

# Accentuate the positive — promoting behaviour change in Lucknow's slums

by Valerie Curtis, Prabhakar Sinha, and Shyamoli Singh

**Telling mothers they are putting their children's lives at risk is insulting and likely to result in wholesale rejection. Is there a better way of getting adults to change their behaviour?**

IN LUCKNOW, THE bustling capital city of Uttar Pradesh, about a thousand young children die from diarrhoeal diseases each year. How can this problem be solved? The simple answer is that there is no short-term solution.

So when we, the Lucknow NGO Ankur Yuva Chetna Shivir, with the help of the London School of Hygiene and Tropical Medicine, were asked to help, we decided that the best way to start would be by trying to understand the problem better. We put our heads together and came up with a list of five things we needed to know:

- What practices are putting people at risk of diarrhoeal infection?
- What safer practices are acceptable — and feasible?
- What could make people want to adopt safer hygiene practices?
- Who should we be trying to reach?
- What is the best way to reach them?

The only way to get useful answers was to work with the target communities. So we decided to plan a small, collaborative investigation, to find out what people do — by using structured observation — and to ask them what they thought, in focus-group discussion, in volunteer trials, and with a simple questionnaire. Technically, such a small-scale, focused, pre-intervention investigation is called 'formative research'.

## What are 'risk' practices?

Small children spend much of their time in the home. If this environment is contaminated with human faeces, they can be infected by the bacteria, viruses and parasites that are present, often in vast numbers. The key to stopping diarrhoea is to prevent the stool containing infectious microbes from getting into the domestic environment in the first place. What happened to the stools of children and adults in Lucknow, and what happened when people got faecal material on their hands? Were hands immediately washed with soap, or could the microbes in the sticky faecal material stay on hands and get into food, or onto toys or utensils?

After visiting several slum communities and spending a few days with families, the team decided to observe people's hygiene practices at first hand. So we designed a form which would allow observers to record what they saw, in a structured format. Female fieldworkers asked families in 12 slum areas if they could visit; most agreed, so from around six in the morning, the fieldworkers sat in their homes, for about three hours, watching the families carrying on with their daily routines — paying particular attention to practices related to stool hygiene.

What they found was very interesting. As Figure 1 shows, the stools of the 74 children aged three or under, met various fates. Some were thrown in the drainage ditch; some washed off into a drain; others were thrown into the street or left lying in the yard. Surprisingly, the presence of a latrine, or lack of one, did not make much difference.

In general, mothers used their bare hands to clean their children after defecation; only 21 per cent of mothers were observed using a cleansing agent (soap, mud, or ash). A third of mothers simply rinsed their hands, while a surprising 41 per cent did not wash their hands at all, but carried on with their other chores. Mothers with a tap or pump in the yard were only slightly more likely to wash their hands than those who had to go to a public tap or pump.

After they defecated, only half of the mothers washed their hands with a cleansing agent — others rinsed or did not wash their hands at all.

These findings suggested that there was a serious problem of diarrhoea transmission taking place via poorly disposed-of stools, and mothers' hands. The necessity to encourage better handwashing and safer stool-disposal was obvious. We could have promoted many other hygienic practices, but we felt we were more likely to succeed if we limited ourselves to these two key practices.

Of course, this is easier to say than do! How does one set about encouraging large numbers of adults to

change the habits of a lifetime? The next thing we needed to know was what sort of new, safer practices mothers would find acceptable to replace the old risk practices.

## Acceptable and feasible?

Though we found out that the main causes of diarrhoea in the slums of Lucknow were probably poor stool-disposal and lack of effective hand-washing, acting on this knowledge requires some work — it is pointless asking mothers to always put stools in

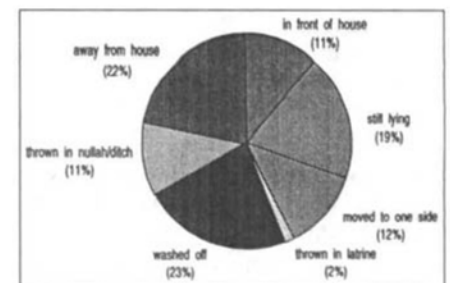


Figure 1. Young children's stool disposal in Lucknow's slums.

the latrine if there is no latrine!

As only mothers can judge what practices are acceptable and feasible in their own homes, we worked with women who volunteered to try hand-washing and safe stool-disposal, to see what worked best.

To keep the home clear of faeces, mothers needed some means of controlling where their younger children defecated. In both developed and developing countries, mothers find that potties help. So we offered this as a possible solution; after four weeks, the reaction was largely favourable, so we decided to keep this option.

Getting people to wash their hands with soap after coming into contact with stools was not as straightforward. Mothers explained that the soap they used to wash their hands after picking up stools was thought to be polluted, or *apavitra* in Hindi. The women's solution was to cut off a small piece of soap to be kept separately in the yard near the *dibba* — the container used for bottom-washing. Though mud and ash are also helpful in getting sticky faecal material off hands, it became clear during the trials that offering three options for handwashing was confusing. So we decided to stick to the simplest message: always wash your hands with soap after touching stools.

Though mothers had found practical solutions to the problem of keeping both the home and their hands stool-free, the biggest problem remained, what would make mothers want to change their habits?

## Persuasion

We need to find out how people thought they would benefit from washing their hands with soap after contact with, and getting rid of, stools. The obvious answer is that people can expect their children to enjoy better health. But there are two problems in using health as an argument for changing household habits. One is that negative messages are not good at making people modify their behaviour. The standard argument, 'If you don't wash your hands, your children will fall sick and die', is profoundly unattractive, and is often seen as insulting by poor communities. Such messages either go unheeded, or are rejected outright.

The second argument against negative messages is that few people see any logical connection between stools and children's diarrhoea. In places as far apart as Africa and the UK, people have their own ideas, ranging from teething, bad breast-milk, to the evil eye. So messages about microbes, stools and diarrhoea just do not make sense. Table 1 shows what people in Lucknow focus-groups thought were the causes of diarrhoea.

Would it be feasible to change these long-held beliefs? The team concluded that neither extension agents, nor mothers were likely to have the time to take part in full-scale education programmes about the germ theory of disease. So we abandoned the idea of [formal] health education, and looked for other ways of promoting handwashing and safe stool-disposal.

We looked instead for positive, attrac-

tive messages that could be communicated simply, rapidly, and repeatedly.

When the trials of the new practices finished, we asked mothers if they felt they had gained anything. In relation to the potty, they said:

'It is convenient: I do not have to take my child out in the night to defecate.'

'My house is clean, there are less flies.'

'I do not have to touch the stools.'

The disadvantages of using a potty were principally related to teaching the child to use it, and finding a suitable place to throw the contents.

As for washing hands with soap, the volunteers commented: 'My hands smell good now' and 'There is no dirt on my hands'.

Other mothers mentioned that it was good to be clean before going to pray — being clean was auspicious and brought harmony to the family. In one of the focus-group discussions, one woman described the importance of cleanliness:

'The house and yard of a clean woman should be well-swept. Garbage thrown away from the house; *chulha* (cooking-pot), dirty utensils washed properly. Children given baths, family wearing clean clothes, and the household articles arranged properly.'

Much of the women's discussion centred on the avoidance of pollution as a key concept in the Hindu religion; Muslim women also explained how cleanliness was fundamental in their religious practice. Other reasons for cleanliness and getting rid of faecal material included the desire to please one's husband, and to have a pleasant home for one's children.

We concluded that the women's primary motivations were the positive aesthetic and religious value of being clean, the social importance of cleanliness, and the convenience of potties. We felt that messages based on the community's existing view of the posi-

tive benefits of good hygiene were far more likely to be effective than trying to frighten people into changing their practices by talking about diarrhoea and the death of children. Messages that suggest that children are dying because their mothers are dirty seemed to be wholly unacceptable in a situation where the poor have little control over the conditions in which they live. We felt that such approaches were more likely to repulse our target audiences than to encourage them to listen. We decided, therefore, to adopt the slogan 'No death, doctors, or diarrhoea'.

So we chose positive messages, borne out in activities such as theatre and story-telling, to generate laughter and a feeling of 'the joy of cleanliness'. But before designing our communications activities, we had to decide who we wanted to reach.

## The audience?

Though the answer to this question may seem obvious, it does require some thought. As mothers are the principal child-carers, their hygiene behaviour is clearly of the greatest importance in protecting children from infection, but we saw many fathers, older children, grandparents and neighbours also involved in looking after young children. Similarly, they too contaminated the home environment with faecal material from unwashed hands, and by defecating close by.

Family members are also important in another sense. Though mothers mostly take responsibility for the domestic sphere, they explained that they cannot initiate changes without the support and consent of their husbands, mothers-in-law, and other members of the family. Furthermore, it is clear that these individuals are, themselves, influenced strongly by the wider community, particularly opinion- and community-leaders; so these would also have to be targeted by the programme.

We chose one further target group in Lucknow: children. School-age children are relatively easy to reach, they are just forming life-long habits, and they are often the most enthusiastic participants in hygiene promotion.

The research findings helped us conclude that the primary target audience for hygiene promotion should be mothers, with prominent community-leaders coming next. This approach of breaking-down audiences into specific groups — stratifying target audiences — allows specific messages and communication techniques to be tailored to specific audiences of known characteristics and sizes.

After piloting the promotion, we

**Table 1. How Lucknow mothers explained diarrhoea**

Disease	Symptoms	Presumed causes
Aon	Mucous stools, loss of weight	'Hot' food
Cholera/Haija	Vomiting, thin, watery stools, loss of weight and appetite	Stale food, hot weather, dirty environment
Dast	Frequent green lumpy stools	Cold
Malaria fever	Shivering, fatigue, thin watery stools	Mosquito bite
Nazar Lagna	Smelly stools. Bad evil eye	Bad/evil eye
Peichis/Katakh	Bloody, mucous stool, loss of weight	Stale food, food left uncovered, and hot weather
Peit Kharab	Liquid stools, loss of appetite	Overeating, irregular eating, too much sugar, eating mud
Sampat/Band Cholera	Severe gastric problems; constipation	Cold weather
Sookha Rog/Mamarkha	Frequent, curdled stools, loss of weight and appetite	Red and white worms in the spinal column
Tutti Lagna	White, frothy stools, pale eyes; occurs during teething	Teething

realized that our research had failed to come up with all the answers. We should have targeted men specifically. Men did not see hygiene as an important issue, and sometimes undermined the efforts of the hygiene-workers.

## Accurate targeting

How do the people living in the slums of Lucknow communicate? To find out, we carried out a small sample survey of 121 women: do they listen to the radio? Do they watch TV? Do they attend religious meetings? Do they have other sources of information, such as newspapers and magazines; or by talking to health-workers or doctors?

We found that only 13 per cent of mothers could read Hindi, while 6 per cent read Urdu; half of all mothers listened to the radio sometimes — but only 12 per cent listened every day. The figures for TV viewing were similar: 12 per cent of mothers had attended the festival of Ramlila, and 35 per cent had been to the weekly market in the last month. Few women attended caste *panchayat* or other community meetings. Many women had hardly any external contacts and relied on their husbands and families for information.

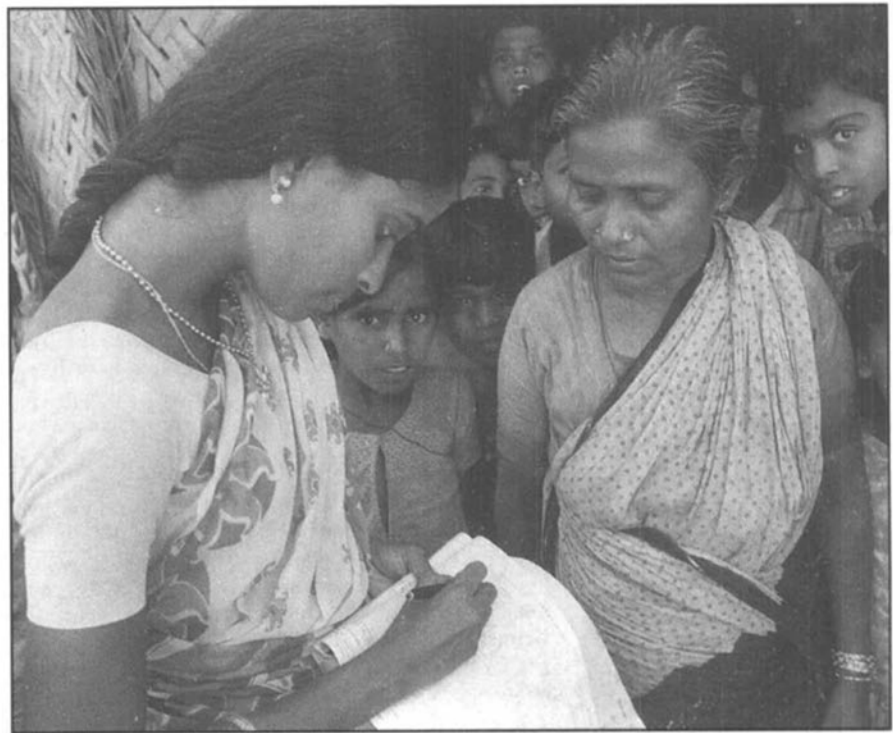
So no one channel of communication would reach all mothers in the area; we would have to use a variety of media, together with arranging for home visits, especially in the slums, where *pardah*, or something approaching it, is common.

## A new way forward

By spending around eight weeks working with our target communities, the project-workers were able to find out what they needed to know to set up a hygiene promotion programme. Such formative research can save projects considerable sums, simply by preventing costly and demoralizing mistakes.

The limited amount of research into what people actually do, think, believe, and want concerning hygiene also showed us that some of the standard approaches of hygiene education were neither appropriate nor desirable. Using the sort of techniques that are seen elsewhere — like haranguing mothers waiting in a health centre about how their dirty behaviour is making their kids sick — is not only ineffective and a poor use of resources, but it can also be insulting. Such approaches 'turn off' mothers who might have listened to the messages.

Hygiene promoters have to stop thinking like medical people and health educators who have all the answers. Instead, they have to make more effort to think like the people for whom they are working. This means finding out



Mark Edwards/Still Pictures

*Karnataka. Only by finding out what people actually do, will healthworkers formulate successful programmes.*

what they do, believe, know, and want. The work in Lucknow showed that it is possible to find out these things using a simple, but sharply focused, programme of formative research.

### Reference

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## Design for better living — a hygiene promotion programme for Lucknow

### Target practices

- Mothers and child-carers wash their hands with soap after contact with children's stools
- Children's stools are disposed of in latrines, drains or, failing that, as far from the settlement as possible
- School-children defecate safely, and wash their hands afterwards

### Motivation for change

- It is good to be clean
- Clean hands and a stool-free home look good, smell good, and please God
- A potty is more convenient

### Target audiences

- Mothers
- Child-carers
- Opinion and community-leaders
- Men

### Channels of communication

- Street-theatre
- Story-telling for children, both in and outside school
- House visits by hygiene workers
- Religious discourses (*Istima*)
- Lessons at school



Sangita Gupta