2.8 A social marketing approach to hygiene promotion and sanitation promotion

As we saw in Section 2.3, sanitation, along with good hygiene, acts as a fundamental ‘primary barrier’ to prevent faecal matter, the source of most diarrhoeal pathogens, from spreading in the environment.

It is as important to enable people to change their hygiene behaviour as it is to provide improved facilities. Practices which stop faecal material contaminating the domestic environment are vital, especially for children. The priorities in behaviour-change programmes are thus likely to include hand-washing with soap after stool contact and the safe disposal of stools (see Section 2.3.3).

According to Almedom et al. (1997),

- Hand-washing with soap and water after contact with faecal material can reduce diarrhoeal diseases by 35 per cent or more.
- Using a clean pit latrine and disposing of children’s faeces in a pit latrine can reduce diarrhoea incidence by 36 per cent or more.

This section looks at ways of encouraging safer hygiene-related practices. It is based on a new promotional approach that draws on social marketing, health communications, anthropology, and health promotion. It emphasizes inclusion and builds partnership at all levels.

**Principles**

The recommended approach differs from classic hygiene and sanitation programmes because it places the consumer at the heart of the programme. Instead of beginning in an office, programme design begins in the community. Consultation actively involves the many different groups in society and develops a shared agenda for action.

The process starts with data collection, to find out what target communities need, want, and do. Appropriate interventions are then negotiated with the health or engineering specialists and developed into a strategic programme.

The approach works well in a participatory, village-by-village manner. It is, however, most useful and cost-effective on a large scale, where the intervention is first developed in a small-scale, participatory manner, and then applied across regions or urban centres.

The promotional approach is not without contradictions. It is centred on the users’ perspective, but it has a firm agenda. It uses participatory methods but it is not wholly participatory. And there are other contradictions to be addressed:

- Faecal contamination of the environment may be the main cause of preventable disease. This does not mean it will be the community’s highest priority for change.
• Though improved health is the programme’s main objective, the target communities are more likely to be interested in latrines and hygiene for reasons of dignity and aesthetics.

• Messages about potential health benefits are not effective at motivating people to change their behaviour. Attractive, positive, messages which appeal to people’s sense of dignity are often more effective.

It is important to consider the implications of these and other contradictions. The agendas and priorities of development workers often differ from those of the communities with whom they work. This problem is not specific to the promotional approach but is inherent in much development work.

The promotional approach aims to make scant public health resources work effectively and sustainably over large areas, and for large numbers of people.

We will look at the principles of social marketing and hygiene and sanitation promotion and then turn to the nuts and bolts of implementation.

2.8.1 Definitions

The following terms are used in this section:

• **Promotion** seeks better health through encouraging behavioural change. It puts consumers at the heart of programmes, ensuring participation and partnership in programme development. The focus of this section is on hygiene and sanitation promotion.

• **Social marketing** uses marketing approaches to match available resources with social needs. Social marketing may be applied to service provision and use, the development and acceptance of products, or the adoption of new behaviour. It can be product- or behaviour-focused.

• **Consumer-orientation** is fundamental to social marketing and demands that social programmes respond to people’s perceptions and aspirations.

• **Data collection** is a systematic process of investigation and collaboration with target communities to find out what they need, do, and want, that provides information that is essential to programme design.

• **Hygiene promotion** encourages people to adopt safer practices in the household to prevent sanitation-related disease.

• **Sanitation promotion** is the marketing and promotion of sanitation products and services.

The two key processes in hygiene and sanitation promotion relate to the consumer. They are:

• the development of messages or products that suit target audiences; and

• communicating these messages in ways that are appropriate, attractive, and motivating.
Hygiene promotion and sanitation promotion are both concerned with facilitating behaviour change. Health education, social mobilization, community participation, and central planning models have failed more than they have succeeded. Marketing models provide an alternative approach to behaviour change.

The promotional approach starts with the systematic use of data collection to find out what consumers know, do, and want. The results are used to develop concise, positive messages that address specific health problems and to develop behaviour-change objectives that can be monitored and measured by the project team.

### 2.8.2 Why hygiene and sanitation promotion programmes need a social marketing approach

Lessons from hygiene education and sanitation programmes have shown that:

- When water and sanitation projects do not take adequate account of individual and community behaviour the expected health benefits are not fully realized.
- In sanitation projects, goals have tended to focus on the number of latrines constructed or the number of people given access to them. The behaviours that determine whether new facilities bring health benefits are rarely considered. These behaviours include hand-washing, safe disposal of children’s excreta, personal and household hygiene, food handling, and so on.

Hygiene and sanitation programmes have commonly been concerned with the ‘supply’ of education, and materials, rather than with satisfying a ‘demand’ from intended beneficiaries. Demand creation is the main aim of commercial marketing. The social marketing

---

**What can social marketing achieve?**

In Honduras, deaths due to diarrhoea decreased almost 50% following a programme to educate mothers about the use of ORS.

Over six months of hygiene promotion with a pilot group in Lucknow, India, the proportion of mothers washing their hands with soap after defecation went from under a quarter to over a half.

It is used in industrialized countries in programmes to prevent heart diseases, smoking, and AIDS, and to encourage the use of seat-belts.

In Indonesia, 85% of women now feed their child a mixed food with green leaves, which has lead to a 40% improvement in the nutritional status of children under two years of age.

A 30% decline in infant mortality was achieved through the promotion and marketing of ORS in Egypt.

44% of men in Bangladesh discussed family planning with their wives within 12 months of campaign launch. Contraceptive prevalence increased by 10%.

*adapted from Mehra, 1997*
approach is demand led in that it uses a strategic, managed process of assessing and responding to felt needs, creating demand and then setting achievable and measurable goals.

Social marketing is a systematic approach to public health problems. It goes beyond marketing. It is not motivated by profit alone but is concerned with achieving a social objective. Social marketing is therefore concerned with how the product is used after the sale has been made. The aim is not simply to sell latrines, for example, but to encourage their correct use and maintenance. The key components of social marketing are:

- systematic data collection and analysis to develop appropriate strategies;
- making products, services, or behaviours fit the felt needs of the consumers/users;
- strategic approach to promoting the products, services, or behaviours;
- methods for effective distribution so that when demand is created, consumers know where and how to get the products, services, or behaviours;
- improving the adoption of products, services, or behaviours and increasing the willingness of consumers/users to contribute something in exchange; and
- pricing so that the product or service is affordable.

### 2.8.3 What happens in social marketing?

1. A sample of the intended audience, or consumers, are consulted and questioned about their needs, wants, and aspirations. They collaborate in the development of feasible, attractive solutions. This is **Data collection** and is crucial to orienting the promotional activities (see box below).

2. Achievable overall marketing (or promotion) objectives are developed.

3. These data are analysed and used to develop an overall marketing plan in collaboration with key stakeholders.

#### Data to collect for a latrine programme

- How many households/neighbourhoods have inadequate sanitation facilities or systems?
- What do people perceive as ‘good’ and ‘bad’ sanitation?
- What do people see as the advantages of latrines?
- What type of system do women prefer?
- What type of system do men prefer?
- What are the characteristics they prefer?
- How much do people pay and how much are they willing to pay?
4. The audience is segmented into discrete units with common characteristics. This is based on an analysis of the initial data.

5. Products and messages are developed based on consumer preferences and characteristics for the relevant segments. These are tested among representative samples of target populations. How much are people willing to pay for this product? How far are people willing to travel for this service? How feasible is the new behaviour? Products, messages, and price are modified, refined, and re-tested until they are acceptable. Key stakeholders are consulted throughout this process.

6. The product is launched or service introduced.

7. The performance of the product or service is monitored and evaluated in the market and the strategy revised accordingly. This may involve revising the marketing plan or improving the product or service.

**The four Ps of social marketing**

As in commercial marketing, the ‘four Ps’ are the basic characteristics of the social-marketing approach (see box below). A clear and well-researched background to define each of these characteristics is essential for the success of social marketing.

<table>
<thead>
<tr>
<th><strong>The four Ps of social marketing</strong></th>
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<tbody>
<tr>
<td><strong>Product</strong></td>
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<tr>
<td><strong>Examples</strong></td>
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<td><strong>Price</strong></td>
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<td><strong>Examples</strong></td>
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<td><strong>Place</strong></td>
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<tr>
<td><strong>Examples</strong></td>
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<tr>
<td><strong>Promotion</strong></td>
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<tr>
<td><strong>Examples</strong></td>
</tr>
</tbody>
</table>
2.8.4 Targeting

Targeting — the audiences
Programmes are more effective if a small number of key messages are focused to specific target audiences (see box above). This concentrates resources and increases the chances that behaviour change will result.

The community is made up of many different groups, or ‘segments’. Each segment of the audience may need to be addressed separately, e.g. house-to-house visits to reach mothers, street theatre to reach fathers, and public meetings with a video show for opinion leaders. It is also important to ensure support for the programme from partner and collaborating agencies; they may also be an audience to target.

Data collection is important as it provides conditions for a shared agenda. Through the process of consultation, the best communications strategy for each segment can be developed.

Targeting — the practices
Stools are the main source of diarrhoeal pathogens. Practices which stop faecal material contaminating the domestic environment are vital, especially for children. The priorities for public health in behaviour-change programmes are therefore likely to include hand-washing with soap after stool contact and the safe disposal of stools, especially children’s stools, preferably in latrines.

Potential risk practices need to be documented and their frequencies assessed. Practices which occur often and which allow faecal material into the domestic environment are likely to be candidates for behaviour change. The final target practices, to replace the risk practices, are developed in collaboration with target audiences.

Communicating messages
Messages about child diarrhoea, doctors, and death are more likely to repel target audiences than to encourage behaviour change. Message positioning involves the selection of positive values that the primary target audience associates with the target practices. For example, if the data collection shows that using a latrine for stool disposal is valued for self-respect and dignity, then the messages should reinforce this existing positive value of hygiene.
The data to inform the message-positioning decision can be collected in three ways:

1. Interview people who already use the safe practices.
2. Carry out focus group discussions.
3. Interview people after they have tried the safe practices for a few weeks.

Communications strategies are then built around these positive values, e.g. ‘hand-washing with soap makes your hands smell good.’

With a simple questionnaire it is possible to find out what social groupings exist and what access people have to information, e.g. whether people listen to the radio and when, whether people read papers, which papers they read, who goes to the weekly market, etc.

In focus groups it is possible to identify which channels are seen as most suitable and attractive for hygiene messages.

### 2.8.5 Political will

Sanitation and hygiene improvements require political will and support. Programmes will benefit if social, cultural, and political leaders are motivated and given an active role (mobilized) such as:

- religious leaders actively supporting the campaign for sanitation; or
- schoolchildren and teachers playing a leading role.

A partnership approach to promotion does not assume ignorance on the part of the people. It is less top-down and develops, and works from, a shared agenda. It widens ownership of the programme by increasing the number of stakeholders who are actively involved from the start. These additional stakeholders not only provide their endorsement (thus widening the appeal of the initiative) but also accept increased responsibility for implementation.

Advocacy creates partnerships with government and NGOs. It operates on many levels: everyone from the head of state to local government leaders should become aware of the importance of the programme (see box on following page).

### 2.8.6 Programme communication

Programme communication covers identification, segmentation, and channelling. First of all, the communication channels used by target groups are identified. Then a mix of channels of communication is devised to combine reach and cost-effectiveness. Specific groups/consumers are reached through:

- strategies and messages for safe sanitary and hygienic practices;
- various mass media and interpersonal channels; and
- improved fieldworker and supervisor training methods.

This process binds advocacy and programme communication together. It makes the programme a priority for the society as a whole and not just the concern of a government department, a programme manager, or a donor.
Programme communication strategies include:

- **Interpersonal communication training:** Strengthen the ability of government and NGO fieldworkers to reach potential latrine adopters and to promote sanitation and hygiene. Address interpersonal communication skills and the quality of available support materials.

- **Mass media:** Build on existing policies and strengthen government and private-sector capacity for creative presentation of standardized messages.

- **Print media:** Promote the development and dissemination of a clearly defined programme logo to build awareness and aid identification. Develop strategies using print media, e.g. billboards, posters, site-signs, interpersonal support, and other learning materials, manuals and programme guidelines.

- **Community-based media:** Use local-level media, e.g. public address systems, and employ traditional, community-based entertainment artists, e.g. popular folk singers, dramatists, and poets, and use their talents through the mass media.

**Ring-fencing the promotional activities**

Too often the promotional effort is an add-on to a project whose budget and timetable is largely committed to hardware (water supplies, sewage, etc.) and the promotional activities (e.g. the software) are swamped, rushed, or curtailed. The separate projects need to be *ring-fenced* but must be carefully co-ordinated to maintain an integrated approach. (See the box on page 210.)
### Table 2.8.1 Examples of mobilization

<table>
<thead>
<tr>
<th>Elements</th>
<th>Aims</th>
<th>Involves</th>
<th>Communication methods</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Political mobilization</strong></td>
<td>Gaining political and policy commitment</td>
<td>National policy-makers and decision-makers</td>
<td>Advocacy, Lobbying, Goodwill ambassadors, Mass media</td>
</tr>
<tr>
<td></td>
<td>Resource allocation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Government mobilization</strong></td>
<td>Informing and enlisting co-operation</td>
<td>• Service providers</td>
<td>Training programmes, Study tours, Mass media</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Other government organizations who can provide direct or indirect support</td>
<td></td>
</tr>
<tr>
<td><strong>Community mobilization</strong></td>
<td>Informing and gaining commitment</td>
<td>• Local political, religious, social, and traditional leaders</td>
<td>Training, Participation in planning, Coverage of activities by mass media</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Local government agencies</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Non-governmental organizations</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Women’s groups</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Co-operatives</td>
<td></td>
</tr>
<tr>
<td><strong>Corporate mobilization</strong></td>
<td>Securing support</td>
<td>National and international companies</td>
<td>Endorsement and space in:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Product advertising</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Product labelling</td>
</tr>
<tr>
<td><strong>Popular mobilization</strong></td>
<td>Informing and motivating the target groups</td>
<td>Community groups, households, families, men, women, children</td>
<td>Training programmes, Establishment of community groups, Traditional (dramas, songs); mass media</td>
</tr>
</tbody>
</table>

### 2.8.7 Hygiene promotion

Health education programmes, traditionally included as the ‘software’ part of a ‘hardware’ intervention, have consistently failed to realize their full potential to effect an improved health status. Why is this? Why do health education programmes fail to hold any relevance to their target audience? If the ‘risky’ practices which health education identifies are socially undesirable, why do they persist?

Hygiene promotion addresses these and other questions. Hygiene promotion does not ‘educate’ people about their ‘risky’ practices but looks at what motivates people to act, and at how hygiene behaviours are articulated within everyday life. It builds on positive values, such as those attributed to cleanliness, and draws on lessons from the social sciences, e.g. anthropology, psychology, adult education, and marketing.

**From health education to hygiene promotion**

Four principles guided the development from a narrow education-focused approach to a broader promotion outlook:

---

The ‘teacher and pupil’ approach is very labour-intensive and not always effective. Hygiene promotion accentuates positive aspects of ‘clean’ behaviour that consumers can relate to day-to-day practices.
Adults are not ‘clean slates’ on which to write new ideas.

All adult societies have their own ideas of what is ‘clean’ and of what causes disease. Those practices and beliefs must be used as the starting point for change, not ignored in the mistaken belief that consumers will instantly reject generations of tradition and rush to embrace the ‘truth’ as pronounced by hygiene educators.

Adults may have neither the time nor the motivation to learn new ideas.

The women of poor communities have little time to sit in on formal education sessions but they are the ones most likely to see the benefits of change and to strive to bring it about. Clear messages must be disseminated along effective communication routes.

New knowledge does not equal new practice.

It is not feasible to expect people to change a whole variety of hygiene practices.

These are discussed in turn.

**Adults are not ‘clean slates’ on which to write new ideas**

Classical hygiene education is based on the premise that people persist in unhygienic practices because they do not know about the germ theory of disease transmission — that microbes cause disease and so on. Hygiene educators, and others, sometimes equate this with ignorance and clash with indigenous systems of knowledge.

All societies have concepts of cleanliness which are central to notions of individual, and group, identity. Throughout the world there are many explanations for the appearance of diarrhoeal diseases in children, all of which are internally consistent. In regions as distant from each other as India, Africa, and Europe diarrhoeal episodes are attributed to a variety of social, climatic, and environmental factors. These include the transgression of particular social rules, the consumption of unsuitable foods, the presence of concurrent illnesses, teething, and straightforward bad luck (see box opposite).

If we take no account of what adults in the target population know and we treat them as ‘clean slates’ on which new (and Western) ideas can simply be inscribed, then, at best, we create confusion and incomprehension. At worst the teaching is entirely rejected: ‘these outsiders have no real idea what is making my child sick’.

**Solution: Hygiene promotion is founded on knowledge of key aspects of what people know, do, and want.**

**Adults may have neither the time nor the motivation to learn new ideas**

Traditional school-type teaching is common in hygiene education programmes. This may be appropriate for children, but is unlikely to appeal to adults, especially hard-pressed mothers who have other higher priorities for their time and energy.

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**How to drive a SanPlat**

The promotion of sanitation and the production of sanitary wares require totally different skills. This is recognized in other markets and should be accepted in hygiene and sanitation promotion.

The person who builds a car is different from the person who sells that car, who is in turn, different from the driving instructor.

SanPlat manufacturers make SanPlats (page 170). They are not necessarily the best people to sell them, to advise customers how to use them, or to suggest to their customers ways of dealing with children’s stools.
Folk taxonomy of diarrhoeal diseases in Burkina Faso — the least important of which is that described by health educators, diarrhée des blancs or ‘white people’s diarrhoea’

<table>
<thead>
<tr>
<th>Name</th>
<th>Symptoms</th>
<th>Causes</th>
</tr>
</thead>
<tbody>
<tr>
<td>KOLOBO</td>
<td>Green, frothy, frequent stools, Vomiting, Weight loss</td>
<td>Teething</td>
</tr>
<tr>
<td>KOTIGUE</td>
<td>Small, mucoid stools, Irritated anus, Fever</td>
<td>Carrying the child on the back, Contact with damp ground</td>
</tr>
<tr>
<td>WOLINA</td>
<td>Whitish, liquid stools smelling of rotten eggs, Sunken fontanelle</td>
<td>Breast-feeding mother steps on an egg, ‘Infection’</td>
</tr>
<tr>
<td>SERE</td>
<td>Thick, whitish, bad-smelling stools, Child thin</td>
<td>Breast feeding after having sexual relations or while pregnant</td>
</tr>
<tr>
<td>DIARRHEE DES BLANCS</td>
<td>Liquid stools, Ballooned stomach</td>
<td>‘Parasites/worms’, Dirt</td>
</tr>
</tbody>
</table>

Solution: Hygiene promotion uses repeated, coherent, and simple messages. These are disseminated through a mix of communication channels designed to reach target audiences for the greatest effect and the least cost.

**New knowledge does not equal new practice**

Promotion must be to practical effect, encouraging changes that are possible and are wanted, not merely relating lists of good hygiene practices that, for the time being at least, have little chance of being implemented.

**It is not feasible to expect people to change a whole variety of hygiene practices**

Long ‘wish lists’ confuse consumers and dilute the promotional effort. Attention must be focused on a few practices that present the greatest risk in the target community.

* New knowledge does not equal new practice
* It is not feasible to expect people to change a whole variety of hygiene practices

<table>
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<td>‘Parasites/worms’, Dirt</td>
</tr>
</tbody>
</table>

**New knowledge does not equal new practice**

Even if the target audience of the hygiene education programme accepts the germ theory of disease, this does not guarantee they will change their hygiene behaviour. Fear is not a good motivation for change. A fear that germs may make a child ill is unlikely, by itself, to prompt people to adopt new domestic practices (see first box on page 212).

There are other reasons why new behaviours are not adopted as a direct result of new learning: the suggested ‘safe’ practices may be too expensive or time consuming, appropriate facilities may not be available, and there may be no support, or even discouragement, from other members of society. In other words change may be too difficult.

**Solution: Hygiene promotion is based on what people can do and what people want to do. It works to find solutions and not problems.**

**It is not feasible to expect people to change a whole variety of hygiene practices**

It is likely that only a small number of practices are responsible for the majority of diarrhoeal episodes (WHO, 1993b). However, hygiene education programmes rarely identify and target particular risk practices (see second box on page 212). Getting people to change the habits of a lifetime is extremely difficult. The more practices that are targeted the more efforts are diluted.
Cries of resistance from a cholera programme

Government efforts to control a cholera epidemic in north-eastern Brazil caused indignation. Favela residents were highly resistant towards the mass media campaigns and official cholera control interventions. They were reacting against the accusatory attitudes and actions of the social élite.

Cholera is popularly called ‘The Dog’s Disease’. It carries many connotations and must be understood as part of a history of domination and social and economic inequity in north-eastern Brazil. The official campaign, which used two stereotypes, *pessoa imunda* (filthy, dirty person) and *vira lata* (stray mutt dog), suffered a backlash as these seemed to equate the poor with cholera and poverty with dirt. Using this disgracing and disempowering imagery blamed, punished, and stigmatized the poor...

*Nations and Monte, 1996*

---

**Solution:** Hygiene promotion is built by providing simple, attractive alternatives to a few common risk practices. The process is systematically planned and monitored and the impact on the targeted behaviour is measured.

### 2.8.8 Hygiene promotion in practice

Consumer-oriented, demand-led promotion is an iterative process with the following stages:

- **Stage 1** Collaborative data collection
- **Stage 2** Feedback and discussion with all key stakeholders
- **Stage 3** Formulation of the hygiene promotion plan
- **Stage 4** Implementation, monitoring, revision, etc.

If resources and key personnel are available, data collection can be completed within three months and the feedback and project design can be completed in a further month. This investment of time and resources in finding out what people know, do, and want will be repaid many times over in enhanced programme effectiveness.

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**Message overloading in hygiene education**

- wash vegetables
- filter drinking water with sand
- place basins of water in the sun
- keep finger-nails cut short
- wash hands with soap
- do not wash hands with mud
- spray insecticides
- wash hands before eating
- wash hands before feeding a child
- wash hands after defecation
- wash dirty dishes after meals
- clean surrounds
- burn rubbish
- do not bottle feed
- wash latrine slabs
- wash well
- use fly-screens for food
- boil drinking water
- do not spit in public
- add disinfectants to drinking water
- chlorinate well water
- bury faeces
- construct water containers with taps
- wash hands before preparing food
- wash children’s hands
- wash hands after contact with child faeces
- sprinkle lime
- bury rubbish
- do not store food
- comb hair
- disinfect latrine slabs
- construct latrines
The table outlines the key questions and some of the quantitative and qualitative data-gathering techniques that can be used (Curtis et al., 1997).

The mix of techniques develops an understanding of the needs, desires, and perceptions of the target audience, and helps to create ‘like-mindedness’ among the project team members and between the project team and the community.

Different methods will be suitable for answering different questions. For example, questionnaires are of little use in finding out about people’s behaviour (Curtis et al., 1993), but may be useful in identifying existing channels of communication. Setting clear objectives for the data collection and a commitment to find out what people really know, do, and think is more important than the choice of methods.

Consultation with key stakeholders is a crucial component of hygiene promotion. A brief, attractive report presenting the recommendations for hygiene promotion is widely disseminated. It is translated into local languages, and made accessible to key stakeholders. A communication plan listing the key objectives of the programme is then drawn up on the basis of the findings (see Table 2.8.3).

**Implementation of a hygiene promotion programme**

The hygiene promotion programme should begin on a small scale. Time must be allowed for testing and revising strategies in the light of continued monitoring. Use structured observations to conduct an initial survey of target behaviour and establish a baseline. Follow this up at intervals to gauge the extent of behaviour change towards the

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**Table 2.8.2**  Key steps in a hygiene promotion programme

<table>
<thead>
<tr>
<th>Objective</th>
<th>Questions to answer</th>
<th>Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify risk practices</td>
<td>Which specific practices allow diarrhoeal microbes to be transmitted?</td>
<td>Epidemiological common-sense</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Environmental walk</td>
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<td></td>
<td></td>
<td>Checklist observation</td>
</tr>
<tr>
<td>Select practices for intervention</td>
<td>Which risk practices are most widespread?</td>
<td>Structured observation</td>
</tr>
<tr>
<td></td>
<td>Which risk practices are alterable?</td>
<td>Behaviour trials</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Focus group discussions</td>
</tr>
<tr>
<td>Define target audiences</td>
<td>Who employs these practices?</td>
<td>Structured observations</td>
</tr>
<tr>
<td></td>
<td>Who influences the people that employ these practices?</td>
<td>Focus group discussions</td>
</tr>
<tr>
<td>Determine message positioning</td>
<td>What motivates those who currently use ‘safe’ practices?</td>
<td>Focus group discussions</td>
</tr>
<tr>
<td></td>
<td>What are the advantages of the ‘safe’ practices?</td>
<td>Interviews with safe practitioners</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Behaviour trials</td>
</tr>
<tr>
<td>Select communication channels</td>
<td>What channels are currently used for communication?</td>
<td>Interview representative sample of target</td>
</tr>
<tr>
<td></td>
<td>What channels are trusted for such messages?</td>
<td>audiences</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Focus group discussions</td>
</tr>
</tbody>
</table>
project’s objectives. Monitoring behaviour change is difficult, but more practical and useful than conducting a health impact study. It is difficult, and expensive, to separate the ‘signal’ of the public health intervention from the ‘noise’ of parallel events such as epidemics, economic, climatic, or social change.

2.8.9 Sanitation programmes and the social marketing approach

Social marketing can be a bridge between technology (hardware) and behaviour change (software) for effective sanitation programmes. The following tables take you through the process.

### Table 2.8.3 Components of a communication plan

<table>
<thead>
<tr>
<th>Components</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behaviour change objectives</td>
<td>• Hand-washing with soap after cleaning a child’s bottom will go from 5% of occasions to 35% in two years</td>
</tr>
<tr>
<td>Key messages</td>
<td>• The targeted hygiene practices</td>
</tr>
<tr>
<td>Target audiences</td>
<td>• Age, sex, number in each group</td>
</tr>
<tr>
<td>Motivation for behaviour change</td>
<td>• Why do the target audiences want the new practices?</td>
</tr>
<tr>
<td>Channels of communication</td>
<td>• Street theatre, house visits, radio, schools</td>
</tr>
<tr>
<td>Communications materials</td>
<td></td>
</tr>
<tr>
<td>Methods of monitoring progress</td>
<td>• In programme activities</td>
</tr>
<tr>
<td>Budget</td>
<td></td>
</tr>
<tr>
<td>Project management</td>
<td></td>
</tr>
</tbody>
</table>

Figure 2.8.1. The process of promotion
Table 2.8.4  A social marketing plan for sanitation

<table>
<thead>
<tr>
<th>Steps</th>
<th>Examples</th>
<th>Notes</th>
</tr>
</thead>
</table>
| **1A Identify data collection needs** | • Low level of latrine coverage in two rural provinces.  
• Children at high risk of diarrhoeal disease  
• Latrines are expensive  
• Materials are hard to find  
• Latrines are seen as urban structures  
• Latrines are ‘too dangerous’ for children to use  
• Pregnant women must not use latrines  
• People dislike using the bush at night  
• Flies and bad smells are seen as a nuisance | • These could be based on overall programme/project objectives  
• Including evaluation indicators with data collection helps measure impact at the end of the programme/project inputs  
• It also means that information need not be gathered separately and it thus saves time and resources  
• Identify consumers and their traits |
| What are the causes?  
What beliefs, attitudes, and current practices contribute to the problem or possible solution?  
Determine and define the evaluation indicators (to include for baseline data) | • Number of latrines  
• Number of latrines in regular use  
• Proportion of children’s stools thrown in latrines | |
| **1B Define the intended audience** | • Fathers take the decision to buy a latrine  
• Mothers encourage  
• Landlords are constrained by law to provide latrines (not enforced)  
Allies such as  
• healthworkers  
• grandmothers  
• community leaders | • Define the ‘Product’ or behaviour |
| Who will be most responsive to the intervention (primary audience)?  
Who can support the primary audience in its new practices? | | |
| **1C Define feasible behaviour(s) or appropriate products for each audience** | A fly- and smell-free, cheap latrine which can be used safely by all family members  
• Adults go to the bush  
• Children defecate in the yard  
• Paying a mason to construct a latrine  
• Buying and using a potty for small children under three | • Define the ‘Product’ or behaviour  
Use research or consumer-based data to:  
• Identify ‘Price’ and ‘Place’ |
| What is the desired ideal behaviour? Or ideal product?  
What is the current behaviour? Or products used?  
What are the feasible behaviours to be promoted? Or appropriate products? | • Why do heads of family not buy latrines now?  
• What would motivate them to do so?  
• Why do mothers not buy potties now?  
• What would motivate them to do so?  
• Project field team  
• Research specialist and students  
• Experienced extension workers  
• Sociologist  
• Quantitative latrine coverage survey 400 households  
• Focus group discussions with mothers, fathers, landlords  
• Construction of six model demonstration latrines  
• Observations in 200 households of child defecation  
• Trial marketing of potties in two provinces | |
### 2. Establish programme goals and objectives

*Use results of Step 1.*

<table>
<thead>
<tr>
<th>Research finding</th>
<th>Possible programme goal or objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>60% of respondents are aware of proposed sanitation method</td>
<td>15 percentage point increase in the level of awareness of modern method of sanitation from 60 to 75% among respondents by two years</td>
</tr>
<tr>
<td>Only 10% of respondents are aware of distribution outlet for sanitation product</td>
<td>A 30 percentage point increase in awareness of distribution outlet from 10 to 40% among respondents by two years</td>
</tr>
<tr>
<td>30% of respondents rate the sanitation product as effective</td>
<td>10 percentage point increase in effectiveness rating from 30 to 40% (or modification of the product to achieve 40% rating) among respondents by three years</td>
</tr>
<tr>
<td>15% of respondents currently use sanitation product</td>
<td>A 5 percentage point increase in use of sanitation product from 15 to 20% among respondents by three years</td>
</tr>
</tbody>
</table>

### 3. Estimate the potential market for a given brand or product

*Research results are very useful if the sample is representative of the total population to be served.*

- 5% of households have a latrine
- Overall potential market is 200,000 households
- 25% would build a latrine if it cost less than 50,000F
- 15% intend to build a latrine this year
- Conservative estimate of potential market is 20,000 latrines in two years

<table>
<thead>
<tr>
<th>Steps</th>
<th>Examples</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>5% of households have a latrine</td>
<td>The data can be projected for the whole population and the size of the market (and potential demand) can be calculated</td>
</tr>
<tr>
<td>3.2</td>
<td>Overall potential market is 200,000 households</td>
<td></td>
</tr>
<tr>
<td>3.3</td>
<td>25% would build a latrine if it cost less than 50,000F</td>
<td></td>
</tr>
<tr>
<td>3.4</td>
<td>15% intend to build a latrine this year</td>
<td></td>
</tr>
<tr>
<td>3.5</td>
<td>Conservative estimate of potential market is 20,000 latrines in two years</td>
<td></td>
</tr>
</tbody>
</table>

### 4. Develop a marketing ‘mix’ strategy

*Use the information from Step 1 for developing marketing ‘mix’*

#### Product Strategy:
- What product(s) will best fulfil the needs of the intended audience/consumer groups

#### Price Strategy:
- What does intended audience currently spend in this area?
- What can they afford?

#### Distribution Strategy:
- What are the distribution channels which are most readily accessible to the intended groups?
- What outlets do they use?
- Where are they most likely to look for the sanitation product?

#### Advertising and Promotional Strategy
- Research findings can be used for
  - Setting the communication objectives for the programme for each intended group
  - The media strategy to reach each intended group

- A choice of models at different prices

- Current models are VIPs constructed by a previous project. They were provided free.
- VIPs are too expensive for most households.
- Mason’s shops in local market towns
- Village mason

- Cost calculations should include both direct expenditures of money and resources and indirect costs e.g. time, energy, embarrassment (difficult to quantify)
<table>
<thead>
<tr>
<th>Steps</th>
<th>Examples</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>When developing the marketing strategy you need to know ...</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Current usage              | • What methods and products are consumers using, if any?  
• What is the competition?                                                                 | • Some VIPs  
• Landlords have provided simple latrines in some compounds                                    |                                                                                             |
| Attitudes/perceptions      | • What benefits are relevant, meaningful, and persuasive?  
• What barriers will need to be overcome?                                                                 | • Advantages include privacy, dignity, and convenience  
Main barriers  
• Cost  
• Previous latrines were subsidized                                                  |                                                                                             |
| Product image              | • What is the image of either the method or product or brand among the intended audience?  
• How can this be improved?                                                                 | • VIPs seen as very grand, only for the wealthy  
• VIPs seen as to be kept for adults and visitors only  
• Emphasize low-cost models  
• Stress child use  
Consider sources of information for  
• product effectiveness  
• product availability  
• correcting any misperceptions                                                      |                                                                                             |
| Consumer communication     | • What information does the intended audience want and need to use?  
• What sources does the intended audience currently use for information?  
• Which one(s) do they believe?  
• What other potential media are available?                                                                 | • Misperceptions about cost and danger to children need correcting  
• 61% of male heads of household listen to local radio regularly  
• 72% of women attend weekly market  
• Baptisms and weddings  
Consider sources of information for  
• product effectiveness  
• product availability  
• correcting any misperceptions                                                      |                                                                                             |
Further reading


This book provides the non-expert with guidelines for evaluating water- and sanitation-related hygiene practices. It focuses on the practical concerns of field personnel and enables existing field staff to carry out hygiene behaviour diagnoses. The book looks at how to gather, review, and interpret qualitative information. It weighs the pros and cons of a wide range of techniques and assumes no prior knowledge of social sciences.

Ankur Yuva Chetna Shivir (1996) ‘Diarrhoea and hygiene in Lucknow slums’. A document produced for the Gomti River Pollution Control Project, Lucknow, London School of Hygiene and Tropical Medicine, June.

An account of a hygiene promotion project in Lucknow which was written for, and disseminated to, project stakeholders. Producing an accessible report is integral to the process of ‘increasing the ownership’ of the project. This is attractive and easy to read and shows how the project was designed and what lessons were learned.


As the title suggests the main concern of this book is hygiene education, and it is based on the paradigm most prevalent in the USA. The book considers issues in project design: for example, negotiations with project stakeholders needed to introduce behavioural components, and the timing of articulating behavioural components with other project components. This is still a good source of techniques for data collection and it stresses the importance of both finding out, and working with, what people know.


A comprehensive analysis of ways of studying hygiene behaviour and interpreting the results. The recommended approaches are demonstrated with lots of practical examples and anecdotes. Planning and pre-testing hygiene behaviour studies, involving community members in study design and information gathering methods, the types of behaviours most relevant to achieving health improvements, and different interviewing techniques are all considered.

A personal perspective on the ten-year effort to provide low-cost waste facilities. This is a concise explanation of how water-supply and sanitation programmes are part of a wider picture which includes land tenure, housing, drainage, and solid-waste disposal, etc. The main lesson is that sustainable success depends on consumer demand and that programmes should be designed and managed to sell a product, e.g. water supply and sanitation, and not to provide a service.


This series of manuals describes how to carry out the data collection vital for the design of an intervention. They are very readable and have lots of graphics.


A brief article by the project team in Lucknow. It covers the techniques used when planning a hygiene promotion intervention and reminds readers of the need for good news, not doom and gloom.


A review of the lessons WASH took from the Water Decade. The book looks at technical assistance, at shared responsibility and different stakeholders in partnerships, at all levels of programme strategies, and at long-term sustainability and the importance of enabling behaviour change through a range of initiatives.