PARTICIPATORY HYGIENE EDUCATION

THE COMMUNITY DECIDES

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The role of Communities in health education programmes in developing countries is often ignored and overlooked by community development workers with the notion that communities have very little to offer in the assessment of their own health needs. This notion has resulted in non-acceptance and under utilization of many programmes intended to improve the health conditions of rural communities in some developing countries.

The Volta Rural Water Supply and Sanitation Project, a ten year project, which aims at contributing towards improvements in the living and health conditions of the rural population in the Volta Region (through the provision of water facilities, improved sanitation and hygiene education) recognizes the communities as owners and managers of the facilities and programmes and as such is making all efforts to involve them in decisions that affect the planning and implementation of the project.

Strategies for the application of community based participatory hygiene eduction have been developed by the project and are being implemented. Some of the participatory activities being undertaken include identification of community based groups, involvement of women in Water, Sanitation and Hygiene education activities, joint action planning with community/group representatives and formation and training of Water and Sanitation Committees.

INTRODUCTION

What is hygiene education?

"Hygiene education is that part of health education which is concerned with the prevention of diseases related to water and sanitation" Mariete (1996). And according to Green (1980) "Health education is any combination of learning opportunities designed to facilitate voluntary adoption of behaviour which will improve or maintain health."

These definitions therefore imply that for hygiene education to be participatory and as such meaningful;

-Hygiene education must not be teaching but learning

-It should be planned, with clear points of departure and objective to reach.

-It should help people to make decisions for themselves and to acquire confidence and skills to put these decisions into practice (Mariete 1996) and

-It should involve other target groups in the community such as school children, women's groups and opinion leaders.

Hygiene education programmes in the Volta RWSS Project are therefore organised along the lines of participation, involvement and community decision making.

This paper will focus on some of the experiences of the VRWSS Project whose hygiene education objectives state among others that:

Target communities will be able to identify and describe water, sanitation and health hazards. This would be assessed by the percentage of the population that can demonstrate the new knowledge. The new knowledge and practices should cover refuse disposal, human excreta disposal and cleaning of water sources etc.

In order to achieve these objectives the hygiene education strategy places emphasis on capacity building of Water and Sanitation Committees (WATSAN) and other community based organisations such as women's groups.

STEPS:

The project goes through eight major steps when planning and implementing hygiene education programmes with communities. They are:

1. Data collection on community profile to serve as baseline information before a hygiene education intervention
2. Awareness creation on the relationship between diseases and unsafe water and poor sanitation
3. Meeting women's groups
4. Action planning
5. Presentation of first Hygiene Plan to the community

6. Training of WATSAN Committee

7. Follow up hygiene education programmes for community based groups

8. Monitoring

1. Data Collection

The first step that is taken by the Environmental Health Assistant (EHA), who is the extension officer, when she enters a community is to identify functional community based groups, opinion leaders, influential individuals and active women's groups/leaders. This action is necessary because these groups/individuals serve as target groups for health education. In the long run some leaders/individuals from the groups serve as health education facilitators within the community.

Identified community based groups such as church groups, literacy groups, youth groups and women's groups and opinion leaders are interviewed through focus group discussions to collect information on the Community Profile. Information collected include:

-available water sources

-sanitation facilities

-sanitation habits

-hygiene habits

-socio-economic activities etc.

-sources of health information and any other information on knowledge, attitudes and practices of the people.

This exercise involves Participatory Rural Appraisal Techniques such as a village walk and problem identification.

2. Awareness creation

An awareness creation meeting is then organised to discuss with community members the relationship between water, sanitation and diseases. The EHA will normally use a participatory tool such as story with a GAP to generate discussions leading to identification of community health problems. Communities that are situated by rivers, dams and other sources of surface water are normally satisfied with their sources of water. It is therefore very important to help such communities to establish the relationship between their water sources/sanitation habits and their health. The use of participatory methods at this stage is very crucial for the realisation of self identification by community members.

3. Involvement of Women in Water, Sanitation and Hygiene Education Activities

Women are the managers and main users of water and sanitation in the home. They also play the role of hygiene educators in the family and must as such be key players in hygiene education.

In line with the VRWSS Project's policy of equal women participation in community ownership, management, operation and maintenance of water and sanitation facilities women's groups in the community are identified and encouraged to be involved in every phase of project activity. Various participatory methods have been used to encourage their participation in decision making. Some of the identified target groups are 31st Dec. Women Movement, Food Vendors, Mothers of infants, literacy groups where women form majority,

market women associations, women's fellowships in churches, women's welfare societies and caretakers of patients, on admission.

The result now is that women in WATWSAN committees have shed their coats of shyness and have taken responsible positions as latrine artisans, caretakers of water supply and sanitation facilities and hygiene education facilitators which hitherto were the preserves of men. Furthermore more positive behavioural changes are taking place in the women's groups than the men's groups. One reason is that since most hygiene behaviour affect actions in the home, women would prefer to be part of the "new thinking" than to remain unfashionable.

4. Action Planning

The EHA takes community groups through 3 planning stages. These are:

-Identification of health problems

-Prioritisation of problems and

-Action planning.

A. Preparation towards the planning

This stage sets the tone for participatory planning. The EHA usually organises a hygiene education session with the group using a 3-pile sorting card or an F-diagram. He may take the group for a village walk. A role play also serves as a discussion point for the group. This stage introduces the group to the planning session. The EHA spends about 2 hours with the group during this session. The result of this approach is that group members are able to come up with their own experiences on what they consider to be a health hazard and what needs to be done to improve the situation. Also the EHA uses this occasion to assess the level of awareness and knowledge of community members.

B. Identification of Health Problems/Hazards

During the second sitting for planning, group members will identify the major health hazards in the community. These hazards are recorded by group members. This activity involves all the group members and the EHA will use pictures or role plays to involve everyone. Women's views are solicited all the time. The whole group at the end of the exercise will have to agree on all the major health hazards discussed as being actually what is persisting. The Watsan Secretary usually takes records of the proceedings. Every member is encouraged to participate. The EHA only serves as a facilitator, guiding the session and never imposing suggestions. After the watsan members have exhausted their stock of hazards, the EHA can add any hazards observed but not mentioned. These hazards mentioned by the EHA must be accepted by the Watsans before recorded.

C. Prioritisation of Problems

Deciding on the problems to tackle first is often difficult and there is no single formula for priority setting. Nevertheless there are many factors that are considered in deciding on the priority. These are:

Prevalence	–	How common is the problem
Seriousness	–	How severe is the problem in terms of spread of disease and death.
Level of concern	–	Does the problem worry the local community? What are the implications of not tackling a particular problem immediately?
Ease of change	–	Is there a simple way of doing something about the problem with our available resources?.

The Plan

This stage deals with the approaches to adopt in solving the problems. This involves taking the problems one after the other. When the first problem is taken, the facilitator asks the WATSANs/Group to come out with "why it does happen or why people persist in doing that". Many reasons may be given for the occurrence of the problem.

The EHA, having got the contributing factors to the problem asks the group what they can do to improve the situation. The group mentions things they can do to rectify the situation taking into consideration the contributing factors already mentioned. When all the actions needed to solve the problem have been exhausted, the EHA asks the next question "Who will be guiding us?" Here the group nominates men and women within the group and the community for these roles. The lesson here is that since community members have decided to take certain actions they are themselves seeing to it that these actions go through.

In order to have a time frame for the commencement and completion of activities under each problem for the purpose of monitoring and evaluation, a duration is often demanded by posing the question "When do we start and finish".

What is the problem	Why does it happen	What can we do to improve it	Who will be responsible	Who is reminding us	When to start and end
Indiscriminate garbage disposal	*Lack of hygiene education *Laziness *Lack of refuse dumps *Lack of maintaining existing individual dumping sites *No by-law on garbage disposal	*Hygiene education *Siting or new public sump *Regular maintenance of dumps and *Banning of individual dumps *Enactment and enforcement of bye law on garbage disposal	Mr. A. Adom	Mr A. K. Atsu EHA	01-09-96 31-11-96

It is important to mention at this point that since communities are in charge of their own hygiene education they must decide on the pace at which hygiene activities must be undertaken. Thus the need for the facilitator to encourage planning for limited number of activities at a time and allowing group members to implement and evaluate their performance before moving on to the next set of activities. It is also important to encourage Women and men to assume roles making sure that women do not end up with a higher workload.

5. Presentation of Action Plan

In order to win the support and commitment of community members the plan is presented to the whole community by the group / WATSAN. This presentation is preceded by a role play, Puppetry show or a discussion poster on the problems. This presentation is very essential for the WATSANs because it is here that their roles as health educators are perpetuated and some doubts and misconceptions about WATSANS (as Sanitary policemen) are dispelled. Additionally, community members at this stage demonstrate their willingness to accept responsibilities towards the improvement of their health situation.

6. Training of Watsan Committees

The first activity after the Presentation of the plan is the training of the Watsans by the EHA through the organisation of zonal and community based workshops to equip them with the requisite knowledge and skills necessary for community mobilization, hygiene education and facility management. The training embraces topics such as water and sanitation related diseases, causes and prevention, faeco-oral transmission routes, hygiene messages and planning, participatory methodologies, community mobilization, leadership, team building and problem solving techniques. This training takes the form of 1-2 day meetings (per topic) of 2 hour sessions.

7. Follow up on Hygiene education by WATSANS

Every hygiene education activity must be directed at behaviour change and unless the whole community is saturated with health and hygiene messages, little will be achieved in the implementation of the hygiene plan. Thus the Watsans are in the forefront of making sure the whole community is aware and involved. To achieve impact, target groups are selected for hygiene education sessions. Participatory methods like focus group discussions, role plays, video shows, health education songs, demonstrations, puppetry etc are used. Target groups include schools, churches, literacy classes, mothers of infants, food vendors, opinion leaders women's groups youth groups welfare societies and the community.

8. Monitoring and Evaluation

The WATSAN/Group members responsible for the various activities monitor the expected outcome of all planned activities. Normally group members will go round to inspect what they planned to do. After which the group discusses what had been observed and decide on whether they were satisfied.

Six months after water and sanitation facilities have been installed, the EHA together with the WATSAN will look out for some indicators of hygiene behaviour change. These include number community based hygiene action plans that community members have undertaken on their own and the availability and use of handwashing facilities.

9. Some Good Ideas

♠ Hygiene education must help people to make decisions for themselves and to acquire confidence and skills to put these decisions into practice.

The use of a variety of participatory methods throughout the various stages of community based hygiene education allowed community members to discover for

themselves issues that affected their health. It also motivated them by equipping individuals and groups with community based innovative techniques in hygiene education. This resulted in a tremendous improvement in the hygiene and sanitation situation in many project communities.

It must however be noted that the various steps taken by the field worker to arrive at this stage is a very long, time consuming, tiring and sometimes frustrating journey. According to an EHA, "behaviour change does not take overnight. It is a very slow but rewarding process".

♠ Hygiene education must not be teaching but learning.

As WATSAN committees asked the question "Why does it happen?" they boldly demonstrated their willingness to take their own health into their own hands as a community. According to a WATSAN Chairman "Our way of life must be nourished by knowledge to grow as an obligation and as an ideal".