KAP Study on Hygiene in Faryab
Baseline Assessment Report

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(1.) Executive Summary

A pilot KAP (Knowledge, Attitude, Practice) study on hygiene was carried out in three districts of Faryab province during November/December of 2005 by male and female interviewers who were trained to conduct standardized interviews and systematic observations of households. The aim of this survey was to measure the level of hygiene knowledge and practice before implementing WatSan projects.

The main findings of this survey were as follows:

A total of 403 households were visited and 468 people in 22 different villages interviewed, whereby more than 90% of them were illiterate.

The main water sources for more than 80% of all interviewees were rivers, streams and ponds and the average time to get drinking water was 262 minutes, ranging from 0 up to 720 minutes.

Almost half of all households had a latrine (48%), many of them were unclean and most of them difficult to empty.

34% of the participants reported diarrhoea cases in their families in the two weeks prior to the survey the majority of which were children.

The majority of people (66.5%) did know that unsafe water could cause diarrhoea, but only 1.9% of the participants had done something to make their drinking water safer.

Most children appeared to be unclean (90%) and also a big part of the adults wore dirty clothes (55%). Interviewers also noted that most areas around the main water sources (80%), most of the yards (81%) and most kitchens (85%) were unclean. Animals, garbage or faeces were spread around those places.

A main implication of this assessment was the need for safe water sources in closer vicinities as well as the need for safe sanitation facilities.

Many responses regarding knowledge indicate that information on hygiene exists, but is not being practiced. Also the observation of several risk behaviours, such as open defecation, lack of personal hygiene and irresponsible waste management suggests the need for hygiene education.

Another study will be conducted in the same districts after finishing the hygiene education in the project area to measure its impact. An increase in knowledge and a change in behaviour in most areas should be expected.
(2.) **Background**

The prevalence of diarrhoeal diseases in Afghanistan continues to be very high, affecting mostly children. Due to a lack of protected water sources and inadequate sanitation facilities plus a lack of knowledge on disease transmission and prevention the incidence of water related diseases is not decreasing.

Hygiene Education (HE) has been an integral part of DACAAR WatSan projects for more than 5 years. Access to safe water alone does not reduce diarrhoeal diseases significantly. Inadequate hygiene practices must be targeted as well when implementing WatSan projects to decrease morbidity and mortality especially in rural Afghanistan. Along with building or improving water points DACAAR therefore provides hygiene education for all user groups.

Hygiene Education is being conducted by male and female Hygiene Promoters, usually married couples, to ensure that all beneficiaries, men and women, are being reached. The number of Hygiene Promoters varies in each site according to the number of water points that are being built or improved in a province/ district.

Hygiene Promoters inform community members about the correct use and storage of water, the need for safe sanitation facilities, personal and environmental hygiene and diarrhoea transmission and management, aiming at sustainable behaviour change.

In order to achieve sustainable changes in practices, attitudes and knowledge all user groups receive two household visits by DACAAR hygiene promoters. The first visit includes the delivery of different messages related to drinking water, hygiene and sanitation (according to MRRD guidelines) in a one hour session. The second ‘refresher’ visit serves to assess what changes have taken place after the first visit and what problems occurred in putting knowledge into practice.

DACAAR provides a high quantity of these hygiene sessions; the overall quality remains unclear. Random observations have previously taken place and small samples have been assessed for quality control. And although both Hygiene Promoters and Supervisors regularly report positive impact and occasionally radical changes of beneficiaries, no systematic evaluation of the quality of our HE intervention has taken place. It is to date uncertain if our approach leads to increased knowledge on the importance of hygiene and more importantly if it brings about sustainable behaviour change.

2.1 **Goal and Objectives**

The goal of our KAP study was therefore to systematically assess the knowledge, attitude and practice **before** and **after** our intervention to identify the impact of our hygiene
education and if necessary implement changes in our HE method. In order to measure a potential change in knowledge and behaviour the same baseline and final questionnaire will be administered.

Another outcome of interest will be the incidence of diarrhoea. WatSan projects typically reduce diarrhoeal disease about 25%.

(3.) Methodology

3.1 DATA COLLECTION

The study took place from 12th of November until 12th of December and data was collected in three districts of Faryab province: Kwhaja Sabz Posh, Dawlatabad and Shirin Tagab. These sites were chosen based on the fact that DACAAR has EC funded WatSan projects in those districts.

The villages for the KAP study were selected by a three step process:

- Firstly a village survey was conducted in all three districts to collect information on the number of households and on the number and type of water sources in all villages.
- Secondly all villages without public or private water points were identified and listed as potential WatSan project villages.
- And thirdly water tests were done to examine the salinity and the water levels of existing water points. All villages with high salinity levels were removed from the list of possible survey villages. From the remaining villages 22 were randomly selected for the KAP study.

3.1.1 Quantitative Data

Ten percent of all households in the chosen villages were interviewed, whereby the households in the villages were also randomly selected (with an Afghani bill). In smaller villages where only few households needed to be assessed a male and a female household member were interviewed. In bigger villages only one person per household was questioned.

Seven interviewers were hired to carry out standardized interviews with an eight pages long questionnaire. Male and female interviewers were trained with the purpose of questioning both male and female beneficiaries.

The questionnaire (see attached) was developed by the DACAAR Hygiene Education Unit and is based on questionnaires from other NGO’s running WatSan projects in Afghanistan, e.g. ICRC. Information from Johns Hopkins University and MRRD guidelines were also taken into account when developing the interview guideline.
Key indicators have been identified which allow measuring the improvement in hygiene knowledge and practices. The indicators include:

- % of households using latrines
- % of households using safe water sources and/ or treating water
- % of beneficiaries who know about diarrhoea causes, prevention, danger signs and treatment
- % of beneficiaries who know about importance of and critical times for handwashing
- % of households practicing safe waste management
- % of households being clean (yard, water source, house, kitchen, latrine)
- % of beneficiaries appearing clean (hands, clothes)

The questionnaire consists of two parts, whereby the first part (Interview) includes questions the interviewees were asked. This part mostly contains open ended questions to avoid influencing the answers of the interviewees. In the second part (Observation) the interviewer was required to note systematic observations, e.g. cleanliness of household, appearance of children etc.

The following topics were covered in the questionnaire: demographic information (age, literacy etc.), water and food handling, diarrhoea, sanitation, personal hygiene and waste management.

### 3.1.2 Qualitative Data

Three pilot Focus Group Discussions (FGD) were held in different villages in order to complement the information collected by the interviews. Two women were trained to facilitate the FGD, one as moderator and one as observer and note taker. In each of the two villages ten women were invited to take part in a one hour FGD. During these sessions they were asked to discuss hygiene related topics, whereby the moderator guided the conversation by asking lead questions (see Annex 2). Due to time constraints the training was very brief and only three FGD could be held.

### 3.2 Data Analysis

The Statistical Package for Social Sciences (SPSS, Vers. 13) was used for the data analysis. In order to explore relationships between variables Chi Squares ($\chi^2$) were executed.
(4.) Outcomes

4.1 Sample Composition

A total of 468 interviews in 403 households in 22 different villages were conducted. 46.2% of the interviewees were male and 53.8% were female. The age varied between 16 and 82, whereby the mean age was 42 years.

The size of the household was assessed by asking how many people shared a meal, 34.2% had between one and six household members, 52.4% had seven to twelve and 13.4% had more than twelve people living in a household.

75.7% of the people had between one and five children living in their household and 21.1% had more than 6 children.

The majority (91.2%) of the people were illiterate (83.8% of the men and 97.6% of the women) and 48.9% owned a radio.

Table 1. Demographics of Sample

<table>
<thead>
<tr>
<th>Site</th>
<th>Total interviews</th>
<th>% of Sample</th>
<th>Male</th>
<th>Female</th>
<th>Illiterate</th>
<th>Age (Mean)</th>
<th>Radio owners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kwahja Sabz</td>
<td>167</td>
<td>35.7%</td>
<td>44.9%</td>
<td>55.1%</td>
<td>91%</td>
<td>42</td>
<td>52.6%</td>
</tr>
<tr>
<td>Shirin Tagab</td>
<td>273</td>
<td>58.3%</td>
<td>45.4%</td>
<td>54.6%</td>
<td>93.8%</td>
<td>43</td>
<td>44.7%</td>
</tr>
<tr>
<td>Dawlatabad</td>
<td>28</td>
<td>6%</td>
<td>60.7%</td>
<td>39.3%</td>
<td>67.9%</td>
<td>40</td>
<td>55.6%</td>
</tr>
<tr>
<td>Total</td>
<td>468</td>
<td>100%</td>
<td>46.2%</td>
<td>53.8%</td>
<td>91.2%</td>
<td>42</td>
<td>48.9%</td>
</tr>
</tbody>
</table>

4.2 Interview Results

4.2.1 Main water source

The main water source of 81.4% of all interviewees was a river, stream or pond. Only 0.2% said they were using a public or private handpump and 0.4% a protected or unprotected well. 0.6% of the people referred to springs and 0.6% to so-called Gandabas (man made ponds to store melting snow and rainwater) as their main water source.

The mean time people reported for getting water was 262 minutes (including both ways). Two families replied they needed 720 minutes (Maximum) to return with water. 20.8% of the people said that the water source was not providing enough water throughout the year.
Table 2. Water source

<table>
<thead>
<tr>
<th>Site</th>
<th>Time to get water (minutes)</th>
<th>Main water source</th>
<th>Provides enough throughout year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Min</td>
<td>Max</td>
</tr>
<tr>
<td>Kwahja Sabz</td>
<td>124</td>
<td>0</td>
<td>600</td>
</tr>
<tr>
<td>Shirin Tagab</td>
<td>371</td>
<td>2</td>
<td>720</td>
</tr>
<tr>
<td>Dawlatabad</td>
<td>26</td>
<td>5</td>
<td>60</td>
</tr>
<tr>
<td>Total</td>
<td>262</td>
<td>0</td>
<td>720</td>
</tr>
</tbody>
</table>

* River, stream or pond

4.2.2 Diarrhoea prevalence

34% of all households reported that they had family members with diarrhoea in the previous two weeks. 47.4% of these households had one person with diarrhoea, 32.1% had two and 18.2% had three or more people with diarrhoea.

91.2% of the families with diarrhoea cases reported they had children with diarrhoea and 27% had adults with diarrhoea in their family.

58.4% of the diarrhoea patients had blood in their stool: 48% of the children and 54.1% of the adults.

In 19 households (5%) people had died from diarrhoea in the previous year, seven households reported more than one death in their family.

4.2.3 Knowledge on Diarrhoea

Causes of diarrhoea

When asked if they knew why people get diarrhoea, 53.8% responded by drinking unsafe water, 16.2% said by eating unsafe food, 13.7% mentioned microbes or bacteria and 30.1% said they didn’t know how or why people get sick with diarrhoea, 44.9% knew one reason, 25% knew two or more reasons.

Diarrhoea prevention

68.4% of all people interviewed replied they didn’t know how to prevent diarrhoea, 24.4% knew one way to prevent diarrhoea and 7.3% knew two or more ways. 17.6% said
using safe water or treating water could help prevent it, 8.1% said handwashing and 7.3%
said washing/peeling/cooking food before eating.

**Danger signs of diarrhoea**

32.1% of the interviewees didn’t know any danger signs of diarrhoea, 46.4% knew at
least one, 15.6% knew two and 6% knew three or more danger signs. Many participants
(34.2%) mentioned 3 three or more loose stools per day, 19.4% blood in stool, 17.1%
vomiting and 13% high fever.

**Diarrhoea management**

When asked what they usually do when someone gets diarrhoea 82% said they visit
a doctor or a clinic, 6% give medicine and 5.2% replied they give lots of fluid. Only 3.9% give
ORS or WSS and 3.4% said they do nothing.

When asked what ORS is 53.4% knew it was packaged powder for diarrhoea patients
and 46.6% didn’t know what it was. Yoghurt, rice water and home made remedies were the
most common other treatments that people specified for diarrhoea treatment.

**4.2.4 Knowledge on unsafe water**

When asked what diseases they knew could be caused by unsafe drinking water
87.3% of all interviewees named at least one disease and 36.5% named two or more
diseases.

66.5% knew that unsafe drinking water could cause diarrhoea, 43.2% said it could
cause skin diseases and 6.6% said it could cause fever. 12.6% didn’t know any disease or
gave wrong answers.

Participants were also asked if they had done anything in the past week to make their
water safer. 97.4% of the people stated that they had done nothing. Only eight people (1.7%)
had boiled their water before using it and one person had filtered it (0.2%).

**4.2.5 Handwashing**

Most interviewees named two (47%) or three (27%) occasions for handwashing and
17.7% named only one occasion for handwashing. Most people said they usually wash their
hands after defecating (72.2%) and before eating (69%). 27.4% said before preparing food,
21.6% after touching animals and only 6.6% before feeding children and 6.2% after handling
child faeces.

When asked why they thought handwashing is important most people said because it
removes dirt (91.7%). 12% said it prevents dirt from getting into food or mouth and only 9.2%
said it helps to prevent diarrhoea and other diseases. Only 18.6% gave more than one reason why handwashing was important.

During a household walk interviewers found that most families had only one place for handwashing (80.6%). Most places for handwashing were inside the yard (77.4%), but only 6% inside the house (kitchen or other room). Only three households (0.7%) had a place for handwashing close to the latrine.

54.2% of the interviewees claimed to have soap in the house, but only in 5% of the households the interviewers found soap at the place for handwashing.

Interviewees were also asked to demonstrate handwashing; 79.8% used running water, 47% rubbed their hands together, but only 1.7% used soap or ash.

4.2.6 Night soil disposal

Most people (73.1%) bury their night soil. But in most cases it remained unclear if it was buried in a safe distance from the main water source and if it was buried inside or outside the yard. 13% said they used it as fertilizer and 15% dump it somewhere outside the yard.

4.2.7 Hygiene Education Participation

9.4% of all interviewees (6.5% of the men and 11.9% of the women) reported that they had received some kind of hygiene education in the past. Women had mostly been taught about hygiene during antenatal care visits in hospitals and clinics.

4.3 Observation

4.3.1 Personal Hygiene

The general appearance of the children was unclean (89.8%), 91.7% had dirty clothes, 92.4% had dirty hands and 68% did not wear shoes outside. The general appearance of 40.4% of adults was also not clean; 54.9% wore dirty clothes, 59% had dirty hands and 32.9% wore no shoes.

4.3.2 Cleanliness of Household

When asked how they dispose their kitchen and other waste 71.2% of the respondents said they dump it somewhere (e.g. a hole inside or outside yard), 24.1% burn it and 11.9% say they bury it.
Whenever possible the interviewers also observed the cleanliness of households. They checked if animals were allowed to run around and defecate freely and if garbage or faeces were lying around.

### Table 3. Cleanliness of Household

<table>
<thead>
<tr>
<th>Area</th>
<th>Clean</th>
<th>Unclean</th>
<th>Reason for Unhygienic Area*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Animals</td>
</tr>
<tr>
<td>Yard</td>
<td>19.6%</td>
<td>80.4%</td>
<td>75.7%</td>
</tr>
<tr>
<td>Water source</td>
<td>18.9%</td>
<td>81.1%</td>
<td>64.8%</td>
</tr>
<tr>
<td>House</td>
<td>61.3%</td>
<td>38.7%</td>
<td>10.9%</td>
</tr>
<tr>
<td>Kitchen</td>
<td>14.5%</td>
<td>85.5%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Latrine</td>
<td>36.7%</td>
<td>63.6%</td>
<td>-</td>
</tr>
</tbody>
</table>

* Multiple reasons possible

### 4.3.3 Water storage

96.8% of all households stored their water in jerry cans and/or metal containers/buckets. The water was covered in 40.1% of all households. 68.2% of the people reported to regularly wash their water storage containers whereas only 41.6% of the water containers that the surveyors saw actually looked clean.

### 4.3.4 Food storage

71.1% of all people said they cover their left over food, 21.3% claimed to store it in a cool place and ??? stated that they give it to their animals. But the interviewers found that only 27.6% of all households stored their food safely.

### 4.3.5 Latrines and nightsoil

47.9% of the households had a pit-latrine, 42.7% had no latrine. When asked where they defecate, 30.5% of those without a latrine said they go outside their yard (field, desert) and 19% have a hole in their yard. 59.1% of the existing latrines were not clean and had either human or animal faeces or garbage in them. 68.4% had a roof, but only 0.4% had doors, none had a window with a mosquito net and only 2 latrines had water for cleansing nearby.

For nightsoil disposal 73.2% said they bury it, 11.8% use it as fertilizer and 14.4% just dump it somewhere. 15.9% of all households (32.5% of those households were the interviewer was able to check) didn’t dispose it at a safe distance from the water source.

When looking at the latrines the interviewers found 76.6% difficult to empty.
4.4 **Focus Group Discussions (FGD)**

A few interesting findings emerged from the FGD complementing our quantitative results despite the small number of sessions held and despite the short training for the facilitators.

4.4.1 Khwaja Gorlama

The women participating in the FGD said that even though soap was available in the villages it was not affordable for most families. When asked how people transport and store water, they said water is carried in jerry cans, but is usually used immediately and not stored in the house.

When people were asked what causes diarrhoea warm weather was frequently mentioned. A causal relationship between warmth/heat and diarrhoea was assumed.

Only one person knew how to prepare ORS, but mothers knew that babies suffering from diarrhoea should be fed in short intervals.

Women reported no deaths due to diarrhoea and bloody diarrhoea was not considered a health problem.

4.4.2 Qalack Big

Well water was considered safe water because as it ‘comes from underneath the earth where it is clean’.

The women in the FGD reported that they knew about five deaths in the community due to diarrhoea. Open defecation in the own yard was the norm as only few people in the community had a latrine.

ORS was known as diarrhoea remedy, but no one knew how to prepare it, most participants gave yoghurt and peas or soup to a sick person.

They reported food was stored in uncovered dishes and said many flies were attracted to it.

Again soap was available but not affordable.

4.4.3 Khwaja Charkhi

Interestingly the participants found that the well water was the best water source because it was considered most delicious.

Similar to the two other FGDs women said they didn’t use soap because it is too expensive, even though it is available in the village shops.

One child had died from diarrhoea in the village and bloody diarrhoea was regarded as a health problem in the village.
Again participating women said that no one in the village had a latrine and most people defecate in their yards.

The remaining information that was gathered from the FGD confirms the results of our quantitative data collection, e.g. regarding main water sources, personal hygiene and knowledge on safe water and diarrhoea.

4.5 RELATIONSHIPS BETWEEN INDICATORS

4.5.1 Literacy

Chi-square tests were conducted to explore relationships between literacy and relevant other variables.

No significant relationships were found between literacy and diarrhoea prevalence or death cases. Knowledge on handwashing, diarrhoea causes, prevention and danger signs was also not found to be related to literacy.

But a significant difference was found between literate and illiterate people regarding their appearance and the cleanliness of their homes: Literate people had a significantly cleaner yard, water source, house and kitchen. However this difference was not seen in the latrine. Nevertheless a positive relationship was found between literacy and the existence of a latrine in the household. The general appearance of literate people (clothes, hands) was also cleaner; this was not observed in their children though.

4.5.2 Radio Ownership

To investigate possible relationships between radio ownership and other indicators several tests were carried out, showing the following results:

A significant difference was found between radio owners and people who didn’t own a radio in regards to latrines. More radio owners had a latrine than people without a radio. And radio owners reported significantly less diarrhoea cases in their families.

Radio owners were not more likely to have soap in their households though.

4.5.3 Children’s general appearance

In families where children appeared to be clean significantly less diarrhoea cases occurred than in families where children looked unclean.

4.5.4 Sex

Regarding most knowledge questions women knew significantly more than men (diseases caused by unsafe water, prevention and danger signs of diarrhoea). Women also reported more occasions when they wash hands. But the general appearance of the men
(incl. clothes) was significantly cleaner than the appearance of the women except for the hands.

(5.) Discussion

The sample is considered representative for the respective districts despite the fact that only those villages were assessed that were accessible by car and that could be reached within half a day drive from Maymana.

From our prior village survey we already knew that all three districts were underserved with water points. It was therefore not surprising that the number of people referring to rivers and streams as their main water source was high.

Since the survey took place in November the number of diarrhoea cases was probably lower than it would be during the warm season.

Considering the high under-five-mortality rate (25%) in Afghanistan the number of deaths due to diarrhoea in our study (5%) seems quite low. This could be due to the fact that death from malnutrition, ARI, Malaria or other diseases among children occurred more frequently than from diarrhoea. Another explanation could be a methodological artefact.

The majority of people (66.5%) did know that unsafe water could cause diarrhoea, but only 1.9% of the participants had done something to make their drinking water safer. These responses indicate that knowledge regarding the necessity for water treatment exists, but is not practiced.

Similar to other findings our data shows that knowledge on hygiene exists, but people don’t practice hygienic habits or act according to their knowledge. This could be because people don’t know about safe practices, e.g. how to make water safer or it could be due to a lack of economic means and therefore a lack of necessary items, e.g. chlorine.

It was previously assumed that because of inadequate information sanitation might not be a priority for the community and individual families. But our data shows a link between economic status and latrine possession. Radio ownership was used as a measure of the economic situation of a household because it is a luxury good which solely serves the purpose of entertainment.

Our finding that more radio owners had a latrine than people without a radio and less diarrhoea cases implies that the economic situation of a family strongly influences the decision to build a latrine. People without a radio are unlikely to have latrines and vice versa.
Even though women in the FGD reported that they couldn’t afford soap, radio owners were not more likely to have soap. This means that probably a lack of understanding the importance of using soap keeps people from buying and using soap, not primarily a lack of financial means.

**LIMITATIONS**

Taking into consideration that this was the first time we carried out an assessment of this kind (conducting both interview and observation) we encountered a few limitations.

Due to time constraints we did not validate the questionnaire before using it. We had one pre-test in a village near Kabul though, to ensure all questions were comprehensible.

Despite training all interviewers in using the questionnaire it is possible that in some cases answers were misinterpreted. This was particularly prone to happen in Uzbek speaking communities, where the interviewer had to translate the questionnaire from Dari. During this process some questions or answers might have been mistranslated and the validity of our questionnaire might have been influenced.

(6.) Implications and Recommendations

Our results support the approach that WatSan projects must include all three components in order to significantly reduce water-borne and water-washed diseases.

DACAAR’s main goal is a) giving people access to safe water and b) safe latrines and c) enabling them to practice hygiene.

Our outcomes show that the majority of people use unsafe water. It is very time consuming for most families to get water and possibly even keeps children from going to school and adults from earning livelihoods. It is therefore vital to provide an alternative safe water source, teach people how to make water safer and reduce the time to fetch water.

Because the data shows that there is an (expected) lack of knowledge and practice in all areas of hygiene (personal and environmental) our hygiene education project will have to focus on all relevant areas. Each household will be visited more than just once to ensure that beneficiaries understand the importance and consequences of healthy habits for personal hygiene and health and accomplish the necessary changes in their lifestyle. And hygiene educators will examine homes and advise the families on safer practices in addition to teaching sessions.

The relationship between literacy and personal and domestic cleanliness shows the positive impact for daily life that could be achieved by education. Country wide education
would have a far-reaching impact and must remain the ultimate goal beyond hygiene education.

The follow-up assessment will show if our WatSan project leads to sustainable behaviour change and a significant reduction in the prevalence of diarrhoea.