

# Loughborough University Institutional Repository

---

## *Hygiene awareness for rural areas in South Africa*

This item was submitted to Loughborough University's Institutional Repository by the/an author.

**Citation:** DUNCKER, L.C., 1999. Hygiene awareness for rural areas in South Africa. IN: Pickford, J. (ed). Integrated development for water supply and sanitation: Proceedings of the 25th WEDC International Conference, Addis Ababa, Ethiopia, 30 August-2 September 1999, pp.79-81.

**Additional Information:**

- This is a conference paper.

**Metadata Record:** <https://dspace.lboro.ac.uk/2134/29968>

**Version:** Published

**Publisher:** © WEDC, Loughborough University

**Rights:** This work is made available according to the conditions of the Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International (CC BY-NC-ND 4.0) licence. Full details of this licence are available at: <https://creativecommons.org/licenses/by-nc-nd/4.0/>

Please cite the published version.



## Hygiene awareness for rural areas in South Africa

*Louiza Duncker, South Africa*

WATERBORNE DISEASES REMAIN a cause for concern in both developing and developed countries worldwide. Diarrhoea affects millions of people worldwide, having the greatest impact on children, especially in developing countries. In developed areas, improvement in wastewater disposal, protection of water sources and treatment of water supplies has greatly reduced the incidence of waterborne diseases. However, in South Africa with its mix of developed and developing regions, the incidence of water related diseases is increasing as a result of unstructured urbanisation and rapid population growth.

The main purpose of programmes and projects for improved water and sanitation is to improve health. On the other hand, the mere provision of water supply and sanitation infrastructures do not and will not by itself improve health. To get maximum benefits out of improved water supply and sanitation infrastructures, people need to be supported with information that will enhance these benefits. This form of information and skills is called hygiene education (Mara, 1996). Hygiene awareness and education provide people with information that they can use to change their behavioural patterns in order to improve their health. However, changes in behaviour do not come automatically, it also has a motivational component (Mara, 1996). In many instances, incentives are necessary to induce a change in behaviour. The major incentive for behavioural change is the perceived benefit derived from the changed behaviour.

There are ways in which communities can change their practices as far as health and hygiene related to water and sanitation are concerned. Hygiene awareness and education inform community members about how to collect, store, use, and dispose of waste water in hygienic ways. Emphasis is placed on use of clean water for feeding infants and general food preparation, bathing practices and domestic cleanliness (Almedom et al 1997). Supplying clean drinking water and methods of excreta disposal do not automatically reduce diseases or improve health. Hygiene awareness and education are essential to even begin to achieve a reduction in waterborne diseases or improved health (Mara, 1996).

As mentioned, hygiene awareness and education inform community members about the correct use, storage and disposal of water, the importance of sanitation and general hygiene. However, supplying clean drinking water and better methods of excreta disposal do not automatically reduce disease or improve health. Therefore, hygiene awareness and education are essential parts of water supply and

sanitation projects. Hygiene awareness and education comprise of a broad range of activities aimed at changing attitudes and behaviours in order to break the chain of disease transmission associated with inadequate water supply and sanitation (Almedom et al 1997). In the context of rural South Africa, where the ideal of providing every household individually with safe piped water cannot be achieved, the art of keeping well - hygiene - assumes great importance.

In South Africa it is essential to understand the attitudes and behaviour of developing communities towards water supply and sanitation. Most developing communities rely on the government to make sure that their projects are sustainable, but it is, however, necessary for the community to contribute towards the sustainability of their projects as well as the development of an appropriate hygiene awareness and education programme. Real decisions on hygiene awareness and education should be made at community level in order to have the biggest impact. These communities, however, need information to be able to make these decisions that will reflect their aspirations, desires and needs regarding hygiene (Duncker 1999).

The Water Research Commission (WRC) funded a research project by the CSIR that focused on the development of an information gathering tool for hygiene in rural communities in South Africa. This information gathering tool is called the KAP tool because it is based on the KAP (knowledge, attitudes and practices) study developed by the World Health Organisation. The information gathered with this KAP tool enabled the researchers to develop a Hygiene Awareness Workshop for rural communities. This KAP tool can also be implemented as an evaluation mechanism after a hygiene intervention in the communities, such as the hygiene Awareness Workshop, to measure and evaluate the impact of the intervention.

The product from the research is a Hygiene Awareness Package for rural areas in South Africa. The KAP tool and the Hygiene Awareness Workshop form the components of the Hygiene Awareness Package for rural areas. These components can be implemented independently, but it is advisable to first determine the needs, priorities and available resources of the communities through using the KAP tool before implementing the Hygiene Awareness Workshop.

### The research

The ultimate aim of the research project was to impact on the general quality of life of rural communities by making

them aware of their hygiene situation in their community. This awareness might lead to the realisation by the members of the communities of the need to change their behaviour towards a higher level of general and personal hygiene and health.

The main objectives of this research project were as follows:

- To develop and pilot a tool to determine the knowledge, attitudes and practices (KAP study) regarding hygiene, water supply and sanitation in developing rural communities.
- To develop and pilot a Hygiene Awareness Workshop for rural communities based on the information gathered.
- To assemble a Hygiene Awareness Package for rural areas consisting of the KAP tool and the Hygiene Awareness Workshop.

The research team consisted of personnel from the CSIR in Pretoria and Durban as well as personnel from the Rural Support Services in the Eastern Cape. The project team acted as the interviewers in the communities. The interviewers were trained in basic interviewing skills and the implementation of information gathering techniques.

The research team followed the SARAR principles in implementing the research. The SARAR process focuses on the development of human capacities to assess, choose, create and take initiatives. These skills can spill over to many other aspects of a person's life in the community (Srinivasan 1994). SARAR is a participatory methodology that is championed by PROWESS (Promotion of the Role of Women in Water and Environmental Sanitation Services).

Three techniques (questionnaire, interview schedule and observation) were selected to gather the information needed for this study. These techniques proved to be the most effective in gathering information regarding hygiene in a community during the pilot phase in the Northern Province. These techniques were developed into the following four information gathering stages:

- a household questionnaire;
- an interview schedule for individuals/households;
- an interview schedule for focus group discussions; and
- a community walk observation schedule.

Four rural communities each in the Northern Province, the Eastern Cape and KwaZulu-Natal were selected as target groups for the research. Two of the four communities in each province had good access to water (i.e. reticulated water to yard taps or street taps), whilst two communities had poor access to water (rivers, streams or unprotected springs).

The household questionnaire was implemented in all the communities. A total of 48 households completed the questionnaire. The interview schedule for individuals/households was implemented with the same households that

completed the questionnaire. A total of 48 individuals/households was interviewed.

The focus group discussions were held in the same communities where the household questionnaires and individual/household interviews were implemented. A total of 26 focus group discussions was held. Each focus group consisted of 8 - 15 respondents.

A total of 36 observation schedules was completed during daily observation in the same communities.

## Results of the research

The data gathered was analysed qualitatively and quantitatively on MS Access. From the analysis it is clear that the level of knowledge regarding hygiene is high in all the communities covered during the research. However, this knowledge is not practised for a number of reasons. One of the major reasons is the lack of financial means to ensure a more hygienic life style. The people in rural areas do not have the money to buy disinfectant and fridges, or to build toilets. Another major reason is that the people in these communities do not have enough water to bathe daily or provide hand washing facilities at the few toilets available.

Another reason mentioned by the respondents was that cultural taboos exist regarding the use of toilets by men and women, e.g. a daughter-in-law is not allowed to use the same toilet as her father-in-law.

Another major reason for the low level of hygiene in rural areas is the lack of knowledge regarding the cause, transmission and prevention of waterborne and faeces-related diseases. The level of knowledge regarding the treatment of these diseases is high because the incidences of these diseases are high. The knowledge regarding the treatment of these diseases was obtained mostly from clinic and hospital personnel.

When the respondents were probed regarding the prevention of diseases, the responses indicated that they confused the term "prevention" with the term "treatment". Some of the local languages also did not have an equivalent word for the term "prevention". The research team concluded that prevention was therefore an unfamiliar concept. This could be attributed to the fact that the respondents viewed illness and disease as "punishment" from their ancestor spirits, and could therefore not be prevented, just treated and cured.

The research team concluded that the development and implementation of a workshop dealing with the general concept of hygiene, the cause, transmission and prevention of water-related and faeces-related diseases, and action planning to improve the hygiene in a community, will have a very positive impact.

## The hygiene awareness workshop

The Hygiene Awareness Workshop was developed based on the information gathered by the KAP tool. The Hygiene Awareness Workshop is a manual for the facilitator/trainer and can be used by health workers, nurses, doctors, social workers, trainers, NGOs, consultants, etc. to assist rural

communities in raising their quality of life by improving their hygiene practices and attitudes with the correct knowledge and information. It should, however, be kept in mind that a major mindshift has to take place in the world view of the people in rural areas in order to understand and internalise the cause, transmission and prevention of diseases so that they can change their behaviour.

The Hygiene Awareness Workshop consists of three days of experiential learning.

- Day 1 focuses on the concept of Ahygiene@ as well as the current knowledge and practices about hygiene and illnesses in the community.
- Day 2 focuses on transferring new knowledge regarding the causes, transmission and prevention of illnesses, with specific reference to water- and faeces-related illnesses. Emphasis is also placed on the necessity and benefits of a hygienic life style.
- Day 3 facilitates the development of action plans in the community to address the improvement of hygiene in the community itself with the resources they have available in the community. A monitoring and checklist is drawn up by the participants in the workshop, to implement in their own village/community.

The research team followed the SARAR principles again in piloting the Hygiene Awareness Workshop. The Hygiene Awareness Workshop was piloted in the same communities in all three provinces where the initial data gathering, using the KAP tool, occurred. This action addressed the need of the communities to obtain something tangible for the effort and commitment they had put into the project during the information gathering stage.

## Recommendations

To achieve sustainable water supply and sanitation development requires effective complementary inputs such as community participation, community capacity building and community training. International trends and research have indicated that hygiene awareness and education play a major role in breaking down the transmission of diseases affecting many rural communities in the developing world.

Hygiene awareness and education are not about coercion, but bringing about change in the behaviour patterns of people, to make them aware of the diseases related to unhygienic practices, poor water supply and improper sanitation (Almedom 1997).

A definition of hygiene awareness and education that emphasises activities aimed at changing attitudes and behaviours, must recognise that behavioural changes cannot be effected from outside the communities. The individuals in the community must want to change and it is only they who can effect sustainable change. The role of the external agent can only be that of a catalyst and providing (or broadening) awareness. Secondly, the role of women cannot be overemphasised. Women are the latent force for change in communities; thus their empowerment and in-

volvement is the prerequisite to the success of any community-based health or hygiene awareness and education programme or campaign or strategy. The main components of a hygiene awareness and education strategy include:

- motivation and community mobilization;
- communication and community participation;
- user education (operations and maintenance);
- skills training and knowledge transfer;
- development of messages;
- presentation of messages;
- maintenance of good practice (Duncker 1999).

The project team of the CSIR made the following recommendations regarding the implementation of the Hygiene Awareness Package:

- An implementation strategy for the Hygiene Awareness Package should be developed to address the needs of national, regional and local levels. This strategy should consider the other health and hygiene interventions (such as PHAST) already being implemented.
- Community participation and ownership of the process of change are essential to facilitate improvement in hygiene and health in rural communities.
- All rural water supply and sanitation projects should include hygiene awareness and education in the form of the Hygiene Awareness Workshop.
- The implementation strategy should be monitored to ensure the sustained quality of the Workshop.
- Follow-up activities and refresher training/workshops to counteract resistance to change are an important component of hygiene awareness and education.
- An evaluation strategy should be developed to evaluate the impact of the Hygiene Awareness Workshop on the communities where it was implemented.
- The Hygiene Awareness Workshop should be dynamic and should adapt and realign as the needs of the communities change (Duncker 1999).

## References

- ALMEDORM A M, BLUMENTHAL U, MANDERSON L, 1979, *Hygiene Evaluation Procedures: Approaches and methods for assessing water- and sanitation related hygiene practices*; London School of Hygiene and Tropical Medicine, London, United Kingdom.
- BOOT M T, 1991, *Just Stir Gently*; IRC International Water and Sanitation Centre Technical Paper, The Hague, Netherlands.
- DUNCKER L C, 1999, *Hygiene awareness for rural areas in water supply and sanitation projects*; WRC research report, Pretoria, South Africa.
- MARA D, 1996,
- WORLD HEALTH ORGANISATION (WHO), 1984, *International Drinking Water Supply and Sanitation Decade*; 2nd Edition.
- LOUIZA DUNCKER, Anthropologist/Social scientist, CSIR, Boutek, PO Box 395, Pretoria, 0001, South Africa.