THE KAP TOOL FOR HYGIENE

A Manual on: Knowledge, Attitude and Practices Study for Hygiene Awareness in the Rural Areas of South Africa

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Water Research Commission

LC Duncker

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A MANUAL ON:

KNOWLEDGE, ATTITUDE AND PRACTICES STUDY FOR HYGIENE AWARENESS IN THE RURAL AREAS OF SOUTH AFRICA

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WHO SHOULD USE THIS MANUAL

This manual is developed primarily for people involved in water supply and sanitation, and health and hygiene projects in the rural areas. The manual was developed from the experiences and inputs of a research team from the CSIR, as well as from inputs by the Water Research Commission (WRC) and other research and implementation organisations, such as the Medical Research Council, Rural Support Services (an NGO in East London) and international publications by IRC International Water and Sanitation Centre and World Health Organisation (WHO).

This manual was developed through hands-on experience and field work by the research team whose backgrounds include anthropology, social work, public health and community development. The draft of this manual was field tested in the Northern Province prior to peer review and finalisation.

The purpose of this manual is to enable researchers from a technical and a social background to gather information regarding the hygiene situation of a rural community or of rural areas. This information gathering tool is called the KAP tool for hygiene because it is based on the KAP (knowledge, attitudes, practices) study which was developed by the World Health Organisation, and it focuses on hygiene issues in rural areas. The emphasis of this KAP tool is on qualitative data to determine knowledge, attitudes and practices and not on statistical analysis of the data. The KAP tool can also be implemented after a hygiene intervention in the communities, such as the hygiene Awareness Workshop, to measure and evaluate the impact of the intervention.

The KAP tool and the Hygiene Awareness Workshop form the components of a 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.

This manual will enable you to gather information regarding the hygiene situation in rural communities/areas. The information you gathered will guide you in the development of a hygiene awareness strategy or workshop for that specific community or area.

This manual will guide you in the following:

- preparing for your research;
- selecting your target group;
- appropriate techniques for gathering the information;
- how to use these techniques;
- analysing and interpreting the data;
- reporting the findings; and
- what to do with the findings.

The people who will benefit the most from using this manual are the following:

Water supply and/or sanitation engineers who deal with implementing water supply and sanitation in rural communities.

Public health workers and health practitioners, social workers and social scientists who work in rural communities.

Facilitators, communication specialists and community liaison officers who work in communities or with groups in helping them to identify and solve health and development related problems, thus building individual and group skills.

Trainers who conduct training for developing communities and who need to be aware of the roles and responsibilities of their pupils/trainees regarding health and hygiene in their communities.

Project planners and project managers who implement water supply and sanitation projects in the rural communities.

Researchers and students in public health and other academic institutions interested in health and hygiene behaviour in the rural areas of South Africa.

The communities where the research is implemented, because the research will make them aware of hygiene issues in their communities.

CHAPTER 1
INTRODUCTION

When the Water Decade commenced in 1981, the statistics on water and sanitation related diseases were staggering: 80% of all sickness in the developing world and 25 000 deaths a day attributable to water-related diseases; diarrhoea killing as many as 18 million of these children; three out of five people in developing countries without access to safe drinking water and only one in four with sanitation.

Two major issues surfaced during the Water Decade. First, as confirmed by a broad study in 1976 (Saunders and Wardford) and another in 1978 (OECD), rural water facilities in the developing world were falling rapidly into disrepair and disuse shortly after the installation. The causes seemed, among others, to be the following:

- the technology used did not withstand the demands of the users;
- the financial costs and logistics of maintaining and servicing the systems proved too great for the limited economic and human resources of the water institutions;
- the systems were in some cases rejected by communities whose needs, preferences and/or cultural beliefs had not been incorporated into the project design.

Secondly, the health benefits always assumed to accompany the provision of potable water came into question, as research increasingly pointed to human behaviour in relation to water as a more critical determinant of health outcome. It became clear that water supply projects could not achieve their full impact without a complementary sanitation and health education component.

These issues had a major impact on defining the agenda for the Water Decade and in influencing the overall shift away from “coverage” (ie number of installations) to a new concern:

> “the effective and sustainable utilisation of water and sanitation services implemented in ways that are replicable” (Narayan-Parker 1989).

In general, this shift in approach has been most applicable to the populations of rural and peri-urban areas, where factors such as greater need, more limited financial resources, and the types of physical and social environments (with their implied technological options) demand higher levels of community participation.

For decades the rationale for the vast majority of water supply and sanitation projects has been the improvement in the health and economic productivity of the target population. Based on what is now known about the complexity of the disease transmission chain, investments in water and sanitation appear to be a necessary but incomplete step to attaining a tangible health impact. Modifications in human behaviour and the way in which people interact with their environments, especially at the level of the household, have been shown to exert a greater influence on morbidity and mortality than the simple provision of clean water or latrines. In addition, the health impacts of water and sanitation improvements have shown to be complemented by factors such as the mother’s literacy and educational attainment, or family income.

In sum, broad recognition is now accorded the value of community-based hygiene education as an essential component of any water and sanitation project. Participatory programmes, in which community members assume a key role in the identification, design and implementation of simple, culturally sensitive health messages, have proven more effective in modifying behaviour than previous didactic approaches.

Although there has been extensive research on water and sanitation related diseases in South Africa, there is a paucity of information on health and hygiene education. This is confirmed by a study conducted on behalf of HEATT, reviewing health education and promotion activities in South Africa (Clacherty & Associates 1997). Most of the available research deals with the health impacts and risks associated with different water qualities, and provide chemical and microbiological water quality criteria for the protection of human life, especially against diseases such as diarrhoea, dysentery and their methods of treatment. Other research is on contamination resulting from water storage and handling (Genthe. et. al. 1996). The Medical Research Council (MRC, 1991) conducted a number of studies looking at the health status and needs of developing communities. Though the investigations were on a broad range of health issues, some of the most important indicators were associated with water and sanitation. In designing an environmental health intervention related to water supply and sanitation i.e. hygiene education, one must take into consideration the various perceptions and attitudes towards the service.

Part of the current research is to explore and understand knowledge, attitudes, beliefs, perceptions and traditional practices of target communities where hygiene education programmes will be implemented. The importance of understanding the social aspects of the community before designing intervention programmes cannot be overemphasised. Emmet et.al. (1993) reviewed South African literature on preferences and attitudes towards water and sanitation facilities and related community health. The study noted that there are misconceptions surrounding water supply sanitation and the origin of disease. The understanding of the causes and sources of these misconceptions would go a long way in fine-tuning the content of the hygiene education programme. In a sociological study of water and sanitation related diseases in South Africa, Mills (1987) concluded that even when appropriate hygiene practices are known through a health worker, there are still many factors that prevent the application of these practices. Some of these obstacles are political, cultural, and economic. A study carried out by the MRC (1991) in selected urban, peri-urban and rural areas in South Africa noted strong perceptions among communities that their inability to practice good hygiene is related to their poor economic circumstances. This implies that the mere gathering of information on community knowledge without understanding deeper beliefs and other social dynamics may give a distorted input into programme design.

Further research has been carried out on message content selection (McKenzie and Oskowitz 1992). This is an important component of a health education programme as it will ultimately determine what sort of information and knowledge is imparted to the community.

The quality of the information gathered is critical in the assessment of hygiene practices in a community. This manual demonstrates the use of more than one information gathering technique in order to obtain useful and valid data from the target groups.

No assessment of hygiene in communities can be done by outsiders alone, without the participation of the people involved. There are three main types of participation as identified by Pretty (1994).

These are the following:

- **Extractive participation**: People participate by answering questions posed by researchers using questionnaires or similar approaches. People do not have the opportunity to influence proceedings, as the findings of the research are neither shared nor checked for accuracy.

- **Consultative participation**: People participate by being consulted, and external agents listen to their views. These external agents define both problems and solutions, and may modify these in the light of people's responses. Such consultative approaches do not allow for any sharing in the decision making and professionals are under no obligation to adopt the people's views.

- **Interactive participation**: People participate in joint analysis, which leads to action plans and the formation of new local institutions or the strengthening of existing ones. It tends to involve interdisciplinary methodologies that seek multiple perspectives and make use of systematic and structures learning processes. These groups take control over local decisions, and so people have a stake in maintaining structures or practises.

The choice of type of participation will depend on how participatory the team wants to make the hygiene research. If it is a once-off information gathering session, the participation of the community may not be necessary.

If, however, you want the participation of the communities, you should have answers to the following questions:

- What institutional mechanisms are there to put the findings of the hygiene assessment to immediate use?

- Who would take responsibility for any necessary changes to be put into effect and how?

- To what extent have local people been involved in the planning, design and implementation of the water supply or sanitation projects?

- To what extent have the project plans taken into account the local needs, beliefs and priorities of the community?

CHAPTER 2
IDENTIFYING THE SCOPE OF THE STUDY

When initiating a hygiene study you will need to identify how wide and how detailed you want your study to be. In order to do that, you have to find answers to the questions posed below in terms of the following:

- geographical boundaries;
- demographics;
- existing problems and priorities;
- existing water supply and sanitation services;
- aims and objectives;
- intended output and
- resources.

2.1 GEOGRAPHICAL BOUNDARIES

Where is the area or community you want to study?

To answer this question you need to have a set of criteria or list of priorities for selecting a specific community or area. This community or area needs to be plotted on a map to enable you to ascertain the geography of the community or area and surrounding areas. This will impact on your planning regarding travel and accommodation, subsistence and communication.

Climate, terrain, soil type and availability of water supply and sanitation services may all influence hygiene practices. If an area is very hilly, the hygiene level tends to be low because to carry water in such an area is too time consuming and too tiring. Similarly, people living in very arid areas, who tend to move periodically from one area to the other, will not want to build toilets, which have an impact on their level of hygiene.

Physical visits are essential to ascertain all the possible geographical factors which will impact on the level of hygiene of the community members, such as:

- climate;
- seasonal variations in climate;
- terrain (rocky, hilly, sandy, etc);
- accessibility of the area and the community (roads, airfields, railroad, etc);
- size of the community in hectares;
- availability of water supply and sanitation services;
- location of agricultural fields/gardens;
- location of clinics/hospitals;
- location of shops, factories, etc.

2.2 DEMOGRAPHICS

How much do I know about the people in the community or area?

You need to find out all information regarding the people you are going to study. Information relevant to your study in hygiene includes the following:

- language;
- ethnic group and cultural practices;
- need for translators;
- religions;
- day-to-day activities;
- key people in the area/community;
- stakeholders (funding agencies, political organisations, etc);
- number of households;
- number of inhabitants per household;
- schools and attendance;
- hospitals, clinics or mobile clinics;
- morbidity and mortality rates;
- doctors (traditional and western) in the area ;
- gender balance in the community;
- gender roles and responsibilities in the community;
- subsistence activities;
- economic activities;
- incidences of water and sanitation-related diseases.

2.3 EXISTING PROBLEMS AND PRIORITIES

What are the existing problems and priorities concerning hygiene in the water supply and sanitation projects in the area you want to study?

This question will require you to contact the members of the community or area you have in mind in order to facilitate a process whereby the community members define their problems regarding hygiene and rank them according to importance. This will enable you to plan for meeting the needs of the community members after the research has been completed.

2.4 EXISTING WATER SUPPLY AND SANITATION SERVICES

Are water supply and sanitation services available to assist in improving the level of hygiene in the community?

This question will require you to visit the community or area you have in mind to find out what the level of water supply and sanitation services are. If the community or area does not have any services available, the hygiene study can be applied as a baseline study to compare with a later study to measure the change in attitude or behaviour after and intervention such as the construction of toilets or a bulk water supply system. The baseline study could also be used to apply for funding for the development of the area/community.

2.5 AIM AND OBJECTIVES

What is the purpose and focus of this study?

The aim and objectives of the kind of study which will use this hygiene information gathering tool, are very important in steering the process of the investigation. The ultimate aim of using this information gathering tool is to gather information about hygiene in the community in order to impact on the general quality of life of rural communities.

There are several ways in which an impact can be made in these communities, one of which is making the community members aware of their hygiene situation in order to facilitate a change in behaviour towards a higher level of general and personal hygiene and health.

The objectives of the study should focus on the possible solutions or interventions in order to impact positively on the level of hygiene in the community studied.

The objectives of using the KAP tool are the following:

- to obtain information on existing hygiene *practices* in the community;
- to obtain information on the existing *attitudes* towards hygiene in the community;
- to obtain information on the level of *knowledge* of the community members about hygiene and water and faeces-related diseases;
- to determine the needs of the community members regarding improving their hygiene situation.

If this tool is being used as an evaluation tool, another objective will be:

- to assess the effectiveness of hygiene related interventions in changing hygiene practices and attitudes that had prevailed prior to an intervention.

2.6 INTENDED OUTPUT

What do you want to do with the information?

The objectives of the study should be decided with the intended output of the study in mind. The aim and objectives of the study should be closely linked to the study's intended output. If, for example, you intend to obtain baseline information on the existing hygiene knowledge, attitudes and practices to develop a successful hygiene awareness programme or workshop or training session, the objectives of the study should reflect that.
It is important to look to the future as well as the present, and link the results to follow-up actions that are indicated for the project. The data will highlight the areas where changes may need to be made. You should also consider plans for future investigations, for example after an intervention.

2.7 RESOURCES

What resources are required to complete the study successfully?

No study can be successfully completed without basic resources. The resources required for a hygiene study, are the following:

- Human resources, i.e. people with experience and skills in social science research and who are familiar with water supply, sanitation and hygiene issues;
- Funds to pay for the researchers' time, accommodation, subsistence, transport, administration costs, training, refreshments during group discussions, etc.
- Stationery and material necessary for the research;
- Computers for information management, data analysis, documentation and report writing.

CHAPTER 3
RESEARCH STRATEGY

The research strategy of your study should also be closely linked to the aim and objectives, as well as the intended output of the study. The aim and intended output of the study will guide you in defining the strategy of the research. For example in a project where improved water supply and sanitation are being introduced, it is preferable to focus on water and excreta related issues in terms of hygiene.

There are five clusters of hygiene practices that can be studied, depending on the focus of the study. These clusters are the following as defined by Almedom (1996):

CLUSTER OF HYGIENE PRACTICES	**RELEVANT FEATURES AND ACTIVITIES**
Sanitation Excreta disposal (Cluster A)	Location of defecation sites Toilet maintenance (structure and cleanliness) Disposal of children's faeces Hand washing and use of cleansing materials
Water Water sources (Cluster B)	Protection of water source(s) Siting of toilets in relation to water source(s) Maintenance of water source(s) Water use at the source(s) other activities at water source(s) Water collection methods, utensils and transportation Water treatment at the source
Water Water uses (Cluster C)	Water handling, storage and treatment in the home Water use and re-use in the home Hand washing Bathing Washing children's faces Washing clothes
Food Food Hygiene (Cluster D)	Food handling/preparation Utensils used for cooking, serving food, feeding young children and for storing leftover food Hand washing Washing utensils Re-heating of stored food
Environment Domestic and environmental hygiene (Cluster E)	Sweeping of floors and yard Household refuse disposal Cleanliness of footpaths, play areas and roads Management of domestic animals Drainage of surrounding area Condition of housing

3.1 RESEARCH APPROACHES

There are a number of research approaches to use for a hygiene study. In the development of this KAP tool for hygiene, it was found that the approaches described below were the most applicable approaches.

3.1.1 KAP STUDY

The KAP (knowledge, attitude and practices) study which forms the basis of the KAP tool, focuses on identifying people's behaviour regarding a certain issue or aspect. It is a model for facilitating change as it occurs in individual relationship, to incorporate new practices that are being introduced to people. It is also instrumental in identifying the factors that influence behaviour.

The steps of the KAP study focus on audio-visual aid as means of communicating knowledge. The steps are based on the assumption that if knowledge is transferred, adoption will follow. The method concentrates on small group discussions with two-way communication in changing attitudes and behaviour. WHO, 1978, p. 5-6, pointed out that the process does not foresee failure or discontinuation if all the steps are carefully followed.

There are advantages of using a KAP study as it provides more accurate insight into what people actually think than other techniques. The results produced also reflect social realities more accurately than a method that asks people to act in isolation. It also provides the opportunity to study group dynamics.

3.1.2 SARAR

SARAR is a flexible methodology using non-traditional learning materials. It releases the creative energy of participants and communities through a combination of skills, teamwork and a positive learning environment, while addressing community needs and problems. This participatory approach is known as a learner-centred approach and is a means of helping learners take greater control of their lives and their environment by developing their skills in problem-solving and resource management. The aim of the approach is emphasised in the following five characteristics of the SARAR approach:

- Self-esteem - the self-esteem of groups and individuals is acknowledged and enhanced by recognising that they have the creative and analytic capacity to identify and solve their own problems.

- Associative strengths - the methodology recognises that when people form groups, they become stronger and develop the capacity to act together.

- Resourcefulness - each individual is a potential resource to the community. The method seeks to develop the resourcefulness and creativity of groups and individuals in seeking solutions to problems.

- Action planning - planning for action to solve problems is central to the method. Change can be achieved only if groups plan and carry out appropriate actions.

- Responsibility - the responsibility for follow-through is taken over by the group. Actions of such responsible participation make results become meaningful.

The responsibility for the quality of community participation rests in large measure in the hands of both the community and the developer. Promoting participation should be to all community members and also amongst other who affects the community. People must become familiar with the goals of participation for any project to succeed and be sustainable (Srinivasan 1990).

3.1.3 DEMAND RESPONSIVE APPROACH (DRA)

The Demand Responsive Approach (DRA) proved to be the most appropriate approach in introducing the research project to the target communities.

The DRA has emerged as a strategy for assisting communities in the development process. It recognises the existing capacity of communities to take responsibility for identifying and solving their development needs. This approach increases the potential for user satisfaction, sustainability and re-orienting development agencies to respond to the needs of the communities. It is therefore a strategy that empowers a community to initiate, choose and implement a development project in which they are willing and able to sustain the process. Thus it implies that where community demand for development is strong, development agencies should desist from setting coverage targets or defining what is best for the communities (Gichuri 1997).

DRA focuses on giving communities the responsibility for making choices and decisions on the following:

- whether and how to participate in development programmes;
- how, when and with whom to develop and maintain a service;
- the type of facilities;
- the level of service;
- allocating resources for service development and management;
- level of involvement of institutions, policies and processes from outside the community.

Using this approach, it provides the communities with the opportunity to make informed choices and decisions regarding their involvement in the research for this document. This leads to the communities taking ownership and responsibility for the end-result of the research (Gichuri 1997).

3.1.4 PARTICIPATORY METHODS

Participatory Rural Appraisal (PRA) is derived from the Rapid Rural Appraisal (RRA). Similar to its parent methodology, it is a "*systematic yet semi-structured*

activity carried out in the field by a multi-disciplinary team and designed to acquire quickly, new information on, and new hypotheses for rural development" (McCracken & Conway 1988:18). Its goal aims at socially acceptable, economically viable and ecologically sustainable development. PRA works on the assumption that rural communities form the active foundation of natural resource de-gradation, and that communities need committed local leadership and effective rural institutions to develop. PRA helps communities mobilise their human and natural resources to define problems, consider previous successes, evaluate local institutional capacities, prioritise opportunities and prepare a systematic and site-specific plan of action - a Village Resource Management Plan (VRMP) for the community to adopt and implement.

PRA enables multi-disciplinary teams of specialists and rural leaders to work more closely together and to understand better their problems, needs and opportunities. It is an excellent tool to bring together development needs from the community groups and the resources and technical skills of government, donor agencies and NGO's. In doing so, it integrates traditional skills and external technical knowledge in the development process.

PRA integrates traditional skills and external technical knowledge in the development process, assisting communities to mobilise their human and natural resources to:

- define problems;
- consider previous successes;
- evaluate local institutional capacities;
- prioritise opportunities; and
- prepare a systematic and site-specific plan of action (McCracken & Conway 1988).

PRA, RRA and other participatory methodologies such as Participation and Learning Methods (PALM) are useful tools in gathering information regarding the hygiene situation in rural communities.

3.1.5 PARTICIPATORY HYGIENE AND SANITATION TRANSFORMATION (PHAST)

PHAST is an innovative approach to promoting hygiene, sanitation and community management of their water supple and sanitation facilities. It is an adaptation of the SARAR methodology of participatory learning and aims to empower communities to manage their water and to control sanitation-related diseases. It does so by promoting health awareness and understanding, which leads to environmental and behavioural improvements.

PHAST helps communities to achieve the following:

- to improve hygiene behaviours;
- to prevent diarrhoeal diseases;
- to encourage community management of water and sanitation facilities.

The above-mentioned is done by:

- demonstrating the relationship between sanitation and health;
- increasing the self-esteem of the community members;
- empowering the community to plan environmental improvements;
- empowering the community to own and operate water supply and sanitation facilities.

3.2 SAMPLING METHODS

Sampling forms an integral part of your research strategy and is as important to information gathering as it is to the analysis and interpretation of the findings. It is often not possible to interview all the people in the community you are studying. Therefore, drawing a representative sample (at least 10%) of the total number of people/households in the community is often the solution. However, the method of sampling places limits on the conclusions you can draw. It is best to include as many people as can provide adequate answers to your questions, within the limits of resources available to you. Feuerstein (1986) defines sampling as follows:

> *Sampling means looking closely at part of something in order to learn more about the whole thing.*

Patton (1990) described the sampling strategies as follows:

STRATEGY	TYPE	PURPOSE
Random Probability Sampling (Representativeness)	Simple Random Sampling	Permits generalisation
	Stratified Random and Cluster Sampling	Increase confidence in generalisations to particular subgroups or areas
Purposeful Sampling (Variability: depth rather the breadth)	Homogeneous Sampling	Focuses, reduces and simplifies variation
	Chain Sampling	Sequence of informants
	Extreme Case Sampling	Learning from unusual manifestations
	Typical Case Sampling	Highlights what is average
	Random Purposeful Sampling	Adds credibility to sample when potential purpose is too wide
	Stratified Purposeful Sampling	Illustrates subgroups to facilitate comparisons
	Criterion Sampling	All cases that meet the same criteria Useful for qualitative measurement

Sampling is a quantitative method of gathering data. Sampling enables you to gather data that is often difficult to obtain during focus group discussions.

Combined or mixed sampling strategies might be used in a hygiene study in order to answer

different kinds of questions. The use of random sampling is preferable for this KAP tool, but using purposeful sampling is not ruled out.

3.3 DATA CHECKING

The nature of qualitative data is such that processes for checking the quality and trustworthiness of the information obtained, have to be into place. Data checking should be put in place before the start of the data collection and should occur throughout the implementation of the study. There are various methods that can be used; some of them are mentioned below:

- **Triangulation of sources, methods and interviewers**

  Cross-checking of information on the same topic gathered from different sources, using different methods by different interviewers is involved.

- **Participant checking**

  Periodic feedback sessions enables you to present the results of the data collection to the members of the community to test whether they agree with your understanding of what they are doing.

- **Prolonged and intense interactions with the community**

  Intense interaction with the community enables you to build trust and rapport with the community members, to learn the particulars of the context and to be open to multiple influences. This will increase the trustworthiness of the data obtained.

- **Parallel studies and team communications**

  If the study covers more than one community and you have more than one study team, the teams can cross-check the quality of each others data sets during regular meetings.

- **Peer reviews**

  Peer reviews allow colleagues and steering committees to explore important aspects of the study that might have been overlooked by the interviewers.

CHAPTER 4
PREPARING FOR THE STUDY

Before the actual information gathering can start, you need to prepare yourself and the study team regarding the area, the people and the project. When gathering information for any project, all sources and resources should be examined.

4.1 SURVEYS

4.1.1 LITERATURE SURVEYS

There is a wealth of information available from the libraries of other development agencies, research institutions, universities, the Government Printers and other government departments. Efforts should be made to trace whatever information is available, even though it is often difficult to trace the unpublished and ad hoc research done by students, tutors, development experts and others.

4.1.2 AERIAL SURVEYS

Although costly, aerial surveys can provide information on the general spatial perspective such as land use, crop zoning, location of villages, etc. *This technique should be used in conjunction with working on the ground and learning from the people in those villages.*

4.1.3 PARTICIPANT OBSERVATION

This technique is one of the most basic and widely used method of gathering data. Observation in one way or another is an essential part of this KAP tool. The observer usually resides in the target community for several weeks or months, observing and recording the activities of daily life. The observer becomes involved in all the activities of the community. In addition he or she asks questions and keeps detailed notes of what is heard seen and felt in the community.

4.1.4 INTERVIEWING

In any community there are people who are more knowledgeable about the aspects of community life, such as the elderly people, health workers, the tribal authority, the teachers, the local councillors, women's groups, etc. Informal interviews reveal issues that cannot be determined by implementing a questionnaire or observation only. Open-ended questions that are broad in nature, are asked according to an informal interview schedule. The questions are respondent-generated, meaning that the answer of the previous question will lead the interviewer to the next question. To keep record of the information, a tape recorder could be used with the permission of the interviewees. This technique can be used for groups or for individuals.

4.1.5 QUESTIONNAIRES

Formal structured questionnaires and interview schedules are administered to a representative sample of the population. Surveys can provide information on income and expenditure patterns, educational levels, morbidity and mortality rates, etc. The results are then captured and statistically analysed.

4.2 TRAINING/CAPACITY BUILDING

The training of the study team or project personnel is a continuous process that starts at the beginning of the project and continues until the end of the study or project. The training encompasses the aim, objectives, processes, implementation and evaluation of the whole study.

4.2.1 SELECTING THE TEAM MEMBERS

You will need to include a range of skills and abilities in your project. This means you will have to employ staff with interpersonal, professional and administrative skills and abilities. You will have to list the skills and capabilities you need for the research project and then select people who fulfil the criteria.

A good team for this kind of research may include the following:

- one or two people from the target group with good communication skills such as community health workers, women's group leaders, teachers, etc;
- two or three people with good writing skills to write the reports;
- people who are experienced in working in communities (eg. anthropologists, social scientists, social workers, etc);
- people who can speak the language of the target group will be an advantage to the project, albeit not a necessity;
- people who are interested in assessing hygiene practices in the cultural, socio-economic and physical settings;
- people who are willing to learn and adopt new skills and attitudes for effective communication with the target groups;
- people who are prepared to initiate and maintain team spirit with the other members of the team for the duration of the project;
- people who are committed to see the project to its conclusion.

4.2.2 TRAINING THE TEAM MEMBERS

The training of the members of your study team should consist of two parts:

- initial training, beginning at the pre-planning stage of the study;
- on-the-job training throughout the study.

The initial training prepares the members of the study team, while on-the-job training sharpens their skills and creates the opportunity for the members to share their knowledge and experiences with each other. This shared knowledge will assist the team members in overcoming problem areas they previously were unable to handle.

4.2.3 TRAINING THE INTERVIEWERS

The interviewers you will use during your study should be well trained in basic interviewing skills and the implementation of the techniques of information gathering specific to this tool. The interviewers should also be also instructed in the following:

- the aim and objectives of the study/research;
- interviewing skills;
- listening skills;
- recording skills;
- communication skills;
- rephrasing skills.

It is important that notes to the interviewers be made available to assist the interviewers in implementing the information gathering techniques. These notes should be clear and should cover all the questions the interviewers asked during the training as well as any problems that might occur or which occurred during previous studies.

Members of the target community can also be trained as interviewers for the project.

4.3 PROJECT AWARENESS IN TARGET COMMUNITIES

In order to obtain the co-operation and support of a community where the study is going to be conducted, the aims and objectives of the study should be introduced to and discussed with the authority figures to obtain their permission to work in their areas or jurisdictions.

The process to advocate and introduce the study is the following:

- Identified and visit the authority structure in the community to explain the purpose and objectives of the research so that the needs of the target group can be identified and incorporated into the research;

- Schedule a community mass meeting to introduce the project to the community members;

- Hold a community mass meeting to explain the purpose and objectives of the research to the community members, including the expected contribution from every member of the community to the research process;

- Schedule meetings with the men, women and children to gather the data.

- Remind the members of the community that a feedback session will occur at the end of the study to inform them of the results of the information gathering session.

CHAPTER 5
APPROACHING THE COMMUNITY

Having identified and defined the project and the suitable community, you can introduce the project to the community. The following process will guide you in approaching the community in such a way that your project has the best chance of being accepted.

5.1 ENTRY INTO THE COMMUNITY

This section touches on the existence and importance of the different community social structures.

5.1.1 GOVERNMENT LEVEL

Ideally you should start at the district or local government/council level and find way down to the specific communities. The reason being that district councils are made of representatives of several local councils. Functioning district or regional councils would have information on which parts of the region are in greater need for project of the nature proposed. The district council would therefore refer you to the appropriate local council(s).

5.1.2 LOCAL LEVEL

Local councils are made up of people from the neighbouring communities. They should therefore be able to supply the you with more accurate information regarding:

- The community that requires the project in question most.
- The community social structures operating in the community.
- The right people to first speak to in the process of introducing the project to the community.

5.1.3 COMMUNITY LEVEL

In many occasions, however, you find yourself entering communities directly at the community level. This is not wrong provided it is done in an acceptable manner. When you are in a similar situation, simply talk to local people. Ask them about their social structures and contacts within the community. Local people can be easily accessed in places like shops or schools. Valuable information about, for example, the right structures and persons to contact, is obtainable in this way. Approaching the identified structure in the manner described by local people is essential since they understand it, having dealt with it themselves.

There are basically two types of social structures in rural areas:

- traditional structures;
- development structures.

Traditional structures consist of the chiefs, tribal councils and headmen of the community. The development structures refer to district councils, local councils, civic organisations and specific development committees, such as water committees or women's groups. You should establish which ones exist, and how they normally function. Also ascertain the working relationship between all the structures present in the community. The possibility exists that there is conflict between the structures in the community. This needs to be managed carefully and tactfully by emphasising the aim and goals of the project without excluding anyone or any structure.

The Committee

The community representative committees are formed either for specific projects or for general development purposes. An ideal situation is where a democratically elected committee is in place. Such, if it exists, is an important structure through which to approach a community. Besides the help it can provide during project introduction, it consists of people who will help in the execution of the proposed project.

The committee can also screen the proposal and indicate whether its community is interested. Being acquainted with all the procedures to follow before initiating a project, committees are of great help during project introduction. Therefore, you should not overlook the committee, but should work with it. Most important of all, some aspects of project execution should be left in the hands of the committee.

Sometimes the existing committees are not appropriate for new projects because of the lack of the necessary skills. The project should in such instances provide for the training of committee members to empower them to handle the project.

The Chief

The Chief is the ruler or highest traditional authority who controls and approves everything that happens in a specific area. The processes and time required to get the chief's permission on certain matters may be lengthy. Therefore, one needs to be patient. Approaching the Chief through the headman or the development committee is often advisable. Depending on the understanding between the Chief and the headman or a development committee, they may allow you to outline a project to the people before the Chief gives his permission. In some places, however, outside people cannot address the community before obtaining the Chief's permission. It is often felt that getting the Chief's permission first is more appropriate. When approached directly, the Chief would refer people to the development committee and/or the headman of the area. After obtaining the Chief's permission, reporting to him on every visit during the execution of the project is usually not necessary. This should be done only when there is something important that requires his attention. You are, however, free to brief him on project development from time to time. This is good practice as it keeps the Chief up to

date with project developments and progress. It is very important that the Chief's authority not be undermined, or the project may not materialise.

Some unavoidable communication problems are present when dealing with rural communities. Usually, the committee, the headman, and the Chief are not accessible by telephone and making an appointment beforehand is therefore impossible. The alternative is to appear without an appointment and hope that they will have time, or to make an appointment in person. This is a tedious and often frustrating process. The Chief may be present but busy and unavailable. Often one has to wait many hours or return at another time. These situations require extreme patience. With committee members and the headman it may be easier as they are often available immediately. Important and sensitive points to highlight under chiefs are the facts that there are chiefs perceived as legitimate, and there are those imposed on people during the apartheid years. This point is only added to make the reader aware of such situations. It is not for a DA to side with anyone, but to get co-operation between the two parties for the benefit of the community and the project.

The Headman

The headman is a Chief's representative in a community and usually has the power to solve some community matters. He can decide whether to refer a matter to the Chief. Depending on the code of conduct between the headman and the Chief, the former may allow introduction of the project to the community without awaiting the Chief's consent. Elsewhere, headmen are members of, or, the community co-opts them onto development committees so that they get first hand information, and be involved in projects. A headman is thus an important person to work through since he can also arrange an introduction to the Chief and to the committee. This has a particular advantage that the community and the Chief knows him and trusts his opinions.

Key People

On rare, unlikely occasions one may find a community without a traditional or development structure. If this is the case, the best approach is to contact a clergyman in the area and inform him or her about the project. The proposed project should be outlined to him or her. He or she can then organise a community meeting for the proper introduction of the team members and the project. Accepting someone introduced by a clergyman is often easy for many people. After proper introduction, provided the community is interested in the project, talks towards the formation of a committee and work on the project can start. It is also possible that in the absence of a committee, the community trusts and usually consults one or more people on community matters. The clergyman may refer you to these people.

An alternative to approaching the clergyman is to speak to the school principal. He can also organise parents' meetings at which the team members and the project can be introduced.

Other Organisations

Other consultants or people such as the Civic Organisation, Development Forums and Women's Groups that have a history of working with the communities are very useful in introducing another project to the community. They already have experience in dealing with communities and can also assist in the clarification of the aims and objectives of a proposed project to the community. These organisations will probably already be known to the people, the committee, the headman and the Chief. It is therefore strongly advisable that you find out whether other organisations are operating in that particular community. Enquiries on their projects, contact(s), and the possibility of joint activities should be made. This has an advantage that involvement with other agencies in projects reinforces a wide range of skills and technologies (Versfeld *et al.*, 1995) and is an invaluable for project success and for ensuring that a high quality product results.

Political Parties

Due to the dynamic politics in South Africa, it is the best policy to not become involved with political groupings before or during the process of the project. However, it is important that you recognise the roles of the political parties in the community, and that you discuss the outline of the project with them.

Members of the target group who are actively involved in politics should not be included as team members of the project as it might have an adverse effect on the data you want to obtain.

5.2 RELATIONSHIP WITH THE COMMUNITY

An important part of a project is the maintenance of a good relationship with the community. One of the many reasons for project failures is the poor understanding and thus poor relationship between project teams and the beneficiary communities. Several communities in South Africa have previously been let down by consultants. As a result, people view new or unfamiliar organisations and project with some degree of suspicion. Therefore, you should build up the community's confidence in your organisation and your project, taking care not to raise unrealistic expectations.

One way of boosting the community's confidence is to present them with the history and experiences of your organisation. This may include both bad and good experiences. Such openness will introduce the community members to the things that are good and those that are bad for community development projects. It will encourage people to learn from your experiences in other communities. You should not be ashamed if you do not have experience in community work; people often enthusiastically welcome the idea of learning together. Thus, there is no need to pose as an expert, but to use the experience you gain.

Another important point to remember is that some development project approaches used in the past have created dependence and have turned people into "non-contributing users". Contribution here is two-fold, physical and financial involvement in the project, as well as participating in the decision-making processes of the project.

Some consultants have, for example, drilled boreholes in communities with the intent of providing the communities with better water sources. Yet, they overlooked involving the communities in selecting the sites. Afterwards they are often surprised when people do not use these boreholes, and conclude that people do not need them. In the first place they should have talked with the communities about their intentions. Secondly, they should be trying to find out why people are not using these boreholes instead of concluding from a distance. This is not an ideal relationship between you and the user.

Also, people may be impatient with the rate of delivery of upliftment projects since they expect delivery almost immediately. If the community itself participates in the project, they are likely to appreciate the time required to start reaping the rewards of the project. Another important point for you to remember is to guard against creating expectations that you and they cannot meet.

CHAPTER 6
WHAT TECHNIQUES TO USE

There are various techniques for gathering information from communities. The list of references provided at the end of this manual is for the purpose of finding more information regarding these techniques. The general rule is that no single method or technique on its own is perfect for assessing hygiene practices and knowledge.

The techniques discussed in this chapter proved to be the most appropriate for the gathering of hygiene information in rural communities for the following reasons:

- Hygiene issues are very personal and potentially very sensitive issues. In the identification of the techniques, care was taken to use those techniques that will accommodate the sensitivity of the issue, as well as the modesty of the respondents/target groups.

- The techniques also had to elicit the knowledge, attitudes and practices of the target group regarding hygiene in the community and the households.

- The techniques had to be easy to use and easily understood by the target group. Complex techniques would hamper the target group in providing relevant information as they would be concentrating on mastering the technique rather than providing the information.

6.1 COMMUNITY WALK OBSERVATION

The purpose of this technique is to familiarise the interviewer with the physical context of the community in which hygiene practices occur. The interviewer spends a number of hours walking through the community to make visual observations regarding the following:

- the location of water sources;
- the condition of these water sources;
- the location of sanitation facilities;
- the condition of these sanitation facilities;
- the use of these sanitation facilities;
- the levels of faecal contamination of public places (roads, schools, churches, meeting places, market places, etc);
- the level of faecal contamination of the domestic environment;
- the behaviour and interaction of the people as they go about their daily activities;
- the presence and behaviour of domestic animals in the community;
- the location and condition of rubbish pits in the yards;
- local customs and social rules;
- any other activity or event that has an effect on hygiene in the community.

The Community Walk Observation Schedule (Appendix A) will help you to gather hygiene information on issues that are too sensitive to ask during focus group discussions or during individual interviews. The observers should make detailed notes as they go along to assist

them in analysing the data later on. Drawing a rough map of the area, indicating public facilities related to health and hygiene, water sources, schools, rough lay-out of the yards and the toilets in the yards, churches, market places, meeting places, etc., will assist in analysing the data as well as understanding the dynamics of the community.

It is important for the observer to absorb the atmosphere of the community. Spontaneous and informal conversations with people from all walks of life, discussing issues on water and sanitation related topics will assist in understanding the dynamics and atmosphere of a community. The Community Walk Observation also provides the opportunity to identify key individuals in the community who are particularly knowledgeable about issues relevant to a hygiene study.

The best time to conduct the Community Walk Observation is at dawn or at dusk. Most of the hygiene practices you want to study occur very early in the mornings or late in the afternoons. Be careful to accommodate and respect the cultural traditions and values of the community members. Try to be unobtrusive, but do not be secretive.

At the end of the Community Walk Observation the observer should meet with the study team to discuss the findings. A summary of the data should reveal observations which might lead to further issues to be investigated.

The information gathered during the Community Walk Observation can be used to:

- formulate and redefine questions to be addressed in the study;
- identify ways to reach different categories of respondents;
- interpret findings at the end of the information gathering stage.

6.2 FOCUS GROUP DISCUSSIONS

This method was developed from market research strategies in which theories of social psychology and communication were applied. A manual for the use of focus group discussions in health research is available in the literature (see Dawson, Manderson & Tallo, 1993).

In a focus group discussion people from similar backgrounds or experiences (eg a water committee, mothers with infants, children in St 8, etc.) are brought together to discuss a specific topic of interest. Keeping the focus groups homogeneous is preferable, as mixing genders, for example, might inhibit the women from expressing their views in the presence of men. The purpose of a focus group discussion is the following:

- to explore the range of opinions and views of hygiene in the community;
- to explore the issues regarding hygiene which can not be captured statistically;
- to explore the extent of community co-operation and willingness to change;
- to identify the vernacular terms and expressions used to describe a disease;
- to identify the cultural taboo's and values of the community.

A range of materials such as pictures, photographs, video recordings, paper clippings, etc. can be used to stimulate the discussion. The interview schedule for focus groups is attached as Appendix B. The interview schedule will assist you in directing of the group

discussion. It is important that the flow of discussion is not interrupted, but it is the responsibility of the interviewer to gently guide the discussion to cover all the topics in order to have valid information for the data analysis.

The best way to identify the participants in the discussion group is with the help of the key people in the community. The most ideal size for a focus group discussion is eight to ten people, but do not turn away those who want to participate, or force those who do not want to participate. It is important that you maintain a neutral attitude and appearance, regardless of the topic of discussion.

You should begin by introducing yourself and explaining clearly the purpose of the study and the discussion, and that there are no right or wrong answers. It must be made clear to the participants that their views will be valued and that the interviewer needs to learn from them. The discussion should be stopped when the topic has been exhausted or issues are recurring. It is important to thank the participants for their contribution. Refreshments may be served at the end of the meeting to maintain good rapport with them.

6.3 INTERVIEW WITH HOUSEHOLD OR INDIVIDUAL

This technique is based on semi-structured (informal) interviewing of an individual. An interview schedule (Appendix C) will guide you in this session where a household or an individual is interviewed.

This technique follows the same structure and process as the focus group discussions. The interview should also be informal and relaxed, and gently guided to cover all topics necessary for the data analysis. Because it is a one-to-one situation, more care should be taken to not offend by asking the wrong kind of question, or overstepping a cultural taboo.

6.4 HOUSEHOLD QUESTIONNAIRE

This technique (Appendix D) is a pure quantitative technique to obtain information regarding the following:

- household size;
- age of the respondent;
- level of income;
- level of education;
- institutions in the community;
- need for a hygiene awareness workshop;
- access to an Environmental Health Officer/Community Health Worker.

CHAPTER 7
WHAT TO DO WITH THE DATA

At the end of the study you should have several sets of data according to the tools or methods of investigation you used. This chapter deals with the processes of analysing and interpreting the data as well as presenting the findings.

There are several textbooks describing the stages in the analysis and interpretation of collected data or information. The four main stages are discussed in textbooks by Patton (1986), Pelto (1978), Miles and Huberman (1994) and Silverman (1994).

7.1 DATA ANALYSIS

You should include sufficient detail in the description of the analysis to enable the reader of the report to understand the steps you have followed, as well as how and why certain decisions were made.

The data can be analysed by using computer programmes specifically designed for the purpose. Very important during data analysis is to check and cross-check in information in order to establish the quality of the data. Data checks were built into the questionnaire and interview schedules in order to assist you in cross-checking your data. The data analysis should present the data clearly, coherently and fully before it can be interpreted.

7.2 RESULTS

The results of the data analysis should be set out and described clearly according to the order in which you want to present it. It is important not to interpret the data at this stage. The results should only show an ordered picture of the information you gathered.

The order in which the results are presented may be chronological or hierarchical.

- The chronological order will follow the order in which the facts were obtained in time;

- the hierarchical order will follow the order of the relative importance of the data to hygiene, or that which was investigated.

7.3 INTERPRETATION

The second stage of data analysis is to determine what the results mean and how significant they are in the specific context of hygiene. The interpretation of the findings should also reflect the comments and suggestions made by members of the community during the feedback sessions.

7.4 PRESENTING THE FINDINGS

It is important to be balanced in presenting the positive and negative findings of the data. You should emphasise positive findings without brushing over the negative findings. Similarly, the negative findings should be listed and discussed in order to explore possible solution or answers to the problem.

The format of the findings of the data analysis and the results of the study will depend on the target audience or the reader of the report. This report should consist of a complete record of the processes of the study or project and the findings, including an Executive Summary that gives a short description of the contents of the report.

Extracts from this report can also be prepared and disseminated or presented to the stakeholders in the area as well as the key people in the community you studied.

Short articles can also be prepared. These articles should summarise your findings for dissemination in the local or regional networks of researchers and practitioners in the field of water supply, sanitation, health and hygiene, and other international information dissemination organisations and institutions.

CHAPTER 8
IMPLEMENTING THE FINDINGS

This KAP tool for hygiene described in this manual has enabled you to establish a picture of the situation regarding hygiene knowledge, practices and attitudes of people in rural areas. However, the hygiene study does not end with the presentation of the findings. The next logical step is, and should be, to identify what needs to be done to either improve the hygiene situation in the community you studied or to address specific issues/problems that were raised buy the community members.

8.1 HYGIENE AWARENESS/EDUCATION

Hygiene education and awareness are the pillars on which hygiene promotion stands. Hygiene education is defined by Boot (1991:4) as “all activities aimed at encouraging behaviour and conditions which help to prevent water and sanitation related diseases”.

The project will have identified high risk hygiene practices which exist in the community within the physical context and cultural beliefs. Presenting these facts to the community will lead to a discussion of what needs to be done to remedy the situation, moving the emphasis from data collection to implementing the findings. It is very important that the community members identify the solution/s and follow-up action plans themselves, because it is the community members who will have to undergo behavioural change to improve their hygiene situation. Community participation is of utmost importance in facilitating behavioural change towards a higher level of hygiene.

8.2 HYGIENE AWARENESS PROGRAMMES AND WORKSHOPS

The result of the project will commonly mean the advocating of hygiene awareness programmes or workshops for the community members. These workshops will draw their focus to the most relevant and highest risk hygiene practices identified during the project to facilitate changing the behaviour and practices of the community members.

Almedom (1996:116) explains that there are four factors influencing behavioural change. In the development of a hygiene awareness programme or workshop these factors should be kept in mind in order to make an impact in the lives of the community members. These factors are:

- **Facilitation**: The new practice or behaviour should make life easier for the person adopting it.
- **Understanding**: The new practice or behaviour should make sense in the context of existing local knowledge and cultural beliefs.
- **Approval**: Important and respected people in the community should approve of and have adopted the new practice or behaviour.

- **Ability to make change happen**: It should be physically possible for the person to make the changes.

An example of a Hygiene Awareness Workshop for Rural Communities is included in the Hygiene Awareness Package for Rural Areas of which this manual forms a part.

8.3 POLICIES AND STRATEGIES FOR HYGIENE AWARENESS

Another result of the study is the recommendation to develop and implement national, regional or local policies and strategies for hygiene awareness. The results and data of the study can be used to facilitate the development process of the strategy and to identify the best possible ways of implementing the strategy in the rural areas. Boot (1991) discusses the seven phases of a framework for health education planning which was largely summarised from Green et al (1980).

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APPENDIX A

COMMUNITY WALK OBSERVATION SCHEDULE

COMMUNITY WALK OBSERVATION SCHEDULE

Date:_____ Observer:_____

Name of the community:_____

1. Draw a rough map of the community, indicating facilities, resources and locations important for hygiene.

2. WATER SOURCE

2.1 What is the main potable (clean) water source in the rainy/dry season?
☐ river ☐ yard taps ☐ street taps
☐ gutters ☐ spring ☐ other .....

2.2 How often is water collected from the above mentioned source?
☐ once a day ☐ twice a day ☐ every second day

2.3 How far is to the abovementioned water source from the households?.....metres

2.4 What container is used for water collection?
☐ plastic jerry can with lid ☐ open bucket ☐ other .....
☐ plastic jerry can without lid ☐ bucket with a lid

3. WATER STORAGE

3.1 Tick the box corresponding to the item that best describes how the households store their potable water.

* The containers are made of ☐ metal ☐ plastic ☐ other.....
* The containers are stored ☐ in direct sunlight ☐ in the dark / shadowed place

* The containers are stored ☐ inside ☐ outside
* The containers are ☐ covered properly ☐ uncovered ☐ half-covered

* The containers sit ☐ on the floor ☐ on a table ☐ other.....

4. WATER TREATMENT

4.1 Tick the box corresponding to the item that best describes how the households treat drinking water.
☐ Boiling ☐ Jik ☐ Alum stone ☐ Other.....
☐ No treatment

5. WASTE WATER DISPOSAL/REUSE

5.1 Tick the box corresponding to the item that best describes what the households do with waste water.
☐ Throw it away in the veld ☐ Use it to water the garden ☐ For building purposes
☐ Other.....

5.2 What happens to the water after each washing of the hands or bodies?
☐ Throw it away in the veld ☐ Use it to water the garden ☐ For building purposes
☐ Other.....

6. SOLID WASTE DISPOSAL/REUSE

6.1 Tick the box corresponding to the item that best describes what the households do with solid waste (kitchen waste, cans, plastic bags, etc).

☐ Throw it away in the veld ☐ Throw it in rubbish pit

☐ Other.....

6.4 Does the households reuse cans and plastic bags? ☐ Yes ☐ No

6.4 What does the households do with the cans and plastic bags? .....

.....

7. SANITATION

7.1 If there are **no toilets** in the yards, where do the members of the community go to relieve themselves?

☐ In the veld ☐ In the stream ☐ Other people's toilets ☐ Communal toilets

☐ Other.....

7.2 If there are toilets in the yards, what types of toilets are there?

☐ Pit toilet Number.....

☐ VIP toilet Number.....

☐ Other..... Number.....

7.3 Describe the condition of the toilets: .....

.....

.....

7.4 Record the responses below:

* Do the toilets have sufficient ventilation? ☐ Yes ☐ No
* Is there a hand washing facility at the toilet? ☐ Yes ☐ No
* Is soap provided? ☐ Yes ☐ No

- Approximately how deep is the pit?
- ☐ Waist deep ☐ Head high ☐ Very shallow

7.5 Do men and women use the same toilets? ☐ Yes ☐ No

7.6 Do children under the age of 12 use the toilets? ☐ Yes ☐ No

7.7 Who cleans the toilets?

☐ Men ☐ Women ☐ Children ☐ No one

7.8 How do the mothers dispose of the used plastic nappy?.....

7.9 Where do the mothers dispose of the faeces of babies?.....

8. NUTRITION

8.1 Do the households have vegetable gardens? ☐ Yes ☐ No

8.2 Is there a communal vegetable garden in the community? ☐ Yes ☐ No

8.3 How and where is food prepared?.....

.....

.....

9. HYGIENE

9.1 When do you observe the members of the community washing their hands?

* After changing the baby's nappy? ☐ Yes ☐ No
* Before handling of food and food preparation. ☐ Yes ☐ No
* Before eating. ☐ Yes ☐ No
* After a visit to the toilet. ☐ Yes ☐ No
* After housecleaning, work and/or disposing of rubbish. ☐ Yes ☐ No
* After touching or contact with animals. ☐ Yes ☐ No

*Other .....

9.2 What happens to the water after each wash?
☐ It is thrown away ☐ Used by someone else ☐ Other.....

9.3 Is the house swept and clean? ☐ Yes ☐ No

9.4 Are the dishes washed up directly after a meal? ☐ Yes ☐ No

9.5 Is the yard swept and clean? ☐ Yes ☐ No

9.6 Do they have a rubbish pit? ☐ Yes ☐ No

9.7 How do they dispose of the rubbish, dirt, old and/or unwanted rubbish?

.....

9.8 Describe the condition of the rubbish pit:

.....

.....

9.9 Are flies are a problem in the community/yards? ☐ Yes ☐ No

9.10 Is the cattle kraal within the household yards? ☐ Yes ☐ No

9.11 Do domestic animals wander free in the yards? ☐ Yes ☐ No

9.12 Describe the household environment:

.....

.....

.....

.....

10. **DISEASES**

9.1 Does any member of the community suffer from diarrhoea? ☐ Yes ☐ No

9.2 How many people suffer from diarrhoea?
☐ None ☐ 1 - 5 incidents ☐ 6 - 10 incidents ☐ 11+ incidents

9.3 Does any member of the community suffer from worms? ☐ Yes ☐ No

9.4 How many people suffer from worms?
☐ None ☐ 1 - 5 incidents ☐ 6 - 10 incidents ☐ 11+ incidents

9.5 Does any member of the community suffer from bilharzia? ☐ Yes ☐ No

9.6 How many people suffer from bilharzia?
☐ None ☐ 1 - 5 incidents ☐ 6 - 10 incidents ☐ 11+ incidents

9.7 Does any member of the community suffer from malaria? ☐ Yes ☐ No

9.8 How many people suffer from malaria?
☐ None ☐ 1 - 5 incidents ☐ 6 - 10 incidents ☐ 11+ incidents

9.9 Does any member of the community suffer from eye infections? ☐ Yes ☐ No

9.10 How many people suffer from eye infections?
☐ None ☐ 1 - 5 incidents ☐ 6 - 10 incidents ☐ 11+ incidents

9.11 Does any member of the community suffer from skin diseases? ☐ Yes ☐ No

9.12 How many people suffer from skin diseases?
☐ None ☐ 1 - 5 incidents ☐ 6 - 10 incidents ☐ 11+ incidents

11. TREATMENT OF DISEASES

11.1 If a family or household member is sick, which services does the community consult first?

☐ Traditional healer ☐ Medical Doctor ☐ Clinic /Hospital ☐ Health Worker
☐ Self treatment ☐ Other.....

11.2 Please answer the following questions concerning the community .

*The households treat diarrhoea with re-hydration mixtures. ☐ Yes ☐ No
*The households have medicines and bandages for treating burns. ☐ Yes ☐ No
*The households have antiseptics and bandages for treating cuts, bites, etc. ☐ Yes ☐ No
*The households have soaps and detergents for washing dishes and pots. ☐ Yes ☐ No
*The households clean the toilet regularly. ☐ Yes ☐ No
*The households regularly treat the house against insects (mosquitos, flies, fleas). ☐ Yes ☐ No
*The households cover left over foods and/or perishables. ☐ Yes ☐ No

12. PERCEPTION OF HEALTH

12.1 Do you consider the general health and hygiene the community as being good? ☐ Yes ☐ No

Explain:

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Thank you

APPENDIX B

FOCUS GROUP INTERVIEW SCHEDULE

INTERVIEW SCHEDULE FOR FOCUS GROUP DISCUSSIONS

Date:_____ Name of interviewer:_____

Name of community:_____

Number of respondents in the group:_____

M		F	

1. WATER SOURCE

Please take note not to provide the options to the interviewees, only mark off what they mention.

1.1 What is the community's potable (clean) water source in the rainy season?
☐ river/stream ☐ yard taps ☐ street taps
☐ gutters ☐ spring ☐ other .....

1.2 What is the community's potable (clean) water source in the dry season?
☐ river/stream ☐ yard taps ☐ street taps
☐ gutters ☐ spring ☐ other .....

1.3 How often is water collected from the above mentioned source?
☐ once a day ☐ more than twice a day ☐ every second day
☐ twice a day ☐ other

1.4 Who fetches the water from the above mentioned water source?
☐ men ☐ women ☐ children

1.5 What containers are used for water collection?
☐ plastic jerry can with lid ☐ open bucket ☐ other .....
☐ plastic jerry can without lid ☐ bucket with a lid

1.6 Does the community sometimes not get enough water for drinking? ☐ Yes ☐ No

1.7 What is the reason for that?.....

.....

.....

2. WATER STORAGE

Please take note not to provide the options to the interviewees, only mark off what they mention.

2.1 Tick the box corresponding to the item that best describes how the community stores its potable water.

* The container is ☐200 *l* drum ☐ 100 - 150 *l* container ☐ other.....
* The container is made of ☐ metal ☐ plastic ☐ other.....
* The container is stored ☐ inside ☐ outside ☐ other.....
* The container is stored ☐ in direct sunlight ☐ in the dark / shadowed place
* The container is ☐ covered properly ☐ uncovered ☐ half covered
* The container is ☐ the same as used for collection ☐ different from the one used for collection

2.2 Do the members of the community think it is necessary to keep the storage containers used for drinking water covered? ☐ Yes ☐ No

2.3. Why?.....

.....

2.4 Do the members of the community think it is necessary to wash the storage containers used for drinking water regularly? ☐ Yes ☐ No

2.5 Why?.....

.....

2.6 How often do the members of the community wash the storage containers used for drinking water?

☐ once a day ☐ more than twice a day ☐ every second day
☐ twice a day ☐ other

3. WATER TREATMENT

Please take note not to provide the options to the interviewees, only mark off what they mention.

3.1 Tick the box corresponding to the item that best describes how the community treats its drinking water.

☐ Boiling ☐ Jik ☐ Alum stone ☐ Other.....
☐ No treatment

3.2 Why does the community use that method? .....

.....

3.3 If the community does not use any treatment method, what is the reason for that?....

.....

3.4 List all the methods of treatment that the community members are aware of.

.. ..

.....

4. WASTE WATER DISPOSAL/REUSE

Please take note not to provide the options to the interviewees, only mark off what they mention.

4.1 Tick the box corresponding to the item that best describes what the community does with waste water.

☐ Throw it away in the veld ☐ Use it to water the garden ☐ For building purposes
☐ Other.....

4.2 Why does the community use that method? .....

.....

4.3 What happens to the water after each washing of the hands?

☐ It is thrown away in the veld ☐ Use it to water the garden ☐ For building purposes
☐ Saved for next hand washing ☐ Other.....

4.4 What happens to the water after each washing of the body?

☐ It is thrown away in the veld ☐ Saved for next wash ☐ For building purposes
☐ Other.....

5. SOLID WASTE DISPOSAL/REUSE

Please take note not to provide the options to the interviewees, only mark off what they mention.

5.1 Tick the box corresponding to the item that best describes what the community does with solid waste (kitchen waste, cans, plastic bags, etc).

☐ Throw it away in the veld ☐ Throw it in rubbish pit ☐ Burn it
☐ Other.....

5.2 Why does the community use that method? .....

.....

5.3 Does the community reuse cans and plastic bags? ☐ Yes ☐ No

5.4 What does the community do with the cans and plastic bags? .....

.....

5.5 What do they do when the rubbish pit is full? .....

.....

6. SANITATION

Please take note not to provide the options to the interviewees, only mark off what they mention.

6.1 If there is **no toilet** in the yards, where do the people go to relieve themselves?
☐ In the veld ☐ In the stream ☐ Other people's toilets ☐ Communal toilets
☐ Other.....

6.2 Do men and women use the same toilet? ☐ Yes ☐ No

6.3 If not, why not? .....

.....

6.4 Do children under the age of 12 use the toilet? ☐ Yes ☐ No

6.5 If not, why not? .....

.....

6.6 Whose responsibility is it to clean the toilet?
☐ men ☐ women ☐ children ☐ Everybody ☐ No one

6.7 Do mothers use plastic (disposable) nappies for their babies? ☐ Yes ☐ No

6.8 If **yes**, how do they dispose of the used plastic nappy?
☐ In the veld ☐ In the stream ☐ Other people's toilets ☐ Communal toilets
☐ Other.....

6.9 Do mothers use cloth (re-useable) nappies? ☐ Yes ☐ No

6.10 If **yes**, where do they dispose of the faeces?
☐ In the veld ☐ In the stream ☐ Other people's toilets ☐ Communal toilets
☐ Other.....

6.11 Why do they dispose of the faeces in that way? .....

.....

7. NUTRITION

Please take note not to provide the options to the interviewees, only mark off what they mention.

7.1 Does the community have a vegetable gardens? ☐ Yes ☐ No

7.2 If not, where does the community get vegetables to eat?
☐ Buy it from the market ☐ From the neighbouring community
☐ Other.....

7.3 How often does the community eat vegetables?
☐ Daily ☐ Twice a week ☐ Once a week ☐ Never
☐ Other.....

8. HYGIENE

Please take note not to provide the options to the interviewees, only mark off what they mention.

8.1 When do the members of the community wash their hands?

* After changing the baby's nappy? ☐ Yes ☐ No
* Before handling of food and food preparation. ☐ Yes ☐ No
* Before eating. ☐ Yes ☐ No
* After a visit to the toilet. ☐ Yes ☐ No
* After housecleaning, work and/or disposing of rubbish. ☐ Yes ☐ No
* After touching or contact with animals. ☐ Yes ☐ No

* Other.....

8.2 Do all members of the community take a full body wash daily? ☐ Yes ☐ No

8.3 If **yes**, what happens to the water after each wash?
☐ it is thrown away ☐ used by someone else ☐ other.....

8.4 If **not** daily, how often does the family get a full body wash?.....

8.5 Does each member use piped, boiled or purified water for the wash? ☐ Yes ☐ No

8.6 If **not**, what is the water source for full body washes?.....

.....

8.7 Does the community think flies are a problem? ☐ Yes ☐ No

8.8 Why? .....

8.9 What does the community think attracts flies? .....

8.10 What does the community do when flies are around? .....

8.11 Why do they do that? .....

.....

9. PERCEPTION OF HEALTH

Please take note not to provide the options to the interviewees, only mark off what they mention.

9.1 Do the focus group consider the health of their community as good? ☐ Yes ☐ No

9.2 If **not**, best describe your reason:

☐ I don't know what to do
☐ No money for treatments
☐ No or not enough clean water available
☐ Chronic condition or illness
☐ Poor diet
☐ Other .....

Explain:

.....

.....

10. DISEASES

Please take note not to provide the options to the interviewees, only mark off what they mention.

10.1 Did any member of your community suffer from diarrhoea during the last six months?
☐ Yes ☐ No

10.2 How many people suffered from diarrhoea during the last six months?
☐ None ☐ 1 - 2 incidents ☐ 3 - 4 incidents ☐ 5+ incidents

10.3 What does the community believe to be the cause for the diarrhoea?.....

.....

10.4 Does the community think it can be prevented? ☐ Yes ☐ No

10.5 How?.....

.....

.....

10.5 Did any member of your community suffer from worms during the last six months?
☐ Yes ☐ No

10.6 How many people suffered from worms during the last six months?
☐ None ☐ 1 - 2 incidents ☐ 3 - 4 incidents ☐ 5+ incidents

10.7 What does the community believe to be the cause for the worms?

.....

10.8 Does the community think it can be prevented? ☐ Yes ☐ No
10.9 If yes, how?.....

.....

10.10 Has any member of your community had bilharzia during the last six months?
☐ Yes ☐ No

10.12 How many people suffered from bilharzia during the last six months?
☐ None ☐ 1 - 2 incidents ☐ 3 - 4 incidents ☐ 5+ incidents

10.13 What does the community believe to be the cause of bilharzia?

.....

10.14 Does the community think it can be prevented? ☐ Yes ☐ No
10.15 If yes, how?.....

.....

10.16 Has any member of your community suffered from malaria during the last six months?
☐ Yes ☐ No

10.17 How many people suffered from malaria during the last six months?
☐ None ☐ 1 - 2 incidents ☐ 3 - 4 incidents ☐ 5+ incidents

10.18 What does the community believe to be the cause of malaria?

.....

10.19 Does the community think it can be prevented? ☐ Yes ☐ No
10.20 If yes, how?.....

.....

10.21 Has any member of your community suffered from eye infections during the last six months? ☐ Yes ☐ No

10.22 How many people suffered from eye infections during the last six months?
☐ None ☐ 1 - 2 incidents ☐ 3 - 4 incidents ☐ 5+ incidents

10.23 What does the community believe to be the cause for the eye infections?

.....

10.24 Does the community think it can be prevented? ☐ Yes ☐ No

10.25 If yes, how?.....

.....

10.26 Has any member of your community suffered from skin diseases during the last six months? ☐ Yes ☐ No

10.27 How many people suffered from skin diseases during the last six months?
☐ None ☐ 1 - 2 incidents ☐ 3 - 4 incidents ☐ 5+ incidents

10.28 What does the community believe to be the cause for the skin diseases?

.....

10.29 Does the community think it can be prevented? ☐ Yes ☐ No
10.30 If yes, how?.....

.....

10.31 If incidents did occur, what did the community do to make it better or to heal it?

.....

11. TREATMENT OF DISEASES

Please take note not to provide the options to the interviewees, only mark off what they mention.

11.1 If a family or community member is sick, which services does the community consult first?
☐ Traditional healer ☐ Medical Doctor ☐ Clinic /Hospital ☐ Health Worker
☐ Self treatment ☐ Other.....

11.2 If the community consult someone else, who do they consult?.....

11.3 Why do they consult the above mentioned person? .....

.....

11.4 What illnesses are treated by the traditional healer? .....

.....

.....

11.5 Are the community members aware of the following treatments?

* Re-hydration mixtures for diarrhoea. ☐ Yes ☐ No
* Medicines and bandages for treating burns. ☐ Yes ☐ No
* Antiseptics and bandages for treating cuts, bites, etc. ☐ Yes ☐ No
* Insect repellent for mosquitos, flies, fleas, etc. ☐ Yes ☐ No

12. COMMUNITY INSTITUTIONAL CAPACITY

Please take note not to provide the options to the interviewees, only mark off what they mention.

12.1 Do you have a health committee in the village? ☐ Yes ☐ No

12.2 Who is the contact person for this committee? .....
12.3 Where can the person be contacted? .....
.....

12.4 What do you think are the responsibilities of this committee? .....
.....
.....
.....
.....

12.5 Do you attend the meetings? .....
12.6 What do they discuss at the meetings? .....
.....
.....
.....
.....
.....
12.7 Do men and women attend the meetings or discussions?: ☐ Yes ☐ No

12.8 Do you have an Environmental Health Officer in your community? .....
12.9 Name: .....
12.10 Where can he/she be contacted: .....

12.11 Do you have a Community Health Worker in your community? .....
12.12 Name: .....
12.13 Where can he/she be contacted: .....

12.14 Do you have a water committee in the village? ☐ Yes ☐ No
12.15 Who is the contact person for this committee? .....
12.16 Where can the person be contacted? .....
.....

12.17 What do you think are the responsibilities of this committee? .....
.....
.....
.....
.....

12.18 Do you attend the meetings? ☐ Yes ☐ No

12.19 If yes, what do they discuss at the meetings? .....
.....
.....
.....
.....
.....

12.20 Do men and women attend the meetings or discussions?: ☐ Yes ☐ No

12.21 Do you have a sanitation committee in the village? ☐ Yes ☐ No

12.22 Who is the contact person for this committee? .....
12.23 Where can the person be contacted? .....
.....

12.24 What do you think are the responsibilities of this committee? .....
.....
.....
.....
.....

12.25 Do you attend the meetings? ☐ Yes ☐ No

12.26 If yes, what do they discuss at the meetings? .....
.....
.....
.....
.....
.....

12.27 Do men and women attend the meetings or discussions?: ☐ Yes ☐ No

13. HYGIENE AWARENESS WORKSHOP

Please take note not to provide the options to the interviewees, only mark off what they mention.

13.1 Do you think a Hygiene Awareness Workshop for communities is necessary?
Q Yes Q No

13.2 What do you think should be addressed in a Hygiene Awareness Workshop in your community?: .....

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Thank the respondents for their time and willingness to answer your questions.

APPENDIX C

HOUSEHOLD/INDIVIDUAL INTERVIEW SCHEDULE

INTERVIEW SCHEDULE FOR HOUSEHOLD/INDIVIDUAL

Date:_____ Name of interviewer:_____

Person interviewed:_____

M		F	

Position in household:_____

1. HOUSEHOLD INFORMATION

1.1 Name of ward/sub ward	

1.2 Number of people in household by age / gender																			
0-3yrs.				**4-12 yrs.**				**13-21 yrs.**				**22-55 yrs.**				**56yrs.+**			
M		**F**		**M**		**F**		**M**		**F**		**M**		**F**		**M**		**F**	

1.3 How many of the young children in the household (aged 3 years to 7 years) attend creche or pre-school class?	
1.4 How many of the children in the household (aged 8 years to 14 years) attend school?	
1.5 How many of the young adults in the household (aged 15 years to 30 years) attend school, college, technikon, or university?	

2. EXPENDITURE

2.1 Please indicate the amount spent by the household each month?

* Rent, bond payments, grazing fees or other land payments? R.....
* Grocery and foodstuffs items? R.....
* Transportation costs? R.....
* School fees and associated costs (if annual, make a note)? R.....
* Stokvels, burial society, or other savings club contributions? R.....
* Medical costs R.....
* Hire purchases R.....
* Other regular expenses? R.....

2.2 PLEASE indicate the average regular monthly expenses total? R.....

3. INCOME

3.1 Please give a brief indication of the monthly income of the household?

* Relatives/family members working in towns/farms send money	☐ Yes ☐ No
* Family member works in the area and stay at home (monthly salary)	☐ Yes ☐ No
* Household member receiving welfare or old-age pension	☐ Yes ☐ No
* Selling of seasonal fruits and vegetables	☐ Yes ☐ No
* Employed as part time field labour or local work	☐ Yes ☐ No
* Selling of livestock seasonally	☐ Yes ☐ No
* Selling goods from a spaza shop	☐ Yes ☐ No
* Other activities (eg. selling locally brewed beer, handicrafts, etc)	☐ Yes ☐ No

3.2 Please list any other form of income that contributes to the household.

.....

3.3 Please indicate the average monthly income for the household.....

4. WATER SOURCE

Please take note not to provide the options to the interviewees, only mark off what they mention.

4.1 What is the household potable (clean) water source in the rainy season?

☐ river/stream ☐ yard taps ☐ street taps
☐ gutters ☐ spring ☐ other .....

4.2 What is the household potable (clean) water source in the dry season?

☐ river/stream ☐ yard taps ☐ street taps
☐ gutters ☐ spring ☐ other .....

4.3 How much water is collected from the abovementioned source daily?.....litres

4.4 How often is water collected from the above mentioned source?

☐ once a day ☐ more than twice a day ☐ every second day
☐ twice a day ☐ other

4.5 How far is to the abovementioned water source from the household?.....metres

4.6 What container is used for water collection?

☐ plastic jerry can with lid ☐ open bucket ☐ other .....
☐ plastic jerry can without lid ☐ bucket with a lid

4.7 Does your household sometimes not get enough water for drinking? ☐ Yes ☐ No

4.8 What is the reason for that?.....

.....

5. WATER STORAGE

Please take note not to provide the options to the interviewees, only mark off what they mention.

5.1 Tick the box corresponding to the item that best describes how the household stores its potable water.

* The container is ☐200 *l* drum ☐ 100 - 150 *l* container ☐ other.....
* The container is made of ☐ metal ☐ plastic ☐ other.....
* The container is stored ☐ inside ☐ outside ☐ other.....
* The container is stored ☐ in direct sunlight ☐ in the dark / shadowed place
* The container is ☐ covered properly ☐ uncovered ☐ half covered
* The container is ☐ the same as used for collection
  ☐ different from the one used for collection

5.2 Do the members of the household think it is necessary to keep the storage containers used for drinking water covered? ☐ Yes ☐ No

5.3 Why?.....

5.4 Do the members of the household think it is necessary to wash the storage containers used for drinking water regularly? ☐ Yes ☐ No

5.5 Why?.....

.....

5.6 How often do the members of the community wash the storage containers used for drinking water?

☐ once a day ☐ more than twice a day ☐ every second day
☐ twice a day ☐ other.....

5.7 Do the members of the household share the same drinking cup? ☐ Yes ☐ No

6. WATER TREATMENT

Please take note not the provide the options to the interviewees, only mark off what they mention.

6.1 Tick the box corresponding to the item that best describes how the household treats its drinking water.

☐ Boiling ☐ Jik ☐ Alum stone ☐ Other.....
☐ No treatment

6.2 Why does the household use that method?.....

.....

6.3 If the household does not use any treatment method, what is the reason for that?.....

.....

6.4 List all the methods of treatment that the household members are aware of.

.. ..

.....

.....

.....

.....

7. WASTE WATER DISPOSAL/REUSE

Please take note not to provide the options to the interviewees, only mark off what they mention.

7.1 Tick the box corresponding to the item that best describes what the household does with waste water.

☐ Throw it away in the veld ☐ Use it to water the garden ☐ For building purposes
☐ Other.....

7.2 Why does the household use that method? .....

.....

7.3 What happens to the water after each washing of the hands?

☐ It is thrown away in the veld ☐ Use it to water the garden ☐ For building purposes
☐ Saved for next hand washing ☐ Other.....

7.4 What happens to the water after each washing of the body?

☐ It is thrown away in the veld ☐ Use it to water the garden ☐ For building purposes
☐ Saved for next hand washing ☐ Other.....

8. SOLID WASTE DISPOSAL/REUSE

Please take note not to provide the options to the interviewees, only mark off what they mention.

8.1 Tick the box corresponding to the item that best describes what the household does with solid waste (kitchen waste, cans, plastic bags, etc).
☐ Throw it away in the veld ☐ Throw it in rubbish pit ☐ Other.....

8.2 Do you have a rubbish pit? ☐ Yes ☐ No

8.3 If **yes**, what do you do when the rubbish pit is full?.....

.....

8.4 Does the household reuse cans and plastic bags? ☐ Yes ☐ No

5.4 What does the household do with the cans and plastic bags?.....

.....

9. SANITATION

Please take note not to provide the options to the interviewees, only mark off what they mention.

9.1 If there is **no toilet** in the yard, where do they go to relieve themselves?
☐ In the veld ☐ In the stream ☐ Other people's toilets ☐ Communal toilets
☐ Other.....

9.2 If there is a toilet in the yard, what type of toilet is it?
☐ Pit toilet ☐ VIP toilet ☐ Other.....

9.3 How many household members use this toilet? .....

9.4 Do men and women use the same toilet? ☐ Yes ☐ No

9.5 If not, why not?.....

.....

9.6 Do children under the age of 12 use the toilet? ☐ Yes ☐ No

9.7 If not, why not?.....

.....

9.8 Whose responsibility is it to clean the toilet?
☐ men ☐ women ☐ children

9.9 What does the household do when the pit is full? .....

.....

9.10 Does the household use plastic (disposable) nappies for your babies? ☐ Yes ☐ No
9.11 If **yes**, how does the household dispose of the used plastic nappies?.....

9.12 Does the household use cloth (re-useable) nappies? ☐ Yes ☐ No
9.13 If **yes**, where does the household dispose of the faeces?.....

9.14 Why does the household dispose of the faeces in that way? .....

.....

10. NUTRITION

Please take note not to provide the options to the interviewees, only mark off what they mention.

10.1 Does your household have a vegetable garden? ☐ Yes ☐ No

10.2 Do the members of the household belong to a community vegetable garden?
☐ Yes ☐ No

10.3 How often do the members of the household eat vegetables?
☐ Daily ☐ Twice a week ☐ Once a week ☐ Never

☐ Other.....

11. HYGIENE

Please take note not to provide the options to the interviewees, only mark off what they mention.

11.1 When do the members of the household wash their hands?

* After changing the baby's nappy? ☐ Yes ☐ No
* Before handling of food and food preparation. ☐ Yes ☐ No
* Before eating. ☐ Yes ☐ No
* After a visit to the toilet. ☐ Yes ☐ No
* After housecleaning, work and/or disposing of rubbish. ☐ Yes ☐ No
* After touching or contact with animals. ☐ Yes ☐ No

* Other.....

11.2 Do all members of the family/household take a full body wash daily? ☐ Yes ☐ No

11.3 If **yes**, what happens to the water after each wash?
☐ it is thrown away ☐ used by someone else ☐ other.....

11.4 If **not** daily, how often does the family have a full body wash?
☐ Twice a week ☐ Once a week ☐ Never ☐ Other.....

11.5 Does each member use piped, boiled or purified water for the wash? ☐ Yes ☐ No

11.6 If **not**, what is the water source for full body washes?.....

11.7 Do the members of the household think flies are a problem? ☐ Yes ☐ No

11.8 Why/why not? .....

11.9 What does the household think attracts flies? .....

11.10 What does the household do when flies are around? .....

11.11 Why do they do that? .....

.....

12. PERCEPTION OF HEALTH

Please take note not to provide the options to the interviewees, only mark off what they mention.

12.1 Do you consider the health of your family / household as being good?
☐ Yes ☐ No

12.2 If **not**, best describe your reason:

☐ I don't know what to do
☐ no money for treatments
☐ no or not enough clean water available
☐ chronic condition or illness
☐ poor diet
☐ Other .....

Explain:.....

.....

13. **DISEASES**

Please take note not the provide the options to the interviewees, only mark off what they mention.

13.1 Did any member of your household suffer from diarrhoea during the last six months?
☐ Yes ☐ No

13.2 How many people suffered from diarrhoea during the last six months?
☐ None ☐ 1 - 2 incidents ☐ 3 - 4 incidents ☐ 5+ incidents

13.3 What does the household believe to be the cause for the diarrhoea?.....

.....

13.4 Does the household think it can be prevented? ☐ Yes ☐ No
13.5 How?.....

.....

13.6 Did any member of the household suffer from worms during the last six months?
☐ Yes ☐ No

13.7 How many people suffered from worms during the last six months?
☐ None ☐ 1 - 2 incidents ☐ 3 - 4 incidents ☐ 5+ incidents

13.8 What does the household believe to be the cause for the worms?

.....

13.9 Does the household think it can be prevented? ☐ Yes ☐ No
13.10 Ho w?.....

.....

13.11 Has any member of the household had bilharzia during the last six months?
☐ Yes ☐ No

13.12 How many people suffered from bilharzia during the last six months?
☐ None ☐ 1 - 2 incidents ☐ 3 - 4 incidents ☐ 5+ incidents

13.13 What does the household believe to be the cause of bilharzia?

.....

13.14 Does the household think it can be prevented? ☐ Yes ☐ No
13.15 If yes, how?.....

.....

13.16 Has any member of the household suffered from malaria during the last six months?
☐ Yes ☐ No

13.17 How many people suffered from malaria during the last six months?
☐ None ☐ 1 - 2 incidents ☐ 3 - 4 incidents ☐ 5+ incidents

13.18 What does the household believe to be the cause of malaria? .....

.....

13.19 Does the household think it can be prevented? ☐ Yes ☐ No
13.20 If yes, how?.....

.....

13.21 Has any member of the household suffered from eye infections during the last six months? ☐ Yes ☐ No

13.22 How many people suffered from eye infections during the last six months?
☐ None ☐ 1 - 2 incidents ☐ 3 - 4 incidents ☐ 5+ incidents

13.23 What does the household believe to be the cause for the eye infections?

.....

13.24 Does the household think it can be prevented? ☐ Yes ☐ No
13.25 If yes, how?.....

.....

13.26 Has any member of the household suffered from skin diseases during the last six months? ☐ Yes ☐ No

13.27 How many people suffered from skin diseases during the last six months?
☐ None ☐ 1 - 2 incidents ☐ 3 - 4 incidents ☐ 5+ incidents

13.28 What does the household believe to be the cause for the skin diseases?

.....

13.29 Does the household think it can be prevented? ☐ Yes ☐ No
13.30 If yes, how?.....

.....

13.31 If incidents did occur, what did the household do to make it better, or to heal it?

.....

14. TREATMENT OF DISEASES

Please take note not the provide the options to the interviewees, only mark off what they mention.

14.1 If a family or household member is sick, which services does the household consult first?

☐ Traditional healer ☐ Medical Doctor ☐ Clinic /Hospital ☐ Health Worker

☐ Self treatment ☐ Other.....

14.2 If the household consults someone else, who do they consult?.....

14.3 Why do they consult the above mentioned person? .....

.....

14.4 What illnesses are treated by the traditional healer? .....

.....

14.5 Are the household members aware of and/or using the following treatments?

* Re-hydration mixtures for diarrhoea.	☐ Yes	☐ No
* Medicines and bandages for treating burns.	☐ Yes	☐ No
* Antiseptics and bandages for treating cuts, bites, etc.	☐ Yes	☐ No
* Insect repellent for mosquitoes, flies, fleas, etc.	☐ Yes	☐ No

15. COMMUNITY INSTITUTIONAL CAPACITY

15.1 Is there a health committee in the village? ☐ Yes ☐ No

15.2 Who is the contact person for this committee?.....

15.3 Where can the person be contacted?.....

.....

15.4 What does the household think are the responsibilities of this committee? .....

.....

.....

.....

.....

15.5 Do members of the household attend the meetings? ☐ Yes ☐ No

15.6 What do they discuss at the meetings? .....
.....
.....
.....
.....
.....

15.7 Do men and women attend the meetings or discussions?: ☐ Yes ☐ No

15.8 Is there an Environmental Health Officer in the community? ☐ Yes ☐ No
15.9 Name: .....
15.10 Where can he/she be contacted: .....

15.11 Is there a Community Health Worker in the community? ☐ Yes ☐ No
15.12 Name: .....
15.13 Where can he/she be contacted: .....

16. HYGIENE AWARENESS WORKSHOP

15.1 Does the household think a Hygiene Awareness Workshop for the community is necessary? ☐ Yes ☐ No

15.2 What does the household think should be addressed in a Hygiene Awareness Workshop in the community?: .....
.....
.....
.....
.....
.....
.....

Thank the respondents sincerely for his/her/their contribution and cooperation.

APPENDIX D

HOUSEHOLD QUESTIONNAIRE

HOUSEHOLD QUESTIONNAIRE

Date: _____ Name of interviewer: _____

Person interviewed: _____ Position in household: _____

M		F	

1. HOUSEHOLD INFORMATION

1.1 Name of ward/sub ward																			
1.2 Number of people in household by age / gender																			
0-3yrs.				**4-12 yrs.**				**13-21 yrs.**				**22-55 yrs.**				**56yrs.+**			
M		**F**		**M**		**F**		**M**		**F**		**M**		**F**		**M**		**F**	

1.3 How many of the young children in the household (aged 3 years to 7 years) attend creche or pre-school class?	
1.4 How many of the children in the household (aged 8 years to 14 years) attend school?	
1.5 How many of the young adults in the household (aged 15 years to 30 years) attend school, college, technikon, or university?	

2. EXPENDITURE

2.1 Please indicate the amount spent by the household each month?

* Rent, bond payments, grazing fees or other land payments? R.....
* Grocery and foodstuffs items? R.....
* Transportation costs? R.....
* School fees and associated costs (if annual, make a note)? R.....
* Stokvels, burial society, or other savings club contributions? R.....
* Medical costs R.....
* Hire purchases R.....
* Other regular expenses? R.....

2.2 PLEASE indicate the average regular monthly expenses total? R.....

3. INCOME

3.1 Please give a brief indication of the monthly income of the household?

* Relatives/family members working in towns/farms send money ☐ Yes ☐ No
* Family member works in the area and stays at home (monthly salary) ☐ Yes ☐ No
* Household member receiving welfare or old-age pension ☐ Yes ☐ No
* Selling of seasonal fruits and vegetables ☐ Yes ☐ No
* Employed as part time field labour or local work ☐ Yes ☐ No

* Selling of livestock seasonally ☐ Yes ☐ No
* Selling goods from a spaza shop ☐ Yes ☐ No
* Other activities (e.g. selling locally brewed beer, handicrafts, etc) ☐ Yes ☐ No

3.2 Please list any other form of income that contributes to the household.

.....

3.3 Please indicate the average monthly income for the household.....

4. COMMUNITY INSTITUTIONAL CAPACITY

4.1 Is there a health committee in the village? ☐ Yes ☐ No

4.2 Who is the contact person for this committee? .....
4.3 Where can the person be contacted? .....
.....

4.4 What does the household think are the responsibilities of this committee? .....
.....
.....
.....
.....

4.5 Do members of the household attend the meetings? ☐ Yes ☐ No

4.6 What do they discuss at the meetings? .....
.....
.....
.....
.....
.....

4.7 Do men and women attend the meetings or discussions?: ☐ Yes ☐ No

4.8 Is there an Environmental Health Officer in the community? ☐ Yes ☐ No
4.9 Name: .....
4.10 Where can he/she be contacted: .....

4.11 Is there a Community Health Worker in the community? ☐ Yes ☐ No
4.12 Name: .....
4.13 Where can he/she be contacted: .....

5. HYGIENE AWARENESS WORKSHOP

15.1 Does the household think a Hygiene Awareness Workshop for the community is necessary? ☐ Yes ☐ No

15.2 What does the household think should be addressed in a Hygiene Awareness Workshop in the community?:.....

.....

.....

.....

.....

.....

.....

.....

Thank the respondent for his/her contribution and cooperation.