

40th WEDC International Conference, Loughborough, UK, 2017

LOCAL ACTION WITH INTERNATIONAL COOPERATION TO IMPROVE AND
SUSTAIN WATER, SANITATION AND HYGIENE SERVICES

Hygiene promotion: have we got the right answers to the knowledge behaviour gap?

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PAPER 2729

Obtaining effective hygiene behaviour change through Hygiene Promotion (HP) remains a challenge. A discrepancy exists between the scientific knowledge now available about human behaviour and the HP interventions implemented by aid agencies. Quality standards need to be defined and applied to ensure minimum quality of HP interventions. This paper presents some insights and practical recommendations for closing the knowledge behaviour gap.

Problem statement

The knowledge behaviour gap is a well-documented phenomenon affecting many, if not a large majority of Hygiene Promotion (HP) interventions across the world. Numerous evaluation studies show that people are able to name the main hygiene behaviours promoted but find it difficult when it comes to adoption.

The reasons for this phenomenon are bound up with the complexity of human behaviour: acquiring new knowledge on a particular behaviour – whatever positive its effects on human health might be - does not lead automatically (actually rarely) to the adoption of this behaviour.

This is due to the fact that such “wise” advice are in competition with other strong determinants of human behaviours. For instance, one's belief in one's ability to perform the behaviour (self-efficacy), the attention paid to what the others think and do (social recognition). A third category exists, whose elements are not competing directly with healthy behaviours but are responsible for inertia: the force of life-long habits, the difficulty in mobilising energy to adopt new behaviours when facing a difficult or stressful life situation.

All these elements make it difficult to achieve results in terms of effective behaviour change, especially if the behaviours targeted are linked to food or hygiene habits, as these habits are acquired at an early age stage in one's development

Source and limitations

The author of this paper is a WASH technical advisor working for an international non-governmental organisation (INGO) implementing more than 20 WASH programmes across the world.

This allows for the comparison of contextual factors on a particular type of approach. This paper provides insights into how the HP approach was applied across a number of country contexts.

The analysis and reflection presented in this paper draws on the author's work experience during the period 2011-2016. This experience draws on a number of processes and activities including: field visits (5 country visit per year), regular exchange with the different WASH teams (skype, emails), internal WASH workshop (2 during this period), WASH sector meta-evaluation (2 during this period) and numerous evaluation reports.

It is important to note that although WASH advisors do not directly implement the HP activities, they support implementation throughout the project life cycle and cannot therefore be considered as an external impartial stakeholder.

Past and current trends regarding the answer to the knowledge behaviour gap

Since the 1980's, agencies such as Concern Worldwide have been applying participative methods. Among these, the PHAST (Participatory Hygiene and Sanitation Transformation) is the most commonly adopted approach used for promoting hygiene-related behaviours. This type of facilitation allows for an exchange of information on the main fecal-oral contamination pathways and how to prevent them.

Although the PHAST approach also includes a planning exercise for putting into practice the behaviours discussed, our WASH teams find it difficult to obtain effective behaviour change by using only this type of approach. Reasons for this might not be intrinsic to the approach – see below the discussion section.

In the 2000s, a change of paradigm occurred in the hygiene promotion world, there was growing evidence that adoption of new behaviours can be reached by using approaches that rely not so much on acquisition of knowledge than on triggering an emotional response.

This is the case for instance with the Community Led-Total Sanitation (CLTS) approach that relies on disgust, a strong instinctive reaction which, when obtained, can trigger a real desire for change. When such a triggering point is reached, the CLTS facilitator uses the momentum to generate a wave of latrine construction in the concerned community.

This is the reason why a majority of Concern's programmes – but to our knowledge, this is also the case for many other agencies - are now using a mixed PHAST/CLTS approach: it allows for conciliating knowledge acquisition (the fecal-oral transmission routes) and new practices to be put in place (latrine construction) in one single momentum.

Nevertheless, in most cases, this mixed approach remains insufficient to obtain behaviour change for behaviours other than “stopping open defecation”, typically, handwashing with soap at critical times (although the CLTS + approach can achieve some results in this regard).

For these behaviours, other types of approaches are now promoted: either targeted campaigns (behaviour centred design approach), using the CLTS on triggering an emotional response, or/and the small doable actions approach.

The behaviour centred design approach focuses on a single behaviour at a time, and is based on the same core principle as CLTS: the idea that to obtain effective behaviour change one needs messages that resonate with people's emotions. These campaigns rely on the same techniques as advertising: search for resonating slogans, storytelling, etc. Context-related “insights” are first collected through formative research and then used for designing specific Information Education and Communication (IEC) material for the campaign. The campaigns are conducted through a series of activities all performed in a short period of time and at the same location to maximise its impact.

For instance, a bus tour going from one community to another, performing a theatre play, organising a round table with community leaders, a door-to-door campaign, the testimonies of people having already adopted the promoted behaviour. All these activities rely on the theatre script, stickers, posters, songs, etc., designed specifically to match the particular context of intervention. These campaigns are much more costly than traditional approaches but bring real results in terms of effective behaviour change (Biram, 2014).

The small doable approach is based on the idea that to obtain effective behaviour change, one should not only disseminate knowledge and messages related to hygiene behaviours. But also support the community to put into practice the behaviour promoted. In other words, this approach focuses on implementing small doable actions, either through specific training – for instance a soap making workshop, construction of tippy taps, - or through direct support. For example, a door-to-door campaign for supporting each Household to build their own handwashing station; setting up of a specific area nearby the water point for cleaning the jerry cans; organising a community cleaning day.

Analysis and recommendations

Defining realistic objectives for HP interventions

Attaining tangible results with respect to effective behaviour change continues to be a challenge for a number of WASH programmes. This is due to a number of factors: either they are in a too challenging context, or the team does not have the skills and/or budget to implement successful BCC strategies. Taking into account these limitations, it is our view that a fundamental distinction should be established between the following objectives:

1. HP interventions that aim at increasing people's knowledge on the main fecal-oral contamination pathways and how to prevent them.
2. HP interventions that aim at obtaining effective behaviour change.

The second objective should be reserved to WASH programmes who have the required skills and means to successfully manage their HP interventions.

The knowledge behaviour gap occurs each time a WASH programme strives to reach the second objective while allocating resources only sufficient to achieve the first objective.

It is important to note that the interventions that can only achieve the first objective are still useful: increasing people's knowledge about the fecal-oral contamination routes and how to prevent them is indeed an important step. Thus, this is not the same thing as obtaining effective adoption of the hygiene behaviours promoted (which of course, is the final goal).

Applying minimum standards for HP intervention

Despite growing awareness of the importance of hygiene promotion, this component often remains the "poor relative" in the WASH interventions. In practical terms this translates into small budget allocations. For example, this can then lead to scenarios where the HP team rely on black and white photocopies to do their work. This can be visually unappealing and reduce the impact of their work. A PHAST or a community-health club facilitation relies heavily on the quality of the support material. Laminated, coloured A3 flip-charts are required for group facilitation.

Respecting the golden rules of HP communication

WASH teams often wish to pass on too many information to the population. For instance during cholera outbreak, it is tempting to describe the prevention measures all at once – see picture 1 – although studies have shown that for a better impact it is best to communicate on one topic at a time (better to have a series of posters or drawings than to add too much information on one single support). If the illustration depicts a process (Ex: how to prepare chlorine solution), then one illustration per step is all that is needed.

Since it is known that to adopt new behaviours, people need information which resonates with their emotions, the text of the HP posters, leaflets, etc. should be appealing: better a slogan than a long text.

To avoid misinterpretation or just a lack of interest from the viewer, the illustrations should reflect people's real life and particular context: the materials should show real people in real world settings.

The Location is crucial for displaying the IEC material (posters): the closer to where the behaviour is to be performed the better. For instance, the inside of the latrine door for messages related to handwashing after defecation.

A pre-test is needed before final printing to ensure the target audience understands the document as expected.

Applying the human-centred approach

There is an obvious connection between hygiene promotion activities and the construction of new WASH infrastructures. Unfortunately, it is not rare for WASH engineers to design WASH facilities without exchanging with the HP/"software" team. Concern strongly encourages a joint reflection between engineers and hygiene promotion teams, based on the human-centred approach. That is to say taking into account the needs and preferences of the future users of the new WASH infrastructure before designing them (either for a new water point, a toilet or a handwashing station).

Building on existing local resources

Whatever the community, certain persons will adopt the behaviours promoted more quickly than others. The testimony of these *early adopters* through informal meetings or formal peer education has often proven to be an effective strategy. For the same reason, gaining support from influential leaders can achieve better success than relying only on a Concern HP team. For instance, working with religious leaders for them to refer to the Holy Scriptures passages related to hygiene promotion.

Fostering innovative approaches

New educational support and technical products are now available for reinforcing adoption of new behaviours. They allow facilitators to put in place new innovative HP activities. Examples: microscope use,

glow germs (who help « making visible the invisible »), or picto micro-projector for displaying short educational videos even in remote places.

Integrating with other sectors

For obtaining results in terms of diarrhoeal diseases, Concern promotes an integrated approach between all sectors that the organisation supports. For the hygiene promotion components, it can translate into increasing exchange, joint work planned or even merging with other networks disseminating hygiene messages. For instance, community health workers, nutrition workers, mother care groups. The impact of the messages will be more important if the messages are harmonised between the different teams (for instance, promoting the same key moments for handwashing). What is more, behaviour which requires regular follow-up campaigns for maintaining the level of behaviour adoption reached, integrating hygiene promotion into already existing community networks allow for sustaining the gains obtained.

Analysing the motivations and barriers towards effective behaviour change

Taking into account the complexity of the factors that can influence positively or negatively the adoption of new behaviours, Concern promotes the analysis of barriers and motivators that lead, in each specific context of intervention, to the proposed behaviour being adopted or not. This analysis can be conducted through applying a formal barrier analysis methodology or simply focus group discussions.

Developing systematic hygiene promotion in schools

Since the adoption of new behaviours tends to be easier during a child's development, it is recommended to develop promotion activities in schools or/and for youth groups. For instance through the CHAST approach or support to youth clubs.

Tackling the gender issue

In a large majority of our contexts of intervention, women are in charge of fetching water and all hygiene activities, whereas men remain the decision makers. Concern promotes a better balance in terms of tasks and decision making linked to hygiene promotion. For instance, by proposing men's group discussions related to daily hygiene tasks or by promoting women to be elected into key positions within the different WASH committees.

Paying special attention to the environmental issues

Acknowledging the reality and the seriousness of environmental degradation, the hygiene promotion strategies should be careful not to affect the environment. For instance, by not promoting boiling as a treatment for human drinking water consumption (which can lead to increased deforestation).

Monitoring and evaluation

WASH indicators for measuring the results obtained at the end of an HP intervention are crucial: one can only analyse what is measured. When only based on self-reporting, hygiene promotion interventions report behaviour adoption rates that do not reflect reality. Only direct observation can provide data that will show whether or not the approach implemented is successful. If the programme only measures whether or not the people are able to provide the "good" answers, then it won't be able to determine if people have adopted new behaviours and, therefore, if necessary, plan corrective actions.

Discussion

- The use of science of behaviour/marketing techniques for obtaining behaviour change raises an ethical question: is it acceptable for an international aid organisation to design intentionally a HP campaign aiming at triggering an emotional response that will, unconsciously, generate a desire for change among the population targeted?
Raising this question may seem unnecessary, since the urgent need for better hygienic practices is clearly manifest, nevertheless the end does not justify all the means and one cannot deny - as it is the case with advertising – there is an element of manipulation in the use of emotional drivers.
- As is often the case in humanitarian work, certain approaches go in and out of fashion. The PHAST approach has been rightly criticised for not providing enough evidence of its success but this lack of

results might result from ineffective M&E plans (unable to measure behaviour change) and/or a lack of resource affected to its implementation, rather than an intrinsic limitation in the approach itself.

- All the HP approaches used by Concern and other agencies are still very much focused on changes at individual level rather than at societal level. The question remains as to whether or not some changes promoted are demanding too much of individuals and consequently relieving the state of any obligation. For instance, is it fair for water treatment to be promoted at household level or should it be the state responsibility to ensure safe delivery of water? Is it fair for the slum dwellers to empty their latrine pits or should it be for the town council to allow for the sewage system to serve equally all the city neighbourhoods?

In this view, HP interventions can sometimes be seen as preventing the state from taking its responsibilities. It is our view that wherever possible, advocacy work should be developed in parallel in which the state’s obligations to its citizens is clearly articulated.

An important limitation to HP interventions is that they are relying on community networks who are voluntary-based so that their members have limited time to allocate to HP activities. In addition to this, they often have numerous prevention topics to promote (health, nutrition and hygiene) which is contradictory with some of the science of behaviour findings who stipulate that it is more effective to focus on one topic at a time. It is to be noted that this could be a major drawback to integration in between health, nutrition and WASH sectors.

The following questions remain to be addressed: To be successful should HP campaigns be performed by professional paid staff? Should we target one topic at a time to obtain effective behaviour change or is there any evidence that multi-behaviours HP campaigns facilitate by community volunteers can still bring results?

Conclusion

In this paper the author has sought to discuss the inherent challenges in relation to how best to influence human behaviour with respect to WASH. The discussion has been framed within the knowledge behaviour gap context. As has been noted people tend to be creatures of habit. Therefore, seeking to change their behaviour and practice can at times be daunting. Nevertheless, the science of behaviours, is providing a lot of useful insights about what can be done to achieve better results in terms of effective adoption of new hygiene behaviours.

Finally and above all the other recommendations proposed in this paper, adequate resourcing of hygiene promotion initiatives is clearly pivotal to bridging the knowledge behaviour gap.

On the communication tools

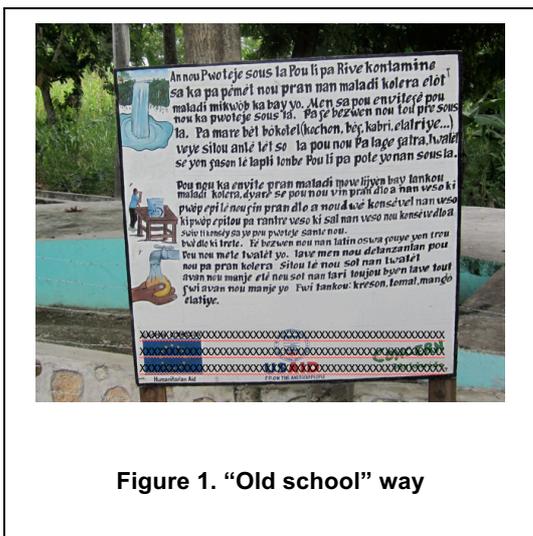


Figure 1. “Old school” way

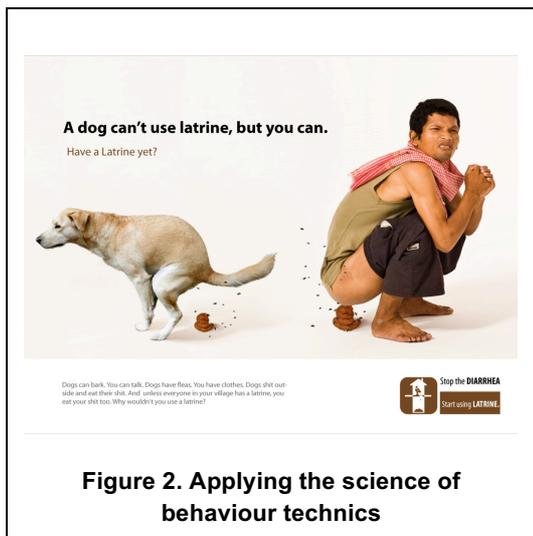


Figure 2. Applying the science of behaviour technics

Acknowledgements

The author/s would like to extend thanks to all Concern Hygiene promotion teams around the world who, often in difficult contexts, despite fighting an enemy that is invisible to human eyes, despite their achievements being rarely acknowledged by the population (as by definition, one cannot see who has been “prevented”), still work hard to make this world a safer place.

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