

From hygiene education to hygiene-behaviour change: Some reflections by Lizette Burgers

Introduction

Poor hygiene and sanitation is largely responsible for the global burden of diseases, such as schistosomiasis (with an estimated current global prevalence of 200 million cases), typhoid fever (16 –17 million cases), intestinal helminthic infections (1500 million people infested), various diarrhoeal diseases (over 2 million infant and child deaths annually) including cholera (endemic disease now in Africa), and Trachoma, the second most important cause of blindness world-wide. Although most diseases can be treated using good case management and effective medicine, the existing needs far exceed the capacity to deliver such services. Neither a strictly medical approach with case detection and treatment neither a strictly engineering approach with provision of facilities like safe water supplies and latrines will result in complete interruption of transmission.

Hygiene education is increasingly being recognised not only as an essential element in water and sanitation programs, but as an important effort in an of itself. Changing household hygiene behaviour is one of the most effective means not only to prevent many of the infectious diseases but also to create a real demand for sanitation services, which will in turn lead to improved health¹. Some donor agencies support the integration of hygiene education in their water and sanitation programmes or integrate hygiene and sanitation activities in primary health care and nutrition programmes but on the field the effective examples remain limited. To date, there has been no consistent hygiene education policy among donors or implementing organisations and world-wide still very little effective hygiene education takes place.

However, a number of promising new success stories suggest that some governments start to include hygiene education/promotion in their policies and that those involved with hygiene promotion or hygiene education programmes are already incorporating the lessons from their own and others experiences to make hygiene education more effective.

Innovations

Dissappointing results of conventional hygiene education programmes

When planners and implementers of water and sanitation projects found out that their original assumption that just designing and constructing better facilities would lead to improved health didn't work they called for health education to teach the people the health benefits of installed facilities and get them accepted and used . However, studies

¹ Studies have shown that improvements in water supply, sanitation and hygiene were associated with a reduction of 22% in diarrhoea incidence, and of 65% in deaths due to diarrhoea. Research tell us that the health benefit from water supply is mainly due to the hygiene improvements which water supply makes possible, so that practically the entire improvement was due to sanitation and hygiene. To reaffirm the point, more recent studies have shown that hygienic disposal of children's stools is associated with 30-40% less risk of serious diarrhoea

on water and latrine use have made clear that hygiene education cannot convince people to use facilities that don't function properly. Many of the hygiene education programmes, as they are usually practised, have had disappointing results. Reasons for failure include: not basing efforts on what people know, do and want; assuming that increasing people's knowledge will make people drop unhygienic practices and adopt improved ones; 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.

Hygiene behaviour-change instead of hygiene education

The past few decades have been fruitful for those who work in the general field of health education and lessons have been learned. In fact, what has been discovered underscores the inadequacy of the term "hygiene education" itself. Education alone is clearly not enough. Hygiene education should be reconceived and renamed "hygiene behaviour-change" or "hygiene promotion". Although perfect recipes for behaviour-change programmes have not emerged, very clear lessons have been documented repeatedly that highlight several common elements required for successful health-related behaviour-change programmes. Some of the principles are:

- Human beings are not empty vessels waiting for information to direct their lives;
- Levels of knowledge can be raised, but this may have little or no effect on behaviour, particularly on preventive behaviour.
- Action is determined not only by knowledge, but also by situational and structural factors.
- Individuals act, but their actions take place within social contexts in which other peoples evaluations of them matter.
- Sustained behavioural change may require continuing input of new ideas and support.

Marketing approaches and formative research

Using approaches from anthropology, epidemiology, communications science, marketing and health promotion, new full scale hygiene promotion programmes have been designed for the wider community in collaboration with the stakeholders. Based on studies, sometimes called formative research, simple, positive and attractive messages are positioned according to what people know, do and want. Measurable behaviour change objectives are set and management, monitoring and evaluation goals complete the hygiene promotion. Practical steps in promoting hygiene behaviour change:

- Identify risk practices: understand what people do and why
- Select practices for intervention
- Determine the positioning of the message: what motivates those who currently use safe practices and what are the perceived advantages.
- Define the primary audiences: who employ the risk practices and who influences the primary audiences?
- Select communication channels and make use of all available resources
- Develop a detailed behaviour-change programme jointly with the community
- Take a gender sensitive approach
- Transfer skills by doing, not just talking
- Monitor and evaluate your work.

Gender-sensitiveness and traditional roles

Targeting women or men in their traditional roles may achieve specific and short-term WES objectives, but it may also have seriously limited results. For example, counting on women alone for changes in hygiene and sanitation behaviours considers their traditional role, but does not address the stereotyping that accompanies it. Nor does it include the important role of men and boys in behaviour change that would lead to healthy hygiene and sanitation practices. In addition, a more balanced gender division of labour needs to be considered.

Private sector involvement

In some countries in Latin America promising results are booked with mobilising the commercial sector for public health objectives. The private sector, like soap manufacturers, marketers and/or distributors mass produce, distribute and promote soaps. These businesses include messages on the health benefits of handwashing with soap on their products and in their promotional materials. The distribution infrastructure of these businesses often reaches the most remote rural areas.

Actions beyond 2000

With the above described emerging health problems and knowing that the poorest 1000 million people on Earth are seven times more likely to die from infectious diseases - many of these due to inadequate hygiene and sanitation - than are the least poor 1000 million, it has become increasingly important that governments develop and implement clear policy priorities and establish enabling frameworks to address under-development and poor hygiene.

A greater focus of hygiene education on measurable behavioural change and conscious utilisation of the factors influencing such change require greater thought and action at higher levels.

- K More commitment must be given to hygiene behaviour-change instead of keeping the character of an add-on to technical interventions. Development of national policies for hygiene education and promotion and implementation strategies are needed in which Government should take the leading role. Where Government does not have the capacity to take the leading role, ESA's should play a supporting role to enable it to lead to the policy development. The policies should reflect the need for different approaches to rural and urban hygiene promotion and hygiene education in schools and learning environments.
- K Hygiene education and promotion is still a rather new domain and, within health education it is still little recognised as a valuable specialisation. This may improve:
 - once we really start hygiene promotion programmes who move from the increase of knowledge to the demonstrated improvement of hygiene conditions and practices;

- When we are not afraid to experiment by using action-learning approaches focussing on building people's capacity to learn through processes of adapting and re-adapting ideas, perceptions, information, knowledge and experience, to deal with reality and, ultimately to bring about change;
 - When we use systematic approaches like formative research, SARAR, PHAST, to design full scale gender-sensitive hygiene promotion programmes in collaboration with key stakeholders and define simple, positive and attractive messages designed for local channels of communication. Measurable behaviour change objectives are set and management, monitoring and evaluation goals complete the hygiene promotion programme;
 - We measure concrete results and carefully document the lessons learnt.
- K Capacity building needs to take place at all levels and at all settings. In order to get hygiene promotion on the agenda a critical mass of trained and experienced people is required. Training courses for improved planning and management, monitoring of hygiene behaviour-change programmes and exchange visits could profit from the lessons learnt to make conventional hygiene education programmes more effective.
- K Evaluations on hygiene practices and effectiveness of hygiene promotion and education interventions should become a standard part of all implementation programmes. Several valuable tools have been established for these evaluations but more financial and technical support should be made available.
- K There is need for more fundamental research to assess replicability of approaches, in particular on what are the most cost-effective methods in motivating people to change behaviour.
- K We need to know better how to deal with gender differences and achieve a more balanced gender division of labour needs instead of targeting women or men in their traditional roles to achieve specific and short-term WES objectives. How to develop educational strategies which also change men, not only women for almost all hygiene improvements.
- K Children, who are so vulnerable but also so eager to learn, can be motivated and equipped with knowledge and skills as well as the facilities to adopt safe hygiene behaviours. Attention should be paid to:
- Opportunities like the initiatives to support Education for All, to integrate hygiene education in school programmes and to identify the role children can play as potential vehicles of change within their homes and communities.
 - The specific preferences and needs of children, especially girls, in the design of the programme. Hygiene promotion programmes can touch upon the unbalanced workload between girls and boys and its consequences for the education and development of girls.
- K Local and regional networks of experiences need to be developed and these should link up with information network initiatives such as GARNET.

- K Partnerships can be stimulated between the public health sector and national and international private companies to create commitment to establish key hygiene behaviours, like handwashing with soap, through a mass and selective hygiene education campaign directed at high risk groups.

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