

*Towards better programming*

# A Manual on Hygiene Promotion

In collaboration with:



Water, Environment and Sanitation Technical Guidelines Series No. 6

*Towards Better programming*

# A manual on hygiene promotion

United Nations Children's Fund (UNICEF)  
The London School of Hygiene and Tropical Medicine (LSHTM)  
1999

## **A manual on hygiene promotion**

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## PREFACE

This manual is part of a series that aims to help implement the WES strategies approved by the UNICEF Executive Board in 1995. These strategies emphasize a catalytic approach in WES programming, where UNICEF support serves to strengthen each country's learning, programming and policy development process rather than to simply provide direct services. This 'catalytic' role, it is hoped, will help produce greater benefits on a more sustainable basis.

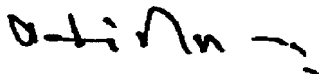
UNICEF Programme Division is pleased to present this Hygiene Promotion Manual as part of its guidelines series on water, the environment and sanitation. This manual was produced for UNICEF by the London School of Hygiene & Tropical Medicine in co-operation with the Government of Burkina Faso. The manual is based on the experiences of the UNICEF-supported Saniya Project, a public health communication project in a West African town.

This manual presents methodologies to assist development workers in the promotion of behavioural change for safer hygiene practices, and to help make hygiene promotion programmes more effective. The objective of the manual is to provide a tool that will contribute towards a reduction in diarrhoeal diseases - one of the top three killer diseases in developing countries - and thus a reduction in child mortality.

The manual describes a methodology for bottom-up programming for hygiene promotion: first finding out what people know about hygiene through formative research in people's knowledge and practices, and then combining this with state-of-the-art expert knowledge and appropriate communication strategies to develop effective and sustainable programming models. The manual is accessible and jargon-free: its audience includes all professionals interested in the area of hygiene promotion.

This manual is only a beginning. We look forward to receiving suggestions and ideas on how to improve this manual in particular, and to strengthen our hygiene programmes for children in general. Also let us know which parts of the manual you find most useful, and which parts, pages or paragraphs you find confusing, least useful, incorrect or unfair. We are particularly interested in adaptations you had to make in order to match with the specific socio-cultural conditions in your specific countries.

We look forward to receiving suggestions and ideas on how to improve this manual in particular, and to strengthen our hygiene programmes for children in general.



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May 1999

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Special thanks are due to Sandy Cairncross, Lizette Burgers, Ibrahim Diallo, Michel Nikiema, Raphael Gbary, Hubert Barennes, Simon Cousens, the staff and fieldworkers of Programme Saniya in Burkina Faso and Ankur Yuva Chetna Shivar in India. Illustrations were drawn by Mamadou Traoré and Emmanuel Nkobi.

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## INTRODUCTION

### New Ways of Promoting Safe Hygiene

#### Why hygiene?

Diarrhoea is one of the top three killer diseases in developing countries, claiming the lives of more than three million children a year. Improvements in water supply and sanitation in the last 20 years have helped to cut the incidence of diarrhoea. But if these technologies have had an impact on health, it is because they make *better hygiene* possible.

Whether modern facilities are available or not, the best way to protect a child from diarrhoeal diseases is to keep the child's living space free of the microbes that cause diarrhoea. That means adopting a number of safe hygiene practices in and around the home.

#### What is this book about?

This book shows how to encourage people to adopt safer hygiene practices. They can also help you to make your current hygiene programme more effective.

In this step-by-step guide we:

- ④ show how you can work with communities to learn what people know, do and want concerning hygiene
- ④ offer you up-to-date ideas about hygiene and communications
- ④ explain how to put these together to plan an effective hygiene promotion programme for large



## Who is this manual for for?

If you are a:

- ④ Decision maker, team leader, manager, trainer or health worker
- ④ Working in Government, aid agencies or NGOs
- ④ In the field of health, water supply, sanitation or urban services
- ④ In urban or rural settings.

Then this book is for you!

## How to use this manual

There are six Chapters in this book.

- Chapter 1 answers the question, what is hygiene promotion?
- Chapter 2 outlines the steps in setting up a hygiene promotion programme.
- Chapter 3 describes what we know about the practices which put people at risk of diarrhoea.
- Chapter 4 shows how to work with people to design safe alternatives to the risk practices.
- Chapter 5 describes how to identify what motivates people to carry out safe hygiene practices.
- Chapter 6 shows how to find out how people communicate and how to use this to design an effective hygiene communication programme.

The manual has been kept short and simple, and is in black and white so that you can photocopy pages. We have minimised the technical jargon, but you may find some key words you have not met before. Definitions can be found in the glossary at the end.



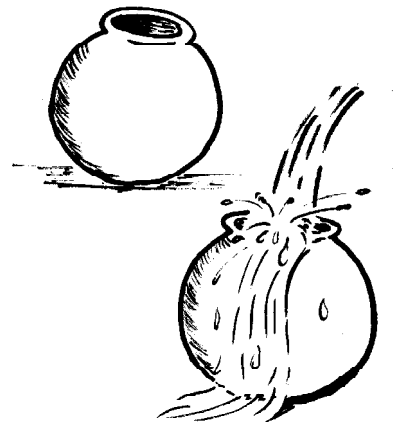




# Chapter 1

## What is Hygiene Promotion?

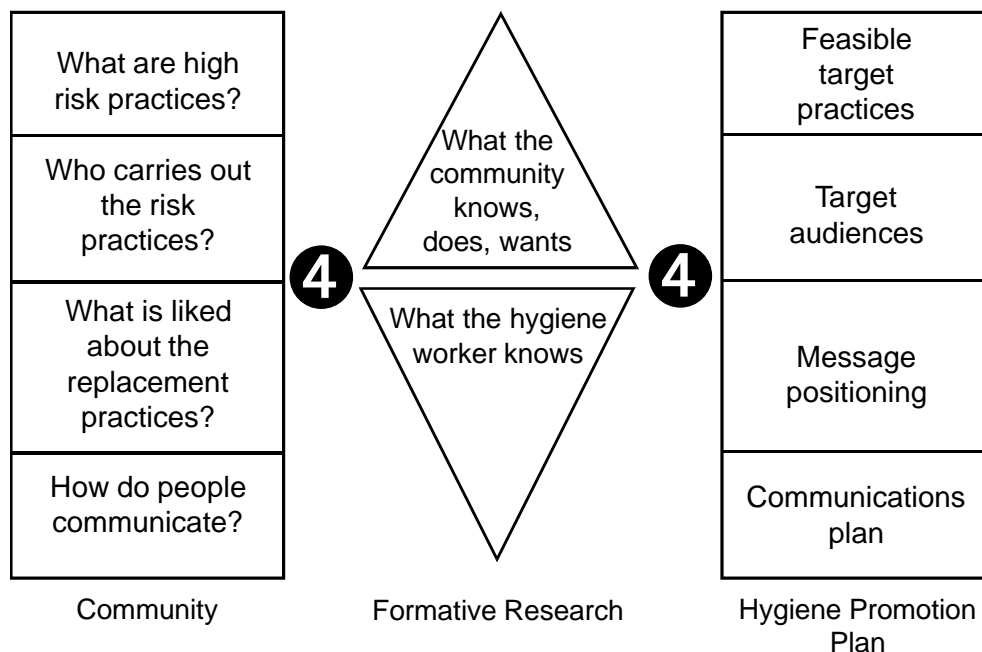
Hygiene promotion is a new way of encouraging practices to prevent diarrhoeal disease in the home. This chapter describes the background to this approach and the advantages that it has over hygiene education, which has been a standard approach until now.



## What is Hygiene Promotion?

Hygiene Promotion is a planned approach to preventing diarrhoeal diseases through the widespread adoption of safe hygiene practices. It begins with, and is built on what local people know, do and want.

The diagram shows how the planning team works together with representative communities in a process known as formative research. The aim is to answer four key questions: which specific practices are placing health at risk? what could motivate the adoption of safe practices? who should be targeted by the programme and how can one communicate with these groups effectively?



This manual shows how to go about answering these questions to design a full scale hygiene promotion programme in collaboration with key stakeholders. *Simple, positive* and *attractive* messages are designed for local channels of communication. Measurable behaviour change objectives are set, and management, monitoring and evaluation goals complete the hygiene promotion programme.

## **Background to this manual**

The new approach to diarrhoea prevention that we call hygiene promotion grew out of a series of detailed studies in the town of Bobo-Dioulasso in Burkina Faso. The aim of the work was to find effective ways of preventing diarrhoeal disease in children. What we learned about what people did showed us that hygiene was a major problem. What we learned of what people believed and wanted showed us that standard approaches to encouraging behaviour change would not work. We looked around for solutions, and when none seemed suitable, realised that we would have to find a new way. Nine years from the start of this work, the new approach has been tested successfully in Africa and India. It has been much written and taught about, and has been enriched in the process (Curtis et al). Finally UNICEF provided support for the London School of Hygiene & Tropical Medicine to condense the lessons and experiences into this manual so that hygiene promotion can be applied more widely in the field.

Of course, we do not claim to have provided a perfect solution; changing hygiene behaviour will never be quick or straightforward. Neither do we claim exclusive use of the term 'hygiene promotion', which is now becoming widespread. Theoretical and practical refinement of the approach we describe in this book will continue with the help of readers, practitioners and fellow researchers. *So please do send us your comments and suggestions.*

## **What is new about this approach?**

Though few of the features of hygiene promotion are new, the idea of combining them into a simple, step-by-step planned approach is. It draws on a synthesis of practical and theoretical lessons from anthropology (the need to see the problem through the eyes of the people concerned), epidemiology (careful identification of risk practices), marketing (motivation research), communication (planning for reach and effectiveness) and development studies (participatory rural appraisal).

## **Why do we need a new approach?**

Everybody working in preventive health knows that getting people to change the habits of a lifetime is not easy. Though health education has been largely abandoned, or renamed 'health promotion' in the West, it is still the standard approach in developing countries. Several reviews of the effectiveness of health education point to very disappointing results (Loevinsohn). One reason for this poor performance is the top-down approach, that fails to respond to what people know, do and want. Another reason is that education is often tacked on as an afterthought in water, sanitation and health programmes; it has low priority and has little claim on management time and programme resources (Burgers). On the next two pages we outline some flaws of the old model of hygiene education.

## **Beyond the KAP study**

If programmes have often been top-down, it is at least in part because we have not had good techniques for finding out what people know, do and want, on which to base our programmes. The limits of the KAP (Knowledge, Attitudes, Practices) study are well known. Respondants in KAP surveys often tell the interviewer what they think she wants to hear, or what they think will bring the greatest benefits (Kroger). Interviewing about hygiene is of little use because of the sensitivity of the subject. However, over the last decades, there has been an explosion of interest in methods which can dig deeper and produce more insight into health problems. Qualitative techniques such as focus groups and participant observation are now taught in most schools of public health. What has been lacking is a systematic approach which links key questions to appropriate methods to inform programme design. This is what we have attempted to do in this manual.

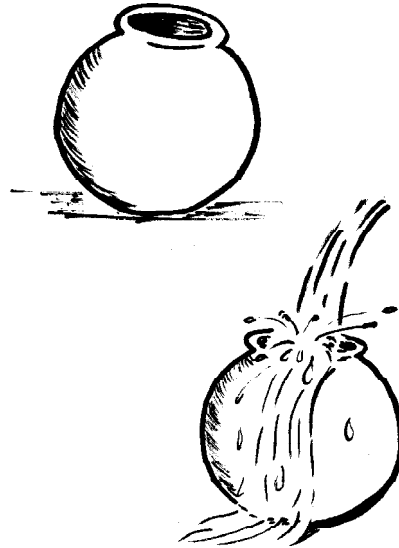
We call this systematic approach *formative research*. It has also been used to find out what people want in a bed net treatment programme for the prevention of malaria in Burkina Faso. Formative research could be used to provide information for the effective marketing of sanitary latrines or for designing village water supply programmes.

## Six Myths of Hygiene Education

The way in which hygiene education used to be carried out had very poor results. This was partly because it was founded on a number of myths.

### **Myth No 1. People are empty vessels into which new ideas can simply be poured**

Hygiene Education rarely starts with what people already know. Every society already has coherent explanations for disease (which may or may not include microbes). If we try to pour new wine into these already full vessels then, the new wine will just spill over. The new ideas create confusion and incomprehension. Some people even reject the new teachings saying: “these doctors just don’t understand what makes my child sick!”



### **Myth No 2. People will listen to me because I’m medically trained**

Hygiene Education often assumes that health personnel are automatically believed and respected. This is often untrue in both developed and developing countries. There is no reason why the outsider with the foreign ideas should be given higher credence than tried and tested local explanations of disease. And a health worker who is thought to be saying “it’s your fault your kids get sick and die, it’s because you are dirty” will gain little respect from the community (Nations).

### **Myth No 3. People learn germ theory in a few health centre sessions**

Everybody likes to learn, but how responsive would you be if you were worrying about a sick child in a clinic waiting room? Even in the best of circumstances, replacing old ideas about disease with new ones is a long, slow process.

**Myth No 4. Health education can reach large populations**

Major improvements in public health require interventions that cover large populations, like vaccination or AIDS prevention programmes. But is it practical to give health education classes about the germ theory of disease to all the childcarers in a region? Lets take an example; say we want to educate the mothers of one province about the role of microbes in diarrhoeal diseases. The population is 800,000 people, there are 200,000 mothers, each of whom need to attend a minimum of three group sessions. If one educator can carry out three sessions per day, *100 educators will be required* working flat out for a year. Few health programmes would find this practicable.

**Myth No 5. New ideas replace old ideas**

Most people hold a variety of ideas about the origins of disease in their heads at the same time. Folk models of illness co-exist with medical models in all countries of the world, and few people anywhere explain child diarrhoea by lapses in stool hygiene. Hygiene education often just adds one more idea about disease without erasing the old ones.

**Myth No 6. Knowing means doing**

Even if we could convince large populations that germs spread by poor hygiene cause disease, would this mean that they would change their practices overnight? Though knowing about disease may help, new practices may be too difficult, too expensive, take too much time, or be opposed by other people. Fear of disease is not a constant pre-occupation and is often not a good motivator of behaviour change.

(These myths are adapted from the useful booklet by Van Wijk & Murre.)

The best health education practice does not make all these mistakes. Unfortunately, in the field of hygiene they are still very common. Of course everybody has a right to know as much as possible about health. In particular, every child in school should have the opportunity to learn health science. (School hygiene programmes are a separate subject which are not covered in this book). But *we cannot assume that education about germs and diarrhoea will lead directly to behaviour change, or have a major impact on diarrhoeal diseases.*

# Hygiene promotion standing on your head

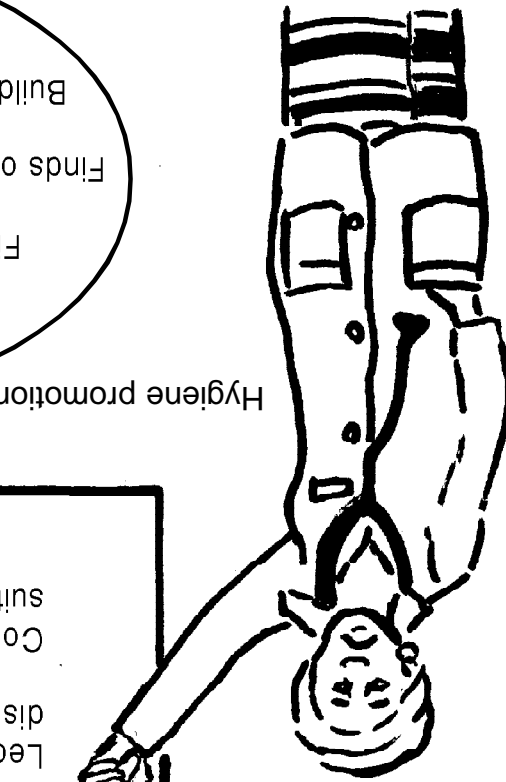


Hygiene promotion...

- Starts in the community
- Finds out about the problems
- Finds out why people want good hygiene
- Builds on how people communicate

Instead of...

- Starting in an office...
- Using only what I know...
- Lecturing about germs, dirt and disease...
- Communicating in the way that suits me...







# Chapter 2

## Six Steps to Hygiene Promotion

In Chapter 1 we saw why a new approach to hygiene promotion was needed. Here we take you through the process of designing a hygiene promotion programme, by planning and carrying out formative research. We offer some examples and some practical tips.



## Six Steps to Hygiene Promotion

This chapter takes you through the steps in designing a hygiene promotion programme. In **step 1** action with the target communities and the team is initiated. In **step 2** a detailed work-plan for the formative research is made. In **step 3** the formative research is carried out. **Step 4** is to analyse and report on your results. In **steps 5 and 6** the results are fed back and discussed with key stakeholders and used to make the hygiene promotion plan. We conclude the chapter with practical advice on sample sizes and teamwork.

### STEP1. INITIATE ACTION

**Define the target area.** Find out what you can about it (maps, population, administration, health services, (etc).

**Make an outline plan, arrange for funding** If you are planning a sanitation/ hygiene programme you should set aside funds for the formative research separate from the main programme. Many donors are keen to fund well-thought out hygiene initiatives at present.

**Set up the team.** Borrow or employ staff, include women and men who live in or come from the target area. You might need 4-5 fieldworkers and a team leader. Project managers, staff and partners can all participate. If you don't have experience with research ask a local university or an agency if they can provide advice.

**Hold a planning workshop.** Discuss what you already know about hygiene in your target zone with the whole team. Share this manual, decide how to adapt the approach to your circumstances. Health workers often think that they already know all about hygiene practices, but don't jump to conclusions at this stage. Remember, the aim is to listen to, and learn from the targeted groups, not to design your programme in your office. Choose a number of sites that are representative of your target area and make a detailed work-plan together.

**Contact the communities:** where you plan to start work, meet with leaders, administrators, women's groups, use local media to let people know what is happening. Propose the setting up of a community liaison committee to advise you and to inform local people.

**Build a network:** Inform any other organisations working in the area, invite them to join the programme. They may be reluctant at first, but when they see the results they will probably want to join in.

**PLAN OF FORMATIVE RESEARCH TO DESIGN A HYGIENE PROMOTION PROGRAMME**

<b>Objective</b>	<b>Chapter</b>	<b>Questions</b>	<b>Methods</b>
Identify risk practices	<b>3</b>	Which specific practices are allowing diarrhoeal pathogens to be transmitted to children?	Epidemiological knowledge, Environmental walk Checklist observation
Select practices for intervention	<b>4</b>	Which risk practices are most widespread? Which risk practices can be altered?	Structured observation Behaviour trials Focus group discussions
Determine message positioning	<b>5</b>	What motivates those who currently use 'safe' practices? What are the perceived advantages of the 'safe' practices?	Focus group discussions Interviews with 'safe practitioners' Behaviour trials
Define the target audiences	<b>6</b>	Who and how many employ the risk practices? Who influences the primary audience?	Structured observation Focus group discussion
Select communication channels	<b>6</b>	What channels are currently used for communication? What channels are trusted for such messages?	Interview representative sample of target audience Focus group discussion

## **STEP 2. MAKE A DETAILED FORMATIVE RESEARCH PLAN**

The objective of step 2 is to make a detailed research plan like the one shown on the previous page. It includes the four key questions of page 4 and some others. This table is at the heart of formative research for hygiene promotion. It sets out the questions and identifies suitable methods for answering them. To produce your own version, you need to decide on your research questions, then find methods which are suited to answering them. The table shows which chapters will help you with which questions. You may know other methods you can use to answer your questions reliably.

**Make a list of questions** you want to answer. This is best carried out as a team exercise. Together cut the list down to only those that are *really* important for the hygiene promotion. You will probably need to answer all the key questions in the facing table and you may have others. But do not make the list too long or your formative research will become unmanageable.

**Choose methods to answer each question.** When you have your key questions, choose a suitable method for answering each question. Questionnaires may be a good way of finding out about channels of communication employed by the population, for example, but they cannot tell you about the frequency of risk practices. The relevant chapters go over these methods in detail. Your own plan may differ in a number of ways from the one shown. However, the principles remain the same.

**Putting it all together.** With the research activities listed out, you can now work out the sample sizes (see p 27). In some cases you can answer several questions in one go. For example, you could ask family members about their radio and TV listening and market-going habits after the morning structured observations. Make a detailed research plan and assign responsibility to team members to carry it out.

**Training the team.** The formative research team will learn much of what they need to know by participating fully in the development of the research. Some formal training will be needed, especially in practicing observing, interviewing and running focus groups. *Hygiene Evaluation Procedures* (Almedom) has an excellent chapter on training.

### STEP 3. CARRY OUT YOUR FORMATIVE RESEARCH

**Identify risk practices, select practices for intervention.** You can work out which practices are posing a problem in your area if you start from the idea that most diarrhoea pathogens come from stools. Any practices that allow faecal material into the child's environment, especially stools on the ground and poor hand-washing after stool contact are likely to be a priority for action. The risk practices that occur most frequently are a priority for intervention. Behaviour trials allow you to work with target communities to choose suitable replacement practices. Chapters 3 and 4 give detailed guidance.

**Define message positioning.** This is discussed in Chapter 5. Briefly, it means finding out from your primary target audience what they like about the target practices. This can be done by interviewing people who already use the safe practices, and in focus groups and interviews after people have tried out the practices for a few weeks. Communication strategies are then built around these *positive* values. For example: 'hand-washing with soap makes your hands smell good.'

**Define the target audiences.** These are the groups you want to contact. Primary target audiences are those who carry out risk practices (for example, mothers, school children). Secondary target audiences are the immediate society of the primary audience who influence them (eg fathers, school children, mothers-in-law). There is a third target audience which is very important: opinion leaders such as religious, political, traditional leaders and elders. They can have a major influence on the success of your programme, as can partner and collaborating agencies.



Each segment of your audience can be addressed separately, so while you may arrange for house-to-house visits to reach mothers, street theatre may be more effective in reaching fathers and youths, and leaflets might be appropriate for partner agencies. Chapter 6 gives more detail.

**Identify communication channels.** By finding out how many of the target audiences read papers, listen to the radio (and when), belong to social groups, etc, you can see which channels are most suitable for hygiene messages. (see Chapter 6)

If all goes well and you have good planning, adequate resources and logistics, you should be able to complete your formative research in less than three months. There is a list of practical tips for managing the work on page 26.

#### **STEP 4. ANALYSE RESULTS, REPORT AND FEEDBACK**

Summarise the data that you have gathered in tables. Go back to your preliminary set of questions and try to answer them from your data. Then write a short, attractive report describing:

- ④ Your objectives
- ④ The methods that you used
- ④ The results that you got
- ④ Your interpretation of the results
- ④ Your recommendations for hygiene promotion

You can get a local artist to do some simple illustrations and give it an attractive cover. If you use only black and white text and illustrations the report can be photocopied easily. Many of your readers will be administrators who have too little time to read, so *make sure that your report is short and clear and that it stands out!*

Distribute the report widely. Ensure that all potential partners have copies. Translate the report into local languages and give plenty of copies to the participating communities. It is worth making several hundred copies as this is an important part of the consultation process. Hold public consultations and workshops with partners.

## STEP 5. MAKE THE COMMUNICATION PLAN

Involve people from the community and partners who had good ideas during the consultation process. Get together for several days to work on the full-scale plan for the hygiene promotion programme. Make a plan with the following elements:

- ④ **Behaviour change objectives:** for example 'Hand-washing with soap after cleaning a child's bottom will go from 5% of occasions to 35% in two years'.
- ④ **Target practices:** the key hygiene practices that replace the risk practices
- ④ **Target audiences:** age, sex, number in each group
- ④ **Positioning:** Motivation for behaviour change (why do target audiences want the new practices?)
- ④ **Channels of communication:** for example, street theatre, house visits, radio, schools.
- ④ **Communication materials:** the supports you develop for your communications activities like theatre scenarios or flash cards.
- ④ **Monitoring:** methods for following progress in programme activities, indicators, programme outputs, and in behaviour change
- ④ **Project management and budget.**

You can get ideas and help with designing communication materials from a local publicity agent or advertising agency, or from local artists, writers and musicians. The communication activities are based on the target practices and motivations and are designed for each target audience. They are tested and revised before being used at full scale (Chapter 6).





## **STEP 6. SET UP AND RUN THE HYGIENE PROMOTION PROGRAMME**

**Pilot, test and revise** everything. Your hygiene promotion programme will start off best with a few months of testing of messages, strategies and communication materials on a small scale, so that they can be refined and improved, before you begin a large-scale operation.

Hold focus groups to review radio spots or theatre scripts. Ask women visiting clinics to tell you what they see in any images or visual supports you produce. If you decide to work in schools, try out your schools programme in one school first. Ask teachers and children what they liked and what they didn't like about the programme and then modify it accordingly. Any materials you produce such as posters or radio scripts will certainly need to be tested and revised, probably several times, before you adopt them. (See Chapter 6.)

**Carry out a baseline survey** of target behaviours. Using the same structured observation technique that was used in the formative research to identify risk practices, take a sample to represent of the target group and observe the target behaviours. Duplicate surveys are then used later to monitor progress towards project objectives.

**Set up supervision and monitoring.** In common with all development programmes, health promotion activities need to be carefully supervised and monitored. Periodic reviews will allow you to ensure that your activities are being carried out, that they are reaching people and that they are effective. The results will allow you to modify the programme to make it more effective.

**Evaluate.** Evaluation will allow the experience to be improved upon, extended and transferred elsewhere.

**Example:** Look carefully at the table on the next page; it shows the research questions, the methods that were used to answer them, the answers that were found, and how these translated into programme decisions in a town in India. Whilst your formative research may ask different questions and will get different answers, the logical process is the same. Formative research guides the programme design.

**FORMATIVE RESEARCH TO DESIGN A HYGIENE PROMOTION PROGRAMME IN LUCKNOW, INDIA**

<b>Research questions</b>	<b>Methods used</b>	<b>Key findings</b>	<b>Key findings</b>
<b>What are the risk practices?</b>	Environmental walk, Checklist observation, Structured observation	Defaecation of most small children was on the ground. Mothers did not wash hands with soap after cleaning up the child. Few people returning from toilet washed hands with soap.	<b>Risk practices:</b> unsafe disposal of child stools. Infrequent hand-washing with soap after stool contact.
<b>What are the target practices?</b>	Behaviour trials, Structured interviews	The ordinary soap cannot be used after defaecation as it becomes polluted. Using community latrine not acceptable, no use for children. Potties liked by mothers.	<b>Target practices:</b> A special piece of soap is kept for hand-washing after defaecation. Local latrine building programme contacted. Potties bought for children.
<b>Who are the target groups?</b>	Observation, Focus group discussions	Mothers deal with child stools. Mothers and fathers do not use soap after stool contact. Mother-in-law and husbands influence mothers	<b>Target groups:</b> Primary target: mothers. Secondary target: fathers, and mothers-in-law.
<b>What motivates behaviour change?</b>	Focus groups, Structured interview	Desire to be clean, pure and auspicious. Desire to save time cleaning up children. Desire to please family and God.	<b>Motivation:</b> Hand-washing with soap after stool contact makes you clean and pure. Potties save time and effort.
<b>How do people communicate?</b>	Interviews, Focus groups	No one channel with good reach. Some mothers had little contact with outside world.	<b>Variety of channels:</b> street theatre, house-to-house visits, religious gatherings.

## Practical Tips

### **Pitfalls and problems**

Following this logical process through from asking key questions, to working with the community to answer them and then using the answers to design the programme may seem straightforward, but there are a lot of points at which things can go wrong. Formative research is not always easy. The advice of someone who knows how to carry out focus groups or structured interviews can be invaluable if you have not done it before. The most important skill you need is to pick out those questions that most need answering, and then to pursue the answers until you are convinced that you have learned what people really think, want and do. Discussing your results with the communities and working with them on the programme design should ensure that you do not go too far wrong.

Depending on where you work, your biggest difficulty may be to get institutions, programmes and collaborators who are used to health education to change to a promotional approach. Sometimes it is harder to change the behaviour of the 'experts' than that of the population! The only solution is to invest in training, activities to build 'like-mindedness' and, if necessary, to be prepared to compromise.

There is an apparent paradox at the heart of hygiene promotion programmes that can be hard to deal with. Whilst the hygiene promotor sets up the programme for the sake of better public health, the community may be more interested in hygiene for the sake of the pleasure of cleanliness or the convenience of the target practices. It will seem strange to some people that the programme focuses on aesthetics and comfort rather than germs and disease. Team members often slip back into the old ways of educating about germs and giving negative messages about death and diarrhoea. Whilst education about germs is a good thing to do, it does not necessarily lead to behaviour change, as we have seen. Programme managers need to monitor message content closely and ensure that it does not deviate too far from the positive messages that were planned.

### The size of the investigation

There are no hard and fast rules for deciding how many focus groups or structured observations you will need to carry out. The size depends on the size of the target area; the larger and more varied it is, the more formative research you will need. One rule of thumb is to carry on with the investigation until you are no longer learning anything new. We give three imaginary cases. You can work out the approximate size of the investigation by taking intermediate values depending on how much your circumstances resemble the ones shown :

**Case 1:** A region with 800,000 people, both urban and rural, with diverse cultural backgrounds.

**Case 2:** a small town of about 200,000 people with two main language groups.

**Case 3:** a cluster of ten villages which are ethnically homogenous.

Case	Environmental walk	Structured observation	Checklist observation	Focus group	Behaviour trials	Structured interview
Region	10 localities	200 households	10 days	12	4 groups of 10	20
Small town	4 localities	120 households	6 days	6-8	3 groups of 10	10
Villages	3 villages	70 households	4 days	4-6	3 groups of 8	10

### Getting the balance right

Another factor in your choice of sample size is the scale of your proposed programme. There would be little point in spending so much time and using up so many resources in formative research that nothing was left for the intervention. But skipping the formative research could lead to costly mistakes, wasted effort and demoralisation for all concerned. What is the proper balance between the two? Spending around 15% of programme resources on getting the programme set up properly at the beginning is well worth while.

## Tips for team building

The quality of the formative research depends on the motivation of the fieldworkers to do a good job. They may have to begin work early, and stay in remote locations; they may encounter difficult people, and they are putting their noses into people's private business, which can be stressful. Good support and morale boosting is essential for the quality of the work.

- ④ Involve the whole team in planning and decision-making and make it clear that their contributions are valued.
- ④ Hold regular team meetings to air problems, share solutions and hold social events to boost morale.
- ④ Choose staff with experience of extension work, who are interested in hygiene, and who speak the local language(s).
- ④ Ensure that contracts and financial arrangements are clear, understood and agreed by all parties from the beginning. Review any problems promptly.
- ④ Stick a weekly planning calendar on the wall, so that everybody knows what everybody else is doing, including team leaders.
- ④ Involve the whole team in piloting the formative research and revising the formats and guides that you will use.
- ④ Allow a long lead-in period to train staff and pilot and develop the formats and guides.
- ④ Harmonise approaches by pairing up staff so they can learn from each other. Settle on an agreed introduction in households, so that everybody explains what they are doing in the same way.
- ④ Regular, frequent supervision assures quality and punctuality.
- ④ Even one field worker who cheats can ruin the whole investigation, so tackle any suspected problems rapidly and seriously.
- ④ Review data as it comes in from the field. Don't make corrections in the office, but go back to households.
- ④ If you are using a computer to enter data, check on the quality of data entry regularly.
- ④ Hold team think-tank sessions to review findings and develop ideas about the key questions. Early results guide the later work.





# Chapter 3

## Risk Practices

The previous chapter gave an overview of the process of formative research and how it is used to design a hygiene promotion programme. This chapter summarises what hygiene promoters need to know about the practices that put children at risk of diarrhoeal disease.





## Risk Practices

### Too many messages!

Look at the lists of messages below. These are all common in hygiene education programmes. But there are so many! And they are confusing. Two messages are normally the maximum for effective communication. So which two would you choose?

“cover water containers”  
“boil drinking water”  
“filter drinking water”  
“chlorinate well water”  
“use a dipper for water”

“cover food”  
“use fly screens for food”  
“disinfect vegetables”  
“reheat food”

“wash hands with soap”  
“wash hands with ash or mud”  
“do not wash hands with mud”  
“wash hands before eating”  
“wash hands before feeding child”  
“wash hands after defaecation”  
“wash hands after cleaning up child”

“burn rubbish”  
“bury rubbish”  
“transport rubbish to a depot”  
“clean well surrounds”  
“build latrines”

“teach child to use a potty”  
“bury faeces”  
“disinfect latrines and slabs”

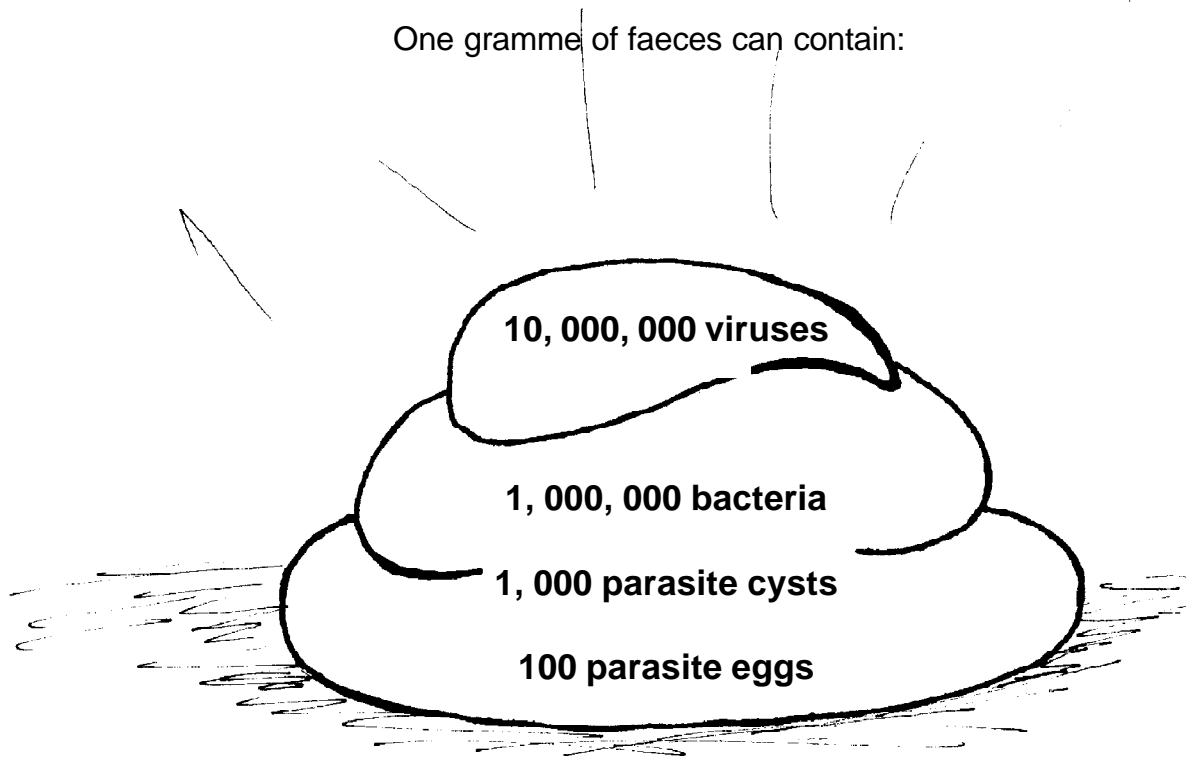
“cut fingernails”  
“comb hair”  
“do not spit”  
“wear clean clothes”

The only way to make a sensible choice is to know about how people catch diarrhoea, and to know what practices are common in your target area. Then you can pick out the most risky practices.

## Where do intestinal infections come from?

The origin of diarrhoea is: EXCRETA!

One gramme of faeces can contain:

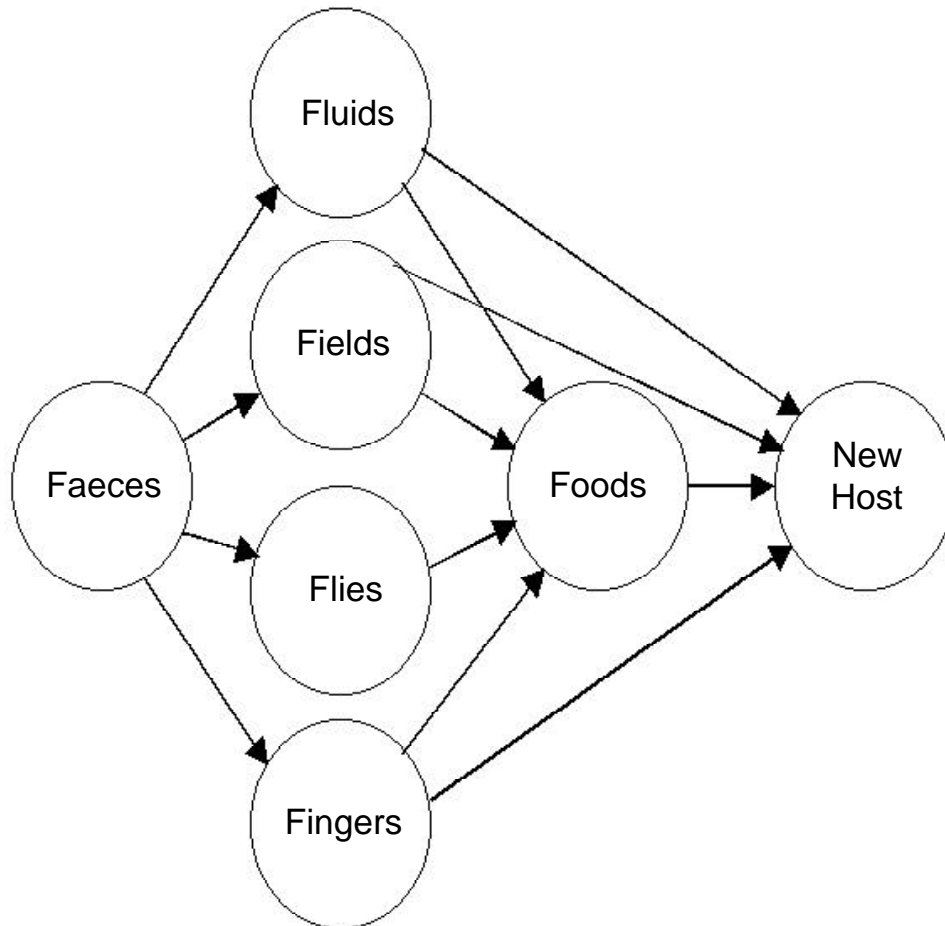


Infectious diarrhoeas (including dysentery, cholera and typhoid) are caused by infectious agents like viruses, bacteria and parasites. These agents get into humans via the mouth and are passed out in faeces.

## ENEMY NO 1: FAECES!

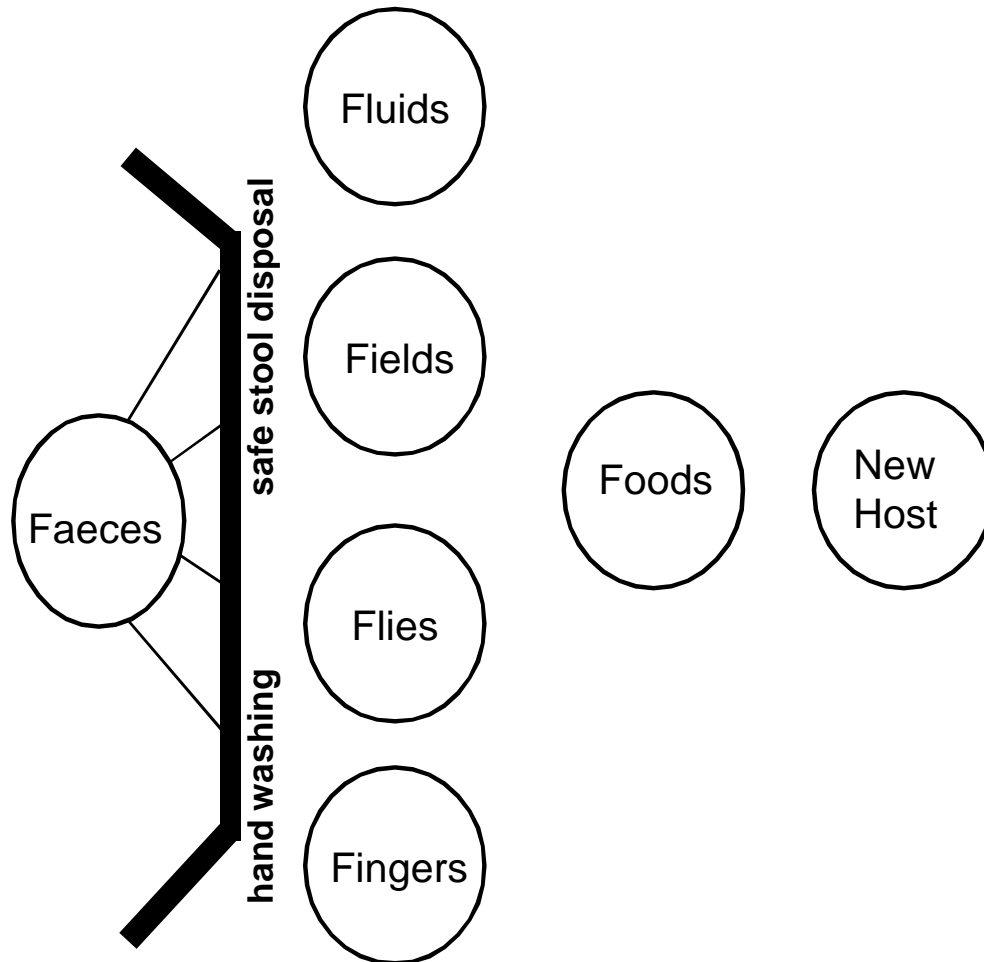


## How do people catch diarrhoea?



This is the famous **f-diagram**, which shows the different routes that the microbes of diarrhoea take from faeces, through the environment, to a new person. For example; microbes in faeces on the ground by a well can get into the water (fluids) and be drunk by a child, hands that have not been washed after going to the toilet can carry microbes onto foods, which are then eaten, infecting another child, who gets diarrhoea and spreads more microbes...

How can we break the transmission chain?



If we can prevent faecal material from getting into the environment in the first place, then we do not have to worry so much about purifying water, storing food correctly or keeping away flies. That is why our first priorities should be:

- **safe stool disposal**
- **handwashing with soap after stool contact**

## Risk Practices: The Evidence

There are many practices that can help prevent diarrhoeal infection. But which are most important? We review the evidence.

### Getting rid of faeces

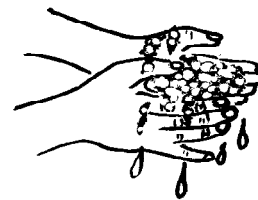
Faeces in the public and domestic environment are the primary source of diarrhoeal pathogens. **Safe disposal of stools is the best way to prevent infection.** Ideally, adult and child stools should be disposed of in toilets or latrines. In places where this is not possible, stools should be buried. As a last resort, it is better to carry stools to a place far from play areas or water sources and cover with earth, than to leave them lying in the yard. In places where they are available, teaching toddlers to use potties can help to keep the home area free of faeces.



Faeces of animals like pigs, cows and chickens can also carry diarrhoea microbes and need to be kept out of the home and where children play.

### Hand washing

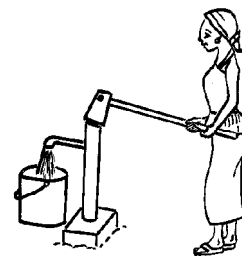
Hands readily become contaminated with faecal material after anal cleansing or after cleaning children's bottoms and stools. Rinsing fingers with water is not enough to remove sticky particles which contain microbes. Hands need to be well washed after contact with faeces; either rubbed with an abrasive such as ash or mud, or with a detergent such as soap.



Handwashing before eating, before feeding children and before preparing food are all helpful. But we now know that following such advice systematically would require a woman to wash her hands with soap about 30 times a day, which may not be practical. **Most important is handwashing with soap (or ash) after stool contact.**

### Keeping water clean

There is much debate about the importance of safe water. A plentiful and accessible water supply makes hand washing and cleaning easier, which helps to keep the environment free of pathogens. Ensuring that faecal material does not get into water supplies at the source is probably far more effective than boiling, filtering, and covering water jars. **Safe stool disposal is a priority.**



### **Fly control**

Though flies can carry microbes from faeces to food, fly control is difficult and expensive to achieve. If stools are disposed of in toilets or latrines and these latrines have covers or fly traps, then fly-based disease transmission will be minimised. **Here also safe stool disposal is the priority.**



### **Food hygiene**

Poor food handling practices contribute to diarrhoeal infection largely because they offer bacterial pathogens the opportunity to multiply. This way people can consume much greater doses of microbes. Diarrhoeas often peak in warm, humid seasons in the tropics, when conditions are favourable to the multiplication of bacteria on food.



Food stored in a warm place is an environment that microbes like, where they can multiply easily. Feeding bottles are especially dangerous because they are hard to sterilise and bacteria grow quickly in warm milk. Poor handling of bottles and child food are therefore major risk factors for diarrhoeal diseases in young children. Hence a cup and spon is preferable to a bottle, both for infant milk and semi-solid weaning food. But the microbes that cause diarrhoea come from stools. **Preventing stools from getting into the domestic environment in the first place is therefore a priority.**

For a summary of the scientific evidence concerning hygiene risk practices see *Actions Speak* (Boot & Cairncross) and *Improving water and sanitation hygiene behaviours* (WHO). Apart from preventing diarrhoea, safe disposal of stools and improved hygiene has other benefits, such as reducing infection with intestinal worms.

**To sum up, unless your field work shows you otherwise, the evidence suggests that the most important way that microbes infect children is by getting into the environment from faeces in the first place. Therefore two of the most important practices for hygiene promotion programmes to target are likely to be:**

**SAFE STOOL DISPOSAL**

**HANDWASHING WITH SOAP AFTER CONTACT WITH STOOLS**



# Chapter 4

## Key Practices to Address

In the previous chapter we saw that the source of diarrhoea causing microbes are stools and that not disposing of stools safely and not washing hands with soap after stool contact are important sources of risk. In this chapter we suggest how you can work with target communities to design safer hygiene practices.





## Target Practices

### How to identify risk practices

We know that certain hygiene practices are more risky than others, and that those that let faecal material into the home environment are the most risky. However, to decide which practices to target, we need to know what people actually *do*. How do they dispose of child or adult faeces? Do they wash their hands with soap after coming into contact with faeces? What other practices are causing a problem locally?

How do we set about finding this out? Just asking is not good enough; hygiene practices are private and are morally loaded; nobody likes to admit to not washing their hands, for example. The first step is to choose a number of representative communities in which to work. A variety of techniques can then be used to collect information about risk practices. These include:

- ④ Environmental walk
- ④ Checklist observation
- ④ Structured observation

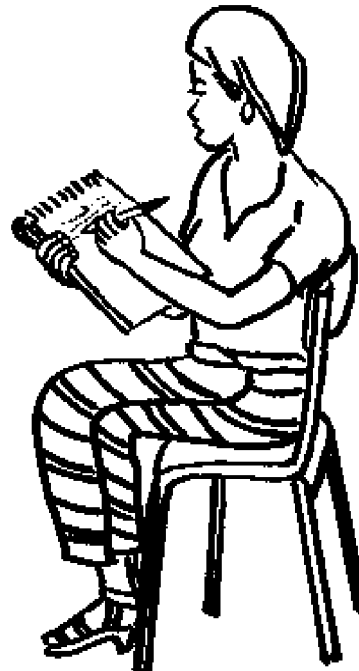


## Environmental walk

A good way to begin the formative research is to take an environmental walk. Choose sites that are representative of your target area, and having made the customary contacts with leaders, administrators, etc, ask a group of local people to show you round your chosen villages/ neighbourhoods. It is a good idea to do it at dawn or dusk as you will see more hygiene behaviour then. Ask to see the water sources, the places where rubbish is thrown. Chat to mothers and fathers about their children, what their problems are, how they manage to keep their households and their children clean. Ask about problems with sewage, latrines, stagnant water, how they manage their babies and children, the age children learn to defaecate alone and where, who helps with the children and so on. Write up what you learned about hygiene straight away after the visit. (*Hygiene Evaluation Procedures*, by Almedom, describes this, and many other useful techniques.)

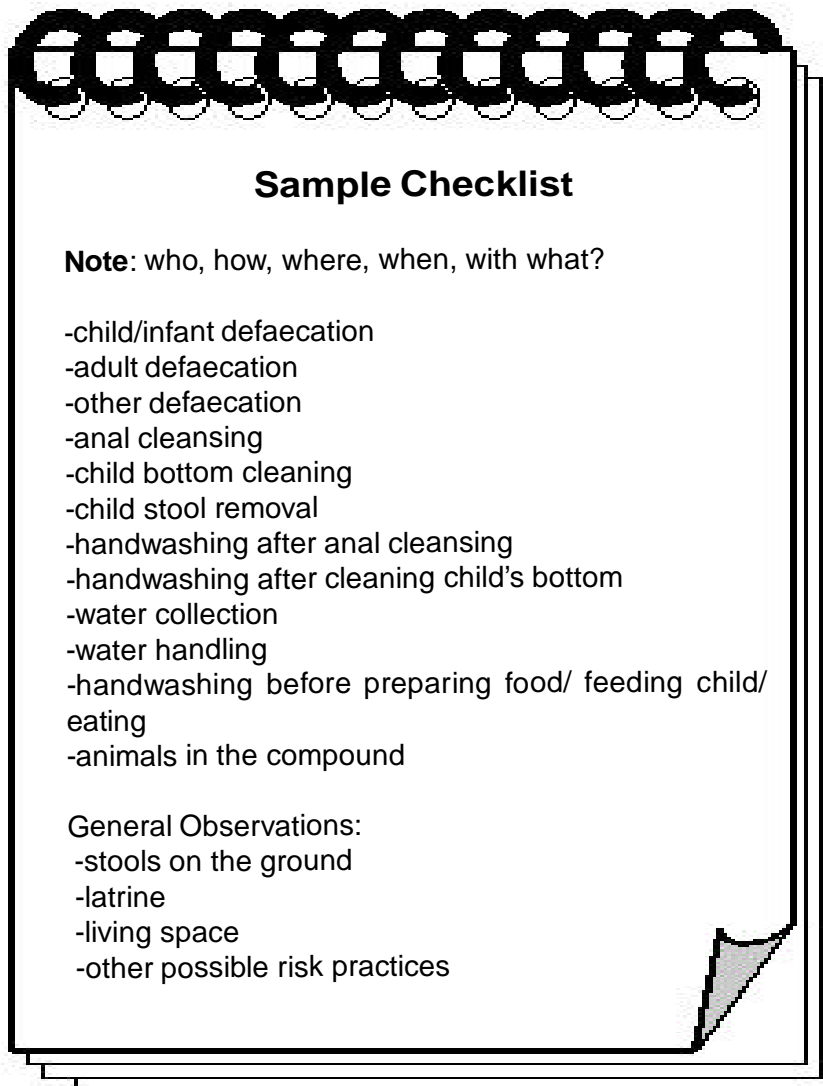
## Checklist Observation

Make a list of all the behaviours that you think might be putting children at risk of diarrhoea (see the list on the next page for ideas). Be sure to include all the practices which might allow faecal material into the environment. Take the team and spend several days in one of your target communities from early morning 'till night. Ask to sit with mothers, childcarers and children and watch what goes on. Join in with the family life. Each time one of the behaviours on the checklist is seen, note when and where it happened and who did what. Tell the family you are interested in child health but not that you are especially concerned with hygiene.



Checklist observation can be carried out in a number of sites, depending on how big and varied your target area is (see Chapter 2). Afterwards, sit down with your team and decide which practices seem to be putting children at risk.

Write up your conclusions in a short report.



### Sample Checklist

**Note:** who, how, where, when, with what?

- child/infant defaecation
- adult defaecation
- other defaecation
- anal cleansing
- child bottom cleaning
- child stool removal
- handwashing after anal cleansing
- handwashing after cleaning child's bottom
- water collection
- water handling
- handwashing before preparing food/ feeding child/ eating
- animals in the compound

General Observations:

- stools on the ground
- latrine
- living space
- other possible risk practices

## Structured Observation

The results of the checklist observation will have given you a short list of practices that are allowing the spread of microbes from stools into and through the environment. Now you need to know how common the risk practices are. Risky practices which are frequent are a major health problem; practices that are rare are probably not a priority for your programme.

Observing behaviour directly gives more valid results than interviews (see et al). Structured observation is a systematic technique for observing and recording particular practices. It lets you quantify specific practices directly. It is also used to monitor the impact of a programme on the target practices before, during and after an intervention.

Structured observation is carried out by a team of trained observers, ask permission and then visit households, often very early in the morning as people get up. They then sit as quietly as possible in a place where they can see what is happening. Each time they see a practice of interest they note down what happens on a pre-coded form. The next page is an example of a sheet taken from a structured observation format: you can adapt it to your needs. To fill it in, the observer puts a ring around the number which corresponds to what sees. This simplifies recording and data handling. You can complete the form with the other practices that you noted as possible risk practices during the checklist observation. You can also add spot checks of whether stools are seen on the ground, animals in the yard, etc.

Child defaecation is likely to be one of the practices of interest, so use households with young children (say, under 3) for the observation. Child defaecation and stool disposal will only be seen on about a half to two thirds of visits. This has been allowed for in the table sizes suggested in chapter 2.

Get advice from local people about the acceptability of structured observations and ensure that fieldworkers do not impose themselves on families who would rather not participate.

## 15 tips for carrying out structured observation

- ④ Plan to cover between 70 and 200 families, depending on how big and how varied your programme area is (Chapter 2).
- ④ Households should be chosen at random (from a map or household list or, if neither exist, by taking every 4th or 5th house along a street, for example).
  - Í Only observe in households with small children.
  - Í Visit families the day before and ask their permission, explain that you are doing a study of child health or of women's work, but not that you are specially interested in hygiene.
  - Í If someone doesn't want to participate, thank them politely and try another house.
  - Í Preferably find female field workers who don't mind getting up very early. (Male field workers may be less welcome observing hygiene)
  - Í In one month, five field workers can cover 100 families.
  - Í Observe for a standard period, say from from 06.00-09.00 each morning.
  - Í Test the observation formats and revise them so that they cover every circumstance you might meet before finalising them.
  - Í Train field workers carefully so that they all fill in the forms the same way. Make a written list of instructions.
  - Í Arrive at the household at getting up time, greet people and then sit down quietly in an corner where you can see what is going on.
  - Í Keep conversation to the absolute minimum.
  - Í Supervisors need to visit the field workers regularly.
  - Í Hold frequent team meetings to decide what to do about unexpected observations and to give moral support to the team.
  - Í Tabulate the results by hand (or use a computer)
  - Í Decide how much you think people changed their behaviour because of the observer, and mention this in your report.

## A sample structured observation format

### Section 2. Structured Observation of child defaecation

2.1 Did you see the child (0-3yrs) defaecate during the observation period?

yes=1 no=2

2.2 Where did the child defaecate?

on a pot=1 on the ground in the house=2  
on the ground in the yard=3  
on the ground outside the yard=4  
in nappies=5 in pants/trousers=6  
in the latrine=7 other=8

2.3 Did someone clean the child's bottom after it had defaecated?

Who?

nobody=1 the child herself=2  
mother=3 sister/relative=4  
maid=5 other=6  
not seen =7

2.4 What happened to the stools?

thrown in the latrine=1 left lying on the ground=2  
thrown outside=3 taken to the rubbish heap=4  
washed off=5 not seen=6

2.5 After cleaning the child's bottom/cleaning up stools did the person

wash both hands with soap=1  
rinse both hands with water only=2  
rinse one hand=3

Tabulate the results, either with a computer or by hand. Look at the frequency of the risk practices that you suspect to be causing a problem and pick out those which are common enough to be a real threat to public health. Finally, narrow down your list to just two or three risk practices.

## Developing Target Practices with the Community

Up till this stage, you have mainly been learning from your sample communities; the time has now come for more active collaboration. You have now identified two or three types of practice which you think are the main causes of child diarrhoea. They will probably include unsafe disposal of child and/or adult stools, lack of handwashing with soap after stool contact and other high risk behaviours which are specific to the locality. You now need help from the communities to develop replacement practices.

### Behaviour trials

Behaviour trials are a new technique which enable health workers and representative members of the community to work together to design replacement practices for those that are putting people at risk. You can also use them to find out about behavioural motivation by asking what people like and dislike about the new practices (explained in Chapter 5).

**Step 1. Set up the trial.** Find a number of women who aren't using your target safe practices. (You can use the results of the structured observations to identify possible candidates). Invite three or four groups of about ten to local meetings. Make sure that they are roughly representative of your primary target audience. At the meeting discuss the results of the observations and your analysis of practices that are putting children at risk. Ask for their suggestions as to what could be done. Ask for volunteers to work with you to try out safer behaviours. Offer physical support such as soap, so the trial does not require them to spend money. If, for example, you noted that children defaecating on the ground was a common risk behaviour, then you might explore whether using banana leaves or potties was feasible and acceptable to mothers in your area.

**Step 2. Home visits.** Fieldworkers visit each volunteer at home and work with her to adapt the target practices to her individual circumstances. They ask her to do her best to carry them out for two weeks.

**Step 3. Follow-up.** Visit each volunteer each day at first (every two days in the second week) to support her, to remind her and to find out how she is getting on. Work with her to solve problems and find alternatives. If she has no latrine for example, can she use a neighbour's or bury child stools, for example? After several weeks most mothers will have developed workable replacement practices. You will, at the same time, gather some lessons which will be useful when it comes to scaling up the intervention. Key questions to ask at each visit are:

- Did you manage to adopt the new practice?
- What difficulties did you have?
- How did you solve the problems?
- What else could we do to make it easier?
- Did you like the new practice? Why? Why not?
- What were the costs (time/money)?
- What were the benefits?

Keep track of the results at each visit by filling in forms like the one shown below.

**Behaviour trials: sample follow-up form**

Day No/date D..... : ...../...../..... Family ID No   _____	Carer	Child			Problems Solutions Advantages of new practices
		1	2	3	
Where did they last defaecate? 1= latrine in the yard 2= neighbour's latrine 3= in a potty 4=on the ground 5=other (note)					
How were hands washed after stool contact? 1= not washed 2= plain water 3= with soap 4= other (note)					



**Step 4.** At the end of the trial, summarise

- the exact sequence of events that go to make up the target practices
- the problems encountered,
- the solutions found by the participants,
- the advantages that participants felt that they got from the new practices.

Meet with the women again to check what you found and feed back the results. Finally write up a statement showing the risk practices and the target practices like the examples shown below.

**Risk practices**

13% of mothers wash their hands with soap after cleaning up a child's bottom.

20% of child stools are left on the ground.

**Target practices**

30% of mothers use soap to wash their hands immediately after cleaning a child's bottom and throwing away the stools.

40% of child stools are thrown in a latrine or buried.



## **Making the links**

In some places it will not be possible to find the ideal solution to problem practices. Soap or water may be unavailable for handwashing, or there may be no latrines for the disposal of stools, for example. When this happens, two types of solution are needed, one immediate, one long term. For the long term, better infrastructure is required. The formative research may highlight this need and recommend the building of water or sanitary infrastructure, or suggest modifications to an existing programme. Community ownership of the results of the formative research can help galvanise further political and community action for better resources.

Nevertheless, the formative research should still be able to find interim solutions that allow better hygiene in homes in the absence of improved infrastructure. For example, it is rare for there to be no soap at all. Most houses keep soap, or a soap equivalent, for washing clothes. Earth or ash can replace soap, and can be promoted if people find this acceptable. If latrines are not available in the short term, the solution may be burying, or ensuring that stools are disposed of well away from households. *The priority is to reduce the faecal contamination of the environment in which children live.*





# Chapter 5

## Motivating Behaviour Change

You have read about behaviours that need to change to protect children's health. However, behaviour change is never easy and conventional health education doesn't work. In this chapter we show



## Motivating Behavior Change

### **A new way of thinking about behaviour change**

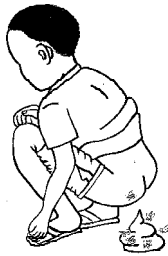
In the previous chapter we saw how to identify the practices that were putting children at risk of diarrhoeal infection. We saw that the unsafe disposal of child stools, and failure to wash hands with soap (or ash) after coming into contact with stools, are probably the main practices which allow microbes into the environment of the vulnerable child. We also saw how to work with communities in the target area to develop replacement practices which are feasible, affordable and attractive. But this is only a part of the solution. We saw in Chapter 1 that teaching people about microbes and diarrhoea is impractical on a large scale, and not very effective in encouraging behaviour change. So what is the alternative?

Hygiene promotion uses a different approach. Instead of being top-down, it starts by finding out what the community *likes* about the target practices. It then uses these positive values to motivate behaviour change. So if, for example, we find that dignity and respect from neighbours are seen as the main benefits of adopting the target practices, then these values are used in their promotion.

To find out about the perceived advantages of the new practices, the first step is to discuss them with groups of women (Focus group discussions, p56 ). The next step is to interview women who are already using the safe practices, to find out why (structured interviews, p 60). Finally, a number of women can be asked to try out the new practices as we suggested in the previous chapter. These women can then

## From smelly yards to happy husbands: an example

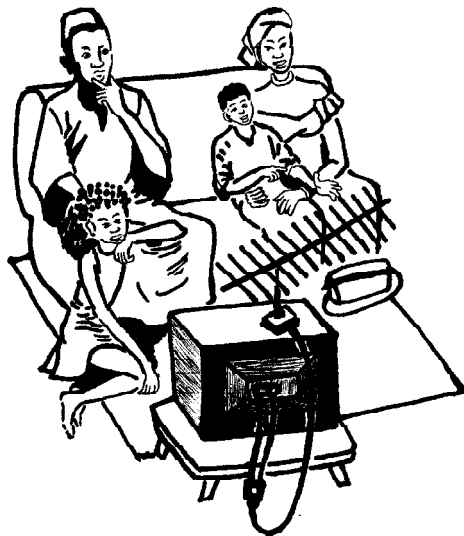
**A health worker wanted to find out about how to motivate people to dispose of child stools safely. This is what she did:**



The health worker and her team carried out four **focus group discussions** to ask about the disposal of child stools. Mothers explained that they did not like to see stools on the ground because they were ugly to look at and “they stop you breathing”. They said that they admired mothers who managed to keep their courtyards free of stools. But they said that it was hard to always keep an eye on the child so as to be able to clean up afterwards.

The team **interviewed** some mothers who managed to keep their yards stool free. “My mother-in-law gave me a potty for the child” said one woman, “I taught the child to use it so now the yard isn’t smelly anymore”. The team asked for volunteers to participate in **behaviour trials**. Each mother was given a potty, and asked to teach the child to use it. After two weeks they were asked what they thought. Mothers said that it had been difficult at first but that the child got used to using the pot after about three days. Others said that the potty was convenient, others that their husbands had noticed that the yard was cleaner and free of smells. They all agreed that even if a plastic potty cost a bit, it was well worth buying one for the sake of living in a nice clean healthy environment.

The health worker decided to build her hygiene promotion strategy around the idea that **a happy, healthy family use potties to have a smell-free yard.**



## Everybody wants to be clean!

Mothers in Bobo-Dioulasso were asked what they thought about stool-related hygiene. Here are some of the things they said:

“There’s a bad smell [from stools on the ground] which disturbs us and if a visitor comes to see you are ashamed that they see and smell the stools. You can’t even eat nearby because it smells so bad.”

“Stools outside, they bother you, they judge a mother by that.”

“Stools on the ground cause problems with the neighbours, we are ...insulted.”

“I’ve noticed that when I use soap I don’t have smelly hands any more, that’s good, especially when I go to pray.”

“I like soap because it gets rid of bad smells...”

“Stools on the ground bother people. They walk in them. The motorbikes get dirty and have to be washed. Not to mention the smell...”

“Washing hands is a good thing because it helps avoid illness. I do it because I’m convinced. What illnesses? Like coughs and malaria.”

“Our husbands like the yard clean”





As you can see, mothers offered many reasons why hygiene is important to them. Nobody likes dirt, nobody likes to have stools lying around, or to have hands that smell bad! As this example shows, we would be wrong to think that the basic motivation for hygienic behaviour is health. More important are the desire for comfort, beauty, and social acceptability. A basic ideas of hygiene promotion is the use of people's existing values to promote safer practices. This is because a better quality of life, self respect and respect from neighbours, convenience and cost saving are stronger motives than disease avoidance.

This is a positive way of promoting hygiene, and much more effective than trying to frighten people that their children will get diarrhoea if they don't mend their dirty habits. In any case, most people don't think

<b>Name</b>	<b>Symptoms</b>	<b>Causes</b>
Kolobo	Green, frothy, frequent stools, vomiting, weight loss	Teething
Kotigue	Liquid stools, ballooned stomach	Anal fissures due to carrying the child on the back or sitting in the damp
Sere	Bad smelling stools Thin, complaining child	Breast feeding whilst pregnant/after having sexual relations
Fariguan (fever)	Liquid, smelly, stools	Mother has fever
Siin coumouni (sour breast milk)	White, milk smelling stools	Mother's milk gone sour in the breast
Toubabou konoboli (white's diarrhoea)	Liquid stools, ballooned stomach	Dirty food

## Finding Out What Motivates Behaviour Change

The question we need to answer in our formative research is: **what motivates the adoption of safe hygiene practices?** It would be hard to find answers in ordinary household interviews. Instead we use:

- Í focus group discussions
- Í interviews with safe practitioners
- Í behaviour trials

The number of each you need to carry out depends of the size and homogeneity of your target area (see Chapter 2).

### Focus group discussions

Focus groups are an excellent way of getting to the bottom of a subject, especially about *why* people do or think what they do. They gather together people with similar backgrounds for a detailed discussion about a subject. In the hands of a skilled moderator they can produce remarkable results. (However, if the moderator does not know how to put people at their ease, or she accepts only superficial answers and does not dig into what people really think, then they are less useful.) The technique is now widely used in health research and there are a number of helpful guides to using this technique, such as that by Dawson. We summarise how to go about it here.

The key things that you need to carry out a focus group discussion are:

- Í clear objectives
- Í a well thought-out discussion guide
- Í a moderator who makes participants feel comfortable
- Í a determination to find out what people *really* know and think.

## 1/ Beforehand

- Í Decide on the objectives of your FGD.
- Í Make a first draft of your discussion guide. Get the team member who knows the community best to propose how to phrase the questions. Improve and revise the guide together.
- Í Choose a location that is convenient for your participants where you won't be disturbed too much.
- Í Invite around 6-12 people who are representative of your target groups.
- Í Select a group with similar backgrounds so that everyone feels at ease to say what they think with the others and everyone feels equally concerned.
- Í Prepare the meeting: arrange for chairs, refreshments, writing materials or tape recorder, batteries and cassettes if you decide to use them.
- Í You need at least two people to carry out the FGD; one Facilitator and one Recorder.



## 2/ During the Focus Group Discussion

- Í Arrange the group in a circle.
- Í Introduce yourselves, explain the reason for the meeting.
- Í Try to put everyone at their ease.
- Í Use the local language.
- Í Include everyone in the discussion, don't allow any one person to dominate.
- Í Don't accept just the first answer but probe until you get to the bottom of what *really* motivates hygiene
- Í Notes need to be as complete as possible a record of what is said. (Tape-recording is ideal, but transcription from tapes is time consuming. Using notes alone can be inaccurate. One solution is to listen to your tape once over, and then transcribe from notes.)
- Í The discussion should last about an hour, and never longer than two hours.

The facilitator leads the discussions, makes sure that everybody participates, and brings people back to the subject when they deviate. She does not dominate the conversation, but leads it gently when

- Í Write up a full and complete transcription of what was said by everyone. This can be done by hand or with a computer. Local words for key concepts (diarrhoea, dirt, etc) should be retained and not translated.
- Í The transcript is your data. It should be carefully saved for future reference.
- Í Go back to your key questions. Use a highlighter pen to show what was said in each discussion on a given subject (e.g blue for handwashing practices). Note points of agreement and points

Below is a sample discussion guide which you could use to help establish the motives for washing hands with soap after contact with stools and disposing of stools safely. (You would obviously have to adapt it to local conditions and to the target practices you have chosen.)

Some people find it helpful to bring along objects or pictures to get the

### **Focus Group Discussion Guide**

**Objective:** to establish what might motivate handwashing with soap and safe stool disposal.

**Note:** date, time, location, participants, facilitators.

#### **1. Introduction**

Introduce yourselves and the participants.

Explain what the focus group is going to discuss and why.

Explain that people are free to say what they like and that they will not be quoted individually. Explain that notes will be taken or a recording made.

#### **2. Perceptions about /hygiene**

What sort of things are clean? Why do you say that x is clean?

What are the advantages of cleanliness?

#### **3. Advantages of handwashing with soap after cleaning up a child**

When is handwashing a good idea? Why?

When do you need soap? When don't you need to use soap? Why?

What do you like about handwashing with soap ?

#### **4. Perceived advantages of stool hygiene**

What about stools? Are they clean or dirty? What's wrong with them?

What's the best way of avoiding stools?

If you throw stools in the latrine what are the advantages?

#### **5. Adopting the target practices**

Could you adopt these practices? Why? What would make it easier?

#### **6. Closure**

Summarise what was said, offer to answer any questions, promise feedback, thank everybody, wait till everyone has left before leaving.

## Structured interviews

Structured interviews (sometimes called semi-structured interviews) are a means of exploring what people think about an issue without the formality of a questionnaire. Instead they employ a discussion guide. The interviewer probes and draws out issues of interest in a naturalistic setting. Handled skilfully they can provide fascinating insights into what people think. They are less useful in the hands of a fieldworker who does not know how to make people comfortable or how to probe to get behind the initial responses.

For good results the interviewer needs:

- Í clear objectives
- Í a good discussion guide setting out areas to probe
- Í the ability to listen carefully

At this stage in the formative research, the key question is “**what are the advantages of the target practices?**” To answer this, you need to find a number of child carers who already use the safe practices (the structured observation should have identified some). Then the interviewer tries to find out what made people adopt the safe practices, and the benefits that they feel they get from them. If health workers are doing the interviewing, mothers will often spend time telling them all about health benefits. But, as we saw, health is only one, and probably not the most important motivation for hygiene, so probe the other benefits which child carers feel that they get from the target practices.

### 7 tips for the structured interviews:

- Í Decide on your objectives
- Í Make a discussion guide (see next page for a sample)
- Í Interview 10 to 20 women who already use the target practices.
- Í Raise the questions which interest you and probe for deeper levels of motivation behind superficial answers.
- Í The interview should not take longer than about 45 minutes. If you need more time, take a break or hold another session later.
- Í Use a tape recorder, or ask an assistant to take notes.
- Í Transcribe the whole interview and keep a copy safe. List out all the motivations for the safe practices and tabulate the responses.

## Sample structured interview guide

**Objective:** to find out what motivated the interviewee to adopt the target practices, and the benefits she feels that they give her

**Note:** date, time, place, interviewer.

### 1. Introductions,

Explain the objectives and the context of the interview. Explain that her name will not be used. Explain that we noticed that she was already using the target practices and that we want to know how to help others do the same.

### 2. Perception and experience of the hygiene practices

Does she manage to use the practices every day even if she is busy?  
How long has she been doing them? What did she do before?  
Who suggested them to her? How did they get her to do it?  
What did other people say?

### 3. Advantages and benefits

What does she see as the advantages of these practices? What does she like about them?

What about disadvantages? (eg cost, time, resources, etc).

How does she think other people could be persuaded to do the same?

### 4. Close

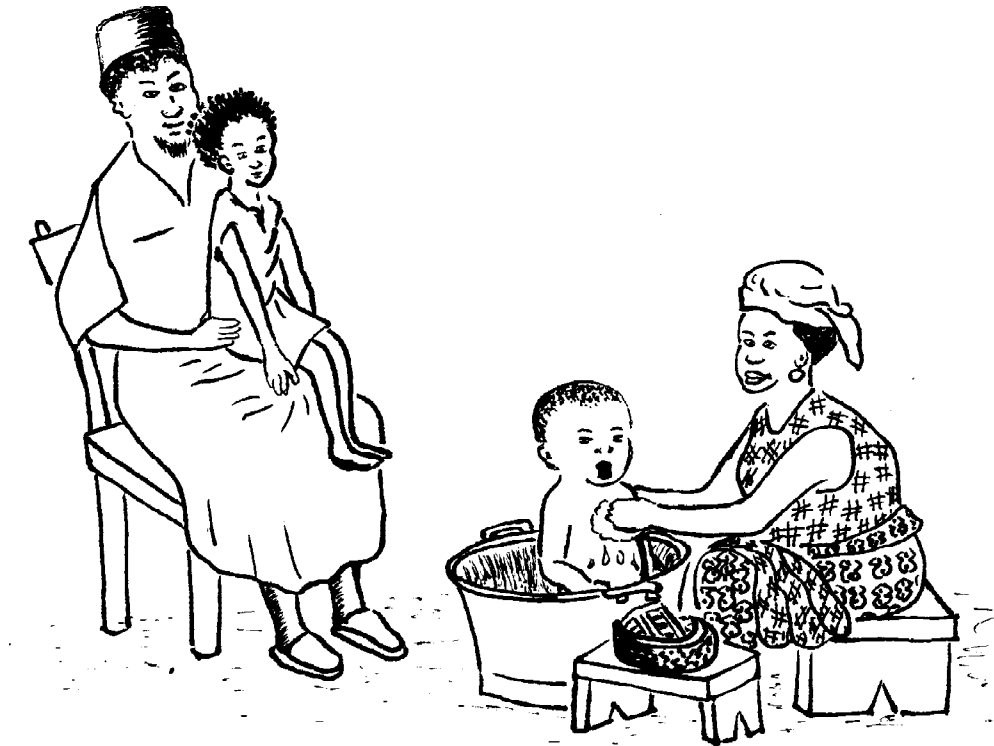
Questions, discussion, thanks.



## Behaviour trials

Behaviour trials were introduced and described in detail in Chapter 4, where they were used to develop target practices which were safe, feasible and acceptable to the community. The team works with groups of women and their families to develop the safe target practices and to test them for a couple of weeks. The mothers who participated in the behaviour trials will know all about the target practices and will have a good idea of their advantages. During and after the trials you can ask mothers about the advantages and disadvantages.

Several weeks after your trials, go back to mothers and carry out a





## Motivational Messages

You now have your data: the transcripts of focus group discussions with child-carers, transcripts of interviews with people who were already using safe practices, and the comments that people made during the behaviour trials. List out the positive benefits that people saw or got from the new practices.

Which themes come up again and again?

Í is it the pleasant smell of clean hands?

Í is it the fact that the husband appreciates the clean courtyard?

Í is it the fact that people felt proud to be clean when visitors came?

For behaviour to change, people have to see short term advantages that are consistent with their long term goals. Here is an example:

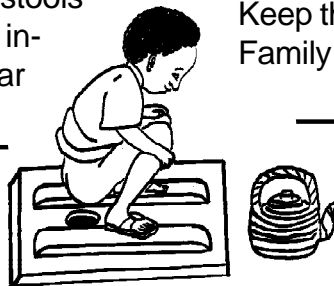
### Why teach a child to use a latrine?

#### Short term advantages:

Courtyard looks nice  
Get rid of bad smells  
Feel comfortable with visitors  
The motorbikes don't get dirty  
People don't walk in the stools  
Husband stays at home instead of going to the bar

#### Long term goals:

Live in an attractive environment  
Behave with dignity  
Respect from neighbours  
Keep the family healthy  
Family harmony



## Message positioning

Work together with your team to classify the short term advantages and long term goals served by the target behaviours in your trial communities.

Produce a **positioning statement** which picks out a key advantage and a key goal for each target practice. (Positioning is a term which comes from marketing, see Hiam, for example). It is not advisable to position your messages around the fear of disease and the death of children. As we saw earlier, messages about diarrhoea don't always make sense to people, and tend to revolt people because they are profoundly unattractive.

### Positioning statement: examples

**“I want to clean up stools and throw them in the latrine because...  
...people can't walk in them  
and my neighbours will respect me.”**

**“I want to wash my hands with soap after contact with stools because...  
...it leaves my hands smelling nice  
and I feel good when I feel clean.”**



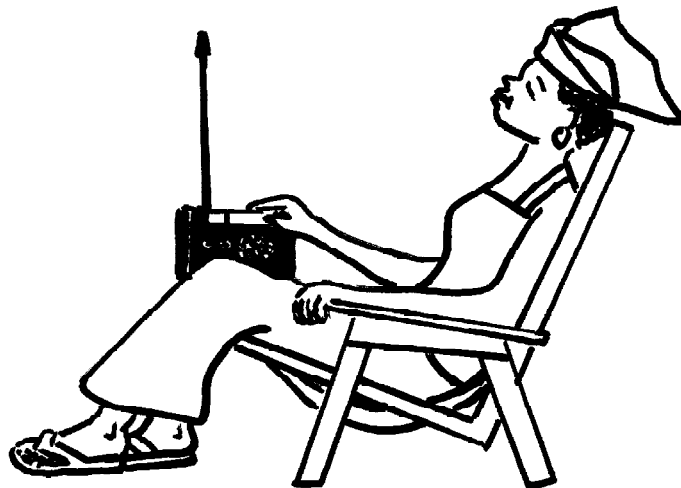




# Chapter 6

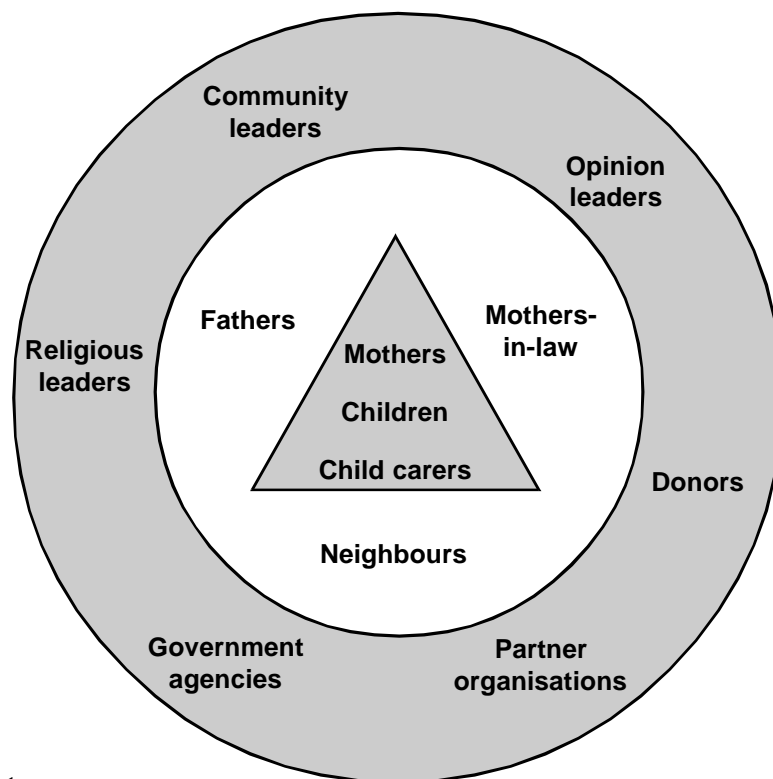
## Communicating Hygiene

In the last chapter we saw how to find out what people like about the safe target practices in order to motivate people to change. In this chapter we show how to use the results of your formative research to design a hygiene communication programme for specific target audiences.



## Target Audiences

No communication programme can expect to be successful if it does not know with whom it is communicating. One of the tasks of formative research is to determine who the targets of the hygiene promotion programme should be. At this stage we should already know who is carrying out the risk practices; they may be mothers of small children, or school age children, or they may be other adults. But people do not act in isolation; they are members of family groups and of a wider society which has a great influence on what they do. These families or social units are, in turn, influenced by people in authority, religious, political and traditional leaders and agencies and institutions as shown below. All of these groups need to be involved, or to support the programme to ensure that it succeeds.



**Target Audiences**

## Audience segmentation

Dividing your target audience up into separate groups to give them different messages is called audience segmentation. The diagram gives an example from Africa. Typically there are three groups to be addressed:

**Primary audience:** those who carry out the risk practices and who are being asked to change their behaviour (inner triangle).

**Secondary audience:** the people in the immediate family or society of the primary audience who support (or hinder) them in their behaviour (middle circle).

**Tertiary audience:** just as important as the other groups are the decision makers, groups, agencies and leaders who need to endorse and support the programme if it is to be successful (outer circle).

## Characteristics of target audiences

Each target audience has its own characteristics. We need to know enough about these groups to be able to target communication efficiently. It is no good, for example, to have an expensive television campaign aimed at mothers if few of them watch TV regularly. However, a TV programme to generate support from officials might be a worthwhile investment. Such decisions can only be made if you know certain things about your target groups. For example:

Who are the members of the target audiences?

Where can they be found?

How many are there all together?

What languages do they speak?

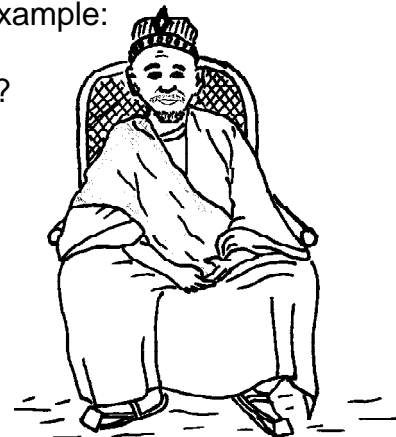
Who listens to the radio or watches TV regularly?

What proportion can read?

Do they read newspapers?

What organisations and groups do they belong to?

Which channels of communication do they like and trust?



### Characteristics of target groups: examples

Target Audience	Who?	Where?	Channels of communication	Objective
Primary	Mothers, children, child carers	Home, markets fields, schools	Weddings, baptisms, lessons, home visits street theatre, video	Change hygiene practices
Secondary	Fathers mothers-in-law, teachers neighbours, etc	Neighbourhood, work places, meeting places bars, churches, temples, sports	Radio, TV meetings, press, video projections, leaflets, special events	Support the changes in hygiene practices
Tertiary	Religious, community, political leaders government partner, donor agencies	Capital, offices churches, mosques, temples	Leaflets, radio, TV, meetings, seminars, ceremonies, print media, workshops, internet specialist press	Support the hygiene promotion programme



## CHANNELS OF COMMUNICATION

Channels of communication are the routes that are used to get the hygiene message across. They include: traditional channels of information such as word of mouth, messengers and social gatherings; modern channels such as radio and TV, and channels which are created for hygiene promotion, such as theatre or video shows and special events.

Channels of communication can be divided into three types:

- ④ One-to-one
- ④ Group
- ④ Mass

Whilst one-to-one communication between skilled communicators and target audiences is probably the most effective way of getting a message across, they are likely to be very time consuming and require many staff. An intermediate solution, less effective, but less costly, is to address groups of your target audience at meetings, video showings or special events. Mass communication such as Radio and TV are used more and more, and though they can reach many people at lower cost per capita, they have a lower capacity to affect behaviour because there is less opportunity for dialogue (Hiam).

### **Reach, effectiveness and cost-effectiveness**

The communication programme that emerges from your formative research needs to balance coverage and cost-effectiveness. To do this you need to find out about how target audiences communicate, and from this work out the **reach** of each potential channel. So, if for example, you find that only 7% of targeted men read the newspapers, but 75% listen to the radio, then radio has the better reach and would be an obvious choice for mass media. If you find that target women do not go out much and have little contact with any channels of communication outside their households, then house-to-house visits will be required. Work out the cost per capita of each form of communication and then select a mix of communication channels which balance maximum reach and maximum effectiveness with minimum cost (Kotler).

## **FINDING OUT ABOUT TARGET GROUPS**

In this manual we describe three ways of finding out about your target groups and how they communicate:

- ④ Existing information
- ④ Household survey
- ④ Focus group discussions

### **Using existing information**

First of all, much information will already be available. You probably already know about your tertiary target group, leaders and decision makers, because you have worked with them before. Demographic and survey data should be available to tell you about secondary and primary groups. How many women of child bearing age are there in the target area? How many school age children? What is the official literacy rate? Contact local newspapers and ask about their circulation figures. This is a list of some key questions to try to answer.

- ④ How many in each target group?
- ④ What is the literacy rate for each group?
- ④ What are the local organised groups? churches etc?
- ④ What are the local radio and TV stations?
- ④ What is their programme of broadcasts?
- ④ Are there any audience research figures?
- ④ What are the local and national newspapers/magazines?
- ④ What are their circulation figures?
- ④ What proportion of children are in school?
- ④ What is the school curriculum? Does it include hygiene?
- ④ How many teachers are employed?
- ④ What are the outreach activities of the health centres?

When you have collected it, make up a table which puts together all the information that you found for each target group. You can then use a simple household survey to find out about how your primary (and secondary) target groups communicate.

## Household survey

Design a survey format that suits what you know about the primary target population. An example is shown below. It will save time and effort if you combine the survey with one of the other activities, say straight after completing the structured observations. You will then have a sample of between 70 and 200 households, depending on the size of the target area (See Chapter 2). If you decide that you also need to target men as a part of the secondary target group you could interview them separately, or at the same time, if it is convenient. Tabulate results in the normal way.

### Extract from a household communication survey form

1. Do you have a working radio in the house?  
yes=1 no=2
2. Do you listen to the radio?  
every day =1, every few days=2, rarely=3, never=4
3. If you do, which radio station do you prefer?  
.....
4. If you do, what are your favourite programmes?  
name.....time.....  
name.....time.....
5. Do you belong to a local group, committee, church, etc?  
.....
6. In the last year how many meetings of this group have you attended?  
0, 1, 2, 3, 4, 5, 6, 7+
8. How often has a health worker come to your house in the last year?  
0, 1, 2, 3, 4, 5, 6, 7+
9. How often have you been to the clinic in the past year?  
0, 1, 2, 3, 4, 5, 6, 7+
10. Please read this sheet for me  
read easily=1, read with difficulty=2,  
not able to read=3

## Focus Group Discussions

Having found out about how people communicate, you need to involve your target audiences in the choice of media for the programme. The target audiences know best which media are most appropriate for hygiene messages. Here is an example:



An AIDS prevention programme in West Africa used traditional messengers called Griots to communicate the benefits of condom use to mothers in their homes. The programme was very successful, partly because Griots are traditionally allowed to talk about sensitive subjects, like sex. However, women in focus groups explained that Griots would not be good messengers of hygiene promotion because they were not seen as being 'clean' people. Griots were, however, involved in composing and singing a hygiene song at public gatherings.

A second series of focus groups may be needed to refine your communications plan, or you may be able to ask questions about communications in the first series of focus groups. You will need to consider holding a few more groups for men or mothers-in-law or other influential secondary targets of your programme. Some of the points to cover include:

- ④ How do people get messages about local and world events?
- ④ How do the local groups and associations function?
- ④ Who are the main influences on household behaviour?
- ④ Who are the right sort of people to promote hygiene?
- ④ What, how and when is the best way to send messages?

## Making a Communication Plan

You are now ready to work out a draft communication plan. Previous chapters helped you to decide on the target practices and the positioning of the messages. This chapter has shown you how to choose target audiences and pick out key channels of communication.

Assemble all of the information you have, and, together with your team, decide which channels of communication are likely to be most effective and to be affordable within your budget.

The next step is the creative part. You need to translate these elements into activities and events designed to get your messages over. These are commonly called communication supports.

### Communication supports

Communication supports use the senses of vision and of hearing to convey messages.

**Audio-visual** supports are meant to be seen and heard; they include theatre, video, film, and teaching with visual materials

**Oral** supports use words alone to pass messages, this may be in the form of a story, a radio announcement, or a visit from a health worker.

**Written** supports include leaflets, posters and articles in the press

**Visual** supports include posters, stickers and flip charts.

According to Hiam, Kotler and Graeff the best support media:

- ④ **are attractive:** so that they pull people in
- ④ **use local idiom** and situations: so that people feel it concerns them
- ④ **are repetitive:** so that messages are retained
- ④ **are easy to understand:** so nobody gets confused
- ④ **are participatory:** an exchange of views is most effective
- ④ **are provocative:** so that they are memorable and discussed
- ④ **show by example:** so that the new practices are seen to be possible.

## **Producing communication materials**

For each channel of communication decide on:

- ④ the principal message
- ④ the target audience
- ④ the motivation (immediate advantage and long term goal)
- ④ the promoter (eg, a respected elder, an opinion leader, a health agent)
- ④ the tone of the communication (e.g. if the ultimate goal of the hygiene practice is a happy family, the tone of a radio advert would be joyful and fun)

Give the task of designing the materials to small groups; include insiders and outsiders, team members and community members and creative people such as musicians, theatre writers, or artists. If you can afford it, use the advice of a local ad agency. If you can't, you may be able to find local publicists, radio journalists or entertainers with good ideas. Brainstorm lots of ideas and then work the best up into detailed scenarios or images. Keep a close track of your messages and their positioning: everybody has their own ideas about hygiene, creative people and 'experts' like go their own way, rather than using your well-researched insights into the target communities!

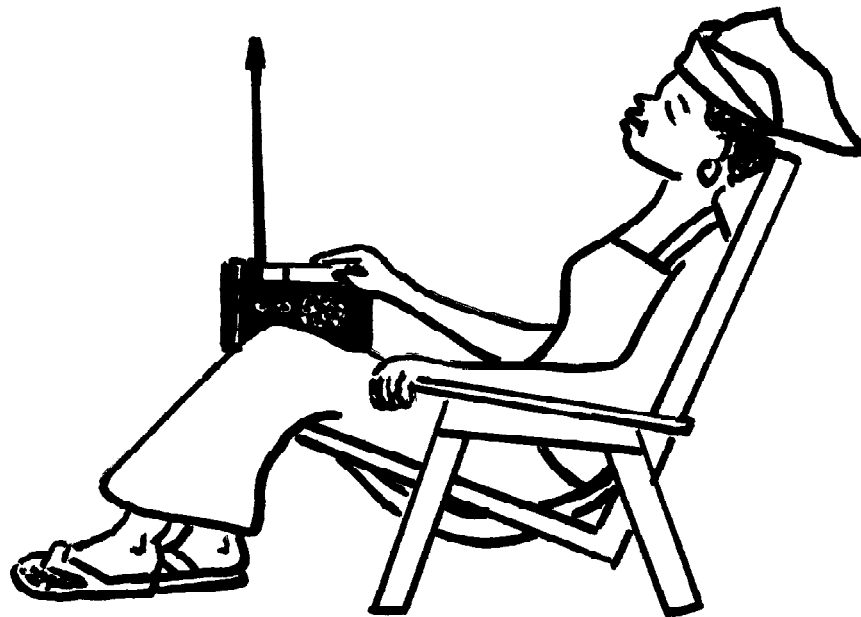
## **Testing communication materials**

Testing is very important because you will not get the communications materials right first time. The poster designed to show a mother washing her hands may look to the target audience like she is taking a pill, the radio ad you produce may be so funny that it distracts from the message. The training materials for health workers may not stop them from reverting to old habits of haranguing their audiences.

You will need to make trial versions of all of your materials and test them. Prototype posters can be taken to a school or a health centre and people can be asked what they see in them. Small focus groups with representatives of target groups can be held to evaluate tapes of radio programmes. Some members of the audience can be interviewed after the first show of a play to see what they retained. Health workers can try out materials and give you feedback on their usefulness.

### **Piloting the intervention**

As with any large scale intervention, it is wise to start on a small scale, to try out and revise all your approaches in one zone, for example. Carry out a detailed evaluation after six months and then revise your approaches and scale up.



## Conclusions:

### Hygiene promotion: practical and effective.

Changing household hygiene behaviour is one of the most effective means of preventing children from acquiring diarrhoeal disease. Indeed, the health impacts of water and sanitation interventions are mostly mediated through improvements in hygiene. However, hygiene education, as it is usually practiced, has had disappointing results. Reasons for failure include: not basing efforts on what people know, do and want; assuming that teaching about microbes will bring about behaviour change; not targeting just a few key feasible hygiene behaviour changes; turning off potential audiences with talk of dirt, death and diarrhoea; not offering positive, attractive solutions and not setting realistic and measurable behaviour change objectives.

This manual proposes a new alternative which sets about designing hygiene promotion programmes in a rational manner. It begins with what people know, do and want, and combines this with what experts know about hygiene to develop effective programmes. The new approach uses formative research to find out about and work with representatives of target communities to develop new, safer practices which are feasible and attractive. It then promotes these safe behaviours on the basis of the advantages that people perceive (which may or may not include health). Finally it investigates how people communicate and uses a mix of modern communication strategies to reach the widest audiences most effectively at the least cost. The formative research process is a simple and logical means of designing a hygiene promotion programme in collaboration with the people who need it.

Once the programme has been designed and the communication strategies and materials thoroughly tested and revised, the programme proceeds in the normal way. Regular monitoring of the process of the intervention, as well as of the behaviour change results, allows the programme to be modified and improved over its lifetime. The techniques described in this book adapt themselves well to the task of monitoring. For example; focus groups are an excellent way of determining what people are taking away from a theatre presentation or a radio play. Questionnaire surveys can help determine the level of coverage of the



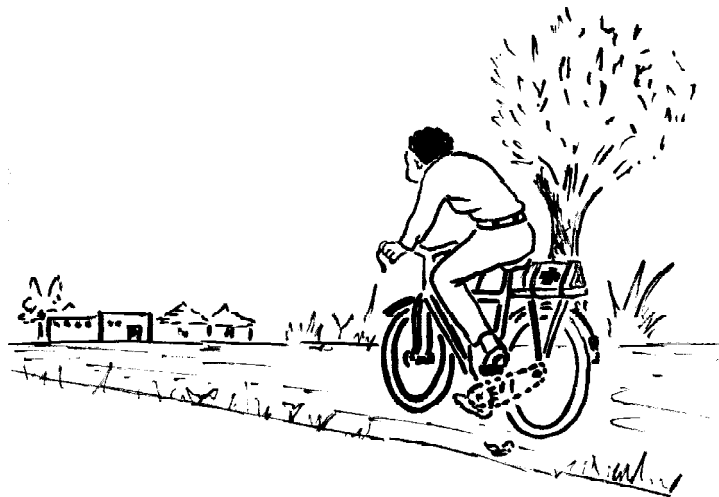
programme in terms of the proportion of the population having had a home visit from a community worker, or how many have taken part in a group discussion about hygiene, for example.

Finally, such programmes can be evaluated using structured observation to determine how much change has occurred in target practices.

Hygiene promotion is a new approach for many institutions who are used to working in old ways. In addition, it is hard to find people with skills in formative research and communication. As a result hygiene promotion teams will have to find out for themselves how to make their work more effective.

It is hoped that this manual is sufficiently clear to be used as a do-it-yourself guide to more effective hygiene promotion. Even if circumstances do not permit the approach to be used exactly as it is set out here, many of the elements of the approach can still be adapted to fit existing projects and programmes. Any ways of working which can help put what people think, want and do at the heart of programme design has to be an advance over the health promotion programme that is designed in an office.

LSHTM and UNICEF are keen to modify and adapt this guide to make it of more practical use. Please send your comments and suggestions to the director of programme division (see preface).



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## GLOSSARY

**Audience Segmentation:** Dividing up the population into groups by age, sex, position in the family, etc so as to use different messages and communications strategies for each group.

**Formative research:** a strategic research process which combines what insiders and outsiders know, do and want so as to develop appropriate interventions

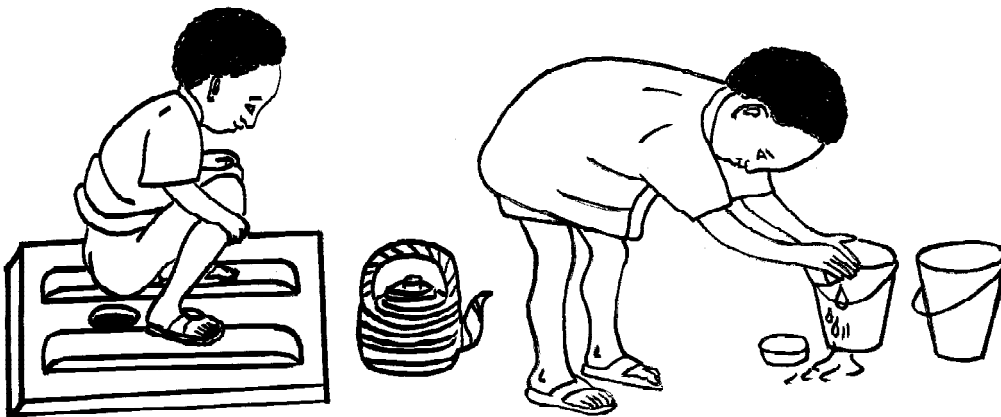
**Positioning:** the way in which a message is pitched to appeal to the factors that motivate behaviour change

**Reach:** the proportion of a particular target audience who can be contacted via a particular channel of communication

**Risk practices:** those few behaviours that are particularly putting health at risk

**Target audience:** the people who carry out or influence the practices that you want to change

**Target practices:** the safe practices which replace those that are putting people at risk of disease



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\*\* Publication upcoming.