

# Peer education without pressure: spreading hygiene messages in Burkina Faso

by Marjolein Dieleman and San Traoré

**However keen the take up of the new technology, a programme stands or falls on whether people change their normal behaviour for the better. But who wants to tell their neighbours what to do?**

THE BOUCLE DU Mouhoun, in north-west Burkina Faso, comprises three provinces, covering an area of 27 000km<sup>2</sup>. The population, numbering around one million, live in 1000 villages, and belong to various ethnic groups; the largest are the Bobo, Peulh, Dafing, Samo, Gourounsi, and the Mossi. A typical Mouhoun village has quite distinct ethnic quarters.

Between 1980 and 1993 the Burkina Faso Ministry of Environment's regional office installed more than 1300 wells and pumps in the Boucle du Mouhoun. This was done through Projet Hydraulique Villageoise de la Boucle du Mouhoun, a close collaboration between the Ministry of Health, the Dutch Government, and IWACO, Dutch water and environment consultants. In the late 1980s and early 1990s, the emphasis switched to pumps because of the better water quality obtained.

## Why health education?

A 1993 evaluation of the fourth phase of the project highlighted the fact that the village pumps and wells were not being properly maintained. It also

revealed that drinking-water taken from the waterpoints was being polluted during transportation and storage. An internal study showed that 52 per cent of the women living in the area used water from the pumps, while 43 per cent of all the villagers took drinking-water from the pumps. The remainder preferred to rely on traditional wells. The project decided that the findings of both evaluations proved the need for a hygiene education programme.

In September 1994, a hygiene education programme was launched. Scheduled to run until May 1998, the programme's primary aim is to reduce water-borne and water-related diseases

by showing people why and how they should improve their hygiene behaviour. Genuine community participation is key to the programme strategy. In this project, the key elements are:

- target-group participation in the preparation, execution, and evaluation of hygiene education;
- peer education at village level — villagers educating villagers;
- interpersonal communication and use of locally conceived and produced visual aids;
- regular training and an intensive follow-up programme carried out by healthworkers; and
- hygiene education in four-month cycles, incorporating simple messages which can be put into practice.

## The right message?

To find out exactly what aspects of people's behaviour had bad hygiene implications, health workers and villagers worked together on a baseline study using RRA (Rapid Rural

### Fetching and carrying water — hygiene messages from villagers in Burkina Faso

- Let us take our drinking-water from a pump
- Let us cover the container used for transporting drinking-water
- Let us wash the container before fetching drinking-water
- Let us wash our hands before fetching drinking-water
- Let us try not to touch drinking-water with our hands
- Let us wash the object we use to stabilize drinking-water during transportation



Carrying water: the everyday activity chosen by villagers and healthworkers as the theme of the first education cycle.

Appraisal) methods. About 20 practices were identified, including how people fetched, transported, and stored water, and their maintenance of water-points.

The theme for the first hygiene education cycle was 'fetching and water transportation'. The fieldworkers and villagers came up with six messages which were translated into a series of pictures and tested in the field. The messages are listed in the box on page 30, while one of the illustrations is shown in Figure 1, below.

## Peer education

People from each quarter of 59 selected villages were asked to choose a man and a woman who would be willing to carry out hygiene education activities for one day every week. These men and women make up the village hygiene team, and they visit each household in a particular quarter twice every four months.

On their first visit they explain, with

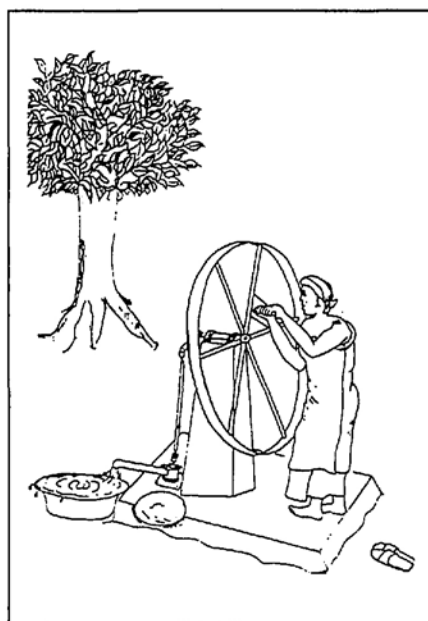


Figure 1. Putting us in the picture.

the help of the drawings, the unhygienic practices common in the village; the consequences of these practices; and how people can adapt their behaviour. On their second visit to the home, two months later, the 'couple' focuses on discussing whether the family has changed its practices. The teams also organize group meetings for men and women to discuss the hygiene education messages in a broader context.

During the first cycle, 451 team members worked voluntarily in the 59 villages. To ensure that this high level of motivation continues, the project has set up a non-financial incentive system in which each member receives a small



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A group meeting in the Mossi Quarter of Tia Village — a chance for villagers and the hygiene team to discuss hygiene education in a broader context.

item — a bar of soap or a jerry-can for carrying water — per cycle.

## Training

The village health teams undertake five days' training before the start of each cycle. They learn how to discuss the messages, use visual aids, and organize group meetings. They also use role play to practise making house visits. At the same time, they learn how to plan and evaluate their own activities. Training is organized by local healthworkers who have been trained by a provincial health agent; s/he, in turn, has been trained by the project. Altogether, a total of 30 healthworkers from 15 local health centres, and three provincial agents were involved in the first cycle.

## Follow-up

An intensive follow-up programme has been devised to support the teams, both in making household visits, and in holding group meetings. The teams discuss how the visits have gone, and get feedback from healthworkers; and healthworkers visit the villages themselves twice a month. They also organize monthly team meetings to monitor progress, and discuss problems. The provincial health agent also meets with the healthworkers twice a month.

## Evaluation

Each cycle is evaluated on two aspects:

- behavioural change in the home, measured by Objectively Verifiable Indicators (OVI); and
- the number of activities actually carried out in comparison to the number planned.

Behavioural change is measured by the village teams. Before the start of each cycle, they pick two or three indicators which are easy to measure by observation. A simple observation sheet is developed, and the teams are shown how to observe accurately, and how to fill in the sheet correctly. For the first cycle the indicators were:

- the number of people who fetch their drinking-water from pumps; and
- the number of people who cover the container used for transporting drinking-water.

Before the start of the cycle, and again at the end of the four months, the team members visited village water-points to observe these indicators.

The village's activities are evaluated by inspecting the plans of the various quarters drawn by the teams. The teams have to mark the households they visit, and where they held group meetings. The healthworkers' activities are evaluated by analysing the reports of their follow-up visits, both at the local and the provincial level.

## Results of the first cycle

The results indicate a change for the better in relation to the covering of water-transporting containers. The number of people taking drinking-water from a pump, however, increased in only one province. The main reasons people gave for still using the well were the distance between home and pump, and the fact that some pumps had broken down.

Of the 5800 households belonging to the 'intervention' villages, 94 per cent had been visited at least once, while 86 per cent had received two visits. The local health centre-based healthworkers have made 78 per cent of their 392

planned follow-up visits. At the provincial level, 89 per cent of the 100 intended visits have been carried out.

The villagers told interviewers that they are satisfied with the hygiene education activities organized in their villages. The team members have also expressed their enthusiasm, and only 2 per cent of those originally chosen have stopped participating.

The first participative evaluation proved difficult for the team members. Also, organizing support from the healthworkers during data collection appeared to be impossible, because the evaluation was being carried out in all the villages, and at all the waterpoints, simultaneously. As a result, only 38 per cent of the intervention villages could be evaluated; the observation sheets for the remaining villages had been filled in incorrectly. This experience taught the project and the teams that the simpler the forms, the better; and that data collection has to be organized in such a way that support from healthworkers is assured.

### One year on

One year after the field-work began, we can conclude that peer education is an appropriate way for spreading hygiene messages to villagers. Results have been good, and both the teams



and the local people are motivated and enthusiastic. The experience has also proved, however, just how important an intensive follow-up programme to assist the village teams in their teaching activities, and that more work is still needed to encourage people to fetch drinking-water from a pump.

Though participative evaluation does not always guarantee the collection of valid data, it is important to include the villagers and the village teams in the evaluation of what are, after all, their

own activities. Evaluation instruments and methods must be chosen with care; and training in the use of these, and support during data collection, must be available.

### References

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### Update

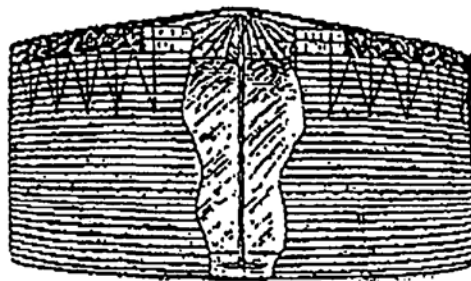
Since this article was written, in 1996, Burkina Faso has undergone administrative change; the Boucle du Mouhoun now comprises six provinces, rather than the three described above. They do, however, cover the same geographical area.

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