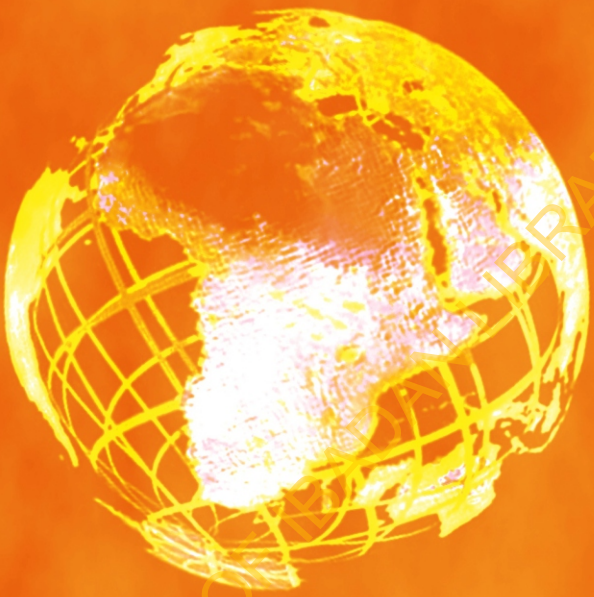

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COMMUNICATION FOR SOCIAL BEHAVIOUR CHANGE: THE USE OF GAMES AND POSTERS TO PROMOTE SANITATION AND HYGIENE PRACTICES

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ABSTRACT

People receive health information from a variety of sources and their health status depends, largely on whether they can understand and remember the health information they receive. Current communication strategies are failing in this regard. Most people forget what their educators tell them and others remember the information incorrectly (Anderson JL, Dodman S, Kopelman M, Fleming A, 1979 and Kessels, 2003). Hence, health services researchers have tested many different types of interventions to improve people's understanding of health information, change health behaviours, and improve health outcomes. However, only a limited number of these interventions have been studied to determine their efficacy, especially among people with low health literacy (DeWalt, 2006). Improved communication between health educators and the people will be a great benefit especially for low literate people within the community. Therefore, there is the need to improve the ability of health educators to convey health information to low literate population to improve their knowledge of essential health information. Hence, the development of effective communication strategies to improve the knowledge of low health literate population will also benefit more literate populations(Dower, Knox, Lindler and O'Neil, 2006).

Studies indicate that community health workers are a cost effective way to improve people's access to health knowledge and health-related behaviours (Lam, McPhee, Mock, et al. 2003). Trained health educators are para-

professionals specifically trained to work with people to increase their knowledge about health promotion and to improve their overall health conditions. If people know they need to understand certain health information, they can reduce the confusion and miscommunication that currently exists (Elder, Ayala and Campbell, et al, 2006; Sherrill, Crew, Mayo, Mayo, Rogers and Haynes, 2005) hence, the need for effective communication strategy in behaviour change communication for promoting positive health behaviour towards social development.

THE CONCEPT OF COMMUNICATION

Communication is a continuous process that begins with a first encounter between people and does not end until the last encounter in their lives. These encounters may involve functional messages that serve practical purposes, or, in cases of close ties, the encounters may also involve nurturing messages that convey a sense of caring and personal connection. Over time, members of a relationship develop increasingly predictable communication patterns and, if they become close, create a relational culture or similar worldview (Galvin and Wilkinson, 2006).

The word communication originates from the word "communis", which means common. Communication, therefore, is an act by which a person shares knowledge, feelings, ideas and information, in ways such that each gains a common understanding of the meaning, intent and use of the message. Sociologists, educationists and psychologists have defined communication according to the disciplines to which they belong. There are various definitions of communication:

· "It is a process by which two or more people exchange ideas, facts, feelings or impressions in ways that each gains a common understanding of the message. In essence, it is the act of getting a sender and a receiver tuned together for a particular message or series of message". Leagans

· "It is a process by which information, decisions and directions pass through a social system, and the ways in which knowledge, opinions and attitudes are formed or modified". Loomis and Beegle

· "Communication is the force by which an individual communicator transmits stimuli to modify the behaviour of other individuals". Howland

Communication is a two-way process which involves transmitting meaning between individuals. This is a process of meaningful interaction whereby a person not only sends but also receives and understands a message. Hence, communication always has a purpose and some of this purpose can be hindered through "Judgmental attitude" which may be reflected through excessive analysis, bossiness, name calling, ridiculing, making value-based comments and judgments, moralizing or ignoring; "Know it all" attitude which may be reflected through advising, moralizing, ordering, patronizing, threatening or lecturing. This form of behaviour often inhibits people from

sharing their concerns and experiences. When communicating with youth, this kind of behaviour/communication should be avoided and "unconcerned attitude" which may be reflected through voicing platitudes, diverting the issue, using excessive logic, offhanded assurances, half-listening, not making eye contact or being flippant. Studies have shown that communication has an important role to play in behaviour development and building positive health behaviour(Galvin and Wilkinson, 2006). Communication is the face-to-face, verbal and non-verbal exchange of information, opinions, and/or feelings between two or more people. There are two major types of communication used in a health context: "Group communication" which occurs when a health worker meets with a small group of people to provide specific information and support them in adopting healthy behaviours. These can be done through the use of games, exercises, posters, pictures and "Counseling" which occurs during a one-on-one encounter between a health worker and a patient (or a patient accompanied by a spouse, family member, or friend) to help the patient make a decision about his or her care and course of action (AIDSTAR-One, 2012).

PARTICIPATORY COMMUNICATION AND BEHAVIOUR CHANGE

Communication is an essential strategy for behaviour development. Behaviour development takes place when people are informed educated and understand the purpose for which they receive the information. Hence, people must participate in the communication process for any change in behaviour. Participatory communication is an essential ingredient in behaviour development. Communication and participation are the processes used: to inform people, enable them to contribute their points of view, reach consensus and carry out an agreed change or development action together, it can be said that communication is participation(Fraser & Restrepo-Estrada, 1998; Figuero, Kincaid, Rani & Lewis, 2002). Whenever participatory communication approaches are adopted, communication: changes its role from that of a vehicle for information-persuasion to that of a tool for dialogue and interservice coordination – which is absolutely essential for participation in problem identification, problem articulation and problem solving (Bordenave, 1994). Hence, participatory communication is a process of social change.

COMMUNICATION AND SOCIAL CHANGE

Communication approaches initially developed for social change have tended to be less participatory in terms of design, implementation and measurement (Khadka, 2000). These approaches "have different goals, controlled by "external" agencies and external resources but owned and driven by "internal" agencies". However, the general consensus was that communication should focus on change at both individual and societal levels (Figuero, Kincaid, Rani and Lewis, 2002). The argument is that for communication to bring the require change, while the process of behaviour change is taking place among the people the environment should also be involve in the process of change in

order to accommodate and sustain the change among the people.

COMMUNICATION FOR SOCIAL CHANGE

Communication for Social Change is a process of public and private dialogue through which people themselves define who they are, what they need and how to get what they need in order to improve their own lives. It utilizes dialogue that leads to collective problem identification, decision-making and community-based implementation of solutions to development issues. It is communication that supports decision-making by those most affected by the decisions being made(Figuero, Kincaid, Rani & Lewis, 2002). Social Change promotes positive change in peoples' lives as they themselves define such change. However, communication for social change promotes a communication process that supports effective community participation, particularly of the most impoverished and marginalized sectors of society (Gumucio-Dagron, 2004) .

This process shifts control of media, messages, tools and content of communication from the powerful to the traditionally powerless. Ultimately, using such skills, previously powerless communities can become "self-renewing" – able to manage their own communication processes for their own good. The participation of social actors, who are in turn communicators, takes place within a process of collective growth that precedes the creation of messages and products such as a radio program, a video documentary or a pamphlet. Messages and their dissemination are just additional elements of the communication process. Communication for Social change focus is on the dialogue process through which people are able to identify obstacles and develop communication structures, policies, processes and media or other communication tools to help them achieve the goals they themselves have outlined and defined. It promotes dialogue, debate and negotiation from within communities. It also supports focused deliberation, collective decision-making and collective action (Mato, 2002).

Communication for Social Change Model focuses on the process by which dialogue as a participatory form of communication is related to collective action. The model includes individual behavioral outcomes as well as social-change outcomes, and thus attempts to integrate the two paradigms of development communication that sometimes compete with one another. Examining communication for social change, (Kincaid, Figueroa, Storey, & Underwood, 2001) stated that the development of a community can occur through a variety of change processes: externally generated change, individual behavior change, social influence and community dialogue and collective action. This paper will examine the importance of communication paradigm like games and poster for individual behaviour change to promote positive behaviour for social change.

OBSTACLES TO COMMUNICATION FOR SOCIAL CHANGE

The following limitations are experienced in communication for change:
Communication projects for development have failed due to lack of participation and commitment from the people who are involved in the change. Hence, continuity and sustainability of social change is more likely if the individuals and communities most affected own the process and content of communication. Communities should be the protagonists of their own change and manage their communication tools(Figuero, Kincaid, Rani and Lewis, 2002).

The communication process has ignore and deny the specificity of each culture and language but it should support them to acquire legitimacy thereby supporting "cultural renewal." Cultural interactions, or the exchanges between languages and cultures, is healthy when it happens through critical dialogue within a framework of equity and respect (Nair & White, 1994).

The information generated from developed countries is seen as the magic path to effective behaviour change for social change focused on shared knowledge from within and outside the culture and collective action (IIRR, 1996).

Communication cannot be seen as an appendix or a set of specific tasks within an already given project but it should involve planning with both the population and potential community concerned (Mato, 2002).

Communication means exchange between different people, organizations and communities but isolation within externally defined issues cannot establish dialogues and nor be sustainable. Communication should rather promotes dialogue not only within the community, but also with others engaging in a similar process (Gumucio-Dagron, 2004).

Communication for social change should engage the people who want a change, to define the change and required actions, and to carry them out. This process should start from individual behaviour to collective action.

THEORETICAL FRAMEWORK

Health Belief Model

Those who developed the Health Belief Model maintain that health-related behaviours are determined by whether individuals perceive themselves to be susceptible to a particular health problem; see this problem as serious; are convinced that treatment or prevention activities are effective yet not overly costly in terms of money, effort, or pain; and are exposed to a cue to take a health action. (John, Guadalupe, Ayala & Stewart, 1999). However, the Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviors by focusing on the attitudes and beliefs of individuals. The HBM was developed in the 1950s as part of an effort by social

psychologists in the United States Public Health Service to explain the lack of public participation in health screening and prevention programs (e.g., a free and conveniently located tuberculosis screening project). Since then, the HBM has been adapted to explore a variety of long- and short-term health behaviors, including sexual risk behaviors and the transmission of HIV/AIDS (Rosenstock, Strecher and Becker, 1994).

The key variables of the HBM are perceived threat; perceived susceptibility; perceived peverity; perceived benefits; perceived barriers and cues to action. Research on HRM has been used to explore a variety of health behaviors in diverse populations. For instance, researchers have applied the HBM to studies that attempt to explain and predict individual participation in programs for influenza inoculations, Tay-Sachs carrier status screening, high blood pressure screening, smoking cessation, seatbelt usage, exercise, nutrition, and breast self-examination. With the advent of HIV/AIDS, the model also has been used to gain a better understanding of sexual risk behaviors (Rosenstock et al., 1994). However, the limitations of the HBM are that it incorporated only selected components of the HBM, thereby not testing the usefulness of the model as a whole; it does not take into consideration other factors, such as environmental or economic factors, that may influence health behaviors; and the model does not incorporate the influence of social norms and peer influences on people's decisions regarding their health behaviours (John, Guadalupe & Stewart, 1999)

Applying this model to promoting sanitation and hygiene is to determine the people's preconceived notions about sanitation and hygiene assess their perceived barriers and benefits in promoting sanitation and hygiene behaviour. This can be done through the use of various games and posters designed to motivate the people to address the sanitation and hygiene issues in their community. This can help them overcome the barriers to their negative behaviour and move towards developing a positive behaviour. The people can also be cued of the potential consequences of failing to change unhealthy behaviour practices.

Transtheoretical Model

The transtheoretical model or stages of change model proposes change as a process of six stages. Precontemplation is the stage in which people are not intending to make a change in the near future (often defined as the next 6 months). Contemplation is the stage where people intend to change (within the next 6 months). People in this stage are aware of the pros of changing but also can identify the cons. Preparation represents the stage where people have a plan of action and intend to take action in the immediate future (within a month). Action is the stage in which people make the behavior change and maintenance represents the stage where people work to prevent relapse. Finally, termination represents that stage where individuals have 100 percent

efficacy and will maintain their behavior. This stage is the most difficult to maintain, so many people remain a lifetime in maintenance (Zanna, and Rempel, 1988)

Psychologists developed the Stages of Change Theory in 1982 to compare smokers in therapy and self-changers along a behavior change continuum. The rationale behind "staging" people, as such, was to tailor therapy to a person's needs at his/her particular point in the change process. As a result, the four original components of the Stages of Change Theory (precontemplation, contemplation, action, and maintenance) were identified and presented as a linear process of change. Since then, a fifth stage (preparation for action) has been incorporated into the theory, as well as ten processes that help predict and motivate individual movement across stages. In addition, the stages are no longer considered to be linear; rather, they are components of a cyclical process that varies for each individual. Stages of change theory, by psychologists, Prochaska, DiClemente, and Norcross (1992), identifies psychological processes that people undergo and stages that they reach as they adopt new behavior

In applying this model to practice it is essential to match behaviour change interventions to people's stages. For example, if an individual is in the precontemplation stage it is important to raise their awareness about a behavior in order for them to contemplate making a behaviour change. Without a planned intervention, people will remain stuck in the early stages due to a lack of motivation to move through the stages. Prochaska, Johnson, and Lee suggest a series of activities that have received empirical support, which help individuals progress through the stages:

- Consciousness-Raising — increasing awareness of the causes (providing educational materials, confrontation, media campaigns, feedback, etc.)
- Dramatic Relief — producing an emotional experience which is followed by a reduced affect if some action can be taken (personal testimonies, media campaigns, drama)
- Self-reevaluation — inviting individuals to make cognitive and emotional assessments of their self image (clarify values, provide healthy models, using imagery)
- Environmental reevaluation — assessments of how the presence or absence of a behavior might impact one's social environment (documentaries, personal stories, family interventions) (Prochaska, Johnson, & Lee, 1998).

Studies have also examined the usefulness of merging aspects of other theories into the Stages of Change. These are done to clarify how individuals move across stages and to gain a better understanding of how behaviour

change occurs. However, some of the limitation of the theory is that it focuses on the individual without assessing the role those structural and environmental issues may have on a person's ability to enact behavior change. In addition, it presents a descriptive rather than a causative explanation of behavior, the relationship between stages is not always clear. Hence, each of the stages may not be suitable for characterizing every population (Posner, 1995).

Communication for Behaviour Change

The aim of communication for behavior change is to help people adopt healthy behaviours and avoid disease. It has been often referred to as information, education, and communication or public education. The use of "behavior change" reflects that the purpose of communication whether group communication or counseling is to inform and help people adopt healthier behaviours. Hence, the task of helping people abandon old practices and adopt new, healthy behaviours requires conveying the right messages in the right way. Experience shows that providing people with information and telling them how to behave is not enough to change behaviour. Providing information is an important part of behaviour change, but communication for behaviour change conveys information in a way that makes it appealing, so people see the advantages of the healthy behavior and understand how they can actually apply this behavior in their own lives(AIDSTAR-One, 2012).

Studies have shown that health workers provide counseling for their patients and engage in group communication by giving talks in the health facility or the community. However, majority of them do not prepare adequately to carry out these tasks. The use of participatory strategies to conduct effective communication for behaviour has help to promote hand washing practices that has been shown to reduce the risk of diarrhea by 42-44 percent (Curtis and Cairncross. 2003), water treatment and proper storage that has been shown to reduce the risk of diarrhea by 30-40 percent (USAID, 2004) and safe feces handling and disposal that has been shown to reduce the risk of diarrhea by 30 percent or more (Fewtrell, Kaufmann, Enanoria, Haller & Coldord, 2005).

What are Healthy Behaviours?

Healthy behaviours are practices that have been proven to keep people healthy and prevent disease. Some examples of healthy behaviours are: drinking safe water, washing hands correctly after going to the toilet, washing fruit and vegetables in clean water before eating, avoid unprotected sexual intercourse and avoid drinking alcohol or smoking cigarette etc. Hence, in communication for behavior change, the task is not only to provide information about healthy behaviours, but also to identify and address the barriers to using healthy behaviours. Promoting healthy behaviour is an arduous task because behaviour change lies with every individual. Nevertheless, health workers have a responsibility to communicate healthy behaviours like these to promote behaviour change for effective social development within the community.

When health workers use communication for behavior change, they help people move from their current behaviour to the desired behavior. That includes helping them overcome the barriers to using the desired behaviour and providing motivation to adopt the desired behaviour (Marx, 2010; AIDSTAR-One, 2012).

Participatory tools to create practical understanding

Participatory techniques are excellent tools to help people realize problems, select priorities, and plan for change. The use of participatory techniques, such as serialized posters, facilitates active participation of all and makes the analysis more interesting and fun for everyone than when just discussions are held. They also help men and women to use and enhance their practical understanding on health and hygiene and give the health educators much insight in a short time in the hygiene concepts, concerns and constraints of the people and on the stage of problem. Participatory techniques can also be used to identify risky practices, underlying beliefs, possible solutions and set priorities for changed (Wijk & Murre, 2003).

Story with a gap

The facilitator presents a poster showing a problem situation and invites the participants to build a story around it, including possible reasons that caused the problem. He/she then presents a 'problem-solved' poster and asks the group to think of steps the people in the picture took to solve the problem. If necessary, the facilitator distributes pictures of in-between steps.

Critical incident

The facilitator presents three posters that illustrate a problem situation and asks the participants to reflect on possible causes and solutions. Pros and cons of different options are discussed and conclusions drawn.

Interpretation of drawings

The facilitator has a set of drawings with a range of risky conditions and practices in the particular area. The hygiene educator asks the group to discuss the drawings and select those which depict practices for change in their own community. These are then sorted in order of feasibility of change.

Pocket chart voting

Yet another technique is to hang drawings of risky conditions on a wall with an open envelope under each drawing. After discussing the meaning of each drawing, each participant is given five tokens to place in envelopes under risks thought to be most risky ('pocket voting'). In mixed groups, a gender specific approach is possible by giving men and women tokens of a different colour and summarizing replies by gender. The same technique is also suitable to assess the importance of hygiene changes in comparison with other development interests.

Case-studies
The facilitator presents a case-study of a risky hygiene behaviour as seen through the eyes of two groups of people with different views. The participants review the opinions of both groups and propose possible solutions.

Open-ended problem drama
The facilitator presents two stories about problems a certain person faced, one problem was solved, the other not. The participants are asked to reflect on the stories and to fabricate a story about a different person with unresolved (hygiene) problems and 2 or 3 other characters giving him/her contradictory advice. What will he/she do?

Environmental walk
Suitable with smaller groups is to make an 'environmental walk' and to visit all places where risky practices may be found. Open and respectful discussions on observed risks offer a good opportunity to exchange knowledge and increase appreciation of reasons underlying such conditions or practices. It is fruitful to combine observations with informal talks, because the two together can add to a more complete understanding.

Communicating through games and posters
Communicative activities include any activities that encourage and require a learner to speak with and listen to other learners, as well as with people in the program and community. Communicative activities have real purposes: to find information, break down barriers, talk about self, and learn about the culture. Studies on second language acquisition (SLA) suggests that more learning takes place when students are engaged in relevant tasks within a dynamic learning environment rather than in traditional teacher-led classes (Moss & Ross-Feldman, 2003). Good communication is central to participatory processes. It is necessary for individuals to express and exchange their perceptions and to engage themselves in common thought and action. But attempts at communication in group settings are often reduced to a monologue or a one-way flow of information. The communication exercises are intended to develop and analyze effective communication skills and to encourage interaction in which people are treated with respect, interest and empathy. They are designed to enhance mutual interchange and constructive dialogue and to reflect on the meaning of good communication.

Studies have shown that the use of participatory processes can be enhanced by games and exercises, carefully placed in the learning process. Good games and exercises make people reflect, feel emotion, bring about a sense of wonder or curiosity, "grab people in the gut", energize, create humour, relax, calm and induce meditation. They provide variety, discovery and surprise and thereby keep participants engaged.(UNICEF, 1998)

Games should be introduced into a process for a purpose, not just for the sake of playing a game or as an attempt by the facilitator to gain "cheap popularity" from the group.

The best games and exercises activate both sides of the brain - the cognitive, logical side and the emotional, creative side. They stimulate perception, affection or expression and create interest through the presentation of a challenging situation. They reinforce learning through experiencing. Experiential learning has proven much more effective than merely receiving, discussing and attempting to digest information from authoritative sources. Games and exercises can simulate the actual experiences of our lives and help us to reflect on the application of knowledge. They may also introduce a certain amount of complexity or questioning, thereby stimulating a process of action-reflection-action throughout the proceedings. Good games and exercises involve everyone in the group, advance the group process, maximize participation and allow as many people as possible to express themselves in unique ways. They catalyse individual involvement and expression in group events and bring about group synergy. They provide common ground for group experience, creating favourable conditions for the growth of participatory behaviour and a democratic spirit. .(UNICEF, 1998)

Games and exercises need to be carefully considered and planned by competent, experienced facilitators who believe in the power of games to advance group processes. They should not be used in a chaotic, ad hoc manner with little thought concerning their outcome. The facilitator must prepare and plan, and therefore have on hand all the materials needed for a particular exercise. Last minute substitutes and switches will appear unprofessional. Games and exercises need to be sequenced properly in terms of their intensity, frequency, duration and intended objective. For instance, a series of highly interactive games at the beginning of a workshop may really warm up participants and "break the ice". However, they may appear to be childish and thoughtless to some participants who may lose faith in the facilitator. Activating senses and energizing people for no apparent reason may also put the facilitator into the role of an entertainer who is not serious about the content of the event. Instead, games and exercises have to be placed and paced in an order and frequency which will allow a gradual build-up of experience and outcomes. They should be carefully built into other plenary and group sessions (UNICEF, 1998).

The facilitator must be aware of the age, physical, gender and cultural differences and, accordingly, avoid inappropriate games and exercises. For instance, older people and pregnant women should avoid rough, physical contact games. Also, in such games all participants must be warned to remove breakable or potentially harmful jewellery or clothing, eye glasses and contact lenses. Physically disabled people should not be made to feel left out. Find

games which can include them.

Not all games and exercises are appropriate for all cultural settings, hence they should be non-threatening and demonstrate the value of differences between people. They should never single out individuals for ridicule. Humour, for instance, varies a great deal in different cultures. In certain countries men and women who are not married should not touch one another. Even if the participants accept such processes for the purpose of the workshop, pictures taken of such interactions may be misinterpreted by non-participants. Setting up games or exercises on taboo subjects may induce conflict in the group and derail progress. The facilitator must be sensitive to the cultural values of participants and should avoid pushing them in a direction which is in direct opposition to their world view.

Studies have also shown that the use of pictures in health information improves consumer comprehension, recall, and adherence (Houts, Doak, Doak & Loscalzo, 2006). Pictures should be concrete rather than complex. Unnecessary details should be removed from pictures to avoid distraction. Also, pictures should be closely linked to the text or captions that explain them. Both health professionals and consumers should be involved in the design of materials. For example, health professionals should be involved in selecting pictures to ensure accuracy, whereas consumers are needed to ensure materials are understandable (Houts, Doak, Doak & Loscalzo, 2006). Adult literacy experts have created guidelines to ensure health information is understandable to a wide audience.

The study of the use of posters describes the development of a behaviour change communication strategy to support routine health services in southern Tanzania. Mixed methods including a rapid qualitative assessment and quantitative health facility survey were used to investigate communities' and providers' knowledge and practices relating to malaria, EPI, sulphadoxine-pyrimethamine and existing health posters. Results were applied to develop an appropriate behaviour change communication strategy involving personal communication between mothers and health staff, supported by a brand name and two posters (Mushi et al, 2008). A brand name, key messages and images were developed and pre-tested as behaviour change communication materials (Panter-Brick, Clarke, Lomas, Pinder & Lindsay, 2006). The posters contained public health messages, which explained the intervention itself, how and when children receive it and safety issues. The aim of the poster was to help health facility staff explain to mothers practices relating to malaria and expanded programme on immunization (EPI). Two posters for display at health facilities were developed and pretested in parts of Dar es Salaam, Lindi and Mtwara regions, to ascertain the clarity and of captions, images and design. Community representatives, health workers and influential people at district and national levels were also consulted to ensure the posters were culturally

appropriate. The poster was perceived to show a single mother, whose dress make her look unhealthy, holding a baby, and an anxious nurse preparing medication ready for administering to the child. Findings revealed that almost all health providers said that they or their spouse were ready to take sulphadoxine-pyrimethamine (SP) in pregnancy (96%) (Schellenberg, Menendez, Kahigwa, Aponte, Vidal, Tanner, Mshinda and Alonso, 2001).

CONCLUSION AND RECOMMENDATION

The strategies to changing attitudes is important but insufficient because studies indicates that there is no direct link between values and action(Futerra Sustainability Communications, 2010). Bickman (1972) studies on environmental attitudes and action shows that 94% individuals had a responsibility to pick up litter, but only 2% picked up litter that was "planted" by the researcher. In another study, people who attended energy efficiency workshops reported knowing and caring more about energy conservation, but only 1 of the 40 participants changed their behaviour (Geller,1981). Hence, there is need to evolve new strategies that will change attitudes and behaviour that will eventually lead to action. The following recommendation could be of immense importance on the use of games, exercises and posters for promoting sanitation and hygiene practices among the people.

There is need use games and posters that will attract the attention of the people and eventually sustain their behaviour

There is need to use games that are easy to understand and memorable to make it simple for people to remember.

The games and posters to be used can be adapted from a familiar local story that is interesting in order to energize, inspire and, motivate them to change.

There is need for the people to understand the message and the need for them to change their behaviour through the use of the games and posters

The games and posters to be used should emphasize the benefits of sanitation and hygiene practices as an individual

The messages from the games and posters to be used to promote sanitation and hygiene practices should conform to social norms because research shows that people conform to social norms (Asch, 1951 and Cialdini, 2007)

Messages are effective if targeted at certain people, those who will to tell others, or those who will be listened to if they do. This will accelerate the spread of the messages through social diffusion especially using community representatives that can spread the message to the rest of the community (Maibach, 2008).Hence, using games and posters are not enough but with the right people who can influence others to change.

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