

# HAPPY, HEALTHY AND HYGIENIC

HOW TO SET UP A  
HYGIENE PROMOTION PROGRAMME

# 1

## PLANNING A HYGIENE PROMOTION PROGRAMME

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# **HAPPY, HEALTHY AND HYGIENIC: how to set up a hygiene promotion programme.**

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This handbook is designed in four parts to help you set up a hygiene promotion programme.

This hygiene promotion handbook is the fifth of ten publications in the Programme Division/Water, Environment and Sanitation Technical Guidelines Series.

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PROGRAMME

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## **Preface**

This mini-manual is part of a series of four being produced by the London School of Hygiene & Tropical Medicine (LSH&TM) in cooperation with the Government of Burkina Faso and with the support from UNICEF. The manuals are based on the experiences of the UNICEF-supported Saniya Project.

The objective of this series is to show how to encourage people to adopt safer hygiene practices and to make hygiene programmes more effective. It advocates the promotion of safe hygiene practices as preventive measures against diarrhoeal disease, and thereby contributes to a reduction of child mortality in developing countries.

The first mini-manual in this series introduces the ideas and techniques of hygiene promotion; the second one covers how to identify practices that need to change and how to develop replacement practices with individuals, families and the community; the third one deals with the topic of motivating behaviour change; and the fourth one deals with how to understand how people communicate and how to build on that knowledge to design an effective communication programme.

We look forward to receiving suggestions and ideas on how to improve support to field interventions in the area of hygiene promotion and to continue partnerships to strengthen hygiene programmes for children.

## **Acknowledgments**

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The pictures were drawn by Mamadou Traore and Emmunuel 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:

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

## Who is this book for for?

If you are a:

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

Then this book is for you!

## How to use this book

There are four sections in this series.

- ⇒ Manual 1 shows how to plan a hygiene promotion programme
- ⇒ Manual 2 shows how to target behaviours that need to change
- ⇒ Manual 3 deals with how to motivate people to change
- ⇒ Manual 4 shows how to design hygiene communication programmes.

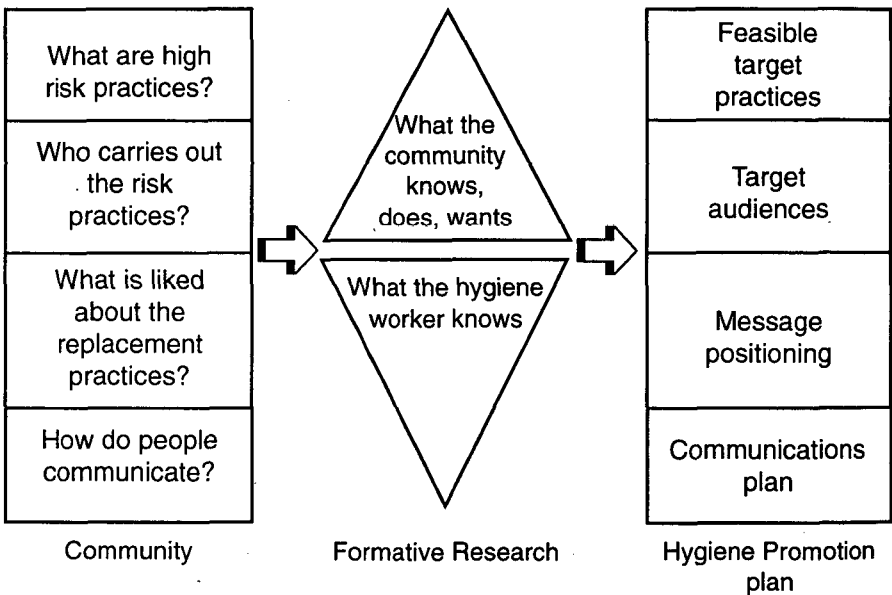
The manuals can be used separately or all together. The other manuals will, however, be easier to understand if you read this one first. They have been kept short and simple, and they are in black and white so that you can photocopy them. We have minimised the technical jargon, but you may find some key words you have not met before. Definitions can be found in the glossary at the end.





## 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?



The manuals show how to go about answering these questions to design a full scale hygiene promotion programme for the wider community, 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 .

## **Background to these manuals**

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). Finally UNICEF provided support for the London School of Hygiene and Tropical Medicine to condense the lessons and experiences into these four manuals 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 this approach we describe in these manuals 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 these manuals.

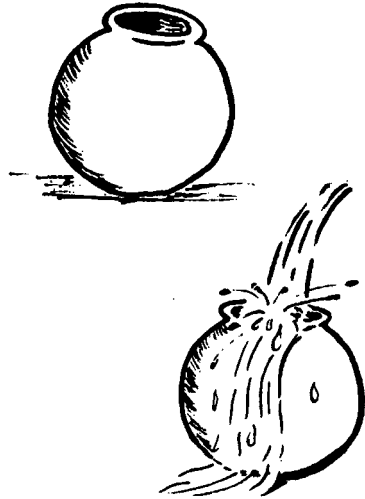
We call this systematic approach *formative research*. It has been used to find out what people want in a bed net treatment programme for the prevention of malaria in Burkina Faso. Formative research could provide information for the effective marketing of sanitary latrines or for designing village water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

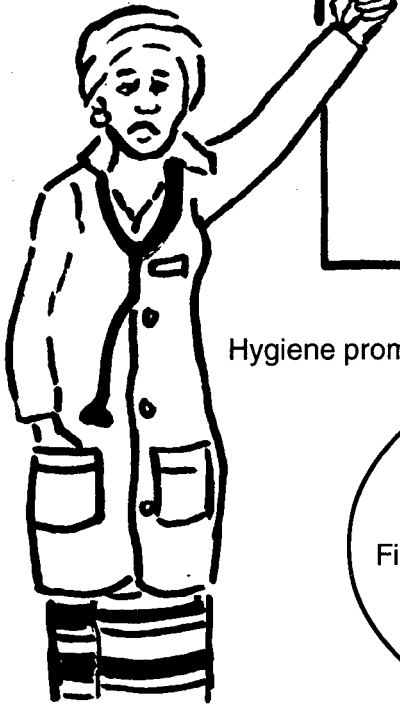
Even if we could convince large populations that germs spread by poor hygiene cause disease, would this mean that they would change their practices overnight? Though knowing about disease may help, new practices may be too difficult, too expensive, take too much time, or be opposed by other people. Fear 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 these manuals). 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

Instead of...



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

Hygiene promotion...

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



## SIX STEPS TO HYGIENE PROMOTION

The next pages take 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. Then implementation can begin.

### 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 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 these manuals, 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

Objective	Manual	Questions	Methods
Identify risk practices	<b>2</b>	Which specific practices are allowing diarrhoeal pathogens to be transmitted to children?	Epidemiological knowledge, Environmental walk Checklist observation
Select practices for intervention  Determine message positioning	<b>2</b>  <b>3</b>	Which risk practices are most widespread? Which risk practices can be altered?  What motivates those who currently use 'safe' practices? What are the perceived advantages of the 'safe' practices?	Structured observation Behaviour trials Focus group discussions Focus group discussions Interviews with 'safe practicers' Behaviour trials
Define the target audiences	<b>4</b>	Who and how many employ the risk practices? Who influences the primary audience?	Structured observation Focus group discussion
Select communication channels	<b>4</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 manuals will help you with which question. 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. Again the relevant manuals 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 ). 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 know that most diarrhoea pathogens come from stools. Any practices that allow faecal material into the child's environment, especially stool disposal 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. Manual No 2 gives detailed guidance.

**Define message positioning.** This discussed in manual no 3. 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 (often mothers, and 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. Manual No 4 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 manual 4)

If all goes well, 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

#### **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:

- ⇒ Your objectives
- ⇒ The methods that you used
- ⇒ The results that you got
- ⇒ Your interpretation of the results
- ⇒ 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 bureaucrats 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. Use the manuals to help make a plan with the following elements:

- ⇒ **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'.
- ⇒ **Target practices:** the key hygiene practices that replace the risk practices
- ⇒ **Target audiences:** age, sex, number in each group
- ⇒ **Positioning:** Motivation for behaviour change (why do target audiences want the new practices?)
- ⇒ **Channels of communication:** for example, street theatre, house visits, radio, schools.
- ⇒ **Communication materials:** the supports you develop for your communications activities like theatre scenarios or flash cards.
- ⇒ **Monitoring:** methods for following progress in programme activities, indicators, programme outputs, and in behaviour change
- ⇒ **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 (see manual 4).



## **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 manual 4.)

**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 representative sample 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

Research questions	Methods used	Key findings	Key findings
<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 group	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 skimping 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.

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

## 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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## A new way of promoting safe hygiene...

This is the first in a series of four manuals which explain how to set up a hygiene promotion programme. The manuals take you through a step-by-step process of working with communities to design a programme which suits what they know, do and want.

Using approaches from anthropology, epidemiology, communications science, marketing and health promotion, the manuals show you how to answer such questions as:

- ⇒ what specific practices are putting health at risk?
- ⇒ what can motivate people to change their practices?
- ⇒ what are the best ways of communicating hygiene messages?

They show how to use the answers to design a hygiene promotion programme that responds to the needs of health consumers.

The manuals will be of use in water, sanitation and health programmes and to community, non-government and government organisations.

