.3 and 41.9 percentage points respectively and entire target communities are declared open defecation free through implementation of community dialogue approach during a year.

Background

Poor hygiene and sanitation practices lead to increased burden of diarrheal diseases which is a leading cause of death among children under five years of age. Globally, around 0.8 million deaths from diarrhoeal diseases could be prevented each year by providing improved water, sanitation and hygiene [1]. The health cost of diarrheal diseases is huge, and falls disproportionately on young children. According to the Afghanistan Demographic and Health Survey (AfDHS 2015), the under-five mortality rate is 55 deaths per 1,000 live births [2]. A heavy burden of it is due to preventable causes such as diarrhea, which have overlapping risk factors. In 2015, 12% of all under five deaths were due diarrhoea [3].

During past decade, Afghanistan made some remarkable progress in drinking water, sanitation and hygiene; however, many people still do not have access to safe drinking water and improved sanitation in the rural areas. According to the Afghanistan Living Condition Survey (ALCS) 2014 around 65% of population use their drinking water from an improved source, and about 39% of people use improved sanitation facility [4]. Moreover, 19% of people in the country still practice open defecation and do not use any type of sanitation facility [4]. There is no comprehensive data available which would show hygiene and handwashing practices in various population categories at national level; however, a number of small scale KAP surveys show that handwashing with soap is between 69-91% before eating and 45-72% after defecation, however, it is assumed that the real practice might be lower [5]. The AfDHS 2015 indicates that soap and water—the ideal handwashing agents—were observed only in 36% of households; another 28% had water only [2].

Afghanistan's Ministry of Public Health (MoPH) has made commitments to scale-up community based programs including community dialogue to improve community awareness, mobilize the entire community to build their resolve for ending open defecation, using local resources which greatly contributes to reduction in prevalence of diarrheal diseases.

Afghanistan context community dialogue which is one of the effective approaches for improving health situation and applied in many countries supported by UNICEF was also implemented by Afghanistan Ministry of Public Health during 2016.

The Community Dialogue approach aims to achieve the following objectives:
1. Increase use of sanitary latrines among members of the target communities, and eliminate open defecation;
2. Improve child faeces disposal practices at household level;
3. Increase handwashing with soap in critical times among Afghan population; and
4. Increase safe storage of water at homes;

Methods

Setting

Three provinces were selected from the ten UNICEF-focused provinces and the Community Dialogue interventions were implemented in two districts of each province.

All districts in the selected provinces were eligible for application of community dialogue, but the districts with the below criteria were prioritized and chosen:
1. Accessibility (in terms of geographical location and political security)
2. Low performance district for polio
3. High prevalence of diarrhoea and other WASH related diseases (e.g. stunting)

Then in each district, twenty communities from within each district were chosen, for a total of 120 communities in three provinces, the choices of communities were via following criteria;
1. Accessibility (in terms of geographical location and political security)
2. Number of families (60-120)
3. Not declared as open defecation free (ODF) community before
4. Not any other hygiene and sanitation promotion related project is being implemented currently.

Intervention period: January – December 2016

Intervention - community dialogue

Pre-intervention assessment

In order to assess Knowledge, Attitude and Practices (KAP) of the families on Water, Sanitation and Hygiene (WASH) situation, and establish a baseline for key indicators in the targeted districts, a quantitative cross-sectional KAP study was conducted by a third party before 2016. The study concludes that only provision of safe drinking water is not enough; hygiene behaviour change program should be also considered to improve hygiene and sanitation.

Considering the study recommendations, community dialogue was designed and implemented to improve the WASH indicators. Through this approach, community dwellers are encouraged to jointly explore their own hygiene and sanitation status, realize hygiene and sanitation related health risks, propose solutions and get their commitment/ support for a joint action to achieve the goal without any financial aid. The program leads to sensitize the target communities to adopt hygienic behaviours, construct/ improve latrines, and use it. Several households improved the pre-existing latrines or built new latrines in various communities where the program was being implemented.

The community dialogue consists of three main phases including pre-triggering, triggering, and post-triggering.

In the pre-triggering phase, the district hygiene promotion officers visit the targeted community and conducts rapid community assessment to identify the followings:
- Community influencers including key influential leaders and powerful groups in the community
- Vulnerable groups
- know about the socio-economic and cultural situation of the community

The community influencers were identified and contacted to help on:
- Selection of site for community dialogue.
- Fixing date and time of community dialogue

Community members were informed beforehand of the activity through their local leaders.

In the triggering phase, discussions take place with the community dwellers on hygiene and sanitation related problems in their community in a participatory manner. The dialogue brings young and old together to share experiences, and the facilitators use the triggering tools such as faeces calculation to motivate the participants discuss the hygiene and sanitation problems and identify the solutions by themselves.

Key steps for conducting the triggering phase are as follows:

A. Greetings and introduction

Greeting and a round of introduction is held to set the tone and context of the dialogue, which could begin with sharing of personal experiences and stories in order to level the playing field among the participants. During this phase the facilitator should:

- Greet participants as they come in to put them at ease and encourage them to speak up
- Conduct introductions and state the purpose of the dialogue;
- Identify key supporters and opponents for smooth conduction of community dialogue and future follow up and support.

B. Problem identification and analysis

It is very critical in a community dialogue session to identify the problems/ gaps. It could be poor hygiene and sanitation due to lack of clean water, sanitary facilities and poor hygienic practices.

At this point the team will identify current problems/ issues. Some questions and their solutions are discussed at this stage.

C. Encourage the participants to identify the best options

It involves generating solutions to the problem/issue, appraising the options and finally coming up with a decision on what solutions to be tried first. The facilitator will focus on the hygiene behaviour change solutions rather than hardware for example provision of safe drinking water. The group by consensus discusses and negotiates until the best option is reached. The facilitator finally identifies and summarizes practical and cost-effective solutions.

D. Engage participants for planning together

In this phase, group members design appropriate plans of action based on the best possible options. The group members transfer the lessons learned from the dialogue and motivate the community dwellers to develop action plans and practice hygiene and sanitation behaviours as well as advocate for it.

After collectively developing an action plan, implementation of the plan should be conducted in a participatory manner, with each member recognizing her/his role.

In addition to that a follow-up committee which comprised of at least five persons (local leaders, religious scholar, community health worker (CHW), and school teacher) is established in the concerned community.

During post-triggering phase, the already established follow-up committee accomplishes the following tasks:

- Track the proposed activities by the community dialogue members such as construction of new latrines by community dwellers in their houses, utilizing water from safe water sources, safely disposal of child faeces;
- Provide information and motivation in case the proposed activities are not accomplished for instance the messages are not delivered to the community dwellers by the community dialogue members;
- Advocate with religious scholars and governmental officials in the area for enabling environment.

On a regular basis, the district hygiene promotion officers follow with the community network/ newly established committee, to make sure planned tasks are on the right track.

Alongside these efforts, some community-based complementary interventions were also conducted in the concerned districts including conducting training sessions to CHWs, and school teachers, engagement and advocacy sessions to religious scholars, house to house visits, and executing community mobilization events, street theatres, and recreational events. [Figure 1]

Results

At the outset, the community health workers with direct support from district hygiene promotion officers, collected baseline data about the key WASH indicators through house to house visits by using standard templates from total number of 13840 households prior to interventions from Jan 15 to Jan 22, 2016.

The baseline assessment indicated that 54.6% of total household (HHs) had latrines, 21.9 % of HHs had handwashing facilities, 15.9% of HHs had soap near latrines, 48.5% of HHs had yards with no signs of visible human faeces, and 52.7% of households were storing drinking water safely. After intervention

through end line assessment conducted by CHWs with close monitoring from district hygiene promotion officers and newly established hygiene committee on Dec 18 to Dec 25, 2016 significant results outlined as 46.4 percentage points rise in the HHs having latrines, 71.6 percentage points rise in the HHs having handwashing facilities, 75.3 rise in the HHs having soap near latrines, 51.5% rise in the HHs having yards with no signs of visible human faeces, and 41.9% rise in HHs storing drinking water safely, were found. Besides, more than 4476 new latrines were built, 5639 latrines were improved, around 1917 latrines were fully functionalised which were not used before starting interventions, and 9829 new handwashing facilities were installed by community dwellers at their households. The changes were verified by other members of the follow-up committees, moreover, through a joint community visit by representatives of provincial directorates of education, rural rehabilitation and development affairs, hajj and religious affairs, and municipality. It was certified/ approved that all 120 targeted communities were declared open defecation free (ODF) which was already reported by district hygiene promotion officers.

Detailed baseline and end line data are depicted in Table 1.

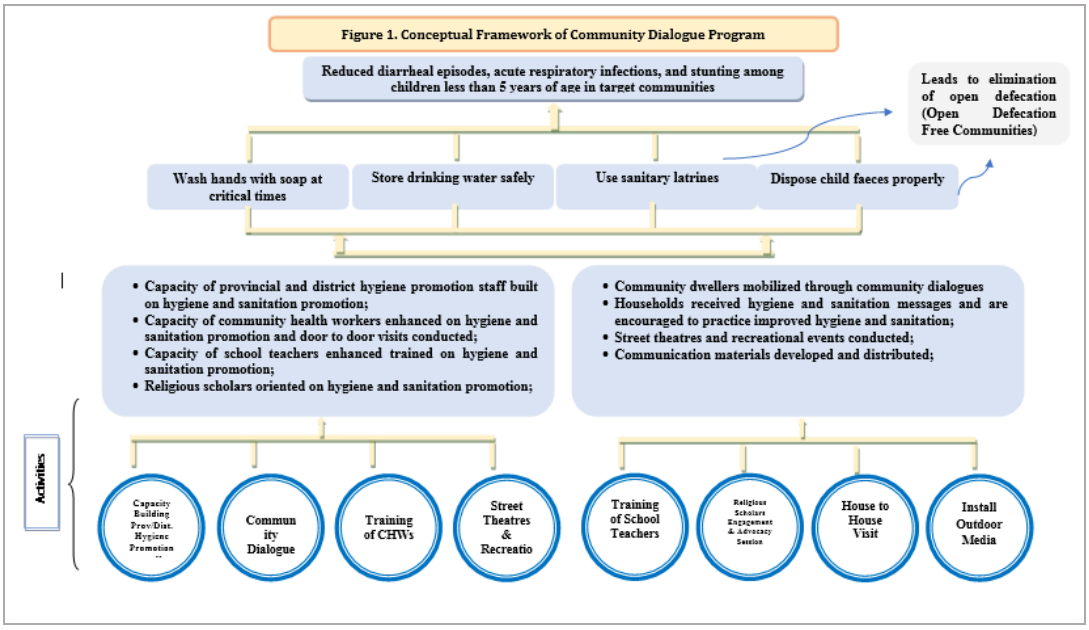

Figure 1. Conceptual framework of community dialogue program

Table 1. Community Dialogue Status - achievements during the project lifespan 2016

Name of province	Name of Districts	No. of communities	No. of households in 20 communities of each district	Baseline and End-line	Proxy indicators									
					No. of households having latrines	%	No. of households having handwashing facilities	%	No. of households having soap near latrines	%	No. of households having clean yard (with no signs of visible faeces)	%	No. of households storing drinking water safely	%
Kandahar	Arghandab	20	2655	Baseline	810	30.5	346	13	315	11.9	485	18.3	1191	44.9
				Endline	2655	100	2560	96.4	2542	95.7	2655	100	2643	99.5
	Dand	20	3140	Baseline	1413	45.3	453	14.4	463	14.7	688	21.9	1675	53.3
				Endline	3140	100	2985	95.1	2915	92.8	3140	100	2675	85.2
Bamyan	Centre	20	1854	Baseline	1155	62.3	670	36.1	670	36.1	1500	80.9	1155	62.3
			1839	Endline	1839	100	1810	98.4	1796	97.7	1839	100	1805	98.2
	Yakawlang	20	2213	Baseline	1023	46.2	310	14	112	5.1	1460	66	760	34.3
			1811	Endline	1811	100	1785	98.6	1768	97.6	1811	100	1784	98.5
Badghis	Qala-e-Naw	20	2488	Baseline	1605	64.5	798	32.1	566	22.7	1744	70.1	1650	66.3
				Endline	2488	100	1990	80	1956	78.6	2488	100	2321	93.3
	Qadis	20	1907	Baseline	1782	93.4	540	28.3	139	7.3	1042	54.6	1081	56.7
				Endline	1907	100	1816	95.2	1642	86.1	1907	100	1860	97.5
TOTAL		120	14257	Baseline	7788	54.6	3117	21.9	2265	15.9	6919	48.5	7512	52.7
			13840	Endline	13840	100	12946	93.5	12619	91.2	13840	100	13088	94.6

Discussion

This paper indicates that remarkable results were achieved through implementation of community dialogue approach. These findings are consistent with achievements of community dialogue approach implementation for promotion of various behaviours in other countries [6, 7, 8, and 9].

We believe that the program was successful, because of, first, well-designed baseline assessment was conducted with community elders and other influential people who supported the program throughout the project implementation. Second, the interventions were more participatory and interactive which resulted collective behaviour change, third, the project focus was more on system building through using existing community structures such CHW and family health action group involvement, fourth, as hygiene has high place in Islam, by involvement of religious scholars, the community dwellers well-accepted the desirable behaviour. More importantly the program involved CHWs and Women's Group to conduct house to house visits for improved hygiene and sanitation. In the future, further research is needed to investigate the magnitude of each effect and possible interactions among the identified interventions; this will help design effective interventions to promote hygiene and sanitation in Afghanistan.

Conclusion

The Community Dialogue approach implementation has brought positive changes in WASH status. Triggering and structured house to house visit under close supervision of district hygiene promotion officers across the nation are likely to improve sanitation and hygiene status in Afghanistan.

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