

# HAPPY HEALTHY AND HYGIENIC

HOW TO SET UP A  
HYGIENE PROMOTION PROGRAMME

# 2

## RISK PRACTICES, TARGET PRACTICES

*Library*  
IWC International Water  
and Sanitation Centre  
Tel: +31 70 30 689 60  
Fax: +31 70 35 899 64

UNICEF

London School of Hygiene & Tropical Medicine,  
Ministere de la Santé du Burkina Faso



203.2 15942

First edition: September 1998

## **WES Technical Guidelines Series No. 5**

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

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United Nations Children's Fund  
3 UN Plaza, TA-26A  
New York, NY 10017  
Web site: [www.unicef.org](http://www.unicef.org)

A joint publication of UNICEF/Programme Division  
Water, Environment and Sanitation Section (ID No PD/WES/98/5)  
and the London School of Hygiene & Tropical Medicine.

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.

### **FOR FURTHER INFORMATION PLEASE CONTACT:**

Chief Water Environmental and Sanitation Section, Programme Division,  
UNICEF, 3 UN Plaza, TA26-A, New York, NY 10017.  
Tel (212) 824-6664; Fax (212) 824-6480; e-mail: [wesinfo@unicef.org](mailto:wesinfo@unicef.org)

The Unit Head, Disease Control and Vector Biology Unit,  
London School of Hygiene & Tropical Medicine,  
Keppel Street, London WC1E 7HT, UK.  
Tel 0171 927 2213; Fax 0171 636 7843

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PROGRAMME

# 2

RISK PRACTICES  
TARGET PRACTICES

**Valerie Curtis and Bernadette Kanki**

LIBRARY IRC  
PO Box 93190, 2509 AD THE HAGUE  
Tel.: +31 70 30 689 80  
Fax: +31 70 35 899 64  
BARCODE: 15942-2  
LO: 203.2 98HA

UNICEF

London School of Hygiene & Tropical Medicine,  
Ministere de la Santé du Burkina Faso

## **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**

The production of these manuals series was funded by UNICEF, with support from the Ministry of Health of Burkina Faso, the London School of Hygiene & Tropical Medicine, the Centre Muraz (OCCGE) and the British Department for International Development. Special thanks are due to Sandy Cairncross, Reader, London School of Hygiene & Tropical Medicine, Lizette Burgers, project officer UNICEF Burkina Faso, Ibrahim Diallo, Michel Nikiema, Raphael Gbray, Hubert Barennes, Simon Cousens, the staff and fields workers of Programme Saniya in Burkina Faso and Ankur Yuva Chetna Shivar in India.

Thanks also to T.V. Luong, Silvia Luciani, as well as a number of UNICEF colleagues from the field offices, whose comments were very helpful in revising the document.

Finally the authors particularly wish to thank the colleagues in Burkina Faso who gave up their time to attend review meetings and other collaborators who offered us so much good advice.

The pictures were drawn by Mamadou Traore and Emmunuel Nkobi.

# 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 are these manuals about?

These manuals show how to encourage people to adopt safer hygiene practices. They can also help you to make your current hygiene programme more effective.



In these step-by-step guides 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 are these manuals 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 these manuals are for you!

## How to use these manuals

There are four manuals in this series.

- ⇒ Manual 1 shows how to plan a hygiene promotion programme.
- ⇒ Manual 2 shows how to target behaviours that need to change and how to develop replacement practices with people
- ⇒ Manual 3 deals with motivating behaviour change
- ⇒ Manual 4 shows how to design hygiene communications programmes.

The manuals can be used separately or all together. The other manuals will, however, be easier to understand if you read the first 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 of manual No 1.



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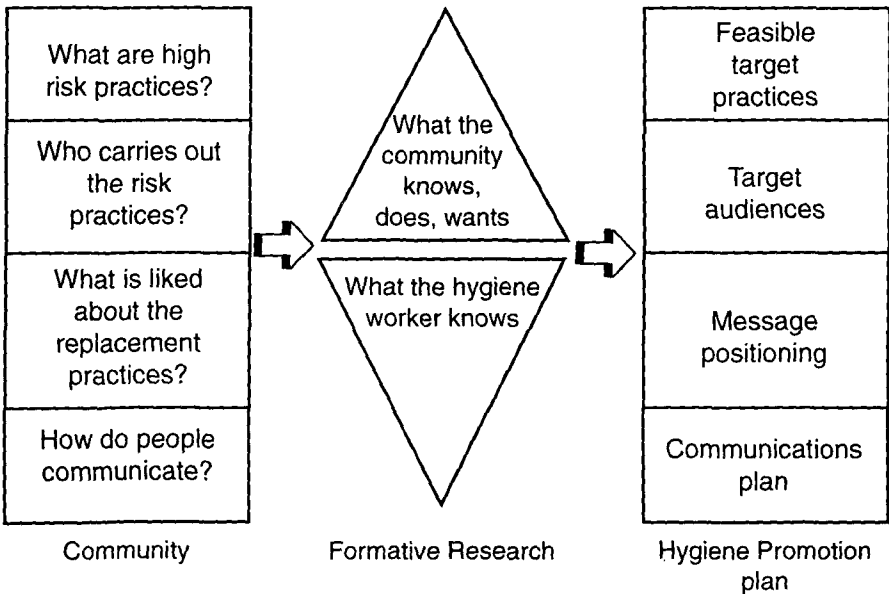
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# INTRODUCTION: RISK PRACTICES, TARGET PRACTICES

The first task in planning a hygiene promotion programme is to identify the practices that are putting children at risk of diarrhoea. Because behaviour change is difficult, we have a better chance of success if we focus on just one or two practices that can break the chain of infection.

The first part of this manual describes what hygiene workers need to know about how microbes get from one person to another through the environment and cause diarrhoea. The second part shows how to work with the community to identify common risk practices and to develop feasible and attractive alternatives to the risk practices; these become the target practices of the hygiene promotion programme. This completes the first part of the collaborative formative research process shown below. Manuals 3 and 4 show how to go about finding answers to the remaining questions and use them to develop your hygiene promotion plan.



# WHAT DO WE KNOW ABOUT RISK PRACTICES?

## Too many messages!

Look at the lists of messages below. These are all common in hygiene education programmes. But there are so many! And they are confusing. Two messages are the maximum for effective communication so which two would you choose?

“cover water containers”  
“boil drinking water”  
“filter drinking water”  
“chlorinate well water”  
“use a dipper for water”

“cover food”  
“use fly screens for food”  
“disinfect vegetables”  
“reheat food”

“wash hands with soap”  
“wash hands with ash or mud”  
“do not wash hands with mud”  
“wash hands before eating”  
“wash hands before feeding child”  
“wash hands after defaecation”  
“wash hands after cleaning up child”

“burn rubbish”  
“bury rubbish”  
“transport rubbish to a depot”  
“clean well surrounds”  
“build latrines”

“teach child to use a potty”  
“bury faeces”  
“disinfect latrines and slabs”

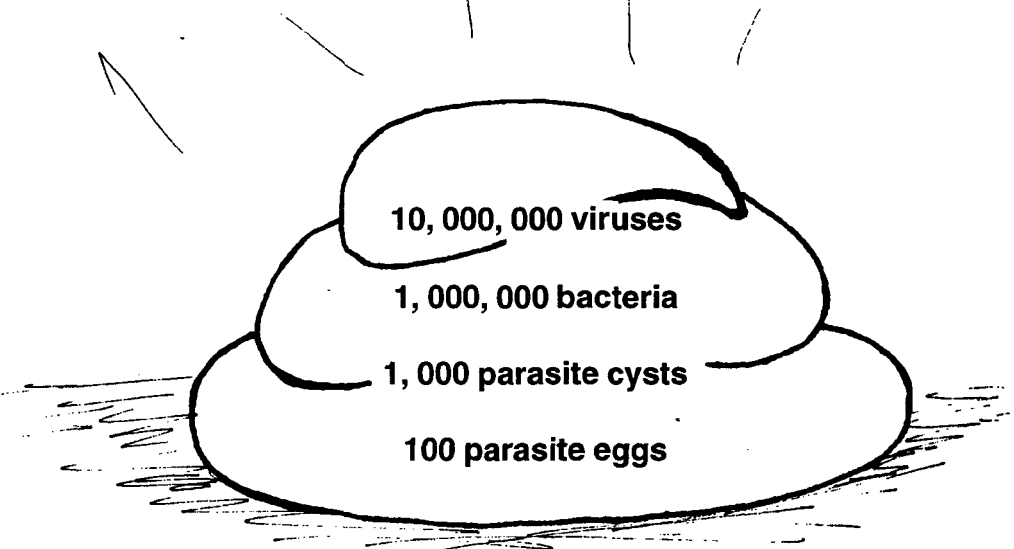
“cut fingernails”  
“comb hair”  
“do not spit”  
“wear clean clothes”

The only way to make a sensible choice is to know about how people catch diarrhoea, and to know what practices are common in our target area. Then we can pick out the most risky practices.

## Where do intestinal infections come from?

The origin of diarrhoea is: **EXCRETA!**

One gramme of faeces can contain:

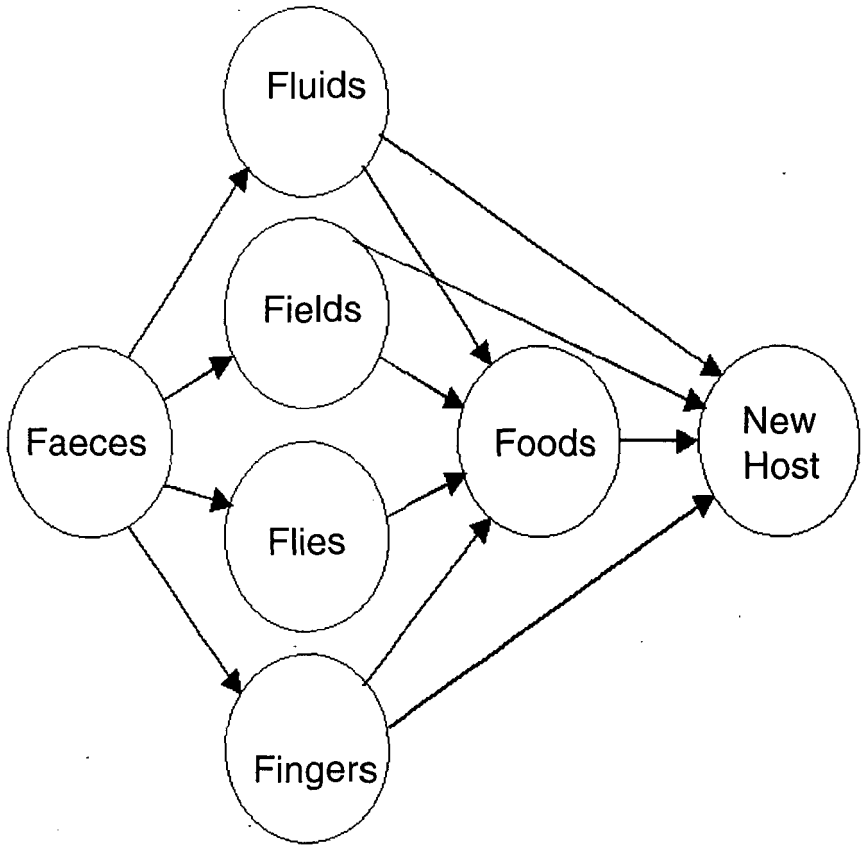


Infectious diarrhoeas (including dysentery, cholera and typhoid) are caused by infectious agents like viruses, bacteria and parasites. These agents get into humans via the mouth and are passed out in faeces.

## **ENEMY NO 1: FAECES!**

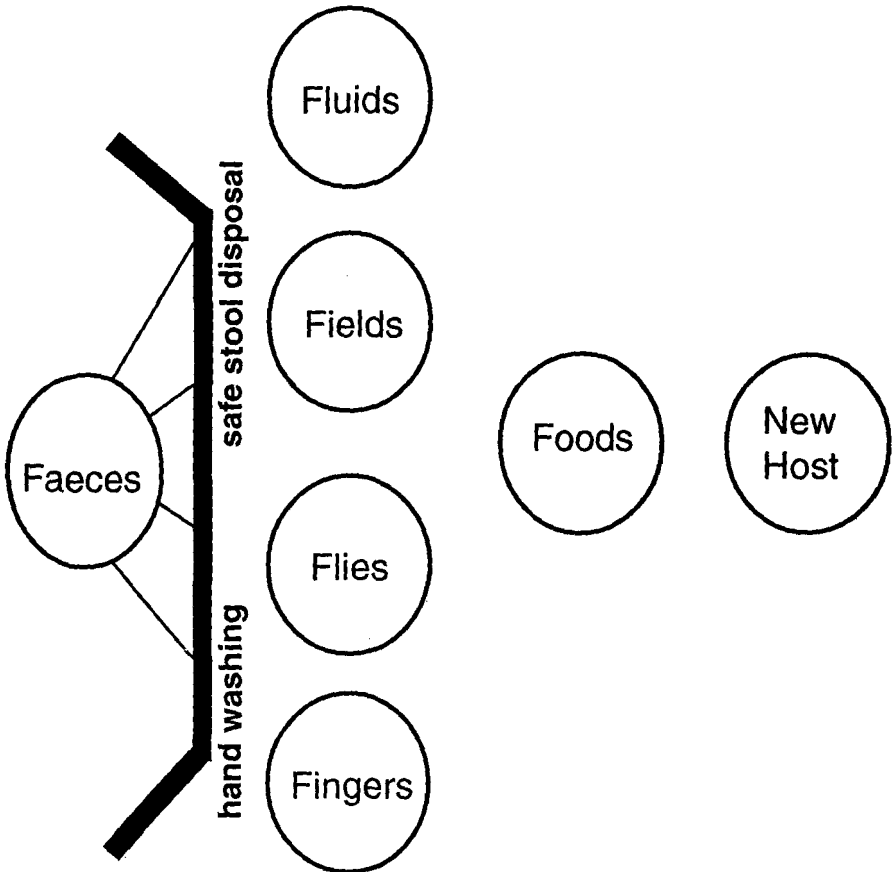


## How do people catch diarrhoea?



This is the famous **f-diagram**, which shows the different routes that the microbes of diarrhoea take from faeces, through the environment, to a new person. For example; microbes in faeces on the ground by a well can get into the water (fluids) and be drunk by a child, hands that have not been washed after going to the toilet can carry microbes onto foods, which are then eaten, infecting another child, who gets diarrhoea and spreads more microbes...

## How can we break the transmission chain?



If we can prevent faecal material from getting into the environment in the first place, then we do not have to worry so much about purifying water, storing food correctly or keeping away flies. That is why our first priorities should be:

**safe stool disposal**  
**handwashing with soap after stool contact**

## RISK PRACTICES: THE EVIDENCE

There are many practices that can help prevent diarrhoeal infection. But which are most important? We review the evidence.

### Getting rid of faeces

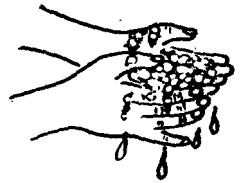
Faeces in the public and domestic environment are the primary source of diarrhoeal pathogens. **Safe disposal of stools is the best way to prevent infection.** Ideally, adult and child stools should be disposed of in toilets or latrines. In places where this is not possible, stools should be buried. As a last resort, it is better to carry stools to a place far from play areas or water sources and cover with earth than to leave them lying in the yard. In places where they are available, teaching toddlers to use potties can help to keep the home area free of faeces.



Faeces of animals like pigs, cows and chickens can also carry diarrhoea microbes and need to be kept out of the home and where children play.

### Hand washing

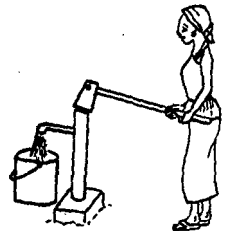
Hands readily become contaminated with faecal material after anal cleansing or after cleaning children's bottoms and stools. Rinsing fingers with water is not enough to remove greasy particles which contain microbes. Hands need to be well washed after contact with faeces; either rubbed with an abrasive such as ash or mud, or with a detergent such as soap.



Handwashing before eating, before feeding children and before preparing food are all helpful. But we now know that following such advice systematically would require a woman to wash her hands with soap about 30 times a day, which may not be practical. **Most important is handwashing with soap (or ash) after stool contact.**

### Keeping water clean

There is much debate about the importance of safe water. A plentiful and accessible water supply makes hand washing and cleaning easier, which helps to keep the environment free of pathogens. Ensuring that faecal material does not get into water supplies at the source is probably far more effective than boiling, filtering, and covering water jars. **Safe stool disposal is a priority.**



### **Fly control**

Though flies can carry microbes from faeces to food, fly control is difficult and expensive to achieve. If stools are disposed of in toilets or latrines and these latrines have covers or fly traps, then fly-based disease transmission will be minimised. **Here also safe stool disposal is the priority.**



### **Food hygiene**

Poor food handling practices contribute to diarrhoeal infection largely because they offer bacterial pathogens the opportunity to multiply. This way people can consume much greater doses of microbes. Diarrhoeas often peak in warm, humid seasons in the tropics, when conditions are favourable to the multiplication of bacteria on food.



Food stored in a warm place is an environment that microbes like, where they can multiply easily. Feeding bottles are especially dangerous because they are hard to sterilise and bacteria grow quickly in warm milk. Poor handling of bottles and child food are therefore major risk factors for diarrhoeal diseases in young children. Hence a cup and spoon is preferable to a bottle, for semi-solid weaning food. But the microbes that cause diarrhoea come from stools. **Preventing stools from getting into the domestic environment in the first place is therefore a priority.**

For a summary of the scientific evidence concerning hygiene risk practices see *Actions Speak* (Boot & Cairncross) and *Improving water and sanitation hygiene behaviours* (WHO). Apart from preventing diarrhoea, safe disposal of stools and improved hygiene has other benefits, such as reducing infection with intestinal worms.

**To sum up, unless your field work shows you otherwise, the evidence suggests that the most important way that microbes infect children is by getting into the environment from faeces in the first place. Therefore two of the most important practices for hygiene promotion programmes to target are likely to be:**

## **SAFE STOOL DISPOSAL**

### **HANDWASHING WITH SOAP AFTER CONTACT WITH STOOLS**

# WHAT DO PEOPLE DO?

## How to identify risk practices

We know that certain hygiene practices are more risky than others, and that those that let faecal material into the home environment are the most risky. However, to develop our programme we need to know what people actually *do*. How do they dispose of child or adult faeces? Do they wash their hands with soap after coming into contact with faeces? What other practices are causing a problem locally?

How do we set about finding this out? Just asking is not good enough; hygiene practices are private and are morally loaded; nobody likes to admit to not washing their hands, for example. The first step is to choose a number of representative communities in which to work. A variety of techniques can then be used to collect information about risk practices. These include:

- ⇒ Environmental walk
- ⇒ Checklist observation
- ⇒ Structured observation



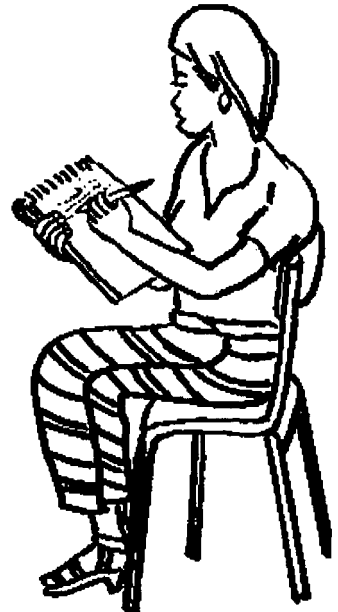


## Environmental walk

A good way to begin the formative research is to take an environmental walk. Choose sites that are representative of your target area, and having made the customary contacts with leaders, administrators, etc, ask a group of local people to show you round your chosen villages/ neighbourhoods. It is a good idea to do it at dawn or dusk as you will see more hygiene behaviour then. Ask to see the water sources, the places where rubbish is thrown. Chat to mothers about their children, what their problems are, how they manage to keep their households and their children clean. Ask about problems with sewage, latrines, stagnant water, how they manage their babies and children, the age children learn to defaecate alone and where, who helps with the children and so on. Write up what you learned about hygiene straight away after the visit. (*Hygiene Evaluation Procedures*, by Almedom, describes this, and many other useful techniques.)

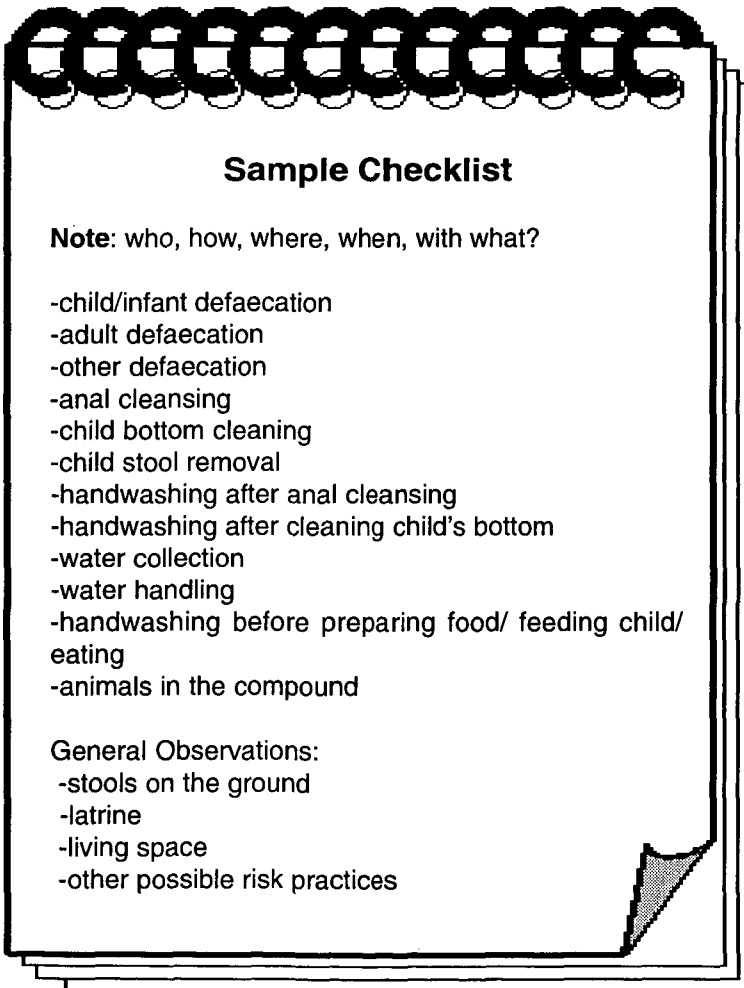
## Checklist Observation

Make a list of all the behaviours that you think might be putting children at risk of diarrhoea (see the list on the next page for ideas). Be sure to include all the practices which might allow faecal material into the environment. Take the team and spend several days in one of your target communities from early morning 'till night. Ask to sit with mothers, childcarers and children and watch what goes on. Join in with the family life. Each time one of the behaviours on the checklist is seen, note when and where it happened and who did what. Tell the family you are interested in child health but not that you are especially concerned with hygiene.



Checklist observation can be carried out in a number of sites, depending on how big and varied your target area is (see manual no 1). Afterwards, sit down with your team and decide which practices seem to be putting children at risk.

Write up your conclusions in a short report.



### Sample Checklist

**Note:** who, how, where, when, with what?

- child/infant defaecation
- adult defaecation
- other defaecation
- anal cleansing
- child bottom cleaning
- child stool removal
- handwashing after anal cleansing
- handwashing after cleaning child's bottom
- water collection
- water handling
- handwashing before preparing food/ feeding child/ eating
- animals in the compound

General Observations:

- stools on the ground
- latrine
- living space
- other possible risk practices

## Structured Observation

The results of the checklist observation will have given you a short list of practices that are allowing the spread of microbes from stools into and through the environment. Now you need to know how common the risk practices are. Risky practices which are frequent are a major public health problem; practices that are rare are probably not a priority for your programme.

Observing behaviour directly gives more valid results than interviews (Curtis). Structured observation is a systematic technique for observing and recording particular practices. It lets you quantify specific hygiene practices directly. It is also used to monitor the impact of the programme on the target practices before, during and after an intervention.

Structured observation is carried out by a team of trained observers, who ask permission and then visit households, often very early in the morning as people get up. They then sit as quietly as possible in a space where they can see what is happening. Each time they see a practice of interest they note down what happens on a pre-coded form. On the next page is an example of a sheet taken from a structured observation format: you can adapt it to your needs. To fill it in, the observer puts a ring around the number which corresponds to what she sees. This simplifies recording and data handling. You can complete the form with the other practices that you noted as possible risk practices during the checklist observation. You can also add spot checks of whether stools are seen on the ground, animals in the yard, etc.

Child defaecation is likely to be one of the practices of interest, so choose households with young children (say, under 3) for the observation. Child defaecation and stool disposal will only be seen on about a half to two thirds of visits. This has been allowed for in the sample sizes suggested in manual 1.

Ask advice from local people about the acceptability of structured observations and ensure that fieldworkers do not impose themselves on families who would rather not participate.

## 15 tips for carrying out structured observation

- ⇒ Plan to cover between 70 and 200 families, depending on how big and how varied your programme area is (manual 1)
- ⇒ Households should be chosen at random (from a map or household list or, if neither exist, by taking every 4th or 5th house along a street, for example).
- ⇒ Only observe in households with small children.
- ⇒ Visit families the day before and ask their permission, explain that you are doing a study of child health or of women's work, but not that you are specially interested in hygiene.
- ⇒ If someone doesn't want to participate, thank them politely and try another house.
- ⇒ Find female field workers who don't mind getting up very early. (It is difficult for men to observe hygiene in most countries)
- ⇒ In one month, five field workers can cover 100 families.
- ⇒ Observe for a standard period, say from from 06.00-09.00 each morning.
- ⇒ Test the observation formats and revise them so that they cover every circumstance you might meet before finalising them.
- ⇒ Train field workers carefully so that they all fill in the forms the same way. Make a written list of instructions.
- ⇒ Arrive at the household at getting up time, greet people and then sit down quietly in an corner where you can see what is going on.
- ⇒ Keep conversation to the absolute minimum.
- ⇒ Supervisors need to visit the field workers regularly.
- ⇒ Hold frequent team meetings to decide what to do about unexpected observations and to give moral support to the team.
- ⇒ Tabulate the results by hand (or use a computer)
- ⇒ Decide how much you think people changed their behaviour because of the observer and mention this in your report.

## A sample structured observation format

### Section 2. Structured Observation of child defaecation

2.1 Did you see the child (0-3yrs) defaecate during the observation period?

yes=1 no=2

2.2 Where did the child defaecate?

on a pot=1                      on the ground in the house=2  
on the ground in the yard=3  
on the ground outside the yard=4  
in nappies=5                      in pants/trousers=6  
in the latrine=7                      other=8

2.3 Did someone clean the child's bottom after it had defaecated?

Who?

nobody=1                      the child herself=2  
mother=3                      sister/relative=4  
maid=5                      other=6  
not seen =7

2.4 What happened to the stools?

thrown in the latrine=1                      left lying on the ground=2  
thrown outside=3                      taken to the rubbish heap=4  
washed off=5                      not seen=6

2.5 After cleaning the child's bottom/cleaning up stools did the person

wash both hands with soap=1  
rinse both hands with water only=2  
rinse one hand=3  
not wash hands =4                      not seen =5

Tabulate the results, either with a computer or by hand. Look at the frequency of the risk practices that you suspect to be causing a problem and pick out those which are common enough to be a real threat to public health. Finally, narrow down your list to just two or three risk practices.

# DEVELOPING TARGET PRACTICES WITH THE COMMUNITY

Up till this stage, you have mainly been learning from your sample communities; the time has now come for more active collaboration. You have now identified two or three types of practice which you think are the main causes of child diarrhoea. They will probably include unsafe disposal of child and/or adult stools, lack of handwashing with soap after stool contact and other high risk behaviours which are specific to the locality. You now need help from the communities to develop replacement practices.

## Behaviour trials

Behaviour trials are a new technique which enable health workers and representative members of the community to work together to design replacement practices for those that are putting people at risk. You can also use them to find out about behavioural motivation by asking what people like and dislike about the new practices (explained in manual 3).

**Step 1. Set up the trial.** Find a number of women who aren't using your target safe practices. (You can use the results of the structured observations to identify possible candidates). Invite three or four groups of about ten to local meetings. Make sure that they are roughly representative of your primary target audience. At the meeting discuss the results of the observations and your analysis of practices that are putting children at risk. Ask for their suggestions as to what could be done. Ask for volunteers to work with you to try out safer behaviours. Offer physical support such as soap, so the trial does not require them to spend money. If, for example, you noted that children defaecating on the ground was a common risk behaviour, then you might explore whether using banana leaves or potties was feasible and acceptable to mothers in your area.

**Step 2. Home visits.** Fieldworkers visit each volunteer at home and work with her to adapt the target practices to her individual circumstances. They ask her to do her best to carry them out for two weeks.

**Step 3. Follow-up.** Visit each volunteer each day at first (every two days in the second week) to support her, to remind her and to find out how she is getting on. Work with her to solve problems and find alternatives. If she has no latrine for example, can she use a neighbour's or bury child stools, for example. After several weeks most mothers will have developed workable replacement practices. You will, at the same time, gather some lessons which will be useful when it comes to scaling up the intervention. Key questions to ask at each visit are:

Did you manage to adopt the new practice?

What difficulties did you have?

How did you solve the problems?

What else could we do to make it easier?

Did you like the new practice? Why? Why not?

What were the costs (time/money)?

What were the benefits?

Keep track of the results at each visit by filling in forms like the one shown below.

### Behaviour trials: sample follow-up form

Day No/date D..... : ...../...../..... Family ID No   _____	Carer	Child			Problems Solutions Advantages of new practices
		1	2	3	
Where did they last defaecate? 1= latrine in the yard 2= neighbour's latrine 3= in a potty 4=on the ground 5=other (note)					
How were hands washed after stool contact? 1= not washed 2= plain water 3= with soap 4= other (note)					

**Step 5.** At the end of the trial, summarise

- the exact sequence of events that go to make up the target practices
- the problems encountered,
- the solutions found by the participants,
- the advantages that participants felt that they got from the new practices.

Meet with the women again to check what you found and feed back the results. Finally write up a statement showing the risk practices and the target practices like the examples shown below.

**Risk practices**

13% of mothers wash their hands with soap after cleaning up a child's bottom.  
20% of child stools are left on the ground.

**Target practices**

30% of mothers use soap to wash their hands immediately after cleaning a child's bottom and throwing away the stools.  
90% of child stools are thrown in a latrine or buried.





## **Making the links**

In some places it will not be possible to find the ideal solution to problem practices. Soap or water may be unavailable for handwashing, or there may be no latrines for the disposal of stools, for example. When this happens, two types of solution are needed, one immediate, one long term. For the long term, better infrastructure is required. The formative research may highlight this need and recommend the building of water or sanitary infrastructure, or suggest modifications to an existing programme. Community ownership of the results of the formative research can help galvanise further political and community action for better resources.

Nevertheless, the formative research should still be able to find interim solutions that allow better hygiene in homes in the absence of improved infrastructure. For example, it is rare for there to be no soap at all. Most houses keep soap, or a soap equivalent, for washing clothes. Earth or ash can replace soap, and can be promoted if people find this acceptable. If latrines are not available in the short term, the solution is burying, or ensuring that stools are disposed of well away from households. *The priority is to reduce the faecal contamination of the environment in which children live.*

# RISK PRACTICES, TARGET PRACTICES: SUMMARY

This manual is the second in a series concerning a new approach to improved hygiene. Using a systematic process of formative research to combine what the hygiene worker and target communities know, do and want, it is possible to protect children from the faecal contamination of their environment which causes diarrhoeal disease.

This second manual in the series explored the routes of transmission of the microbes that cause diarrhoeal disease. It shows how practices which stop faecal material getting into the environment, such as washing hands with soap after contact with stools and the safe disposal of child stools are likely to be a priority for intervention. The manual shows how to pinpoint risk practices through checklist and structured observation and how to develop replacement practices with volunteers from the target communities using behaviour trials. The following manual looks at the issue of how to motivate behaviour change.

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

This is the second 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.

