United Nations Development Programme

Office For Project Services

FIRST DRAFT

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Health Education
In Northern Afghanistan

"Facts for Life"

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1.0 Introduction

1.1 What is Health Education

Health education aims to improve the health and quality of life of the whole community

Typically health education aims at imparting simple messages concerning personal hygiene, tackling common illnesses, safe motherhood and child care & development. Clearly it therefore needs to be targeted at women (and children) since through their labour they clearly have the greatest influence over the quality of life within the family.

1.2 Approaches to Health Education

Firstly it is important to recognise that there are usually long delays before any significant results will be seen. Before people are willing to accept any change in habits and practices they not only have to learn the facts but also need to be convinced of the relevance of such innovations to their lives.

Traditionally health education has been conducted through supplying posters and on-going formal training at clinics, schools and religious establishments. However if any long lasting influence is to be achieved emphasis needs to placed on changing habits through ;

- Direct discussion and involvement of the community through dialogue. Avoiding a one-way flow of information and enabling emphasis to be placed on issues raised by the community.
- Employing innovative training techniques based on local forms of communication such as; mime, street plays, stories, songs and poems.

Remember the speed of change will be influenced by many factors. Ill-health may be a direct result of customary practice that is entrenched within a culture or it's habits, such as; female circumcision or denying a child the first few days mothers milk. So consideration and patience is an essential part of any approach however good a methodology practiced.

On the other hand where the time lag between health intervention and its effect is short, the impact on peoples understanding of health care and willingness to learn may improve dramatically. For example, the time lag between treatment and effect with oral rehydration is very short despite the otherwise possibly fatal effects of diarrhoea or cholera on young children. Similarly a good immunisation programme which demonstrably reduces the rate of mortality caused by a communicable disease will be accepted rapidly.

An approach that combines a mixture of teaching treatment for simple illnesses and encouraging immunisation. Together with a long term education policy to tackle culturally sensitive issues is most likely to succeed. Communities will recognise initial improvements in their families health and learn to trust and accept the input of health workers in the long term.

2.0 OPS's Programme Objectives

2.1 What does UNDP/OPS want to achieve ?

Firstly it's important to recognise that OPS does not have a specific mandate to provide health education to communities across Afghanistan. Other UN organisations such as UNICEF & WHO are arguably responsible for such work, however limited funds have necessarily forced these organisations to concentrate operations in cities (Mazar-i-Sharif, Sheberghan & Herat) and at present neither are tackling these issues in rural communities.

OPS has to-date lined over 160 wells across northern Afghanistan, and has plans for further well rehabilitation and improvement subprojects as well as the rehabilitation of other water supply structures, (such as water storage tanks and spring protection structures). It would be irresponsible of OPS to improve water supplies to rural communities and not attempt to: firstly provide the community with the skills to maintain the supply; secondly, increase the community's awareness so they can gain the full benefit of the improved water supply; and thirdly, use this opportunity to increase the overall awareness in the community of basic health care issues.

In order to both avoid conflict with other agencies and yet maintain a responsible approach to subprojects in the Water Supply & Sanitation sector. This paper recommends that OPS combines both maintenance training and health education with its water supply subprojects, targeting only the villages where structures have been or will be improved & rehabilitated. However OPS should simultaneously encourage NGO's and implementing partners assisting us to target other communities within the district from alternative funds.

2.2 Maintenance Training

For all water supply structures there is always a certain degree of on-going operation and maintenance requirements. Since the skills required for such work will vary depending on the structure and associated equipment, OPS will need to ensure suitable villagers are selected and trained to coordinate maintenance work. For example most men and women in the village can be trained to assist in cleaning a storage tank, but only a few will be particularly good it mending a broken handpump. The three most likely structure types to be reconstructed, rehabilitated or improved are listed below.

2.2.1 Well Structures

Since we are rehabilitating and improving existing wells the majority of well structures will be hand-dug (generally 7m to 20m deep) very occasionally tube wells and hybrid wells (partly hand-dug & partly tube well) may require rehabilitation.

Maintaining Lined Hand-dug Wells

Construction techniques for hand-dug wells can be classified into two types, largely as a result of the cohesion and stability of aquifer material. In loosely consolidated aquifers (gravelly or sandy materials) side wall material will collapse as the well is dug below the water table, in consolidated material (rock, clay soils etc...) there is no such problem. Generally well lining requires no maintenance, however villagers need to be trained how to deepen wells since water tables may drop damatically in exceptionally bad droughts.

In consolidated ground this is no problem, it is simply a matter of deepening the well. If skilled labour is available rings may be lowered by careful removal of soil beneath the lower edge of the lowest ring and letting all the rings settle down to their new position.

If conventional rings have been used in unconsolidated aquifers it would be extremely difficult to deepen a hund-dug wells. Please see Annex IV for a hand-dug well lining design specifically adapted to such conditions which will also enable villagers to deepen wells.

Abstraction Equipment

The conventional bucket and pulley system requires little maintenance and villagers are more than capable of supplying or replacing the bucket and tackle required. However if a handpump is to be fitted to the structure a comprehensive training programme will be needed to ensure villagers are able to :

i) Remove and replace the handpump.
ii) Identify the cause of any problem that may be experienced with the pump, and how to resolve the problem.
iii) Either make or buy spare parts that may be required to repair the unit.

2.2.2 Storage Tanks

Generally designed to store enough water to provide villagers with sufficient water throughout dry seasons. Storage tanks are most commonly fed by canals and on occasion by a piped supply from a spring or other groundwater source. Generally covered and constructed below ground level, tanks have a sloping base to concentrate water for abstraction and deposits for cleaning. Water is commonly abstracted by bucket or handpump as with a shallow hand-dug well.
Maintenance depends on the accessories supplied for abstraction, the comments under wells relating to abstraction equipment applies equally to storage tanks. Annual cleaning of the tank is a simple operation, however when a tank is covered villagers may be reluctant to carry out cleaning unless it is absolutely essential to maintain supply. Tank design should make allowances to ease cleaning operations by providing a (lockable) trap door for easier access.

2.2.3 Spring Protection Structures

In northern Afghanistan spring protection structures generally take the form of a tank with a gravel and sand base covering a natural spring, occasionally covered such structures may feed a gravity fed pipe or canal system.

Maintenance is therefore minimal and largely limited to cleaning the collection tank to remove debris and algae. However villagers should also be shown how to remove and clean the upper layers of the gravel and sand base should it become clogged up with dirt and algae.

2.3 Defining Health Education for the Programme

Outlined below is a set of core subject areas to be addressed by the health education programme, they have been taken from the "Facts for Life" booklet produced by the UN. Core subject areas will tackle many issues in detail including technical points such as constructing pit latrines, improved drainage etc...

Safe motherhood	Over 1,000 women die per day from problems related to child bearing. To make maximise the use of health care knowledge, women need the support of their husbands, communities and local authorities.
Breastfeeding	Babies fed on breastmilk have fewer illnesses and less malnutrition than babies who are bottle-fed on other foods.If all babies were exclusively breastfed for about the first six months of life, then the deaths of more than 1 million infants a year would be prevented. Bottle-feeding is a special threat in poor communities where parents may not be able to afford sufficient milk-powder, may not have clean water to mix it with, and may not be able to sterilize teats and feeding bottles. Many mothers lack confidencein their own ability to breastfeed. They need encouragement and practical support of fathers, health workers, relatives and friends, any women's groups and employers.
Timing births	Births which are 'too many or too close' or to women who are 'too old or too young' account for approximately one third of all infant deaths worldwide.
Child growth	Poor food and frequent infection lead to malnutrition and hold back the physical and mental development of millions of childeren.The great majority of parents either grow enough to earn enough to provide an adequate diet for their young childeren - if they know about the special needs of the young child and if they are supported by their communities and governments in putting that knowledge into practice.

Immunisation

Without immunization, an average of three out of every hundred childeren born will die from measles. Another will die from tetanus. One more will die from whooping cough. Onen out of every two hundred will be disabled by polio.

Vaccines can protect childeren against these diseases. But several vaccinations are needed before a child is fully protected. Even when vaccination services are available, infants are rarely brought for the full course of vaccinations.

Diarrhoea

Diarrhoea causes dehydration, malnutrition and kills over 3 million childeren every year. The main causes of diarrhoea are poor hygeine, lack of clean drinking water, overcrowding, and the trend towards bottle-feeding rather than breastfeeding.

Coughs & colds

Coughs and colds can indicate pneumonia, which kills approximately 2 to 3 million childeren each year. All parents should know what to do about coughs and colds - and when it is essential to get trained medical help.

Hygeine

More than half of all illness and death among young childeren is caused by germs which get into the child's mouth via food and water. For good practices to be effective It is important to emphasise the need for the whole communities involvement.

In communities without latrines, safe drinking water and safe refuse disposal, it is very difficult for families to prevent the spread of germs. The linkage between health problems and poor habits should be emphasised, communities must be mobilised to provide facillities and promote good habits.

Malaria

100 million malaria cases a year cause hundreds of thousands of child deaths, mostly easily peventable. In areas where malaria is common, all families and communities should have access to information for preventing and if possible treating the disease.

Aids

Although not considered a priority in the context of Afghanistan, acquired immunodeficiency syndrome, or AIDS, is a new global problem. Every nation is threatened by it and as many as 13 million people may already be infected with the AIDS virus worldwide.The virus which causes AIDS is called the human immunodefficiency virus (HIV). It kills by damaging the body's defences against other diseases. There is no known cure.

For the purposes of OPS's operations AIDS awareness is of little importance however it is an aspect that master trainers should be aware of.

Child development

Babies begin to learn rapidly from the moment they are born. By the end of the second year of life, most of the growth of the human brain is already complete. The first few years are also vital for the development of behaviour and personality.Parents must ensure childeren grow up in an atmosphere as positive as possible so they are well behaved and well balanced - and to build the foundations for a child to learn well at school.

3.0 Proposed Methodolgy

Rural communities in Afghanistan are deeply conservative societies organised and run according to local traditions. Central government influence in these communities over the last 15 years has either been non-existent or extremely divisive. Intervention by government often choosing to challenge traditional values head-on rather than encouraging them to evolve.

In the last few years rural communities have had to fend for themselves, young childeren study in local mosques, and occassionally where the community is more organised older childeren may benefit from community schools.

Not surprisingly such experience has made rural communities in Afghanistan suspicious of outsiders. Indeed in some areas external organisations have only added to this mistrust by failing to appreciate the sensitivity of the situation.

By it's definition Health Education is focussed on women. It is important that our staff appreciate that we must ***earn*** the trust of the community. ***If we hope to involve women in the programme the community as a whole and men in particular must be comfortable with our approach and our aims.***

3.1 Breaking the Ice !!

3.1.1 Deserving the trust of the community

Since we shall only be targeting communities where we already have or are planning a water supply project, we at least have an inlet to the community and should have achieved some measure of trust from the villagers.

Clearly this will be far easier if a solid base of trust has been achieved through involving the community from day one. Initially through the DRS process and then through discussion of project design, well location, community contribution etc... with village elders and representatives.

Once we have shown that we are committed to improving the existing water supply they will be prepared to consider any follow up more seriously. For example, having lined a well within a village previously, on our return to add a hand-pump we can emphasise the need to train assistants to maintain the pump and simultaneously promote the need to improve the communities awareness of basic health care issues.

3.1.2 Approaching the community

When opening initial consultation with a community the Mullah and Qaryadar (elected village head) should first be approached. Staff need to make a point of carefully explaining and discussing the reasons why we consider this work an important part of the water supply project. Since long term consultation and discussion with the community needs to be consistent the master trainers, who will later identify and train health education facilitators, need to be involved from the first contact with the village.

Discussion and consultation with the community should be initiated when water supply structures are being considered prior to the location of wells or the design of storage or protection structures, in order that health education be viewed as an integral part of the project.

The pair of master trainers (a team of one women and one man) who will be responsible for the long term education of the community need consistent and regular contact with the village. Initially to obtain the trust of the community and later to encourage the development of improved sanitation, safe refuse disposal and influence their habits. It is therefore essential they are involved in DRS and community liaison from the day the DRS identifies water supply structures as one or more of the district's priorities, (ideally they would be involved in DRS establishment too). From assisting engineers in obtaining community input to project design and ensuring a commitment to participation in implementation and on-going maintenance. To identifying and training facilitators, carrying out monitoring of the programme and resolving any confusion or problems.

- *It is important that the female master trainer is involved as early as possible within this process. They should be introduced to the Shura and involved thoroughly from the earliest stages of consultation within the community. Consulting with women in the community and specifically getting their input into project location, design etc... Projects may take longer to get off the ground but as women make specific requests for modifications to design, (i.e. to ease water collection, provide washing areas or animal watering troughs away from the collection points etc...), men in the village will hopefully appreciate and possibly more readily accept their involvement in health education (particularly if the womens involvement is deliberately low profile).*

3.1.3 Establishing a working relationship with the community

During the first meetings with the village, staff will need to spend a number of days in the district centre returning to the village daily. The initial contact with the village elders and representatives is extremely important and should never be rushed. Master trainers will have to think on their feet adapting their approach to the community concerned.

More often than not male master trainers will hold initial consultations with the mullah and Qaryadar. As soon as possible the female master trainer should be introduced to the village representatives and arrangements made for her to consult with women from the village. These early discussions preferably held simultaneously with the men and the women should explain the type of water supply structure being considered, technical training needed for maintenance and operation and introduce the topic of health education.

Master trainers need to openly discuss the importance of clean water, touching on related health issues. It must be explained that in order to maximise a projects benefit to the community we need their advice on issues we should consider during design of the structure (i.e. location, length of dry season, suitability of different designs, access, associated facilities etc...). Stimulating interest at this stage will ensure the active involvement of the community in the future.

These discussions are a good opportunity for master trainers to get a good impression of the community's willingness, interest and attitude towards health education. Similarly they can take this chance to start identifying suitable individuals to train as health education facilitators.

Anecdotes from the Quran regarding the importance of clean water, hygeine, careful food preparation etc... should be used to emphasise that our programme is in their interest and does not conflict with traditional life.

On subsequent visits, once the villagers have had time to discuss things amongst themselves master trainers should assist engineers in the follow up. From tackling queries and getting ideas from both men and women on adaptions to design. To exploring ways in which the community can take on-board responsibility for supply of certain materials, assist in implementation or support us through monitoring.

Once staff have discussed and finalised a project design with villagers, the community should be aware of it's role in participation, in whatever form, and should fully understand what the project will provide them with. Having stimulated this interest and already held discussions throughout the village master trainers need to recruit "facilitators".

At this stage it is vitally important that contracts on projects are not delayed, to maintain and build on the trust gained ***we must deliver.***

Ideally identification and training of facilitators will be started as soon as possible within this consultation process however it is important that fears are

assuaged and objectors won over before the training begins. Inevitably it will take a number of visits before the community understands or accepts our approach. Unfortunately this process cannot be rushed and the response in different communities will vary dramaticaly. Not just in the progress concerning the involvement of women but also in the process of consultation on project design and involvement of the community within the project cycle.

*The project belong's to the community **not** OPS.*
Staff are employed to help the community.

3.2 Heath Education Facilitators

Facilitators are individuals from the community who will be identified and trained specifically to discuss and promote improved habits and practices in health and hygeine throughout the community. They will be trained to use simple and innovative communication and teaching techniques aswell as given a solid foundation in related health issues.

Facilitators are the key to the success of the programme. As members of the community they are essential to assist us in influencing peoples daily habits.

3.2.1 Identifying and recruiting facilitators

Although men will have little impact on the habits of the household it is important that they consider themselves to be actively involved. More likely than not as they become comfortable with our operations project staff will have more interaction with the women than the men.

Female and male facilitators will necessarily have different roles, thus female and male master trainers will be looking for different abilities and skills.

Female Facilitators

After initial consultations and explainations the ***female master trainer*** will need to visit different extended families to discuss the project with village women. These discussions concerning the role of OPS and the project (suitable design, site, health aspects etc...) provide an ideal opportunity to assess the suitability of different women to act as facilitators. Enabling the master trainer to begin to identify women who are particularly interested, respected by others, have special skills or who simply grasp issues quickly or stand out due to their personality and charisma.

Facilitators will ideally be women already respected for their experience or knowledge, (such as skills in massage, fixing broken bones, Dia's, or teachers). Alternatively individuals interested and keen would probably make excellent facilitators, their enthusiasm carrying others along.

Male Facilitators

For the ***male master trainer*** identification of suitable candidates will be far easier, since he can arrange meetings in the village mosques and discuss issues openly with individuals. However he is more likely to find few are genuinely interested in a long term involvement.

Where as female facilitators will primarily be tackling health issues within the extended family or amongst small groups of women. The male facilitator will play a very different role.

Male facilitators cannot be used to greatly influence the adoption of good habits amongst the community. However they play a key role in ensuring the acceptance of health education messages, since the head of each household must be convinced that the programme is at least doing no harm.

Male facilitators main roles are therefore twofold.

Firstly in explaining to the men through meetings in the mosque and amongst smaller groups from extended families, what health education is, why it matters and what is planned under the OPS programme. These discussions should encourage open and frank discussion. Initially focussing on what the community wants from us, how we should adapt our plans and raising / answering peoples queriesand doubts. Later hearing from them concerning the value of issues tackled and jointly discussing the future direction of the programme. On-going consultation with the men is important to maintain their trust even though they are not necessarily vital for our programme. Particularly if at a later stage we hope to promote better sanitation refuse collection etc...

Secondly, taking it upon themselves to become the focal point of any technical training for maintenance and operation of the structure or equipment installed.

Similarly to female facilitators, male facilitators will need to have good communication skills and preferably be individuals already well respected within the community. As well as interested in our plans they will ideally have a background in teaching, health care, or be technically skilled, such as a builder, iron worker etc...

Recruitment of facilitators will hopefully be largely a matter of approaching those people identified earlier in the consultation process. Unfortunately it will rarely be so simple. Inevitably different individuals will be favoured or disliked by influential individuals and elders in the village. Often people preferred by staff or villagers will not be interested. The facilitator will receive no payment or reward for her/his services apart from the skills learnt from master trainers and the general appreciation/respect from the community.

In reality it may be necessary to hold meetings with all the men in the village before we can approach influential women, staff will have to guage the mood while making the first visit. Similarly it may be necessary to identify potential facilitators through influential persons (women and men) in the village. Although this may not the best way of operating it will at least enables us to

initiate work in the community, with time we can always train additional facilitators should earlier trainees prove ineffective.

3.2.3 Training Facilitators

Master trainers will be responsible for the training of facilitators and later for monitoring and evaluating the progress and in-roads made within the community. Training will be conducted in the village over a number of visits. Although a planned curriculum will need to be developed by master trainers the material and progression of training programmes will need to be tailored to the interests and abilities of individuals selected to act as facilitators.

Maintaining and nuturing the interest of trainees will not be easy, health education does not show dramatic results - it is a slow process. But a carefully thought out training programme that creates a good base of knowledge initially and promotes good habits by the trainee in her personal life will maintain their interest. For example training them to tackle simple illnesses in childeren, encouraging them to improve their diets and promoting better child care practices will over time make a large difference to the health of the family. Also, teaching trainees how to make and use simple oral rehydration solutions to tackle the effects of diarrhoea, that often proves fatal in malnourished childeren, will illustrate very clearly the value of the health education message.

Once we have convinced the facilitators that our information and messages are important we have won half the battle.

Training is a long process requiring repeated visits over a long period, building on the trainees knowledge and skills step-by-step, never over-reaching trainees capacity to learn and impart the information to others.
OPS will need to be committed to a long term programme if there is any hope to have sustained impact on both the community and on the trainees habits.

If there is a school regularly used by the community, school teachers should be encouraged (and assisted by OPS) to take part in one of the 2 - 3 week training courses organised by IFRC as part of their Basic Health Teacher Training Programme. Courses designed to train teachers how to pass on basic health care messages during their regular lessons at school. Such courses are presently available in Herat and will be in Mazar from November 1994.

3.3 Master Trainers

Although the role of male and female master trainers is very different they will not necessarily require different skills. They will both need to have a good grasp of the technical and health issues involved as well as being capable of varying their approach village by village.

Personal skills are far more important than technical ability, for example, being confident and flexible, able to take the initiative and plan her own activities, being a good listener and diplomatic, having excellent communication skills and enjoying working with people.

Master trainers do not need to have a college background or formal qualifications. Providing they can understand and pass on the basic health messages, simple technical issues and easy traing techniques they can have any background. Indeed we may well find that teachers or nurses based in the district centre and travelling to outlying villages and clinics would make ideal master trainers. However in such a case contingency plans would have to be made to train the master trainers.

4.0 Pilot Project

This paper recomends that OPS initiates two pilot projects to assess the feasibility of a health education training programme for rural communities in Afghanistan. The two pilot projects should be located in different regions, run simultaneously and both be initiated as soon as possible.

OPS should make a point of dicussing proposals with other agencies actively involved in water and sanitation projects in Afghanistan, (such as UNCHS, UNICEF & WHO), and keep them informed of developments. Most of these agencies have staff actively inviolved in similar work (health eduction, rehabilitating & improving water supply structure, installing or training staff to maintain hand pumps etc...), although they tend to focus on the cities.

Each pilot project project would be planned and implemented through close collaboration between the community, OPS and a well established NGO. The WID specialist and regional manager would be responsible for preparing contract documents and developing the pilot project's strategy through discussion and negotiation with the selected NGO. Different pilot projects should be implemented by different NGO's, and the WID specialist should encourage each project to develop approaches best suited to the organistaions and staff involved.

Both OPS and the NGO's need to be flexible. OPS will be forced to rely on the NGO to carry out all of the field activities and needs to be prepared for continuous changes in work schedules and proposed work plans. Similarly the NGO will need to accept close scrutiny by OPS and allow OPS staff to carry out detailed monitoring and evaluation. Such details should all be worked out well in advance and written into the contract document.

The NGO selected will need to have experience in both health education and operating on community based programmes in rural Afghanistan. Furthermore it is important the NGO, independently of OPS both has the resources to and plans to, operate in the region long term. OPS's input may be restricted to the pilot project and even if OPS is able to start a nationwide health education programme activities may still br restricted to only water supply projects.

Throughout the process of drawing up contracts and establishing the pilot project, particular attention should be paid to

- Individual staff selected by the NGO for coordinating activities and acting as master trainers.
- Strategy for approaching and establishing a working relationship with the community.
- The detail of the curriculum for training facilitators, especially the training techniques and aids to be utilised by both the NGO's master trainers and facilitators.
- The procedures to be established for on-going monitoring of the training, education and the community's response to the project.our approach,.
- Maintaining detailed records regarding the progress of operations, (an essential aid to evaluating the success and failures of the pilot projects if a larger scale programme is to be considered).

These pilot projects should be subject to a rigorous evaluation after three months to critically assess operations, providing feedback to help refine the pilot projects further. After six months a second evaluation should be conducted, again critically evaluating project activities and programming to-date, but also specifically assessing feasibilty of scaling up operations. Ideally to ensure that health education and technical training becomes a common component on all water supply projects.