The role of hygiene education

The need for hygiene education

In many settings, the provision of clean accessible water and ideal sanitation facilities is not within the community's reach. But communities and individuals can still adopt improved hygiene behaviours which can lead to better health. They can also work gradually to improve their sanitation and water facilities. Even when good facilities are available, they will not lead to a great improvement in health unless they are accompanied by changes in hygiene behaviours.

What hygiene education seeks to do

A good hygiene education programme provides information and understanding about those behavioural changes which bring the greatest heath benefits, and proposes gradual improvements both in practices and hygiene facilities. Hygiene education means helping individuals, families and communities to become aware of the links between poor hygiene behaviours and disease. It also means encouraging and helping people to improve those behaviours which, if changed, will lead to the greatest reduction in disease. At the level of households and communities, hygiene education will help people to find ways of improving their situation by designing and constructing their own improved facilities.

How hygiene education works

Hygiene education and communication support should not solely be a device to make the community accept and use what sanitation technology is provided. It should promote *informed* decision-making and *empowerment* of communities to tackle the causes of cholera and other diarrhoeal diseases. This will involve giving the community opportunities to participate in decision-making and in the selection of sanitation technologies that are most appropriate to their needs.

Use of appropriate technologies

Hygiene and sanitation technologies should be effective, acceptable and affordable to the local community. No attempt should be made to try to persuade people to carry out actions that conflict with their cultural beliefs. An appropriate sanitation technology should be compatible with the culture of the community, technically feasible using locally available skills and materials, require the minimum of user maintenance and be simple to use.

For example if initial investigations show that the community prefer to squat when using the toilet, then toilet designs with squat holes should be introduced. If seats are preferred, toilets should have seats. If there is a fear that children will fall into a latrine, the hole can be made small enough so that there is no danger of a child falling in.

It is important to emphasize technologies which provide the maximum public health benefit and take into account factors such as the users' ability to pay. The use of low-cost locally-available materials is preferable in many circumstances. If special materials are needed, it is important to make sure that they are available at affordable prices. When a financial contribution by the community is necessary, the level should be determined taking into account the ability of all sectors of the population to pay. Schemes such as credit loans may be considered to make the programme affordable.

Intersectoral collaboration

Cholera prevention education programmes should be accompanied by action in complementary areas, such as water supply, housing, women's programmes and primary health care. People cannot be expected to practise good hygiene if they do not have enough water or live in poor housing. Another important resource is time, especially for women where they have a dual role, for instance in agriculture or industry and the home, and are expected to shoulder the considerable burden of improving home hygiene.

Achieving improvements in hygiene is a massive task to be shared between environmental health services, primary health care workers, schools, home economists and other services. Hygiene education is particularly vulnerable to divisions and lack of coordination between services. The community is often exposed to inaccurate and conflicting information from different agencies ; this should be avoided.

Community participation

Community participation is not a way of making people do what someone else wants, but a process of partnership and sharing in decision-making. It is a philosophy which should be incorporated at all levels of the programme.

Community participation at the planning stage will eliminate inappropriate designs and anticipation of unrealistic behaviour changes. It will ensure, for instance, that latrines are used and maintained, and will provide a catalyst for the spread of new ideas through ordinary communication channels.

Careful planning is, however, needed to ensure community participation. The needs felt by a community cannot be determined at a single meeting. A process of active dialogue and *listening* is required. Educational methods should emphasize participatory learning methods that are open-ended and promote critical consciousness. Effective participation requires fieldworkers to spend a considerable length of time in a community, building up a relationship of trust and overcoming divisions and conflicts that may exist.

Staff and project donors should be briefed on the full implications of community participation. A programme should incorporate a realistic time-scale, open-ended objectives, an infrastructure of field staff and opportunities for training in communication skills.

Primary health care

Cholera control activities should be integrated within a comprehensive primary health care approach. Primary health care emphasizes a decentralized approach to health care using appropriate technologies, community participation and health education. These are undertaken as part of a multisectoral approach which addresses social and economic issues, such as the need to provide food, water and sanitation and also to tackle poverty and inequality.

Planning cholera prevention programmes

Planning a cholera prevention programme in a community involves taking the following steps :

- Dialogue with the community and local agencies.
- Selection of priority cholera prevention behaviours for change, based on surveillance data and the needs felt by the community .
- Analysis of influences on selected behaviours and implications for hygiene education.

Preparation of an *action plan* for hygiene education includes making the following decisions :

- How will community participation be achieved ?
- Who should the education be directed at (target group) ?
- What should the content of the education be ?
- Who should carry out the educational activities ?
- What educational methods should be used ?
- What accompanying social and economic programmes are needed ?
- What other fieldworkers or sectors should be involved ?
- How can technologies be designed to make them affordable and acceptable ?
- How will the programme be managed ?