# Knowledge and Peer pressure as Motivation for Hygiene Behaviour Change

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# A HYPOTHESIS OR PROPOSITION

A Theory is not the absolute truth, it is a proposition, and it cannot be said to be true unless, it can demonstrate that what it predicts will in fact come about.

***"I believe that Community Health Clubs can bring about some of the highest levels of hygiene behaviour change in rural communities."***

# Social Planning

1970's

**People only change when they are forced to do so by authority.**

# 1980's Health Belief Model

**People will improve their hygiene**

**if they know the reason**

# 1990's

# The Participatory Approach

## People will change if they participate

**PRA: Participatory Rural Appraisal**

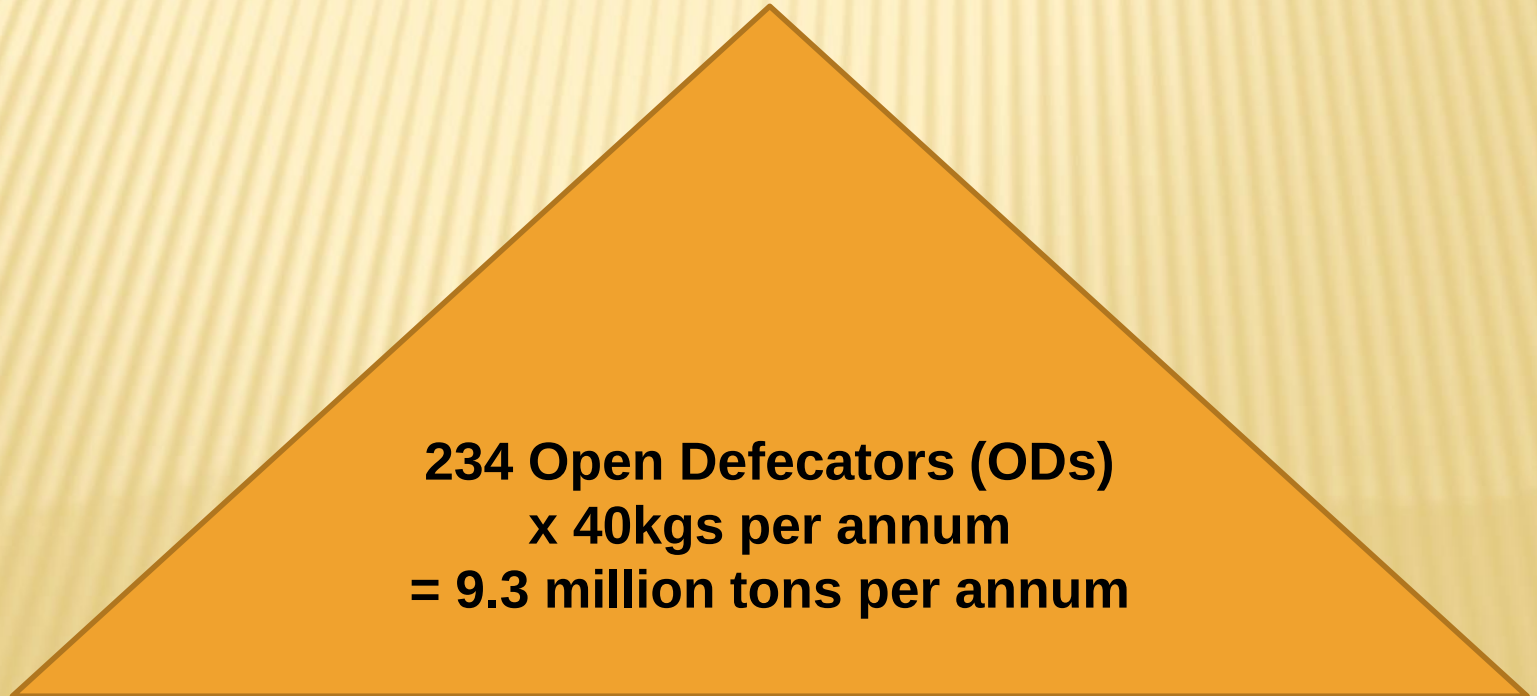
**PHAST : Participatory Hygiene and Sanitation Transformation**

# 2000

**The MDG Challenge :**

**To halve the number without sanitation by 2015**

**234 million people in Africa**



# WHO has set these targets?

**Have the 'the beneficiaries' agreed to change?**

**Is it them or is it us?**

**We have failed to get behaviour change from communities.**

**Why ?**

# 2000's Community Led Total Sanitation (CLTS)

People will change their behaviour to avoid Shame

**Public Naming and Shaming; tracking and ostracising offenders**

Source: Kar, K & Pasteur, K. (2005) Subsidy or Self-Respect? Community Led Total Sanitation. An Update on Recent Developments. IDS Working Papers - 257.

# CURRENT DEBATE BETWEEN CHC & CLTS

## CHC Approach: Implementation strategy

- 6 months PHHE
  20 sessions (each week)
- Learning through fun participatory activities reinforce good practice (song, drama)
- Informed group decision making and weekly homework
- Voluntary household improvements
- Zero Open Defecation (ZOD) & 20+ other hygiene improvements

## CLTS Approach Implementation strategy

- One 'Triggering' day + a few follow-up visits
- Village walk to shock community that they are eating their own faeces
- Community shamed into action
- Leaders enforce change with fines
- Open Defecation Free (ODF ) Village free ODF zone

**Which to choose?**

2000's

# Social Marketing

People are more interested in being smart than healthy

**APPEAL TO STATUS : SUBLIMINAL METHOD**

- National health days
- Radio and TV programs
- Flyers and pamphlets
- Advertising on posters
- Celebrity advertising
- Community drama


Source:Vietnam: Social Marketing through Bill boards

# HEALTH PROMOTION THROUGH SOCIAL MARKETING

**ASSUMPTION 1: Mothers desire hygiene, not for the sake of avoiding diarrhoea, but for aesthetic and social reasons**

**ASSUMPION 2: Mothers value only improvements in quality of life when excreta were removed and could therefore not be seen or smelt.**

**METHODOLOGY: Health promotion is kept simple and appeals to status only (what others think)**

**THEREFORE : No attempt to improve knowledge of mothers and empower through informed decision making**

# The Community Health Club Approach

# CHC ASSUMPTIONS

**ASSUMPTION 1.**
**People change behaviour because they want to improve their children's chances of survival and well being**

**ASSUMPTION 2.**
**People change behaviour because they want to be part of the main group.**

**ASSUMPTION 3.**
**People want knowledge on how to ensure child survival**

**ASSUMPTION 4.**
**To get people to change needs constant reinforcement with at least 20 face to face interactions for at least six months using peer pressure**

## Diagnosis of failure of past methods

- **Lack of Organisation**:
  No designated group with mandate
- **Lack of Mandate:** no mechanisms for overcoming dissent,
- **Undemocratic Leadership:**
  Selecting Local leaders top down,
  Reinforcing existing elites
- **Inappropriate targeting**: Appealing to individuals rather than a group
- **Assuming common unity of 'community'**

# The Need for Knowledge

# INTELLECTUAL STARVATION

Women want to learn : provide the forum!

Community Health Clubs are attractive for this reason

# INTELLECTUAL STARVATION

**86% literacy men and women (Unicef, 1999)**

**78% literacy women only**

**50% of those +60 years were illiterate in 1990**

**Jesina Chimombe**
**Age 63.**
**4 years of primary school**
**Nyazonya Health Club Treasurer**
**Married : husband at home**
**8 children, 3 surviving**
**5 grandchildren orphaned**

I am a learner.
I have written Grade 7 in literacy class.
I passed and I got an 'A' in Shona.

# KNOWLEDGE AS A MOTIVATOR

Friere emphasied the importance of  humanising the oppressed and uneducated masses and empowering them with a sense of worth and confidence to change.

*It is necessary to trust in the oppressed and in their ability to reason.*

*Whoever lacks this trust will fail to initiate (or will abandon) dialogue, reflection and communication and will fall into using slogans, communiqués, monologues and instructions.*

*Superficial conversions to the cause of liberation (good health)  carry this danger* (Friere, 1970.p.48*).*

# RESEARCH QUESTIONS

**1. Popularity:**

Are under-educated rural populations attracted to programmes that provide knowledge?

**2. Knowledge:**

Do semi-educated people, given the chance to acquire knowledge succeed and retain information?

**3. Behaviour:**

If so, does this knowledge translate into behaviour change?

***4.*** **Cost-effectiveness:**

If so, how does this behaviour change relate to levels reached by other methodologies?

# PAIR-WISE RANKING

***… the group thinks, feels and acts entirely differently from the way its members would if they were isolated.***

***If therefore we begin by studying these members separately we will understand nothing about what is taking place in the group* (Durkheim, 1895).**

Pair-wise ranking done in 10 health clubs

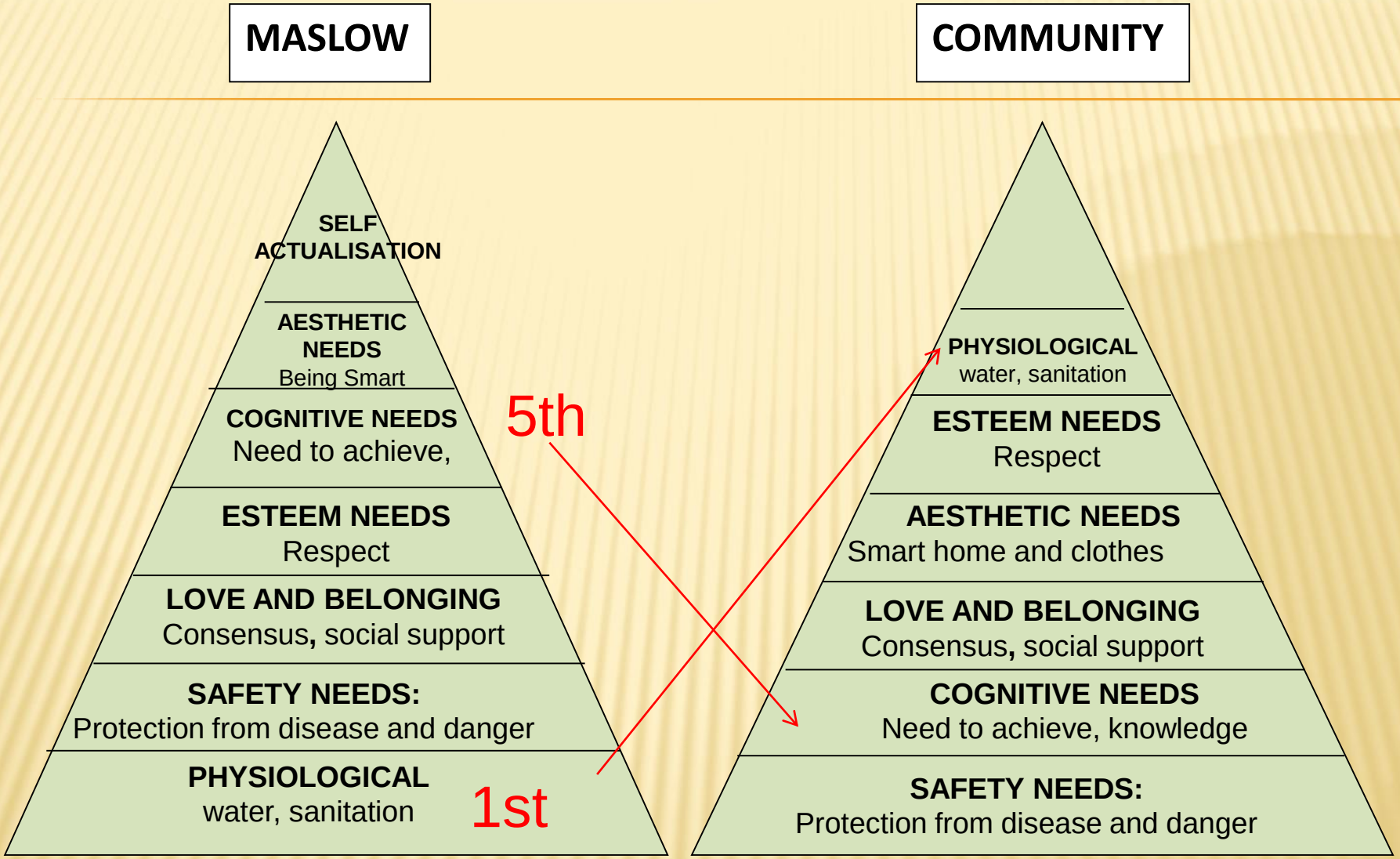
*What has changed since you have had a health club?*

Discussion in small groups to itemise 10 main points

10 points from each groups collected and sorted by consensus into the 7 categories of Maslow's Hierarchy

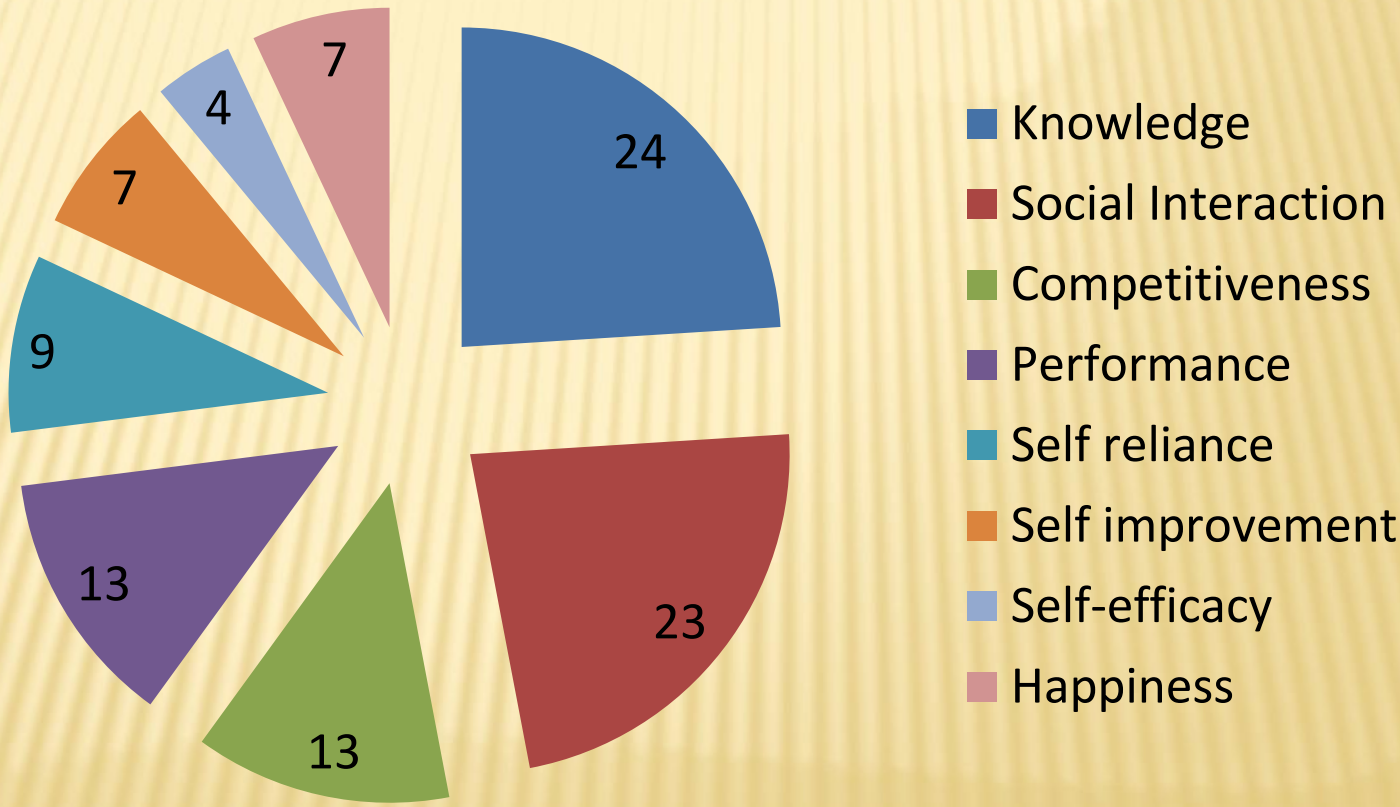
# WHAT IS MORE IMPORTANT TO YOU?

| | Scarf | Flower | Paper | Stick | Leaves | Rock | Shoe |
|---|---|---|---|---|---|---|---|
| **Scarf** | | | | | | | |
| **Flower** | Flower | | | | | | |
| **Paper** | Paper | Paper | | | | | |
| **Stick** | Stick | Paper | Paper | | | | |
| **Leaves** | Leaves | Leaves | Paper | Leaves | | | |
| **Rock** | Rock | Rock | Paper | Stick | Rock | | |
| **Shoe** | Shoe | Shoe | Paper | Shoe | Shoe | Shoe | |
| Total | 0 | 1 | 7 | 2 | 3 | 2 | 4 |


MASLOW
COMMUNITY
SELF ACTUALISATION
AESTHETIC NEEDS
Being Smart
COGNITIVE NEEDS
Need to achieve,
ESTEEM NEEDS
Respect
LOVE AND BELONGING
Consensus, social support
SAFETY NEEDS:
Protection from disease and danger
PHYSIOLOGICAL
water, sanitation
1st
5th
PHYSIOLOGICAL
water, sanitation
ESTEEM NEEDS
Respect
AESTHETIC NEEDS
Smart home and clothes
LOVE AND BELONGING
Consensus, social support
COGNITIVE NEEDS
Need to achieve, knowledge
SAFETY NEEDS:
Protection from disease and danger

# What did you enjoy best about the Health Club?

## 20 individual interviews:



# COMMUNITY HEALTH CLUBS MEET A COGNITIVE NEED

- **Need for knowledge** — **Correct information**
- **Intellectual starvation** — **Mental stimulation**
- **Lack of Confidence** — **Empowers women**
- **Lack of Responsibility** — **Group problem solving**

**Health Promotion as an entry point:**

**A solid basis for other development …**

# Individual approach
# vs
# Group Approach

# INDIVIDUAL CHANGE MODEL

**Social Planning Model**

- Top down
- Prescriptive
- Enforced

**Health Belief Model**

- Voluntary
- Top down
- Educative

**Social Marketing**

- Voluntary
- Commercial
- Open ended

# INDIVIDUAL CHANGE MODEL

**LINEAR WORLD VIEW:**
**progressive, ever onwards**

**INDIVIDUALISTIC: self first**

**CARNIVORE  survival strategy**

**SELF SUFFICIENT: nuclear family**

**INDEPENDENT: no community**

# CYCLICAL WORLD VIEW:

**Round and round with the seasons**

## Weighing up the benefits of change:

**Can I afford it financially? …no margin for error …wait and see**

**What will people think? … I don't want to attract jealousy**
**Pull him down syndrome (PhD)**

**Have I got the time?… I'm tired and busy all day….why bother**

**Will the gain be worth the effort? … My ancestors survived, why change?**

**SELF EFFICACY**
**But am I able to do it?**
**Lack of confidence**

**PEER GROUP**
**Positive or negative peer pressure**

# Reasons for failure of development by community

## People change through peer pressure / Group Consensus

I fear the jealousy of others if I change.

Pull her down (PhD) Syndrome

I am not sure if the decision is correct

I don't like being different from others

I prefer to wait and see if changes bring reward

# Coping Strategies in Traditional Societies

**Traditional societies are often characterized by:**

- **Love of rapport and togetherness**
- **PhD syndrome (pull him down) for those who challenge existing norms and values to keep equity**
- **The group is more important than the individual**
- **Therefore anything that enhances this togetherness will resonate and succeed**

# Constraints to Change

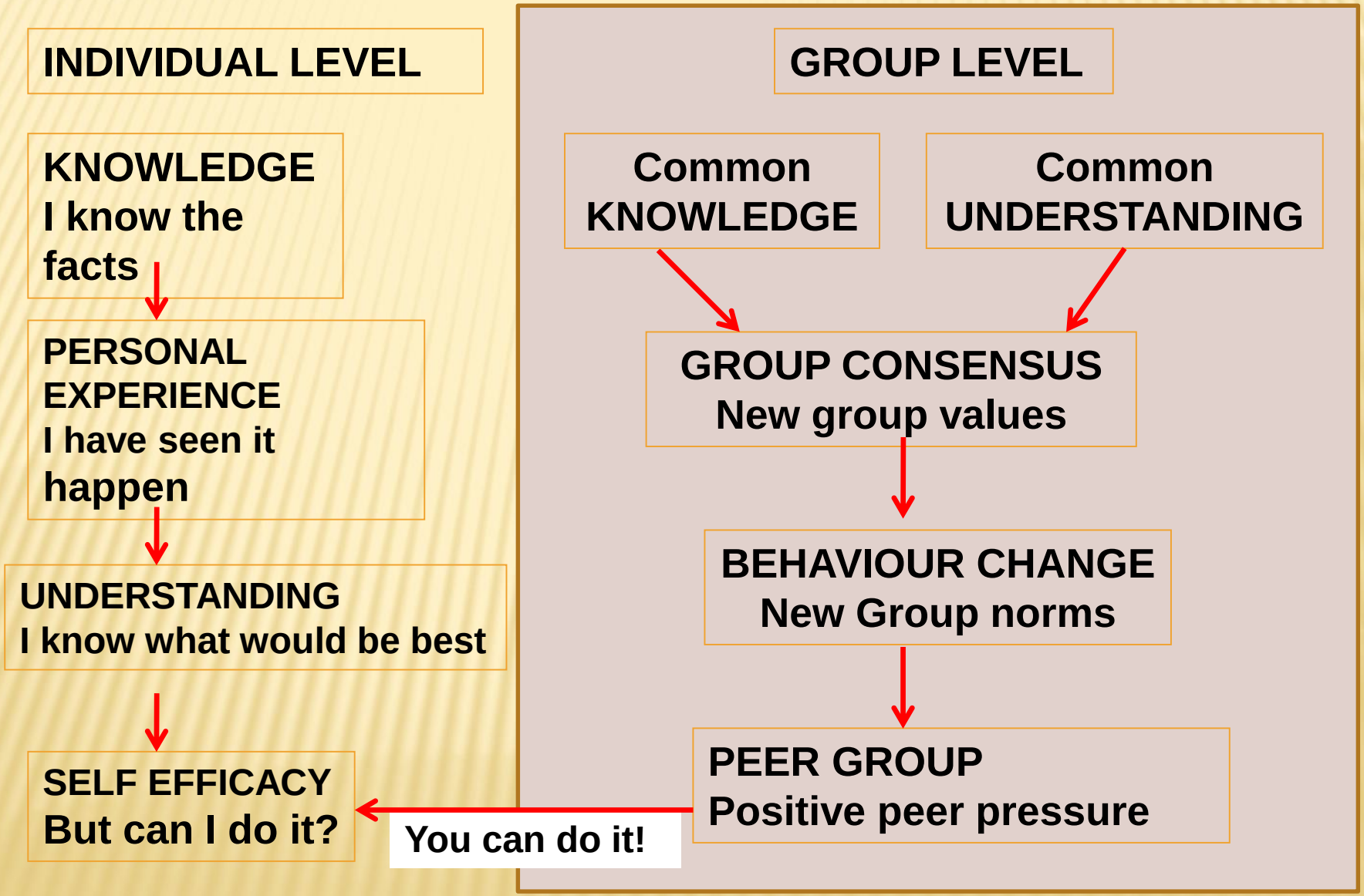
- **Levelling Mechanism (Haviland, 1993)**
A societal obligation compelling a family to distribute goods so that no one accumulates more wealth than anyone else (Local field workers refer to this as the PhD Syndrome: Pull her Down Syndrome, see below).

- **Limited Good Syndrome (Foster, 1965, 1972)**:
Individuals compete for personal gain when material subsidies are distributed and this undermines group cohesion.

- **Lack of Self-efficacy (Bandura, 1977)**:
Those who lack self confidence are afraid to make individual decisions which may not be approved by husband / elders.

- **Big Man Syndrome (Haviland, 1993)**:
If existing structures are used for the new intervention there is every likelihood that traditional leaders may highjack benefits for their own families whilst distancing planners from the poorest of the poor, who have little voice to object.

# Community Health Club Model: Behaviour change mechanism



# COMMON UNITY

Not all communities have common unity:

**The CHC Model works on the assumption that:**
***Many communities are dysfunctional***

**Therefore communities need building in order to have common unity of knowledge, understanding and objectives.**

**This enables informed decision making and an ability to act effectively as a group**

**2005 Waterkeyn, J and Cairncross, S. No 61. Soc. Sci. & Medicine. Creating demand for sanitation and hygiene through Community Health Clubs: a cost-effective intervention in two districts of Zimbabwe.**

**2006 Waterkeyn, J. District Health Promotion using the Consensus Approach. Well / London School of Hygiene and Tropical Medicine**

## www.lboro/conferences WEDC papers: Waterkeyn et al.

**1999: Structured Participation in Community Health Clubs.**

**2000: Demand Led Sanitation in Zimbabwe.**

**2003: Cost-Effective Health Promotion: Community Health Clubs.**

**2005: Decreasing communicable diseases through improved hygiene in CHCs**

**2005: Rapid Sanitation uptake in Internally Displaced People Camps N. Uganda through Community Health Clubs**

**2005: Waterkeyn A. How to Achieve Sustainable Behaviour Change.**