

WELL FACT SHEET

Hygiene Promotion

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The following summary of principles is based on a paper by Valerie Curtis, Bernadette Kanki, Raphael Gbary and Prabhakar Sinha. Further guidance is available on request from WELL.

Hygiene education is potentially one of the most effective weapons we have to reduce the toll of diarrhoeal diseases (see box). However, it has usually failed to achieve convincing results, largely because of four fallacies which underlie traditional hygiene education programmes.

Fallacy no. 1. Adults are 'clean slates' on which to write new ideas.

All societies already have their own explanations for diarrhoeal diseases, and rationalisations for their existing practices. People will reject messages which simply contradict these views.

Fallacy no. 2. Adults have the time and motivation to learn new ideas.

Traditional school-type teaching is of little value to hard-pressed mothers, who have other uses for their time and energy.

Fallacy no. 3. New knowledge equals new practice. Fear of germs or disease is rarely a strong enough motivation to change domestic practices. The change may also be too expensive or time-consuming, and there may be discouragement from other members of society.

Fallacy no. 4. A whole variety of hygiene practices should be encouraged.

Only a limited number of hygiene practices are likely to be responsible for most diarrhoeal episodes, but hygiene education programmes rarely seek to identify them and target them specifically. Getting people to change the habits of a lifetime is extremely difficult; the effort should not be diluted by targeting too many practices.

...Hygiene practices help prevent diarrhoea

...Handwashing with soap and water after contact with faecal material can reduce diarrhoeal diseases by 35% or more.

...Using a clean pit latrine and disposing of children's faeces in it can reduce diarrhoea incidence by 36% or more.

...*Source: Almedom et al. 1997*

Fallacy no. 5. Health education can be added-on.

Education sessions are often organised to fit in with other activities such as building a well or a mother's visit to a health clinic, and are often tacked on to a programme as an afterthought. Little thought is given to the cost, the potential population coverage and clear targets are rarely set.

Building on field experience in Africa and Asia, researchers associated with WELL have developed a new approach, called **hygiene promotion**. Instead of beginning in an office, programme design begins in the community, finding out what people know, do and want. The approach works well in a participatory, village-by-village manner. However, it is most useful and cost-effective on a large scale, where the intervention is first developed locally, by participatory research, and then applied across regions or urban centres.

The key principles are as follows:

1. Target a small number of risk practices.

From the viewpoint of controlling diarrhoeal disease, the priorities for hygiene behaviour change are likely to include hand washing with soap (or a local substitute) after contact with stools, and the safe disposal of adults' and children's stools.

2. Target specific audiences.

These may include mothers, children, older siblings, fathers, opinion leaders, or other groups. One needs to identify who is involved in child care, and who influences them or takes decisions for them.

3. Identify the motives for changed behaviour.

These motives often have nothing to do with health. People may be persuaded to wash their hands so that their neighbours will respect them, so that their hands smell nice, or for other motives. By working with the target groups one can discover their views of the benefits of the safer hygiene practices. This provides the basis for a motivational strategy.

4. Hygiene messages need to be positive.

People learn best when they laugh, and will listen for a long time if they are entertained. Programmes which attempt to frighten their audiences will alienate them. There should therefore be no mention of doctors, death or diarrhoea in hygiene promotion programmes.

5. Identify appropriate channels of communication.

We need to understand how the target audiences communicate. For example, what proportion of each listens to the radio, attends social or religious functions, or goes to the cinema? Traditional and existing channels are easier to use than setting up new ones, but they can only be used effectively if their nature and capacity to reach people are understood.

6. Decide on a cost-effective mix of channels.

Several channels giving the same messages can reinforce one another. There is always a trade-off between reach, effectiveness and cost. Mass media reach many people cheaply, but their messages are soon forgotten. Face-to-face communication can be highly effective in encouraging behaviour change, but tends to be very expensive per capita.

7. Hygiene promotion needs to be carefully planned, executed, monitored and evaluated.

At a minimum, information is required at regular intervals on the outputs (e.g. how many broadcasts, house visits, etc.), and the population coverage achieved (e.g. what proportion of target audiences heard a broadcast?). Finally, indicators of the impact on the target behaviours must be collected.

Links with other activities

Hygiene promotion can be a stand-alone activity or it can figure as a planned part of water, sanitation and diarrhoeal disease programmes. The principal danger of subsuming it into a wider programme is that it usually becomes the poor relation, with a low priority for resource allocation and management time. This is almost inevitable when the main priority is seen as the number of wells or latrines constructed. It may be advisable to create separate but linked programmes, each with their own targets and management arrangements.

Reference

Almedom, Astier M; Blumenthal, Ursula & Manderson, Lenore (1997) *Hygiene Evaluation Procedures; Approaches and Methods for Assessing Water and Sanitation Related Practices*; London School of Hygiene and Tropical Medicine (LSHTM) and International Nutrition Foundation for Developing Countries (INFDC).