

EFFORTS TO PREVENT THE PRACTICE OF OPEN DEFAECATION

How sensitive are health promoters
to local views and conditions?



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Abbreviations

ANT	Actor Network Theory
BDM	Behavioural Decision Making
CHC	Community Health Clubs
CLTBC	Community-Led Total Behavioural Change
CLTS	Community-Led Total Sanitation
DDC	District Development Council
FGD	Focus Group Discussion
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
LTBCFs	Lead Total Behavioural Change Facilitators
OD	Open Defaecation
ODF	Open Defaecation Free
PHC	Primary Health Care
PHM	Persuasive Health Message
PRA	Participatory Rural Appraisal
PMT	Persuasion Motivation Theory
RWSSP-WN	Rural Water Supply and Sanitation Project –Western Nepal
TB	Tuberculosis
TRA	Theory of Reasoned Action
UNAIDS	Joint United Nations Programme on HIV/AIDS
VDC	Village District Council
WASH	Water Sanitation and Hygiene

EXECUTIVE SUMMARY:

Health promotion efforts to prevent the practice of Open Defaecation (OD) reflect current trends in other health promotion fields. The value accorded to community participatory approaches is widely recognised as well as an increasing appreciation of principles involved in the more commercially oriented field of marketing. Included in these principles are audience research, creation of demand versus supply and the incorporation of both communication and behaviour change theory.

This research was undertaken to find out more about these efforts and to gain an impression of how sensitive health promoters are to local views and conditions.

Due to personal restraints, I was unable to spend any considerable time in the field, the research has been primarily literature based. A short three week visit was made to Nepal to visit the RWSSP-WN and has served as a case study. This visit enabled me to gain an impression of the sensitivity of health workers, involved in this project, to local views and conditions and compare these to findings in literature.

The approach for this research has been from an anthropological/sociological and communication perspective. The main objective has been to look for underlying meanings in the practice of open defaecation to both people practicing it and those trying to prevent its practice.

The sensitivity of the topic as well as the sensitivity of health promoters working to prevent this practice is doubly important. Defaecation is inherently related to notions of dirt, pollution and purity and as such has significant implications for social processes at work in communities. It is not surprising then that findings in this research have pointed to the relevance and perceived benefit of 'community participatory' approaches in an effort to prevent this practice.

Support for this approach reflects an increasing awareness of the impact of social and cultural 'norms' on behaviour. It also reflects anthropological assertions that intrinsic to meanings about dirt, cleanliness and purity are notions of 'proper order', 'social order', 'social status' and 'well orderliness'.

From an anthropological and sociological perspective, the increasing support for commercial marketing techniques in health promotion programmes is interesting. Marketing techniques promote intensive audience research and encourage the development of a profile of the

target audience. This profile should include audience demographics, information about age distribution, ethnicity, gender, income and education. It also encourages a profile of audience psychographics, information about prevailing attitudes, beliefs and values.

An anthropological perspective is deeper than this, in its search for 'meanings' of behaviour, never-the-less the integration of techniques to find out more about the target group is interesting and has provided relevant material for this study. Such research reflects a desire to find out about existing views and conditions.

Wanting to find out as much as possible about local views and conditions, however, does not necessarily translate as 'sensitivity' of health workers. Sensitivity implies understanding, empathy, an understanding of self and active respect toward the views of others, which is not so easy to deduce from literature. What I have looked for therefore is some evidence of what health workers have been able to report about this practice and the people practicing it, and compare this with the impressions gained in Nepal.

The impressions I was left with after the field trip to Nepal, indicated a fairly high level of sensitivity. No doubt community participation to a certain extent guarantees this, however, a high degree of sensitivity was apparent among the staff of the RWSSP-WN.

Much of what was said about OD in Nepal reflected findings in the literature. Findings pointed to determinants of this practice being related to cultural dictates, perceptions about the value of faeces as a fertilizer, and the very fact that it is easy, convenient and often preferred over the option of using a 'dirty, smelly, latrine'.

Enthusiasm for the Community Led Total Sanitation (CLTS) approach, initiated in Bangladesh in 2000 by Dr. Kamal Kar, was evident. This approach is based on a number of premises. First and foremost, it pushes an anti-subsidy approach to the building of latrines. The belief is that toilets constructed with subsidies are not used, create dependencies, reduce any sense of ownership and create social tensions in communities. Secondly, it is believed to be more 'people' oriented than 'task' oriented. Thirdly, it strongly favours 'creating demand' for latrines, believing the emphasis in sanitation programmes needs to be behaviour oriented and not focused on the provision of hardware. Finally, the CLTS approach advocates eliciting emotions such as disgust, shame and fear as key motivators in sanitation behaviour change. The eliciting of these emotions is a factor that sets this approach apart from previous health promotion efforts to prevent the practice of open defaecation. This factor has major implications from an anthropological and sociological perspective.

Prior to going to Nepal, I was sceptical about this approach as I believed it to be too negative, harsh and insensitive. I struggled to believe some of the claims being made as to the speed with which this approach was having an effect, resulting in villages being declared Open Defaecation Free (ODF) within very short periods of time. I must concede, however, that after having visited a number of villages that had been implementing this approach and reading more about it in the literature, I am convinced it is having a major impact. The approach reflects sensitivity of health workers to local views and conditions, as they need to be aware of the influence of social and cultural factors in eliciting disgust. Additionally, this approach has significant implications in regard to health promotion efforts, behaviour change theory and health communication strategies, some of which have been addressed in this research.

The first chapter gives an introduction and the justification for this research. This is followed by an outline of the main research question and sub-questions, and a brief description of the methodology is given. The second chapter provides a review of what has been found in the literature as well as relevant impressions gained in Nepal to support these findings. Headings used in the review are reflective of the research questions in an attempt to categorise the literature into a meaningful order. The third chapter begins with a brief ethnographic account of my short encounter with the RWSSP-WN, followed by a presentation of the findings from the field trip in an attempt to answer the main research question as well as those that emerged during this study. The fourth and final chapter will discuss findings in the literature and integrate these with impressions gained in Nepal. Headings used in the discussion will reflect the emergent themes that have been found. The chapter addresses the notion that sensitivity of health promoters to local views and conditions will enhance efforts to prevent the practice of open defaecation. Finally, conclusions of the findings and recommendations will be presented.

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CHAPTER 1: INTRODUCTION AND STUDY DESIGN

1.1 INTRODUCTION:

It is believed that open defaecation is a cause of diarrhoeal diseases, which are the leading cause of morbidity and mortality among children in the world. Currently, 2.4 billion people in the world have no access to adequate sanitation (UN 2002, in Waterkeyn 2005), and approximately 2 million children per year die from diarrhoeal diseases. Additionally, loss of earnings because of ill health or needing to care for others has considerable impact on socio-economic situations of millions of people.

Considerable efforts have been undertaken to improve the state of sanitation and hygiene throughout the world with varying degrees of success. Although there have been some encouraging changes these efforts need improving to reduce the continuing high burden of morbidity and mortality caused by diarrhoeal related diseases.

Sanitation and hygiene practices are a sensitive issue to address, and this more so when it involves poor personal hygiene practices. It is noticeable that there is a tendency for projects working in sanitation and hygiene to 'medicalize' the situation and in doing so run the risk of being insensitive to underlying reasons that contribute to the persistence of the behaviour.

Behaviour change is complex involving confounding factors, and changing behaviour related to personal sanitation and hygiene is not easy. Factors inclusive of upbringing, personality, experiences, social position as well as context and current situations are all influential.

The primary aim of this research is to gain an impression of how sensitive health promoters, in programmes aiming to prevent the practice of open defaecation, are to local views and conditions.

The assumption is that to achieve the desired behaviour change health promoting programmes need to be sensitive to these factors. This assumption is drawn from a sociological and anthropological enquiry that seeks to understand the relationship between individual behaviour and existing social structures (Thorogood 2002).

My belief is that the more sensitive health promoters are to local views and conditions, the greater the level of understanding about underlying meanings of existing defaecation and sanitation practices. Further, I believe that this greater level of understanding will in turn

increase the chances of projects aims to achieve sanitation behaviour changes that will result in less diarrheal morbidity and mortality.

Given the sensitive nature of this topic and the anthropological and sociological perspective, it is important that the reader has some understanding of my background and experiences that have contributed to my understanding and perceptions.

The practice of open defaecation is a practice that is relatively unfamiliar to me and although I have had some exposure and experience of it, it certainly is not part of my daily life.

I was born and raised in New Zealand within a Christian environment with parents that had immigrated to New Zealand from Scotland. My father was a medical doctor with a deep concern for people, relationships, social issues and inequality. His life and way of thinking had a great impact on my life.

After leaving school I trained and worked as an Occupational Therapist and worked for several years in New Zealand in a variety of settings, inclusive of medical wards, psychiatric settings, and for a considerable time in a spinal unit. For nine years I was in a relationship with a tetraplegic of Maori descent and consequently providing physical care on a daily basis, inclusive of management of his bowel habits. This relationship undoubtedly had an impact on my perceptions of defaecation as well as the influence of culture in communication.

In the mid 90s I went to Nigeria with The Leprosy Mission International where I lived and worked for a period of 5 years. The first two and a half years I lived and worked within the grounds of a local Leprosy Hospital, in the predominantly Christian South of the country. The latter two years, I moved up to the predominantly Muslim North, where I met and married Erik, a Dutch Medical doctor, also working in the field of Leprosy. I continued to work in Leprosy related work on a voluntary basis. Undoubtedly, all of these experiences have had an impact on my perceptions of the sensitivity of health promoters and it had an impact on my perceptions of sanitation and hygiene practices.

Leprosy has been a highly stigmatized disease and due to this stigma, demands extra sensitivity from health workers. People engaged in the practice of open defaecation are also often highly stigmatized. Stigma has significant effects on the behaviour of people, particularly in regard to exclusion and inclusion behaviours.

These years of work in a variety of settings resulted in my placing high value on communication skills and in particular the ability to 'listen' and search for underlying

meanings of people's behaviour. With regard to sanitation and hygiene practices, these years taught me to recognize the 'relative' nature of this topic. Perceptions of what is 'dirty', or not, is highly determined by different contexts.

My interest in communication has grown since completing a Bachelors degree with a double major in Cultural Anthropology and Public Relations (PR) through a distance learning programme with the University of Southern Queensland, Australia. I undertook this study during a four year period living in Indonesia. My anthropology thesis focused on the interactions between Dutch expatriates and Indonesians in an International school. It was, however, my PR thesis "*PR Strategies and Tactics to assist UNAIDS in their role within the National HIV/AIDS Programme, Indonesia*" that stimulated my specific interest in health promotion and behaviour change theories.

Going to Nepal for my field trip was not my first encounter with Nepal and its people. Each January, for the past four years, I have been delivering a 'Training and Communication Skills' course for health workers there. My involvement with this course led to my introduction to the Rural Water Supply and Sanitation Project in Western Nepal (RWSSP-WN). The project uses an approach titled "Community Led Total Behavioural Change" (CLTBC) with the aim of preventing the practice of open defaecation. The principles of this approach fed my curiosity to find out more and seemed a worthwhile subject for a Masters' thesis.

Although the primary focus of this research is on sensitivity of health promoters in sanitation and hygiene programmes, writings about other health programmes have also been studied. The reason for this is to ascertain if there are some common attributes in programmes aiming to change health related behaviours, particularly in regard to sensitivity of health promoters to local views and conditions.

1.2 RESEARCH QUESTIONS:

MAIN RESEARCH QUESTION:

To what extent are health promoters within sanitation and hygiene projects, aiming to prevent the practice of open defaecation, sensitive to local views and conditions?

SUB-QUESTIONS:

LITERATURE

- ✓ What evidence is there for the cultural appropriateness of health promotion efforts (both content and communication techniques) in the area of sanitation and hygiene, in specific those relating to defaecation?
- ✓ How do the findings in Nepal compare with findings elsewhere?
- ✓ Are evaluations of health promotion giving attention to the level of sensitivity of health workers to local conditions and situations?

The following sub-questions have been primarily related to the fieldwork, although where possible have also been applied to the literature.

CHARACTERISTICS OF HEALTH PROMOTERS

- ✓ What are the characteristics of the health workers in the programme?
- ✓ Who are they?

KNOWLEDGE, ATTITUDE AND SOCIOCULTURAL AWARENESS OF HEALTH PROMOTERS

- ✓ What are their beliefs about open defaecation and the people who practice it?
- ✓ Have health promoters sought to understand why this practice is happening?
- ✓ Can they describe particular beliefs that contribute to this practice? Is it merely because of lack of latrines or are there other factors? Is it determined by beliefs about faeces and defaecation? Is it a family tradition? Is it an act of rebelliousness?

- ✓ What awareness do health promoters have of the characteristics of the villages in which this practice is engaged?
- ✓ What do health promoters have to say about the attitude of villagers toward people who practice open defaecation?

PRACTICES AND TECHNIQUES OF HEALTH PROMOTERS

- ✓ What is the most important aspect of the programme for the health workers? Is their focus 'task' oriented or 'people' oriented?
- ✓ Why are they working in the programme?
- ✓ Are health promoters able to describe the effect of health messages and their 'interactions' with the target population?
- ✓ What health promotion techniques are practiced? Are those techniques appropriate for the cultural setting?
- ✓ What content does the health promotion contain? Is it appropriate for the cultural setting and the target group(s)?

1.3 METHODOLOGY

A literature search has been conducted and a brief visit to a sanitation and hygiene project, aiming to prevent the practice of open defaecation, in Western Nepal. The period of time in Nepal was limited to three weeks, permitting an impression only and no conclusive evidence. My visit to Nepal, was hindered by an unstable political situation, as a *Bandh* (a nationwide strike) was imposed by the Maoist party in the first week. This *Bandh* paralyzed the country and prevented any movement of vehicles on the roads. I was, however, able to use this time to conduct in-depth interviews with some staff in their own homes.

During the remaining period data collection involved the following (Appendix 1):

- In- depth interviews with:
 - Project level staff
 - Lead Total Behavioural Change Facilitators (LTBCFs)
 - Triggerers
- Informal interviews with Nepali friends whom I believed would have a good knowledge of this topic
- FGDs (Focus Group Discussions) with: (some were not strictly FGDs but rather mass meetings. I then asked the group to divide into smaller groups and create posters in response to some questions).
 - LTBCFs
 - Triggerers
 - Project Level Staff
 - Water and Sanitation and Hygiene (WASH) reporters, local journalists designated to report on WASH activities as part of their job description
- Community meetings

- Questionnaires:
 - 10 completed by project level staff
 - 27 completed by LTBCFs and triggerers
- Visits to diverse communities within the RWSSP-WN region

All in-depth interviews and FGDs were recorded and three interviews transcribed word for word, for the remaining recordings relevant quotes have been noted and incorporated into the writing of this thesis.

The questionnaires sought information about the personality of the people working within the project, existing beliefs towards OD, information about the villages and target audience, and information about their perception of RWSSP-WN health promotion efforts.

Visits were made to two different geographical districts, one in the Hills and one in the low plains of the Terai. This included visits to seven small communities, diverse in terms of geographical location, ethnic, religious and social constructs. The impressive number of opportunities to meet with health promoters and visit project areas in the short three weeks was possible because of the enthusiastic support of the RWSSP-WN staff.

A literature search was carried out in PubMed, Web of Science, Cochrane Library, Science Direct and ERIC. In addition to these well known data bases a search was done using Google Scholar. The following terms or key words were used in the initial search: 'open defaecation', 'sanitation', 'hygiene', 'diarrhoea', 'health promotion', 'health education', 'faecal oral contamination', 'designing health messages', 'behaviour change', 'attitude', 'health workers', 'community-led total sanitation', 'community participation', 'cultural sensitivity', 'dirt', 'cleanliness', 'belief', 'latrine acceptance', 'excreta disposal', 'Nepal' and 'toilet habits'. This resulted in 277,196 hits. To refine the search certain aspects of the words were paired: and resulted in a preliminary selection of 453 article based on titles only (Appendix 2). An initial selection of 49 articles was made. Articles were selected through the following process:

- i. English only
- ii. Reading the title and abstract
- iii. Eliminating articles without a focus on central themes of interest (Open defaecation, behaviour change, health promotion, design of health messages, context sensitivity)

- iv. Reading and analyzing the initial selection
- v. Latterly, bibliographies of these were referred to for further articles
- vi. Final selection was based on references to cultural sensitivity, perceived relevancy of the description of behaviour change and references to anthropology, and approaches that indicated recognition of the importance of a 'bottom-up' approach
- vii. In order to further refine the selection, articles were categorized under several subheadings, including anthropological, behaviour change, health promotion, cleanliness and beliefs, latrine and toilet use and Nepal related articles. Articles were chosen from each of these subheadings to ensure a broad perspective for the writing of this research

It needs to be noted that there is a paucity of literature as to why programmes fail, most literature focuses on success stories, which has imposed a limit on this research.

CHAPTER 2: LITERATURE REVIEW

The review will be structured under themes inherent in the research questions and relevant impressions gained in Nepal will be incorporated. It has been difficult to deduce from the literature answers to some of the research questions. As a consequence of this paucity, I decided to report on findings that highlight principles relevant to the questions. In this section the main principles are Community Participatory Approaches and Community-Led Total Sanitation (CLTS). Given the anthropological and sociological perspective taken in this research the starting point for the literature review is an overview of a few relevant anthropological and sociological concepts.

2.1 ANTHROPOLOGICAL AND SOCIOLOGICAL PERSPECTIVES

Anthropological and sociological notions about the concepts of dirt, purity and pollution provide a useful lens through which to address underlying meanings related to defaecation practices. Frequently, these underlying meanings are related to processes of social interaction among people. Paul Farmer, in referring to the remarkable failure of health programmes to eradicate tuberculosis (TB), despite the use of effective chemotherapy, states “Anthropologists and other social scientists have long argued that tuberculosis will not be eradicated without attention to ... fundamentally social forces” (1997:349). The same can be said about efforts to prevent the practice of open defaecation, health promoters need to be attentive and sensitive to social forces, inclusive of local views and conditions.

Symbolic meanings of dirt and disorder

Mary Douglas’s ‘Matter out of place’

In regard to dirt, Mary Douglas’s concept of ‘matter out of place’ as well as the symbolic framework that she encourages helps clarify the ‘meaning’ of defaecation practices to its practitioners. It cautions that issues concerning ‘dirt’ should not be addressed or explained away in medical terms, but rather need to be understood in terms of the wider social and cultural context. Douglas asserts that people’s efforts to shun dirt should be understood as an attempt to create social order. Her analysis of ‘taboo’ is also pertinent to the practice of defaecation as she highlights the ‘mechanics’ involved and the way they reduce intellectual and social disorder by relegating certain behaviours to the sacred. I choose the word ‘mechanics’ deliberately, as the way she describes dirt, taboo and purity, reminds me of the way Foucault describes power. It is not an attempt to define or even theorize, but rather an

analysis of the way power works. In much the same way I believe Douglas analyzes the way dirt works. Her analysis encourages awareness of the symbolic significance of health promotion efforts (Douglas 1966).

Anthropological discourse on pollution and purity affirm this, stressing that pollution and purity beliefs dictate social categories that are assigned to people (Ortner 1973). Ortner highlights the mechanics of this process in her paper "Sherpa Purity" where she "explores the underlying relationship between explicit culture forms ("symbols") and underlying cultural orientations. It assumes the position that the two are intimately interrelated, indeed inseparable, and further that it is the symbolic forms themselves which are the mechanisms underlying cultural orientations to observable modes of socio-cultural action" (1973:49). Ortner's primary concern in this paper is with 'pollution' and what is considered polluting for the Sherpa. Findings shed light on the fact that pollution practices indicate social status, and she notes that in India the system of pollution practices serves as a charter for the caste system (Ortner 1973). These dictates play a significant role in the dynamics that occur between different classes or castes and serve to reinforce social positions and attributes (Beall 2006). Dynamics of social categories and class inevitably involve processes of inclusion and exclusion. People are included in a particular category or class because of certain rules determining inclusion and exclusion (Das 2006).

Most sanitation and hygiene programmes in lower income countries target poorer people who tend to be excluded and marginalized. Inherent in this exclusion and marginalization are notions of dirt and pollution that serve to both reinforce those that are included and maintain the excluded status of some people.

Sjaak van der Geest in his ethnographical account "Children and Dirt in Kwahu, Ghana" highlights the symbolism inherent in concepts of dirt and sanitation. Drawing on Mary Douglas's concept of "matter out of place" he highlights the 'relative' position of the concept of dirt and emphasizes the symbolic attributes that objects or actions make about life in a broader sense. The example provided is that through the identification and removal of 'dirt' an attempt is made to observe and restore order in life. He points out that this concern for order is a central intuition and may have possible consequences for hygiene and health. He proposes that from this vantage point ideas about health are derived, hence the reference to the term 'disorder' in health discourse (van der Geest 2009).

Van der Geest addresses the 'social character of dirt' and highlights the discourse around the concept of 'dirt'. Dirt emerges as a sociological phenomenon that provides information about the status and social position of its producer. In his description of life in Kwahu, van der Geest demonstrates how the social phenomenon of dirt becomes an interpretative tool. The description gives an account of the place 'dirt' assumes in Kwahu, and the diverse linguistic uses of the term. He highlights the way in which this concept plays a central role, for example, to say someone is dirty amounts to an almost complete rejection of the whole person (van der Geest 2009) .

A significant interpretative aspect that has become apparent in the discourse surrounding 'dirt' in Kwahu is in relation to the practice of latrine use. In his ethnography van der Geest establishes the almost obsessive concern with cleanliness and the abhorrence of 'dirt' among these people. This obsessive concern with cleanliness accounted for why people were reluctant to build toilets in their homes and ensured their location on the edge of town (van der Geest 2002; van der Geest 2009)

Inclusion Exclusion Practices

An ethnographic study undertaken among Christian street sweepers in Faisalabad, Pakistan addressed the dynamics involved in waste management. Dynamics occurring between people in different religious and cultural groups were explored in relation to the symbolic meanings of dirt and pollution. Christian street sweepers were executing impure tasks that served to maintain the purity of other caste groups, highlighting the interdependence promoted through the caste system. The findings illustrated the way pollution and 'danger' beliefs serve to maintain social categories and distinctions. The visible reminder of what people produce and consume was evident in the garbage and showed how waste collection is not only about environmental health and hygiene but projected 'aesthetics' and issues of class (Beall 2006). In the same way practices that are considered 'polluting' such as defaecating are complex and infused with significance and meaning for social relations within society.

Symbolism of Ownership

Another perspective on the symbolism inherent in issues related to defaecation and dirt is evident in a study undertaken in Benin. A qualitative study involving 40 households was conducted to determine motivations to install a latrine (Jenkins 2005). The study echoed

Yoder's findings that there is "... rarely found a close correspondence between changes in knowledge and changes in behaviour" (Yoder 1997:132).

Undertaken in rural areas, the study sought to challenge the persistent 'health related' framing of messages in sanitation programmes. The aim was to challenge the notion that faecal-oral contamination should be the motivator for people to adopt latrines. Findings established that this approach is largely ineffective. Eleven distinct drives emerged and these were grouped into three main categories, namely prestige-related, well-being and situational. Strongest drives were the prestige-related, in particular to be affiliated with the 'urban elite' as well as aspirations for a royal status. Also mentioned was the fact that people wanted to avoid the shame and embarrassment of directing visitors to open defaecation areas. Intrinsic to this finding are the symbolic meanings of dirt and disorder. The people owning latrines are symbolic of those elite and revered people in society. Jenkins and Curtis put it this way, "In rural Benin, prestige or status conferred by latrine ownership comes from their symbolic ability to display an owner's affiliation with the urban world ..." (2005:2455).

Finally, in this account, the central role that perceptions of dirt and hygiene have in socially marking people is obvious, particularly in terms of position and social relationships. It echoes van der Geest's findings that low social rank is ascribed to people occupied with cleaning work and affirmed in loss of the privileged position of childhood when children, at a very young age, are given sanitary and cleaning tasks (van der Geest 2009).

Habitus and 'Habitual'

Bourdieu's notion of Habitus provides yet another interesting perspective on social relations, he describes Habitus as "... systems of durable, transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles of the generation and structuring of practices and representations which can objectively be 'regulated' and 'regular' without in any way being the product of obedience to rules, objectively adapted to their goals without being the product of an orchestrating conductor" (1977:72). He describes the way our personal histories determine particular practices, both individually and collectively, and are more influential in our 'practices' than formal rules and explicit norms (Bourdieu 1990).

Bourdieu was concerned with 'classes' and factors that determined different behaviours of people and the practices of people within the various classes. He created a framework to explain the dynamic relationship between structures and action. In doing so he provided a

'relational analysis' of social tastes, preferences and pleasures of people and their practices. Although Bourdieu's analysis was concerned with preferences of people in terms of art and cuisine, the framework he uses can usefully be applied to other issues concerning 'markers' of people's social status. At times these 'markers' operate at a subconscious level. This analytical framework helped explain the belief that peoples "tastes and practices are organized by actors relative relations in social space" (1990:53). He explains that habitus does not function as a set of rules and regulations dictating what people should or shouldn't do or like, but rather as a loose principle that may function at a subconscious level (Bourdieu 1990). The concept of 'Habitus' is relevant to the discourse of health promotion in that it encourages a relational analysis of what is taking place, particularly relations within social places.

The following quotation taken from Mary Douglas's book *Purity and Danger* (1966:154), highlights the 'taken for granted' attitude that exists in this practice:

"Indians defecate everywhere. They defecate, mostly beside the railway tracks. But they also defecate on the beaches; they defecate on the streets; they never look for cover. ... These squatting figures – to the visitor, after a time, as eternal and emblematic as Rodin's Thinker – are never spoken of; they are never written about; they are not mentioned in novels or stories; they do not appear in feature films or documentaries. This might be regarded as part of a permissible prettifying intention. But the truth is that Indians do not see these squatters and might even, with complete sincerity deny that they exist".

(Naipaul, V.S., 1964, An Area of Darkness)

This quotation of Naipaul draws attention to a number of issues that are relevant to this research. Firstly, although Naipaul refers to India, he points out that open defaecation is a widespread practice. Secondly, places in which it is practiced are widespread and varied. He points out how embedded this practice is within certain cultures, so much so that it goes unnoticed. Thirdly, to visitors, people for whom this practice is neither common place nor integrated into their own lifestyles, there is a deliberate choice to avoid reference to this practice. And fellow Indians, according to Naipaul, don't even acknowledge it and perhaps go so far as to deny that it exists.

These chosen behaviours of 'turning a blind eye', and denial, have implications, which not only account for the difficulty programmes have in trying to change this behaviour, but in terms of social and cultural fabrics of societies. Douglas asserts, practices such as defaecation are considered 'dirty' or 'polluting', and when they happen out of place they serve to reinforce social categories and 'order'. This highlights the need for health promoters to be sensitive to local views and conditions. It is important that health promoters seek to understand 'places' that are considered acceptable for defaecation. For example, it may be perfectly acceptable to defaecate in an open field, as it is good fertilizer, but not on the pathway into a village.

Actor Network Theory

Latour and Callon developed Actor Network theory to address relations that occur between 'micro' structures and 'macro' structures and the various 'actors' within those structures (Latour 1999). They focus on the relationship between human and physical phenomena and draw attention to the interrelated processes that take place at various scales. The example given referred to the existence of a scientific laboratory within a social milieu and the relations that develop between the laboratory and various actors. (Almedom 1996). Using the scientific work of Pasteur and what he describes as a 'short circuit' Latour describes how Pasteur was able to draw attention to his laboratory work and engage the interests of a diverse group of people. He was able to 'construct interest' in his work. As Latour states Pasteur "... was an expert at fostering interest groups and persuading their members that their interests were inseparable from his own" (Latour 1999).

Pasteur demonstrated the destabilizing role of the microbes and how they would impact on the lives of others. What he is referring to here is transformation of relationships between people that previously would have had little 'connection'. Pasteur's statement "It is through laboratory practices that the complex relation between microbes and cattle, the farmers and their cattle, the veterinarians and the biological sciences, is going to be transformed" (1999:262), puts a voice to the network existence not only between people but also between people and 'things'. This relationship inherently results in the various 'players' fulfilling different roles in relation to each other.

2.2 CULTURAL APPROPRIATENESS OF SANITATION AND HYGIENE PROGRAMMES

- *What evidence is there for the cultural appropriateness of health promotion efforts (both content and communication techniques) in the area of sanitation and hygiene, in specific those relating to defaecation?*
- *How do the findings in Nepal compare with findings elsewhere?*
- *Are evaluations of health promotion giving attention to the level of sensitivity of health workers to local conditions and situations?*

Community participatory approaches

Literature describing health promotion efforts to prevent the practice of open defaecation is scarce, however, there is ample material describing health promotion efforts of programmes aiming to change other health related behaviours.

Evidence in the literature indicates a strong preference for community participatory approaches. Integral to this approach is the need for health promotion to be sensitive to local views and conditions, inclusive of cultural beliefs and this is frequently mentioned (Larkey 2010; McDonald, et al. 2008; Mukherjee 2008; Panter-Brick, et al. 2006). The CLTBC (Community-Led Total Behavioural Change) approach used in Nepal by the RWSSP-WN reflects the value accorded to participatory approaches.

Increasingly evident, however, are tones of caution as to how realistic this ambition is and in order to increase chances of success, certain prerequisites are being suggested. It should not be a given that because the approach is community based it will be successful. Merzel and D'Afflitti assert that "effectiveness ... appears to be related in part to extensive formative research and an emphasis on changing social norms" (2003:557). Inherent in this assertion is that this will enhance sensitivity of health workers to local views and conditions. Reasons cited for this are that formative research seeks to understand the nature of the risk behaviour, enables programmes to tailor approaches to fit the target group, looks for other relevant community concerns and in doing so elicits more interest in the project. It was also proposed that formative research resulted in a higher degree of involvement of the community (Merzel and D'Afflitti 2003).

Despite the success of community participatory approaches, there are voices of concern about the modest impact of many programmes. Lack of success has been attributed to methodological issues, influence of secular trends, smaller than-expected effect size, limitations of the interventions and limitation of theory (Merzel and D'Afflitti 2003). Comparison of the greater success of HIV/AIDS programmes over other health related programmes can be attributed to two major factors, namely extensive use of formative research and the prominence given to addressing social norms. Significant to this finding is that community-based health promotion is believed to have been driven by the rationale that individuals cannot be seen separately from their social milieu and context (Merzel and D'Afflitti 2003). This gives rise to the belief that programmes using multiple interventions tend to be more successful in achieving behaviour change. It is important, however, to acknowledge the limitation on being able to tailor interventions so that they reflect all conditions within a community. Most programmes use a single approach and in doing so are unable to develop strategies that will reach the subgroups (Merzel and D'Afflitti 2003).

Merzel and D'Afflitti draw attention to weaknesses in delivery of interventions used in community based programmes and propose that factors such as “limited duration and intensity, insufficient scope of activities, and inadequate penetration into the community” are partially responsible (2003:564). They also point out that outcome measures are often only defined as complete avoidance of a specified behaviour, and little recognition is given to less absolute changes. Other factors also play a major role, inclusive of the ‘nature’ of the communities involved and the nature of the risk involved. For example the perceived immanent risk of contracting HIV/AIDS compared to perceptions of contracting a diarrhoeal disease provide a more compelling argument to adopt the proposed new behaviours.

A phenomenon labeled the ‘Prevention paradox’ has been proposed as a contributing factor as to why HIV/AIDS programmes are relatively more successful than other programmes. The ‘prevention paradox’ relates to the ‘level of benefit’ of behaviour change. Prevention measures that are seen as providing more benefit to the community than to the individual, apparently contribute to the relative lack of success of health programmes targeting chronic diseases (Merzel and D'Afflitti 2003). The ‘Prevention paradox’ refers to interventions that target the ‘general population’ as opposed to targeting high risk groups and are apparently more successful (Allebeck 2008). In relation to sanitation and hygiene programmes the lesson is that programmes need to target everyone and avoid targeting only the more

selective 'at risk groups'. This is reflected in the RWSSP-WN project in Nepal where the emphasis is on the whole community as opposed to specific target groups.

A community-based approach was compared to a non-community based approach in a study in rural Bangladesh. The impact of a behaviour change intervention on cleanliness, diarrhoea and growth of children was evaluated (Ahmed, et al. 1993). Findings indicated that the non-community based approach was less successful as it lacked consideration of cultural context on behaviour and many proposed interventions were alien to the target group.

A number of factors were believed to contribute to the relative success of the community based approach. Firstly, a good rapport was established with village leaders who were seen as being very influential. Secondly, full support for the programme was sought from local officials as well as these village leaders. Thirdly, a rapid survey identified existing hygiene practices and sanitary conditions, and acknowledged cultural beliefs about causes of diarrhoea. Fourthly, the programme trained mothers to train other mothers. Messages used in the programme, were simple, active and drew on local proverbs, poems and folk songs .

Ahmed and his colleagues summarised the 'key' findings in relation to the more successful community based approaches as being:

- Identification and relatively comprehensive understanding of local norms and cultural beliefs
- Full involvement of the community and local opinion leaders
- Using existing hygiene practices to increase acceptance and adoption rates of the new behaviours
- Development of simple and direct messages reflecting local popular proverbs, poems and folk stories was believed to increase recall, motivation and effectiveness
- Germ theory was taught through an interactive method with the community proposing their own solutions

The finding in regard to the teaching of germ theory is interesting in light of findings in other literature that suggests health related education has very little impact on behaviour change. The suggestion is that it is not so much 'content' but 'process' that is important, and so long as an appropriate process is used, health education can still have an impact.

Community Led Total Sanitation

In regard to sanitation and hygiene programmes a relatively new approach, Community Led Total Sanitation (CLTS), is gaining recognition and is being widely implemented. Since its inception in 2000 in Bangladesh, its use has spread to other South Asian countries such as Cambodia, China, India, and Nepal and some African countries (Appendix 3). CLTS is based on a number of premises, most notably no subsidy and its promotion of a sense of disgust to trigger behaviour change (Kar 2006).

The no subsidy approach has been strengthened because of the awareness that subsidized approaches reduce any sense of ownership, which in turn is believed to lead to poor maintenance of hardware. This has important implications when talking of latrines, as poorly maintained latrines or toilets are believed to lead to more diarrheal infection than no latrines (Ahmed 1994; Khan 1987; McDonald, et al. 2008; Pattanyak 2006). A study conducted in Bangladesh, to determine whether or not the presence of a family latrine would reduce the incidence of childhood diarrhoea, indicated there was actually an increase of diarrhoea in many homes with latrines. The increase in diarrhoea was attributed to the inadequate disposal of excreta from the latrines (Ahmed 1994).

This finding affirms another study by Khan in an urban area of Dhaka where he concluded, “ Use of communal latrines, without strict disposal of everyone's excreta, does not affect parasite prevalence and diarrhoea rates. People must be educated about the use of communal latrines and the safe disposal of all excreta, including that of children” (1987:187).

Although, not related to the issue of latrine construction, William Easterly made the observation that when poor people make a modest financial contribution to the provision of health services it results in an increase of accountability, as people have paid for the service. If the care is not of a high enough standard they will certainly make their demands known and insist on better care (Easterly 2006).

The CLTS is characterized by its use of ignition-processes and draws on tools developed in Participatory Rural Appraisal (PRA) (Kar 2003), they are as follows:

- Defaecation area transect
- Sanitation mapping, collective calculation and flow diagrams
- Visual tools

- Planning for collective and household implementation
- Children as agents of change
 - ✓ The defaecation area transect involves a simple walk around targeted villages. Essentially, this walk involves all participating members of a community taking a group of outside dignitaries on a walk through the village to identify common area's for OD. These transect walks were identified by facilitators in Bangladesh, as being the single most significant motivator for behaviour change (Kar 2003). One main reason offered is that it is believed the sense of shame generated is a powerful motivator for change. Sanitation mapping involves identifying and drawing maps of household latrine status and taking note of which households do or don't have a latrine. Included on the map are common sites for OD with a record of which people frequent that site. The calculation flow literally calculates the amount of faeces per person, per household, per village, over a set period of time. Finally, diagrams are drawn to trace routes of faecal contamination, ponds, utensils, food, and so forth.
 - ✓ Visual tools were developed by WaterAid-B and its partners to promote understanding of basic hygiene and sanitation principles.
 - ✓ The collective planning, household action and implementation will vary according to the decision of different communities, but generally has resulted in the formation of action groups, identification of current sanitation status, and plans to start constructing both temporary and permanent latrines.
 - ✓ Children have been identified as key agents of change, and reasons for this are varied. Perhaps it is because, they have the most energy and have been found to initiate the digging of pits to start the process for latrine construction.

It has been proposed that one of the main reasons for the CLTS approach being so successful relates to the facilitation skills of those implementing it. In particular their ability to motivate and mobilize communities and its focus on people as opposed to the provision of hardware (Deak 2008). Health promoters are encouraged not to prescribe, but to facilitate communities to come up with their own solutions to sanitation problems. It has been reported that in rural areas of Bangladesh, one of the effects of the CLTS approach was the

emergence of 32 innovative toilet models based on local knowledge and affordability. The costs ranged between 0.25\$ and 10\$ (Hossain, in Deak 2008).

Following the success of CLTS in Bangladesh, Indonesian policy makers and sector professionals decided to engage with this approach as it seemed to complement the aims of the government (Mukherjee 2008). Following its inception in Indonesia it was observed that it indeed supported the wider decentralization agenda, and was perceived as an effective tool to empower communities, improve services and promote gender equality.

Appeal for this approach was strengthened by the awareness that it resulted in communities becoming more self-reliant and taking more initiative for their own sanitation needs. This contrasted with previous efforts where supply oriented approaches were perceived to result in poorly sustained sanitation facilities and the exclusion of target communities.

Another observation was that CLTS transformed the government role from implementer to facilitator, and communities were put in the driver's seat, assuming responsibility for planning, construction, management and finances (Mukherjee 2008).

An observation made in this study and one that resonates with anthropological notions of the social implications of sanitation and hygiene, is clearly evident in a story they shared. Following a day of 'triggering' activities, one village dug 17 pit latrines over night, it was reported "One of them a man over seventy years old, laughingly told us that he would look for a new wife now that he had a toilet!" (2008:10). It was observed that previous behaviour change efforts based on motivating people for positive reasons was considered outdated, and the new approach based on eliciting shame was more effective.

CLTS has since been implemented in several other countries in Asia and Africa, and reportedly with much success. In terms of the assumption of this research, that health promoters need to be sensitive to local views and conditions, its wide implementation in diverse countries makes it particularly interesting.

A working paper for the Institute of Development Studies, wrote an update on developments of this approach since its inception in Bangladesh. The report covers other Asian countries, inclusive of Bangladesh, Cambodia, China, India and Nepal. Reading through this update gives the impression that health promoters are indeed demonstrating a fair degree of sensitivity to local views and conditions, as is evidenced by the different findings in these places.

In Bangladesh, the update reports progress in sanitation is going on steadily, despite there being some persistent challenges to this approach. There is an increasing awareness of the need to change the attitude of donors wanting to support and promote CLTS. Most donor agencies, as is reflected in the term 'donor', are used to a mindset where 'supply' is the norm and is contradictory to CLTS principles where 'demand' is essential.

Another finding is that the push for Open Defaecation Free (ODF) status of targeted communities results in foul play at a political level. The government of Bangladesh has been offering significant incentives to achieve this status, and this process has backfired in some areas, that have witnessed the rapid building of latrines of poor quality and pressuring families to build. This is completely against the grain of the CLTS approach, as households are expected to build voluntarily in response to increased level of demand (Kar 2006).

In areas where it has been successfully implemented the impact has snow balled with the effects diversifying. It is widely recognised that open defaecation practices pose more problems for women than for men. In many contexts where OD is practiced, women are quite restricted in their movements and cultural dictates exist in terms of prohibitions on in-laws sharing the same location to defaecate, times of day and the need for privacy. As a result women are often placed at risk having to wait until dark and to walk long distances, away from villages, before being able to defaecate. Now that more and more latrines are being built, the quality of life, especially for woman has dramatically improved. In relation to this a report on the progress of CLTS in Nepal, observed that the practice of OD is more visible than it previously was and attribute this to deforestation and increased population (WaterAid 2006).

To measure the 'effectiveness' of these approaches is complex and beyond the scope of this research. The health promotion field comprises a myriad of players, structures, concepts and principles that all contribute to the complexity of measuring effectiveness. The focus has been to look for evidence of the sensitivity of health promoters to local views and conditions. To talk of sensitivity, to some extent implies a search for meaning and understanding of perspectives of the various players in the field. It has been proposed that the limited biological explanations to ill health led to the emergence of 'health promotion' as a discipline as it encompassed a wider view of health and illness. This leads on to the next focus in the literature review, health promotion.

In the literature it was difficult to ascertain the amount of attention given to the level of sensitivity of health workers to local views and conditions within projects aiming to prevent the practice of OD. There was, however, conclusive evidence in literature about other health promotion projects, that strongly affirmed the need for health promoters to be aware of local culture and beliefs that contribute to health behaviour choices.

2.3 CHARACTERISTICS OF HEALTH PROMOTERS

- *What are the characteristics of the health workers in the programme?*
- *Who are they?*

Health Promotion is a fairly recent discipline, having gained prominence over the past 20-30 years. It not only makes a claim to know what healthy behaviour is, but also claims to understand the best way to encourage people to do this (Thorogood 2002). It draws from a number of different disciplines, inclusive of sociology, psychology, education, epidemiology and communication. There is little emphasis on medical sciences and this is believed to be the result of dissatisfaction with the bio-medical model as it offered little explanation as to why people think and behave the way they do (Bunton 2002). This description of 'health promotion' highlights the need for health promoters to possess characteristics that are inquisitive and sensitive, that will strive to understand the health behaviours of the people they are working with.

From a sociological and anthropological perspective this observation is significant as behaviour cannot be interpreted independently from social contexts. 'Health promotion' demands that health promoters are sensitive to local views and conditions.

It has been difficult to deduce from literature much about the character of health promoters and exactly 'who' they are. It has been possible, however, to find evidence of characteristics of both health promoters and programmes that are valued and considered important.

Narrative theory reflects health promoters ambition to understand local views and conditions. Although reference to this theory has been in relation to other health related programmes, it provides some lessons for what may be applicable in sanitation and hygiene programmes.

Anthropology, communication and psychology have all contributed significantly to the conceptual framework of narrative theory (Larkey 2010). The underlying rationale is the belief that much of our socially constructed world is the result of narrative exchange. It is through

the medium of narrative that we create a sense of self identity, organize our thoughts, and communicate through conversation, non-verbal interactions and storytelling (Larkey 2010). Narratives are believed by social constructionists to be integral to shaping culture and cultural identity, create cultural meaning, a sense of belonging and provide guidance. Narrative theory proposes that narratives not only express identity, but sense can be made of experiences, and interpretation can be gained through social interaction (Larkey 2010).

Narrative theory considers the wide spectrum of situations in which people are exposed to health messages, both intentional and incidental, and acknowledges the dynamic role of the individuals involved. It recognises that information exchange is never static. Preexisting beliefs and attitudes, perceived characteristics of narrators and relationships, and social and physical context all influence the way in which health messages are interpreted (Larkey 2010). Kreuter et al, in Larkey and Hecht, define narrative as “A representation of connected events and characters that has an identifiable structure, is bounded in space and time, and contains implicit or explicit messages about the topic being addressed” (2010:120).

Certain characteristics of the narrative need to be present to increase its effectiveness. The characters need to be realistic and engaging, should generate empathy and need to be perceived as similar. The story should be appealing, dramatically sequenced, and create a sense of curiosity or suspense. Research on persuasion has suggested that both emotional connection and perceived similarity of characters is central to promoting positive behaviour change (Larkey 2010).

Larkey and Hecht propose that it is not only the ‘characteristics’ of narrative that are important but also ‘mediators’. Mediators refers to the underlying mechanisms through which influence occurs, “... including transportation, (i.e., getting “*carried away*” by the story including complete attention, absorption, and emotional involvement consistent with the events of the story) and identification with the characters in a story (or the storyteller) (Italics and brackets in original, 2010:122).

Narrative is believed to have considerable ‘spillover effects’. As people are affected and respond to narrative it is likely they will share this with others, an effect called ‘social proliferation’ (Larkey 2010).

The ‘Narrative as Culture-Centric Health Promotion’ Model as proposed by Larkey and Hecht, is “culture-centric” as opposed to “culturally appropriate” or “culturally sensitive”. It seeks to identify existing cultural texts within cultural groups and use these to frame

messages. It therefore is an applicable and transferable intervention that can be used in a variety of settings.

Applicability and transferability of health promotion interventions has been the focus of a study by Wang and her colleagues. The aim of the study was to see to what extent public health programmes are affected by the contexts in which they operate (Wang 2006a). The main findings were that public health interventions are 'context dependent'. Context was described as "the particular social and cultural environment and the particular social and cultural organizational system in a society" (2006:77). A number of contextual factors were identified, inclusive of the skill of health providers, the familiarity of the approach, the level of access that a population has to requisite facilities and possible biological differences between populations (Wang 2006a). The issue of interaction being dynamic was raised, with recognition given to the fact that not only does the intervention depend on the context, but also the intervention places demands on the context.

Literature about health promotion efforts is littered with reference to culturally appropriate and culture centric approaches (Avvannavar and Mani 2008; Chambers 2006; Choprapawon, et al. 1991; Larkey 2010; Merzel and D'Afflitti 2003; Mukherjee 2008; Stone 1992; Wang 2006a; Wang 2006b; Waterkeyn and Cairncross 2005). It is difficult to determine from the literature 'who' health promoters are within sanitation and hygiene projects. I believe, however, culture centric trends reflect a high degree of sensitivity to local views and conditions within health promotion inclusive of some sanitation and hygiene programmes.

2.4 KNOWLEDGE, ATTITUDE AND SOCIOCULTURAL AWARENESS OF HEALTH PROMOTERS

- *What are their beliefs about open defaecation and the people who practice it?*
- *Have health promoters sought to understand why this practice is happening?*
- *Can they describe particular beliefs that contribute to this practice? Is it merely because of lack of latrines or are there other factors? Is it determined by beliefs about faeces and defaecation? Is it a family tradition? Is it an act of rebelliousness?*
- *What awareness do health promoters have of the characteristics of the villages in which this practice is engaged?*

- *What do health promoters have to say about the attitude of villagers toward people who practice open defaecation?*

Defaecation is a topic that is generally avoided, to the extent that it is almost considered ‘taboo’. One explanation for this is that people are generally bound by ‘cultural codes of propriety’ and to discuss a ‘dirty’ topic such as faeces, results in discomfort and breaking of etiquette (van der Geest 2007). This probably accounts for why it is difficult to deduce much from the literature about beliefs concerning OD and people practicing it. What follows, begins with the scarce findings in literature about beliefs surrounding OD. This is followed by reports on findings in the literature that reflect relevance to the research questions. These findings have been categorised under the headings, Beliefs about Open Defaecation, Understanding Unfamiliar Practices, ‘Place’, Historical Legacy, Child Care Practices, Political Support, Community Health Clubs. Following this a section that reports on current issues in Sanitation and Hygiene Promotion. The report highlights the challenges and issues facing Sanitation and Hygiene programmes.

Beliefs about Open Defaecation

Defaecation practices, as well as latrine use, are the result of a multiplicity of factors. A study in Kenya, Tanzania and Ethiopia, using a combination of anthropological and participatory tools, was undertaken to measure indicators of hygiene behaviour. The discussion asserted the importance of promoting a greater understanding of the context, purpose and meaning underlying certain hygiene practices (Almedom 1996). Findings in the study indicated that the more programmes learn about target communities the better chance the programme has to tailor interventions to match the target group. Techniques used in the research such as the ‘structured walkabout’ encouraged planned observation of the community.

One major finding was that homes with children are more open to discussion about issues related to hygiene and sanitation, than those without. The point highlighted was that the presence of children helped bridge the barrier to sensitive issues as it was notably easier to discuss children’s defaecation practices than adults. Essentially, children were perceived as a tool to accelerate the disclosure of information that people usually take a great deal of effort to conceal (Almedom 1996).

Also in relation to children, it was noted that young people were more acutely conscious of the absence of latrines than adults. It was found that adults use latrines less than children. This was attributed to latrines not being private enough, not convenient enough, or not

considered 'real'. They were 'chief latrines', these were latrines that had been rapidly erected in response to an edict of the chief following an epidemic. The latrines were clearly a façade as when entering the latrine it became clear that there was no pit or too shallow a pit.

The study also found that OD in fields was considered good practice, as it was safe and practical (Almedom 1996). The study mentioned socio-cultural taboos that would dictate who could or couldn't share the latrine and dictates determined by social categories, such as in-law relationships (Almedom 1996).

Another belief that is thought to contribute to the persistence of OD is that faeces is considered a good fertilizer. In some societies the practice of OD in fields has persisted for generations due to the value of it as a fertilizer (Karadag, et al. 2006).

Another factor thought to contribute to this practice concerns geographical dictates. In some areas of China, for example, it was reported that due to freezing conditions it is impossible to build latrine pits (Karadag, et al. 2006). Seasonal freezing conditions have the added problem that OD occurs closer to homes, as people are reluctant to walk long distances in such conditions (Karadag, et al. 2006).

Just prior to completing the write up of this thesis, I stumbled across an article that gives an enlightened perspective on the practice of OD. The article points out that the main reason to push for safe and sound handling of human faeces, is to prevent faecal-oral contamination and water borne diseases. Recognition is given to the fact, however, that approaches to safe sanitation are often at odds with prevailing psycho-socio-economic mentalities of communities (Avvannavar and Mani 2008). The writers insightfully propose that mentalities are governed by attitudes that are moulded by combinations of knowledge, feelings, and action, and state "This is crucial as people look at sanitation through their cultural lenses" (2008:2). They go on to state "Three cultural considerations must be addressed if proper sanitation approach needs to be devised and adopted ... *psychological* (universal) deterrents associated with handling waste, *gender issues* which are both universal and local and *religious influences* ..." (Brackets and italics in original 2008:2). Additionally, recognition is given to the crucial influence of economic well-being (Avvannavar and Mani 2008).

Understanding Unfamiliar Practices

The above findings affirm the importance of health promoters being sensitive to local views and conditions, as well as the valuable contribution of anthropological research to facilitate

understanding of unfamiliar practices. Existing views, norms and local conditions all contribute to practices that people engage in, inclusive of defaecation practices. Unless these are understood and not judged as 'good' or 'bad' there is little ground for health promoters to begin health promoting dialogue with their target group.

The CLTS approach, where the recruitment of local 'natural leaders' is encouraged, recognises the need to understand, not only people engaged in the practice of OD, but also environmental influences. The involvement of local people, who have themselves been engaged in the practice of OD, helps guard against strongly negative attitudes about this practice.

Supporting the value of 'local knowledge' it has been found that applicability and transferability of any health promotion activity is dependent on the 'level of local knowledge' of implementers. Wang and her colleague's state, "... the availability of contextual information about the public health intervention is crucial in applicability and transferability appraisal" (2006:82).

'Place'

A refreshing perspective offered by Cummins, on a notion inherent to local knowledge and contextual information, concerns 'place'. He believes that for a long time health promotion research has underestimated the influence of 'place' to health. He asserts that there is a reciprocal and mutually reinforcing relationship between people and place (Cummins, et al. 2007). He challenges health promoters to reconsider the concept of 'place'. He asserts that power relationships and particularly 'power struggles' are important for understanding place.

Referring to Latour's Actor Network Theory, Cummins quotes Hudson stating "spaces, flows, and circuits are socially constructed and temporarily stabilized in terms of social rules and norms which enable or constrain different forms of behaviour" (2004:463). There is little doubt as to the impact of these power relationships on levels of poverty and these in turn impact on social norms and influence behavioural choices, inclusive of open defaecation.

Another interesting perspective Cummins highlights in relation to 'place' is the 'dynamic' nature of place. He points out that more attention needs to be given to the impact of flows of capital, culture and people, particularly in remote geographical areas (Cummins, et al. 2007). The assertion is that people moving in and out of places has an impact on behaviours, values, and economy. The implication of this to the sensitivity of health promoters to local

views and conditions is that health promoters in sanitation and hygiene projects need to be aware of what it is that influences hygiene behaviours.

Historical Legacy

Most literature read for this research focused on disadvantaged communities in developing countries. It is important when addressing health promotion efforts to consider the 'composition' of these communities. Many disadvantaged communities are characterized, among other factors, by their historical legacy. The legacy that people carry is influential on attitudes of people towards others as well as the conditions in which they live. A study undertaken to evaluate the impact of hygiene and public health interventions on Australian Aboriginal children highlights the importance of this. Aboriginal communities in Australia carry an historical legacy that has depicted them as 'savages' to be dominated and eliminated (McDonald, et al. 2008).

This legacy has had considerable impact on their current health status reflected in high levels of alcohol abuse, violence, physical and mental ill health and low incomes. It was thought that this legacy contributed to current levels of suspicion and resistance to hygiene and sanitation behaviour change. The belief was that efforts to improve sanitation and hygiene levels can be seen as perpetuating cultural denigration (McDonald, et al. 2008).

Child Care Practices

Another interesting finding emerged from the study in regard to child care practices. These practices were believed to contribute to diseases related to poor hygiene practices. Observations included behaviours such as shared mothering, encouragement of young children to be independent and explorative, the expectation that mothers should avoid stressing young children, and the focus on avoidance of immediate physical dangers (McDonald, et al. 2008).

These findings seem surprising as many developing countries have cultural communities that function at a collective level. The issue of 'shared mothering' is more prevalent in collective societies, and yet not all these societies suffer the same ill health related to poor sanitation and hygiene practices. Perhaps it is not the child care practices, but rather the circumstances that contribute to these behaviours happening in the first place, that lead to sanitation related ill health. It also reflects something of the attitude of health promoters toward OD.

The study identified four major behaviour practices that were believed to be more detrimental to poor health than others. Firstly, the tradition of sharing the care of very young children and the fact that many young children, especially girls, were involved in this shared responsibility. Secondly, these young children were expected to meet the hygiene needs of infants and toddlers. Thirdly, the fact that the practice of young children defaecating in the open was generally an accepted practice. Fourthly, the lack of awareness of transmission routes of bacteria. Other less major factors concerned the complex housing programmes that led to widespread confusion at community level (McDonald, et al. 2008).

Political Support

Findings in literature pointed to the importance of garnering political will and reflects increasing awareness of characteristics of communities. The observation is that often the level of success of programmes is determined by the extent of political support (Atkinson 2002; Kar 2006; Ngondi, et al. 2010; Peal 2010; Stone 1992; Wang 2006a; Wang 2006b).

There is little doubt that the effectiveness of health promoting organisations is affected by the political culture in which it is embedded and this will have repercussions for the ways in which it can function and implement policies (Atkinson 2002). A report about CLTS progress in Indonesia referred to the political implications inherent in the approach being accepted there so readily. The inference made is that political will not only serves to support sanitation and hygiene projects, but the CLTS approach has been seen to support the wider decentralization agenda of the Indonesian government (Mukherjee 2008).

The importance of establishing rapport with village leaders and seeking the support of local officials has also been reported in a longitudinal study conducted in Bangladesh to study the impact of behavioural change intervention on sanitation practices (Ahmed, et al. 1993).

A study, undertaken to challenge traditional knowledge, attitude and practice (KAP) surveys in hygiene promotion, asserted that other determinants need addressing if behaviour change is to be achieved. It was noted that a shortcoming in conventional approaches concerned the rigid identification of opinion leaders. The focus tended to be exclusively on religious leaders, female health workers and teachers whereas it was believed, especially in urban areas, that elected councilors are key opinion leaders. This finding supports the importance of generating political will for projects (Riaz 2010). This finding has been echoed in Ethiopia that attributed increase in latrine coverage to the political commitment of local government and intensive community mobilization (Ngondi, et al. 2010).

Community Health Clubs

The use of Community Health Clubs (CHCs) is gathering support in sanitation and hygiene programmes (Waterkeyn 2005). Reasons for the increased support, confirm what has been found in other studies with regard to the emphasis on social norms, the need to consider historical legacy and the creation of demand (Kar 2003; McDonald, et al. 2008; Merzel and D'Afflitti 2003). CHCs in Zimbabwe within sanitation and hygiene programmes and have been found to be an effective way of creating new norms within communities.

Sanitation and hygiene programmers were convinced about the value of participatory approaches. Rather than the usual traditional leadership, CHC promoted membership of clubs and enthusiastic leadership from community level. Interestingly, one reason given for the acceptability and effectiveness of the clubs was historical legacy. In former colonial times various mission organisations and other philanthropic societies had built up an image of club membership as a prime example of a smart, woman who would be a 'pillar of society'. The concept of 'club' tapped into existing values of conformity in rural communities having tapped into the long history of women's groups that had developed since colonial days (Waterkeyn 2005).

The rationale behind the concept of CHCs is to build community cohesion, and to promote a 'culture of health' through the creation of demand for sanitation and improved hygiene. A stated aim of the clubs is to change norms and existing beliefs that have been recognised as determinants of behaviour. The concept of 'clubs' was seen as an effective way to address underlying causes of poor health. Waterkeyn and Cairncross identified these underlying causes as "limited information, poverty, lack of social capital, including organisational capacity within the community to effect sustainable change" (2005:1959). According to questionnaire results, the clubs were seen as an effective way to address these underlying causes, as many needs were being met.

Popularity of the clubs was attributed to the enjoyment of learning, interest in the variety of topics being discussed, the strong pleasure gained from the social contact, singing, dancing and drama. The clubs promoted members to make 'pledges' to improve sanitation and hygiene practices at home, the sense of competition and achievement accomplished through these pledges has a double effect. Not only did this result in pleasure in the clubs but improvements at home (Waterkeyn 2005). Other 'spin-off' effects have been noticed in other

sanitation and hygiene programmes, such as the emergence of literacy classes, income generating projects, and increased community support for AIDS victims (Waterkeyn 2005).

Another finding, also affirmed in other projects, concerned the role of women and the point made makes an interesting contribution to understanding of local conditions. The observation was that in more deprived areas, where agricultural conditions are harsh, women have less agricultural demands placed on them, and as a result have more time to dedicate health promotion in the home (Waterkeyn 2005).

2.5 CURRENT ISSUES IN SANITATION AND HYGIENE PROMOTION

Health promotion efforts continually face challenges and emergent issues as is evident in findings from a workshop held in Bangladesh, in February 2010. Other key issues concern the very nature of development work and the strong support for the anti-subsidy approach. This section begins with a report of the themes that emerged in the workshop in Bangladesh and concludes with findings in the literature that concern development work and the anti-subsidy approach.

In the Bangladesh Workshop, one of the papers addressed challenges and issues confronting hygiene promotion in South Asia. Key issues that emerged included the need to raise the political agenda, the need to scale up hygiene approaches, a call to demonstrate the cost-effectiveness of hygiene promotion, a need to convert high levels of hygiene knowledge into practice, the importance of menstrual management and a challenge to increase awareness about the benefits and opportunities to other sectors (Peal 2010).

It was strongly advocated that hygiene promotion activities should aim to 'create demand' for increased sanitation and hygiene coverage. Acknowledgement was given to the fact that promoting hardware is not enough. Previous top-down approaches used in sanitation and hygiene were criticized and bottom-up approaches were encouraged (Peal 2010). There was a call to increase awareness of the benefits of improved sanitation and hygiene for the community. Perceived benefits include, increased comfort, privacy, convenience, dignity and safety for women. Interestingly, it was noted that a perceived benefit is the rise in social status of people who adopt improved sanitation and hygiene practices (Peal 2010).

It was noted in the workshop that since 1990, with the exception of Afghanistan, there has been a general improvement in South Asia, with regard to rates of both child and adult mortality. Reasons cited for the improvement, included, an increase in hygiene awareness,

knowledge and practice, changes in socio-economic conditions, political influences, education opportunities, and access to health care, clean water and sanitation facilities. Many interventions were based on the following concepts, three broad categories of behaviour change theory, as well as typical behaviour change approaches inclusive of communication campaigns, participatory learning activities, social mobilization, hygiene activities and the use of incentives (Peal 2010).

The creation of 'social norms' was highlighted, as well as the emergent tool of disgust, which is widely used in the CLTS approach. The notion of children as change agents was also raised and encouragement to target schools in hygiene programmes (Peal 2010). The workshop identified the common elements of success as being the emphasis on a participatory approach, the context specific nature of programmes and the use of key community figures as role models. Additionally, it affirmed the need for a supportive political environment, as well as some degree of harmony with existing social norms (Wang 2006a).

In relation to other sanitation practices has been established that hand washing practices are much higher in the presence of others. This is important in terms of behaviour change theory as it affirms the fact that social norms are a high motivator of behaviour change (Jenkins 2007; Jenkins 2005; Larkey 2010; Peal 2010; Riaz 2010; Waterkeyn 2005).

'Development Work'

Literature describing health programmes frequently asserts that health promotion programmes should be sensitive to local contexts, inclusive of cultural beliefs (Larkey 2010; McDonald, et al. 2008; Mukherjee 2008; Panter-Brick, et al. 2006; Wang 2006a; Wang 2006b). There is little room to argue with this and indeed it has become an aspiration of many health programmes, however, it is a complex aspiration. One major reason for this complexity is the various perspectives of players in the health field, in particular health programmes that fall under the umbrella of 'development work'.

Linda Stone refers to Robert Chambers observation, that the majority of development workers, especially in rural development projects, are 'outsiders' and are "people concerned with rural development work who are themselves neither rural nor poor" (Stone 1992). Furthermore, she challenges the notion of 'culture' within discourse surrounding community participation and asserts that often these programmes reflect more the culture of the health developers and promoters, than the culture of the target community (Stone 1992). This potentially creates a dilemma as regardless of the good intentions of development workers

they are inherently in an 'external' position with notions that are ingrained in particular cultural values (Stone 1992).

This notion of 'externality' of development workers can be taken a step further. James Ferguson, in his analysis of a development project in Lesotho, provides an illuminating perspective of what actually takes place under this term 'development'. Drawing on Foucault's analysis of the 'prison', Ferguson suggests a parallel in terms of the mechanics that are at work in the 'development industry'. He asserts that both Foucault's account of 'the prison' and his own account of 'development' are not primarily focused on the failure of these institutions, but rather with the 'side effects'. The 'side effects' provide some political intelligibility and demand 'technical solutions' for their existence and keep them functioning (Ferguson 1994).

The push for hardware such as latrines in sanitation and hygiene projects reflects this notion of political intelligibility and demand for 'technical solutions'. The CLTS approach in many ways counters this push for 'technical solutions' and challenges the 'political intelligibility' with its push to create demand as opposed to pushing to 'supply' (Kar 2003). The CLTS approach advocates evaluations of sanitation programmes based on evidence of no open defaecation rather than on the number of latrines constructed. Prior to its development, projects had been providing hardware to construct latrines and toilets and discouragingly, after three decades, there was no evidence of open defaecation free villages (Kar 2003). It was found that despite the construction of latrines the practice of open defaecation continued and this was attributed to the cultivation of a dependency culture (Kar 2003).

Anti-Subsidy

Experience with the CLTS approach in Indonesia supports the anti-subsidy approach, they found that previous subsidized approaches demonstrated a lack of understanding of the importance of the concept of 'ownership' and the 'creation of demand'. Additionally, the provision of subsidies resulted in even greater disparity between the powerful and less powerful in the targeted communities (Mukherjee 2008).

Water Aid's involvement in CLTS approaches in Nepal has led them to become strong advocates of the non-subsidized approach. They are convinced of the effectiveness of the 'behaviour' focus rather than the 'provision of hardware'. They have observed that this generates a collective spirit among the targeted communities resulting in more sustainability. The other aspect they note is its appeal for poorer communities as it results in the design of

low-cost options that obviously are more acceptable. During a visit to Nepal in 2003 to specifically gain insight into the CLTS approach, Water Aid made the following assessment of lessons learned. They stressed those differences in caste, ethnicity, local customs and location need to be taken into consideration if CLTS projects are to succeed. They observed that migrant communities were more open to change than were traditional communities under the influence of leaders that were resistant to change. They noted the role of children and good facilitators as change agents in their respective communities. Finally they acknowledged the importance of local language in accelerating the internalization of sanitation and hygiene lessons (WaterAid 2006).

2.6 PRACTICES AND TECHNIQUES OF HEALTH PROMOTERS

- *What is the most important aspect of the programme for the health workers? Is their focus 'task' oriented or 'people' oriented?*
- *Why are they working in the programme?*
- *Are health promoters able to describe the effect of health messages and their 'interactions' with the target population?*
- *What health promotion techniques are practiced? Are those techniques appropriate for the cultural setting?*
- *What content does the health promotion contain? Is it appropriate for the cultural setting and the target group(s)?*

Health promoters wanting to learn about views of the people they are targeting as well as learning about the conditions in which they live, have much to learn from communication theories. Increasingly, literature on health promotion embraces the need to implement strategies based on 'communication theory' in order to address barriers to effective communication. One such group of theories falls under the category of 'Behavioural Decision Making' (BDM) approaches.

BDM approaches are based on the assumption that people make decisions according to the way they cognitively process alternative courses of action and this encompasses their perception, structuring and evaluation of those alternatives (Maibach 1995).

These theories in practice are often implemented alongside behavioural change theories, specifically the stages of change models. These models tend to consider behavioural

change or behavioural adoption as actions that move along a single continuum. “Non-stage theories and models” are based on the assumption that people take action to change behaviour in a relatively calculating manner based on their beliefs or attitudes, and ability to predict outcomes, the assumption is that interactions are constant from the time threat is evident to the time action is taken.

In contrast, “stage models” view behaviour change as a series of actions or events ... (they) allow researchers to detect movement toward a behaviour change ... (they) can see the influence of factors at the beginning and throughout the change process ...” (Maibach 1995: 26). Basically, stages of change models acknowledge that behaviour change is a process and not an event, the assumption is that people ‘weigh up the odds’ and adopt change if they think the advantages will outweigh the disadvantages. These theories seem to complement theories concerning the social construction of knowledge, particularly phenomenology, which has been described as “... (An) approach that developed ... as a form of attention to individual consciousness, to develop a new sociology of knowledge and intersubjective understanding” (Calhoun 2007:6). An important distinction that needs to be made in health communication is the need to determine if the main objective of the communication is to inform or persuade (Nelson 2002).

“To inform” or “to persuade” are obviously related, but still a distinction between the two has implications for the use of behaviour change theory. One prominent behaviour change theory, the Precede-Proceed Model, identifies factors as occurring in two phases, the needs assessment phase and the implementation phase (Nelson 2002). The needs assessment phase, concerns “**p**redisposing, **r**einforcing, and **e**nabling constructs in **e**ducational/environmental **d**iagnosis and **e**valuation” (Precede), and an implementation phase consisting of “**p**olicy, **r**egulatory, and **o**rganizational constructs in **e**ducational and **e**nvironmental **d**evelopment (Proceed)” (Nelson 2002:63). This model is particularly relevant for health promoters seeking to understand local views and conditions, as without an understanding of current predispositions, reinforcing and enabling constructs, it is difficult to tailor programmes to fit target groups.

Health promotion programmes aiming to change health related behaviour face enormous challenges not only in facilitating the process of behaviour change, but also in sustaining it. Success is determined by the degree to which interventions build on existing practices, skills and priorities, recognise constraints, mobilize the community and target those most likely to change (Panter-Brick, et al. 2006).

A study undertaken in Ghana, based on a social ecology model, to encourage behaviour change in the use of bed nets to prevent malaria, promoted the use of 'culturally compelling' strategies. This is much in line with the 'Narrative as Culture-Centric Health Promotion' as proposed by Larkey and Hecht (2010). Prerequisites for this culturally compelling strategy are that there needs to be considerable contextual information gathering (Panter-Brick, et al. 2006). Contextual information makes it possible for programme designers to understand local situations and ensure interventions will be well received. The study in Ghana, made extensive use of songs as a vehicle for change, as it recognised the prominence of songs in the local context (Panter-Brick, et al. 2006).

A study in Orissa, India, evaluating information and communication strategies to promote latrine use and improve child health, presented findings that affirm much of what has been found in the literature. Of note in the main findings were the emphasis placed on approaches that would 'increase demand' for latrines, promotion of bottom-up approaches, the emphasis on children as change agents, and the need to be sensitive to local traditions and customs (Pattanyak 2006). The study highlighted the importance of behaviour change theories to the design of programmes.

This finding is echoed also in an article by Susan Michie and her colleagues, who state "There is increasing recognition that interventions to change behaviour should draw on theories of behaviour and behaviour change" (2008:661). This realisation has been strengthened by the awareness that the use of these theories enables the targeting of causal determinants of behaviour and behaviour change. The testing and evaluation of interventions is considered to be more likely if the intervention is theoretically informed. Another reason for the push for use of behaviour theories is that it is believed it will facilitate understanding of what works and therefore encourages the formation of theories that can be tailored to different contexts, populations and behaviours (Michie, et al. 2008).

A framework entitled 'Persuasive Health Message' (PHM) has been developed to assist programme designers design messages for health campaigns (Witte 1995). (Appendix 4). The framework makes use of three persuasion theories, the Theory of Reasoned Action (TRA), the Elaboration Likelihood model and the Protection Motivation Theory (PMT). The underlying belief was that no single theory could explain everything, and it was felt that combining aspects of different theories would provide a useful framework that could be used in the design of messages. Drawing on the work of researchers and communication practitioners, Witte states that "Messages must be culturally, demographically, and

geographically appropriate if they are to influence the audience as intended” (1995:146). PMH states that two separate factors need to be addressed prior to the development of campaign messages, namely, constant factors and transient factors. The belief is that “content and features of a persuasive message are structured by the constant components of the framework” (1995:146). It has been proposed that the constant components are a threat message, an efficacy message, and various cues and should be targeted toward a specific audience. All these components of a message should be present regardless of the topic, type of message, or the environment (Witte 1995).

The threat should make audiences feel susceptible, the efficacy components makes people believe the recommended response can avert the threat. Two variables, source and message, act as cues. Source variables include credibility, attractiveness, similarity, or power. Message variables refer to the way that messages are delivered, inclusive of type of appeal, repetitiveness and language use. The final component, audience profile, is important for ensuring a message ‘fits’ the audience. The message needs to be demographically and psychographically appropriate.

The transient components are those that change given the different target groups. These include significant beliefs, important referents, culture, environment and the message goals. Transient features should determine the actual content and features of a message. PMH recommends that two categories of transient information needs to be collected. First, information relevant to the threat and efficacy of the recommended response, as well as existing beliefs about the threat, and beliefs about the referents as well as information about referents beliefs about the threat. Second, information about the environment, culture and preferences of the target group needs to be collected, as this helps develop cues and the audience profile (Witte 1995).

Witte summarises important prerequisites for increasing the chances of facilitating behaviour change, these are, “(a) the whole set of salient beliefs toward an advocated behavior change must be uncovered, and (b) salient beliefs that inhibit the behavior should be countered while salient beliefs that encourage the behaviour should be supported” (1995:150). Once this has been established the way is paved for creating messages that will ‘fit’ the target group.

The PHM model complements what Resnicow and his colleagues have to say in regard to ‘cultural sensitivity’. They define it in relation to ‘surface’ and ‘deep’ structures. Surface structures refer to those aspects of a health intervention that are able to be targeted to

observable characteristics of a target population. To do this health promoters need to be familiar with 'preferences' of the target audience such as language use, places, and current trends in clothing and music. 'Surface structures' reflect the extent to which health interventions can be tailored to a specific culture. 'Deep structures' involve the incorporation of aspects such as cultural, social, historical and environmental factors that influence health behaviours of target groups.

Surface structures tend to result in higher degrees of receptivity, while deep structures convey 'salience' (1999:10). This definition of cultural sensitivity has drawn from the fields of health communication and social marketing (Resnicow, et al. 1999). There is little doubt that the more familiar health promoters are with existing views and salient beliefs, of their target group, and the more aware they are of the conditions in which they live, the more able they are to deliver messages that will be persuasive.

In relation to other sanitation practices has been established that hand washing practices are much higher in the presence of others. This is important in terms of behaviour change theory as it affirms the fact that social norms are a high motivator of behaviour change (Jenkins 2007; Jenkins 2005; Larkey 2010; Peal 2010; Riaz 2010; Waterkeyn 2005).

One of the main reasons for my undertaking this research was to satisfy my curiosity about the CLTS approach being used by the RWSSP-WN. I was particularly curious to find out about the level of sensitivity of health promoters using this approach. Although CLTS has its roots in Participatory Rural Appraisal, hence the transect walks, mapping and community discussion, there are some major differences. "The major differences are first, in the focus, PRA have innumerable applications while CLTS concerns one topic and in its classical form has a rough sequence of events, and second in behaviour and attitudes" (Deak 2008:298). While PRA favours a non-confrontational approach, CLTS demands a confrontational approach and deliberately sets out to evoke strong emotional responses. This approach therefore requires more skill from the health promoter, particularly in terms of sensitivity. The main emotion being targeted is disgust, and is believed to be a powerful motivator. As Deak points out, however, this requires special skills of the health promoters, the facilitators, in the programme. These facilitators need to develop an art of being able to provoke, humour and tease, and although confrontational they need at the same time to be sensitive (Deak 2008). The role of disgust is particularly important and requires special attention.

2.7 DISGUST

Disgust plays a pivotal role in the CLTS approach and had the biggest impact on the impressions I gained in Nepal, for this reason additional attention will be given to this phenomenon. Although disgust is a universal phenomenon, there is much that differs in terms of individual and group sensitivity to 'disgusting' stimuli. These differences are determined by factors such as people's current state, past experiences, level of exposure to 'disgusting' experiences, as well as cultural and social norms (Curtis 2009a). Regardless of factors that contribute to these variants, universal cues that trigger a disgust response have been identified. These cues include such matter as bodily wastes, body contents, sexual behaviours, certain foods and so forth (Curtis 2009a). Not the least of these is the bodily waste, faeces.

Theorists addressing the phenomenon 'disgust' have taken some interesting perspectives, some of which are relevant to this research. Mary Douglas talked of dirt and disgust as being products of culture. Of particular note she believed that matter that could elicit disgust are considered 'dirty' and are perceived as 'anomalies'. Within a particular cultural context, anomalies concern objects and events that do not fit with local understandings and are therefore rejected in an attempt to create some sense of social order (Douglas, in Curtis 2009). Other theorists take a more dramatic perspective, Rozin and Haidt propose that disgust originates in the rejection of spoiled foods and also helps cope with existential terror (Rozin and Haidt, in Curtis 2009). Aurel Kolnai talked of disgust as a result of excess and believed it was an indifference to quality and a desire towards death (Kolnai, in Curtis 2009). The psychologist Freud considered disgust a learned reaction, one that could be cultivated toward any activity through development (Phillips et al, in Curtis 2009).

These various theoretical constructs about disgust are very interesting in terms of this research, as some of these suggest that indeed local views and conditions will contribute to the elicitation of disgust. Curtis, an expert on sanitation and hygiene programmes, believes that despite the variability in disgust sensitivity, disgust motivates hygiene behaviour through learned mechanisms (Curtis 2009b). Although Curtis acknowledges the role of learned mechanisms in disgust, she also asserts, from an evolutionary perspective, that disgust and hygienic behaviours predate culture and have served to protect people from disease. This she believes may have important implications in the sense that health promoters need to exercise caution in regard to their use of disgust as it may not always result in desired behavioural responses, particularly at a policy making level. To illustrate this point she cites

situations in public health where quarantine measures have been imposed on 'infectious' people, and this may not always be the best response (Curtis 2007a).

Sjaak van der Geest differs with Curtis in regard to the assertion that disgust predates culture and firmly asserts that disgust is inherently connected to culture. In regard to disgust, drawing on Douglas, he talks of the 'role' that dirt plays in providing an "opportunity for (people) to order their life" (2007:381). Referring to the classification that is given to dirt, he illustrates that the very 'classification' process reinforces boundaries between good and bad, right and wrong, and inclusion and exclusion.

As a 'tool' to be used in hygiene programmes, the emotion of disgust, has been tested in a study in Australia that sought to determine whether or not this would promote hand washing. Factors that were found to be determinants also reflect difference in disgust sensitivity, inclusive of gender, habits, social facilitation, modelling, and environmental barriers. The study was primarily an intervention study, and different interventions in various settings were used. One of the interventions was to place disgust eliciting images as well as health messages in public restrooms and compare the hand-washing practices in these places with rest-rooms that had health messages only. Findings strongly indicated that the presence of disgust eliciting images significantly increased hand-washing (Porzig-Drummond 2009). It was stated, "Obviously, cultures differ, and so might reactions to using potentially confronting stimuli in health related campaigns, but this did not appear to be an issue here" (2009:1012).

An interesting perspective on disgust as a powerful social tool was illustrated in the 'Dirty Protest'. The 'Dirty Protest' occurred in Northern Ireland in the late 70s early 80s. It involved Irish Republican Army (IRA) prisoners protesting the treatment they were receiving in prison as well as the prohibition on clothing or any other form of dress that reflected their association with the IRA. The protest was extraordinary in that it powerfully elicited reactions of disgust, as the prisoners chose to live in the midst of their own dirt and body waste. Suggestions were made that this happened in reaction to the historical legacy of the Irish being portrayed as barbaric, savage and dirty, and through this form of protest the Irish literally became shitty and dirty (Aretxaga 1995). The article described the way organised ideas of savagery and civilization are highly significant for determining social boundaries and cultural differentiations (Douglas, in Aretxaga:135).

Another interesting perspective on this form of protest, was the way the 'dirty' protest used the power of 'symbols' to tap into diverse areas of experience. As well as prisoners using

their faecal excreta to protest treatment against them, female prisoners also used menstrual blood, and researchers into the protest believed the action served to “interconnect domains of prison violence, colonial history, unconscious motivation, and gender discourse” (Aretxaga 1995:126). In sum it was felt the ‘Dirty Protest’ simultaneously signalled both rejection and power. It was suggested that excreta on the wall of the cells made visible the hidden history of prison violence.

Another very significant issue in relation to practices and techniques of health promoters, concerns “sensitivity” and I believe deserves special attention. The following section outlines some definitions offered in the literature.

2.8 SENSITIVITY

Given the main research question to find out how sensitive health promoters aiming to prevent the practice of OD, it will be useful to take a look at what is meant by ‘sensitivity’.

Resnicow’s definition of ‘cultural sensitivity’ relates to both ‘surface’ structures and ‘deep’ structures refers to obvious and less obvious structures in a communication context. Surface structures include use of language, people, music, location and clothing in the design and implementation of interventions for specific target groups. These factors are believed to influence the extent to which interventions can be tailored to ‘fit’ the target group. Deep structures refer to cultural, social, historical as well as psychological and environmental influences in the health behaviour of people (Resnicow, et al. 1999; Resnicow, et al. 2000).

‘Interpersonal sensitivity’ is defined by the ability to accurately recall non-verbal behaviour of another person (Hall, et al. 2006). ‘Accurate’ recall involves the ability to correctly interpret non-verbal cues that give information about emotions, roles, relationships, deception and personality (Hall, et al. 2006).

Another definition of cultural sensitivity offered by Foronda states “Cultural sensitivity is employing one’s knowledge, consideration, understanding, respect, and tailoring after realizing awareness of self and others and encountering a diverse group or individual” (2008:210)

Foronda identifies antecedents that ‘set the stage’ for sensitivity to be exercised, these include diversity, awareness and encounter. Differences in beliefs, values and norms for example need to exist, a person needs to be aware of his or her own culture and cultural

perspective and finally an encounter needs to happen in order to 'exercise' sensitivity (Foronda 2008).

In summary, sensitivity in a health promotion context requires the ability to accurately read another's non-verbal behaviour, the use of appropriate verbal and non-verbal communication, inclusive of the use of space and place, that reflect an awareness of the 'other'. It also demands an awareness of environmental influences on behaviours. Additionally, for sensitivity to be practiced it requires an awareness of 'self' and one's own culture and perceptions. Finally, sensitivity also affords a certain respect for another's view, and refrains from passing a judgment of right or wrong.

As a final issue in relation to practices and techniques of health promoters, I would like to go now to another extreme, one that is far from the use of a tool such as 'disgust' but one that is gaining some prominence in health promotion, that of consumer marketing.

2.9 CONSUMER MARKETING

Health promoters are increasingly aware that there are few successes in programmes trying to elicit behaviour change. An aspect of this awareness is that increasing knowledge does not necessarily result in the desired behaviour change. As a result of this realisation health promoters are turning to tactics used in consumer marketing, where the aim is to respond to inner desires and motivations of target audiences (Scott 2007). Although there have been tones of caution, in regard to the place for consumer marketing techniques being employed in health promotion, the approach is seemingly gaining ground and recognised as having a valuable contribution (McDonnell 2009). A study was undertaken in Ghana to determine motivating factors for handwashing with soap. The Ghana Community Water and Sanitation Agency (GCWSA) decided to implement a programme to increase hand washing with soap, using a marketing approach. Key to marketing approaches is the need to understand what drives and motivates 'consumers'. Significantly, this approach is a far cry from approaches that are based on health belief models of behaviour change, such as the Theory of Reasoned Action.

Findings were that, rather than being motivated by health concerns, the strongest motivators were related to nurturance, social acceptance and disgust of faeces and smelly latrines (Scott 2007). Scott echoes what Douglas and van der Geest have to say about 'dirt', in

pointing out “to ordinary people hygiene behaviours are rarely carried out for health related reasons. Factors such as wishing to appear attractive, smell good, remove dirty contaminating matter from ones life or protecting children ... ” (2007:226). Although the disciplines of anthropology and commercial marketing are a far cry from each other, perhaps there is this one common element in the aim to find out what it is that makes people living in communities ‘tick and click’. In the Ghanaian study, using commercial marketing techniques, in-depth interviews were conducted with the key aim of finding out key motivations for soap use and handwashing (Scott 2007).

As the above example illustrates, there is little doubt that health promoters can learn something from commercial marketers. Curtis and her colleagues, summed up the key lessons the following way: “(1) understand consumer motivation, (2) employ 1 single unifying idea, (3) plan for effective reach, (4) ensure effectiveness before national launch” (2007:63). These key lessons were a summed up following an extensive research in Ghana, looking at ways to increase the habit of handwashing with soap. A concerted effort was made at a national scale and implicitly decided to incorporate consumer research and up-to-date consumer marketing skills. A priority was to understand the consumer, this enabled programme planners to then use ideas generated by the consumer that would have the greatest impact and feasibility. Significantly, health and germs were not mentioned, rather the decision was made to use the wording “something invisible on hands”. Outlining what health promoting programmes could learn from the private marketing sector, the following main principles were identified: the consumer is central to marketing; probe for deep motivations of behaviour; focus on deep emotional triggers to achieve behaviour change (Curtis 2007b). Another lesson was to narrow the target audience to the most receptive group. Further, the importance of testing, retesting and revision of materials to be used in the campaign. One of the most significant findings was that standard health education has a tendency to blame people for their dirtiness and supposed ignorance. Whereas marketing approaches were seen to dignify the consumer by placing him or her at the centre of the communication effort (Curtis 2007b).

These findings are significant for community-led and community participatory approaches, as they seem to avoid the victim blaming that is so often inherent in health education approaches.

CHAPTER 3: FIELDWORK

3.1 NEPAL

Nepal is has a population of close to 27 million, and is divided into 5 developmental regions, 14 zones and 75 districts. 75 districts comprise a total of 3915 village development committees (VDCs). 85% of the population lives in villages, with about 70% of population dependent on agriculture. Rural unemployment is very high and this is thought to directly associated with high levels of landlessness. The landless status, particularly Dahlit communities in the Terai, is leaving little physical space to build toilets ((SCNSA) 2009).



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Toilet coverage in 1990 was merely 6 percent, in years from then until now, coverage has risen to 40 percent ((SCNSA) 2009). It is important to note here, however, that ‘toilet coverage’ does not have any direct relation to the practice of OD. Also important to note here, is the “prominent gap between access to sanitation (40 percent) and water supply (80 percent). About one third of the 75 districts have sanitation coverage below 20 percent ((SCNSA) 2009). Most affected are children and women among disadvantaged communities. This results in the death of nearly 13,000 children under the age of five each year, due to diarrhoeal disease.

Another contributing factor to the poverty level is the ethnic composition of communities. Although now officially prohibited, the traditional four-tiered hierarchical caste system has contributed significantly to state policies as well as to social and economic interactions within communities. The two higher caste groups, Brahmin and Chhetri, generally remain in a relatively affluent and powerfully advantaged position ((SCNSA) 2009). The problem of landlessness is particularly acute for the lowest caste groups, generically referred to as Dahlit, and especially those living in the Terai region. The issue of landlessness is a major factor frequently cited in reference to the difficulty such groups have in building toilets, this was clear in both the literature and in reasons given during my field trip to Nepal. This issue brings into the light one aspect of the importance of political will for programmes aiming to

prevent the practice of open defaecation. It has been proposed that VDCs could play an important role in allocating land as public spaces that could be used for poor households to build toilets ((SCNSA) 2009).

The impact of tourism and in particular processes of globalization on Nepalese society has been studied by Guneratne. His study highlights the way these processes impact on local cultural practices and reshape existing systems of thought. He draws attention to the caste system and the impact that tourism is having on traditional expressions of caste. The generally accepted caste system was officially overthrown in the early 50s. Since this overthrow, Nepali people view relationships differently to how they did under the previously enforced caste system. In Nepal today the conceptualizing of relationships can no longer be usefully described within the traditional caste system. Guneratne proposes that notions of modernity or backwardness are now more significant than issues of class (Guneratne 2001). These concepts of backwardness or modernity are reinforced in the dynamic relationships that occur for Nepali tourist guides. These relationships can be seen as triangular, relationships between the tourist guide and the tourist, as well as the relationship between the guide and people in the villages that tourists are guided through. The tourist guide with his or her affiliated status with the tourist is frequently perceived as 'modern' and the people in the villages as 'backward'. Guneratne suggests that notions of 'backwardness' are replacing former group attributes of class and notions of purity and pollution.

These suggestions of Guneratne resonate with Cummins assertion that 'place' is a dynamic concept and needs to be thought of in relational terms with existing reciprocal and reinforcing relationships between people and place (Cummins, et al. 2007). In relation to this research, awareness of these concepts were expressed when visiting one of the hill region villages, where it was claimed ODF status had been relatively easy to attain, one reason offered was that the village had a number of migrant workers. I think what significant is that the worker expressing this demonstrated an understanding of the impact that migrant workers had on the community's ODF status. The implication being that these workers had been exposed to other cultures where OD was not practiced and were transporting some of these ideas back to the village.

Although written over 20 years ago, the results of Linda Stone's research into Primary Health Care (PHC) in Nepal is still relevant. She addressed the relationship between particular sociocultural factors and PHC activities (1986). The findings of her research reveal the contradictory situation between the "stated PHC intentions to address local interests and

promote community participation ... and the actual approach ..." (1986:293). She attributes the difficulties that PHC is encountering in Nepal to the following three main reasons: a) Failure of PHC providers to appreciate existing values and perceived needs of villagers, b) the existing views of PHC providers toward people in the villages tend to be very negative portraying them as resistant to education, c) the false belief of PHC providers that villagers passively value traditional medical practices (Stone 1986). Findings indicated the PHC emphasis on health education over curative services is at odds with the wishes of villagers in Nepal. The finding was that these villagers value curative care more than health education. The general impression was that PHC was failing to provide what villagers most wanted and what the health education they were offering was primarily perceived as unneeded and irrelevant.

Results of research in the villages indicated that there was social pressure to move the health worker from an educative role into more of a 'curative' doctor role. As well from the perspective of the health worker in a village context, there is more prestige and personal satisfaction gained when the role is curative as opposed to delivering unwanted health messages (Stone 1986). The recommendation was made to view culture in a manner that attempts to understand local medical beliefs and practices within the context of the lives of the villagers. The example given related to latrine construction and the suggestion that it might be more appropriate to promote latrine building with ideas about ritual pollution, rather than the more alien idea of 'cleanliness'.

The research took a look at the dynamics that occur between the villagers and people in 'care giving' roles. The finding was that quite a lot of bargaining takes place which involves the negotiation of health care and gives a strong sense of participation. Significantly, it was found that it is a fundamental and pervasive notion in Central Nepal that successful treatment is often dependent on the quality of the personal relationship between client and healer (Stone 1986).

In relation to the prime focus of this research, namely the sensitivity of health promoters to local views and conditions, it will be helpful to take a brief look at existing beliefs about causes of diarrhoea. A research was carried out to find out existing perceptions of diarrhoeal diseases and practices in Nepal (Stapleton 1989). One of the most important findings was that diarrhoea was not considered very important nor potentially life threatening. The predominant belief was that it was caused by natural as opposed to supernatural causes. Most prominent, was the belief teething was the main cause in babies. Included in the

beliefs, but not very prominent was the awareness that dirty water and incorrect diet can contribute to diarrhoea (Stapleton 1989).

To complete this brief section on Nepal, a challenge has been made in regard to the gender focus of most sanitation and hygiene programmes. The suggestion being that all gender groups need to be involved, and specifically men. The concern was that most programmes target women and overlook the role that men often have in communities. In terms of male roles in the community reference was made to their decision making, control of finance, help they give to women, and acting as ‘models’ in the community (Krukkert 2010). The challenge was presented in the Asia Hygiene Practitioners' Workshop, and recommendations were made that hygiene programmes need to ensure that men are not overlooked when programmes are engaging with communities in Nepal.

3.2 RURAL WATER SUPPLY & SANITATION PROJECT – WESTERN NEPAL (RWSSP-WN)

The RWSSP-WN is supporting the Government of Nepal in its aim to achieve access to sanitation facilities by all in 2017. RWSSP-WN operates in nine of Nepal’s 75 districts, eight of which are in the Western region and one in Mid Western Region.

Before moving on, it will be helpful to give a little background information in regard to the political and cultural environment in which the RWSSP are working. The two geographical areas in which they work are the hills and the lowlands of the Terai. During my visit, I was able to visit both areas. It was repeatedly voiced that the area presenting the most difficulty was the Terai region.

According to my understanding the Terai region is politically and culturally the most complex and diverse region in Nepal. The main reason cited for this is the high level of cultural diversity in the region. Culturally, it consists of three major cultural groups the Tharu, Madhesi and Pahadi. The Tharu are considered to be the ‘real’ indigenous people of the Terai, having been there for the longest period of time, they are also the minority. The



Illustration 1: RWSSP-WN Logo

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Madhesi are also considered to be indigenous Terai, but are not originally from this region, having migrated over hundreds of years from Uttar Pradesh, India. Quite often the Tharu and Madhesi are grouped together. An image depicting them as backward, and less educated than most other Nepali's is quite prevalent. They are widely considered to be unfairly discriminated against by the Pahadi. The Pahadi are a migrant group having, over more recent years migrated into the region from the hill regions. They are generally considered to be educated and well off and are recognised for coming into the Terai and dominating the Madhesi and taking over land.

It was in January of this year, when I was in Nepal to facilitate a training course, that I had my first introduction to the RWSSP-WN. I was able to make a brief visit to their offices in Pokhara and the first person, I met was Arto Suominen, the Chief Technical Advisor of the RWSSP-WN. I was given a warm and friendly reception and was particularly impressed by Arto's awareness of the situation in Nepal. Amongst other, impressions the most vivid recollection I have is when Arto, spoke of the fact that latrine use for many communities is a completely foreign idea, and actually quite a disagreeable thought for many, who perceive the notion of defaecating within a small four walled room to be extremely offensive. His proposal was that open-air latrines are an option that may be more acceptable for these communities and his comment later "... my idea is not taking ground ... People claim that due to heavy winds in the Terai my idea is not sustainable. I personally think this is only 'engineers perception' but not really Terai people' perception" reflects the high level of sensitivity he has to local views. This meeting set the tone for what I was to encounter within the RWSSP-WN project level, people that are enthusiastic for change and aware of perceptions about latrines of people in their population.

When I went back to Nepal for my fieldtrip visit coincided with ongoing political tensions and the nationwide *Bandh* (Illustration 2). To complicate matters further, Arto was unexpectedly admitted to a hospital with an acute medical condition. Despite it not being possible to use the office space for fear of reprisals, the staff at the head office did their very best to assist me with my research. The first interview with Chhabi Goudel, the RWSSP-WN Health and Sanitation Specialist, was held under a tree at the hospital where Arto had been admitted, the following



Illustration 2 : Bandh Pokhara

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two days I was invited into the homes of both Chhabi and Sangita, the RWSSP-WN Gender Expert. They extended the usual warm Nepalese hospitality and willingly allowed me to interview them at length about the project. Theme's that emerged during these two interviews were recurrent in following interviews with other staff from the head office: the strong support for a no subsidy approach, the five triggering tools and the push to 'create demand' among the communities being targeted. The use of the 'five triggering tools' was enthusiastically described, and the majority of project staff interviewed spoke of the dramatic effect these tools are having in terms of 'triggering' behaviour change.

One of the most noticeable characteristics of the RWSSP-WN is the high level of enthusiasm and dedication of its staff. An illustration of the high level of enthusiasm and dedication was evident in my first week during the nationwide *Bandh*. As was pointed out earlier this *Bandh* paralyzed transport throughout the country. Despite the lack of transport, Chhabi was determined to help me and to make sure I could still visit some of the community's targeted by the project. He began to make plans for us to trek into some of the community's in the hills. The trek would have taken at least 10 hours. Although trekking is nowhere near as big a deal for a Nepali as it is for an unfit New Zealander like me, it is still not by any means a daily occurrence. This is particularly so for Nepali's involved in projects that have four wheel drives that take them into the more remote villages. To me this clearly illustrated Chhabi's enthusiasm for the project. Luckily for me, the *Bandh* was called off and we managed to drive up to the village in the four wheel drive!

One of the most striking impressions, of the RWSSP-WN, is their conviction of the value in the 'creation of demand' for toilets among their targeted communities. There was quite some talk of the fact that it is against the principles of CLTS to even use the word toilet, let alone suggest that one be built. The conviction is that emphasis needs to be placed on behaviour change through eliciting disgust and creating an awareness of the contagion effect of OD. The belief is that this will result in communities 'wanting' toilets and not being coerced into constructing them.



Illustration 3: A frequent sight on RWSSP-WN journeys

Let me take you on a brief journey with the RWSSP-WN. The four wheel drive took us to a village in the hills



Illustration 4: Welcome ceremony

and involved driving over some roads that, for me, were quite hair raising. A few times I commented that I had to close my eyes, not wanting to look down the sheer cliff faces that the vehicle was driving along, to which Sangita laughing replied, “*this is nothing, it is a ‘highway’ compared to many roads we have to drive over*”. These staff are regularly having to travel to remote places and in doing so frequently put their lives at risk with the treacherous driving conditions (Illustration 3). When we arrived close to the village, we were taken to a roadside kiosk, where the staff was warmly welcomed by locals who served us lunch. After lunch we took about 15 - 20 minutes to walk into the village, and again, there was a very warm reception. This involved a line of women with garlands flowers and tikka was pasted on our foreheads to give us a traditional welcome (Illustration 4).

After this traditional welcome we were taken on a tour of the village. I have visited many villages in low-income countries, but this village was different to any I had seen before. Most striking was the cleanliness, and presence of rubbish containers and plastic bags nailed to trees (Illustrations 5,6) . Before starting with a mass meeting, we were taken to visit some homes that had recently constructed latrines. The pride and visible pleasure of the villagers was clearly evident. There may be a number of factors to account for this, it could have been



will **Illustrations 5, 6**

all staged as they knew we were coming, it may have been a one off effort to have the place looking impressive for the visitors, or it really was an impressive display of real change in sanitary conditions in the village. I would need to pay another unexpected visit I guess to really know the answer, but regardless of explanations, it was truly impressive. Responses given in the mass meeting be described in the next chapter.

Finally, to characterize the RWSSP-WN, I would describe the organization as highly motivated, enthusiastic for change, but not at the expense of sensitivity to local views and conditions.

3.3 FIELDWORK DATA

The data gathered on this fieldwork was the result of no less than six in-depth interviews, seven FGDs, 37 questionnaires and direct observation. Although most information collected came from health promoters, supported by the RWSS-WN, additional information was gathered as a result of informal and semi-formal conversations

with Nepalese friends whom I believed to have a sound knowledge of health promotion. I was privileged, due to the willingness and enthusiastic support of the RWSSP-WN staff, to visit diverse communities in both the Terai and in the hills. Despite the limited time I had in Nepal, I believe the opportunity I was given to visit such diverse communities and interview a variety of people gave me a good insight into the efforts of health promoters in Nepal.

A significant aspect of the programme to note here is that although the RWSSP-WN have drawn heavily on the principles of CLTS as developed by Kamal Kar, they have adapted the approach in a way ensures the approach is tailored to fit the Nepali situation. They have altered the an acronym CLTS to the Community-Led Total Behavioural Change in Sanitation (CLTBCS). The underlying belief is that this more accurately reflects the people oriented emphasis of behaviour change as opposed to provision of hardware. It needs to be noted as well that the programme is not solely focused on the prevention of OD, but maintains a focus on five key sanitation behaviours. These key behaviours are:

1. Hand washing with soap or cleaning agent
2. Safe disposal of faeces
3. Safe handling and treatment of household drinking water
4. Regular nail cutting, bathing, cloth washing, daily combing and proper tooth brushing
5. Proper waste management in and out of home.

Significantly, the approach for achieving this is called Small Doable Action (SDA), which are perceived as feasible, effective and will act as a stepping stone to other sanitation practices (Goudel 2009).

3.3.1 CHARACTERISTICS OF HEALTH PROMOTERS

- *What are the characteristics of the health workers in the programme?*
- *Who are they?*

Before describing the characteristics of health promoters it will be helpful to clarify the different categories of workers. There seemed to be four main groups, those at an administrative RWSSP-WN project level; those Lead Total Behavioural Change Facilitators (LTBCFs) employed by the District Development Council on a contract basis; District Water

Sanitation and Hygiene (WASH) Advisors, paid by the projects, one per district; and Triggerers Village District Council (VDC) volunteers trained by the LTBCFs to conduct triggering exercises in the community. It is important to be clear here about the distinction between RWSSP-WN project staff and the other health promoters. WASH Advisors are directly employed and paid by the RWSSP-WN. The other two categories, the LTBCFs and Triggerers, are not directly employed by the RWSSP-WN, but rather are supported by the project in their various capacities within the districts or villages where they work.

RWSSP-WN Project staff

The project staff, that I met, were predominantly male, middle aged and Nepali, of Brahmin or Chhetri descent. Exceptions were the two Finnish staff members, Arto, the Chief Technical Advisor, and Eva the Junior Technical Advisor, and Sangita the female Nepalese Gender Inclusion and Social Mobilization Expert for the programme. For the official project staff composition see Appendix 5. For the composition of LTBCFs see Appendix 6.

Generally, I believe the project level staff are very sensitive and observing their interactions in the villages we visited they were certainly received well. There were some hints of frustration among the LTBCFs, however, due to local government politics. The appointment of LTBCFs is by local government officials and occasionally results in the appointment of people that are not always the most sensitive to local views and conditions.

Interviews with RWSSP-WN staff, however, indicated sensitivity to local views and conditions. This was voiced through the following comments:

- Interview with Chhabi: (The following the response given in answer to a question about the one of the triggering tools being used in the communities).

Chhabi:

“And they do this mapping of everything ... the river the forests, houses and number of toilet, number of people everything ... and then there is one scenarios of that community and ... sometimes they come and they sit and they can also discuss there and how that OD ... open shit comes to involve this place ... has come there ..

Fiona: ... and do you think ... there are many big differences between the hilly region and Terai ... did you have to make changes within Nepal with the way you do your trigger training?

Chhabi: Yes this is very different areas very different geography, culture, different society ... the level of people ... yes many things are different the language is also different ... and yes ... this in our experience we found it somehow easier in the hill district to convince the people than the Terai ... In Terai because they don't have enough land and they have a different family system and the culture in Terai, is very deeply ... how to say this ... very different ... if the daughter-in-law uses the toilet ... and his father in-law he will not go And newly married girl she cannot go to defaecate during the daytime...

Fiona: (asking about the selection of 'triggerers') ... and what are the criteria for triggerers ...

Chhabi: The triggerers, the main criteria is their motivation and interest ... and we didn't give the criteria for their qualification ... for if someone has completed his Master ... his Bachelor ... if he has no interest he cannot be a triggerer ... we look for interest and their influence to others ...

○ Interview with Sangita:

Fiona: ... can you tell me something more about the characteristics ... the type of people that are being selected as triggers ... what sort of people are they? ... are there any special qualities that you look for?

Sangita: yes they should have some special qualities ... actually these are selected from the natural leaders ... like natural leaders who comes forward and that ... and there are some individuals ... like in the hill region there are some female health worker ... since long time they are working with the community ... and they can be the triggerers also because the community they already accepted those peoples ...

Fiona: And Sangita what can you tell me about the actual practice of open defaecation? Can you tell me something about what you believe are the underlying beliefs or what are the circumstances in terms of the environment that lead to that practice or family tradition and how it varies from district to district .. is there anything you can tell me about that?

Sangita: Yes .. well in Terai .. especially in Terai they don't have much land you know .. and it is too hot and so the people they go out for the defaecation like in the jungles ... they have a lot of land outside of that jungles .. If it is too hot it is very difficult to live in a

small places ... and if it is not clean .. and everybody because of that everybody are using the same toilet ... they don't like to .. like yesterday I explained that if the father-in-law uses the same toilet the children cannot use that .. this is a cultural practice ..

- Interview with Bimal: (Operation and Maintenance Management Specialist)

Fiona: What do you think is the main reason for it being so different in the hills and in the Terai?

Bimal: Maybe it is still to be researched ... there is no clear conclusion ... but maybe due to social and custom and ... there are a lot of social issues, custom issues ...

Fiona: One suggestion was that in the Terai people are more individualistic ...whereas in the hills the communities have more of a collective spirit ... and in the hills seemingly people in the villages will listen to more to one leader and if one leader says it the rest will follow ..

Bimal: Yes, and another reason is the case of landlessness ... this is high in the Terai ... If I have no land no space and little land for my home ... there is no way to build toilet ... and ... one house has built toilet within cow shed ..

- Interview with Eva (Junior Technical Advisor)

Fiona: `... You don't need education and you don't need wealth to go to the toilet .. so there is something more .. what is the huge difference do you think in these communities .. (the Hills and the Terai) ...

Eva: One very practical one is they always say they don't have any land .. but then they do also have a lot of fields ... and their communities ... the houses are very close to each other .. so basically they don't have any space there in between the houses ... but surrounding the houses you will have plenty of open fields ... it is actually more convenient for OD in the Terai

To summarise my impression of the characteristics of this group of health promoters within the RWSSP-WN, I would describe them as highly intelligent and well educated. They demonstrated a warmth and level of sensitivity that was clearly appreciated by

people in the villages that we visited, as was evident in the welcome reception we received. They were able to teach me a lot about the practice of open defaecation and talked of this practice in an open and non-judgmental manner.

Lead Total Behaviour Change Facilitators

Generally, this cadre of health promoters seemed less sensitive to local conditions and situations than project level staff. The impression gained from the few FGDs that were held, was that these people are highly motivated and perceive themselves very much as 'change agents'. Many described themselves as social activists. A lot of the responses were characterized by concerns that seemed more *task* oriented than *people* oriented. Although, the responses in the questionnaire indicated more of a concern with finding out about people, the verbal responses indicated more of a concern with task. This was voiced through the following comments in FGDs:

- Fiona: Asked participants to describe their personality

Respondents 1 and 2 and 3: (translated for by Sangita) described themselves as *change agents ... innovator ... able to change the community ...* Respondent 5: *A social activist ...*

Fiona: *Asked what most important role was as a LTBCF, just tell me one role, what is your most important role?*

Answers from at least 4 respondents: *to facilitate change behaviour in community in sanitation and hygiene practices ...*

To summarise my impression of the characteristics of this group of health promoters I would describe them as highly charged with the ambition to bring about behaviour change. In one of the FGDs there were some murmurings of dissatisfaction with their positions. I later learned this due politics at a District level and reflected some insecurities they were feeling about their position within the programme. Overall, they were focused very much on the 'task' of preventing the practice of OD more so than on attempting to understand the reasons why this practice persists.

WASH Officers

I met only a few of these people, one who was a participant in one of the FGDs and the other couple I met during visits either to the RWSSP-WN offices or to the villages. It is therefore difficult to describe them as a 'group'. I can, however, share something of an interview I had with a WASH advisor . The interview was held in a kiosk next to the RWSSP-WN office where we were sharing a lunch. He came across as a very relaxed, easy going person with a good knowledge of the area and the people in the area of his work. The interview focused primarily on criteria that is used before declaring a village ODF. He was able to give a good account of the prerequisites for this declaration, inclusive of:

- A three month minimum period since the beginning of ODF activities
- Every household must have and be using a latrine
- Toilets and latrines must be used 'properly'
- No evidence of OD
- Every institution must have a toilet
- House to house visits are made
- Verification must be made by a neighbouring village or another VDC

Triggerers

These people are community members and already have inside knowledge as to the conditions and situations of the community. In the questionnaire there was a choice, out of two questions, trying to determine whether the main concern was with task or people. A striking difference in the responses from the triggerers compared with project staff or LTBCFs was that they were more open about their concern with 'task' and particularly the female respondents. Perhaps this is explained by the fact that they are already so familiar with the community they do not see the need to understand the people. It is difficult to provide exact quotes here due to the way the meetings were conducted with this group of health promoters. Many of the meetings were very large and required full translation as very few people at this level spoke English. One of the more surprising impressions I had of this group had to do with the role of women. I was led to believe that many women are very submissive and are reduced to a very subservient role, however, in these groups the women were vocal and lively. Many have been selected as 'triggerers' due to the natural leadership qualities they possess.

In terms of ethnic or caste affiliation the 37 health promoters who were given the questionnaire, classified themselves as the following:

Brahmin/Chhetri	24	Marginalized	4
Janjati/Tharu	4	Unknown	3
Finnish	2		

The people with whom I spent the most time in the project were Chhabi and Sangita and they made a very deep impression on me. Both Chhabi and Sangita struck me as highly intelligent people with experience in various fields of health promotion. Chhabi is Brahmin and Sangita is Chhetri, so both these people, due to their birth status, come from relatively privileged backgrounds. Both Brahmin and Chhetri are generally recognised in Nepal as being the better educated and higher socio-economic group within Nepali culture. Although the caste system was officially abolished in the 50s in Nepal, cultural practices and norms, accorded to these caste groups are still fairly widespread and adhered to by the majority of people.

Traditionally Brahmin and Chhetri have strict pollution and purity rules to observe, inclusive of dictates that prohibit them from entering homes of people that fall into what is now generically referred to as Dahlit people, previously known as the 'untouchables'. As well as not being permitted into the homes of these people, formerly it would be unthinkable for a person from the Brahmin or Chhetri caste to accept food or drink offered to them by this people from the Dahlit castes.

To give an illustration of the character of both Chhabi and Sangita, let me take you on one of our visits. Chhabi had organized for me to meet with a group of triggerers in the Terai, and we managed to hold an FGD under the shade of a tree, in Rupendehi district. It was a relatively lively FGD with a number of vocal and animated participants who contributed actively to the discussion. One particularly animated participant was a young Dahlit woman. She spoke passionately about the efforts of her community to attain ODF status and referred to the way she was sometimes derogatorily treated by members of higher classes. She made reference to the fact that even though she was Dahlit, she was human and deserved to be treated as such, and not as an animal. Following the FGD Chhabi and Sangita arranged for us to visit her house and to see the latrine that she had recently constructed in her home. Apparently, in her eagerness to build the latrine, she tore down half of her already very small home, to ensure there was enough space for the latrine. It was with absolute pleasure and

pride that she showed her home and latrine to us. Not only were we taken into the home to see this latrine but she also served us all with water. Chhabi and Sangita sitting on a bed in the home of this woman, without any visible hesitation accepted with gratitude the drink that was offered to us. It was later in the car, that Sangita confided to me that with her upbringing as a Chhetri she still occasionally felt awkward accepting drinks from Dahliit. Despite this awkwardness Sangita did not in any visible way, to me at least, display any sign of hesitation.

Although the caste system is a completely foreign way of living for me, I could still appreciate, that Sangita and Chhabi's 'habitus' is such that they had to struggle with a disposition that would have, in previous circumstances, forbidden them from accepting this hospitality. This small example spoke volumes of the character of these people, one of sensitivity and openness to change and an eagerness to encourage and support people's efforts to prevent OD. Although, the example provided here concerns Chhabi and Sangita, the behaviour they exhibited in this situation is quite reflective of the character of others in the RWSSP-WN.

Generally, the health promoters I met, interviewed and held discussions with were sensitive to the views of local people about the practice of OD and appeared to pass no particularly strong judgment toward these people.

3.3.2 KNOWLEDGE, ATTITUDES AND SOCIOCULTURAL AWARENESS OF HEALTH PROMOTERS

Most of the health promoters were able to give explanations as to why they believed practice of OD was happening and were able to identify factors that they believed contributed to the difficulty in preventing it. Most frequent were the comments that it was lack of awareness or poverty. In line with explanations related to poverty were explanations that latrines were seen as an unnecessary luxury. These comments by far exceeded any other explanations and were given by all groups of health workers. Many respondents talked about the fact that for many people existing toilets or latrines are too smelly and dirty, and the option of defaecating in the open is much more appealing. Another frequent explanation was that this practice is 'traditional', has been practiced by fathers and forefathers, who had no problem with it so there is no reason it should stop. Cultural explanations were also offered quite frequently, particularly in relation to in-laws being

prohibited from using the same defaecation places. In particular, a daughter-in-law should not use the same place as her father in-law.



Illustration 7: Triggerers Poster Presentation - Reasons for OD

Less frequent but important explanations included the awareness of faeces being considered good fertilizer. Interestingly the majority the people giving this information were almost all 'triggerers', those in the project that are living in many of the targeted communities. Among the CLTBCFs there was awareness of some religious dictates about the location of toilets or latrines in relation to places of worship. The point was made that in Hinduism latrines or toilets should not be above temples, and most Hindu homes have designated places of worship in their homes. Additionally, some people spoke of the fact that places of defaecation should not be in close vicinity to people's homes. More unusual explanations offered were that this practice is considered a 'social activity', especially for women. Mention was made of women making excuses to leave the home together in search of firewood or some other product, and use this time collectively to defaecate in the 'jungles' and chat together (illustration 7).

Generally, there was a much more negative attitude toward people in the Terai and in particular the Madhesi people where the prevailing attitude expressed frustration at the difficulty encountered when trying to prevent this practice with these people. Most of the information gathered about this 'problem' was generated in either interviews or FGDs with project level staff or LTBCFs. I did not feel very comfortable discussing this with the triggerers. All were villagers themselves, either from the Terai or the hills, and I felt it would not be appropriate to discuss these perceived difficulties with them.

Most of explanations offered, by both RWSSP-WN staff and District level LTBCFs, were that the Madhesi communities are more 'backward', 'less educated', 'landless' and 'living in crowded conditions'. The prevailing attitude toward the Madhesi was that they were much more resistant to change. In contrast, the Pahadi communities also known as the 'Migrant communities', were portrayed in a very positive light and the general image was of communities that were much more 'advanced', 'well educated', generally more 'open to change'.

Arto offered an explanation in regard to the perceived resistance of the Madhesi. He asserted that the negative perception is mere 'talk' or 'fear' as there has been limited involvement with the Madhesi. He did state, however, that he "... agree(d) to some extent that the attitude with Madhesi resistance is not because they do not want toilet, but because they want to 'get something' more in return if they start using the toilet. They are more businesslike people. I feel strongly that they see sanitation more as their right ... which should be provided to them by the government. In Pahadi community they ... do things by themselves. In Madhesi community they used to do things ordered by the landlord. For Madhesi it is more 'land lord' (presently the government) responsibility to give them toilets".

RWSSP-WN project staff, as well as the LTBCFs talked a lot about problems of landlessness and lack of space in the Terai. The 'lack of space' refers mostly to areas where there is housing. In the Terai 'residential' areas are densely populated with houses all very close to each other with little space to build latrines, however, in neighbouring fields there is plenty open space that is inviting for OD.

Health promoters, at both RWSSP-WN project level and LTBCFs, talked in a sympathetic manner about the difficulty many villages had with access to water. It was reported that in the hill regions this resulted in some villages having to trek for kilometers from as early as two or three in the morning to go and collect water, in the dry season.

Difficulties imposed by poverty, landlessness and inadequate water supply, was talked about among the triggerers in a manner that was considerably more animated and expressed frustration. In one of the FGDs with a Madhesi, Muslim community, there was a rare display of anger, when one female participant became visibly angry when the discussion turned to cost effectiveness of building latrines. Sangita was explaining the economic gains to be made once latrines would be built and used, stating that there would be much less

expenditure on health costs. One of the women reacted, almost explosively, insinuating that health workers did not have an appreciation of how poor and desperate their situation was.

3.3.3 PRACTICES

Practices of health promoters in the programme in terms of their 'focus' seems to be determined by their position in the programme. People in the administrative level, of the project seem much more focused on 'people' than 'task'. Other health promoters, namely the district level LTBCFs and Triggerers seem much more 'task' oriented. This was reflected in some of the answers offered when questioned about the reasons they were working in the programme. Staff in administrative positions offered answers such as, to *'create demand'*, *'increase motivation of target group'*, and it's a *'community led process, sustainability, pace and quality are set by the community'*. The LTBCFs and Triggerers, seemed driven by a 'zeal' to implement the ignition tools developed by Kamal. In response to the same question answers included, *'Use of the Ignition Participatory Rural Appraisal (IPRA) tools make them realize they are eating shit'*, to achieve *'ODF declaration'*, to encourage *'Total Behavioural Change (TBC)'*, to encourage *'care in personal hygiene'*.

There is little doubt that practices of health promoters across all levels of staff, is dominated by the use of the triggering tools developed by Kamal Kar. The tool most widely talked of was the 'glass of water technique' as it was felt this particular exercise had the most impact in terms of 'igniting' people and making them realize they were 'eating shit'. The other triggering tools, the transect walk and the mapping exercises were also spoken about enthusiastically. What seemed especially effective was the tracing of 'who' was responsible for the OD to the extent they would calculate quantities of shit being produced. It is through these techniques that messages of contamination are being produced. In terms of the predominant Hindu religious culture, this strikes a chord with observations of ritual purity and pollution. According to the majority of respondents this is having a major impact.

The other major aspect of the programme is the anti-subsidy stance, and this is being framed very much in terms of it promoting a sense of ownership and self-respect. The 'creation' of demand from the perspective of the health promoter is believed to lead to better sustainability. If people have been brought to a place where they are 'wanting' toilets and latrines, rather than having them provided regardless of any desire, it is believed they will be maintained well and will result in sustainable behaviour change.

The 'content' of messages was difficult to assess in that there is actually very little emphasis on health education per se. This I believe reflects insight that increasing knowledge alone does not result in behaviour change, but rather recognition is given to the value in creating demand. The CLTS approach encourages 'ignition' and 'triggering' of behaviours through literally mapping areas of defaecation and calculating quantities of shit and its eventual consumption by the community. In regard to the literature that had been read for this research this was surprising. Seemingly, the more people were aware of the contamination effects of 'shit' the more they were willing to change their hygiene practices.

In relation to 'health education' I would like to share with you an issue that was raised by one of the LTBCFs in the first FGD that was held. When the discussion focused on content and delivery of health messages, one of the participants, spoke with concern about 'case studies' that were being used in the programme. He voiced concern that many of the successful case studies being used referred to Pahadi and this was problematic for Madhesi people who felt they could not relate to this. Significantly, the CLTBF making this comment was himself a Madhesi, and the only LTBCF Madhesi who happened to be present in the FGD. Speaking about this later with Eva, and expressing my surprise that there were so few Madhesi LTBCFs, she pointed out the difficulty the programme has in recruiting these people. Not only do too few Madhesi apply to be LTBCFs, there is also the complication of political influence in appointing health workers to the programme.

OPEN DEFAECATION FREE (ODF) DECLARATION

A major 'practice' in the CLTS approach is the declaration of Open Defaecation Free (ODF) villages. This practice left me with some reservations about its appropriateness. During my last week in Nepal, I was fortunate to be able to attend one of these declarations. I have attended long and elaborate ceremonies in both Nigeria and Indonesia, however, this ceremony in terms of time and richness, far exceeded anything I have experienced before.

The ceremony began in the early hours of the day and was still not finished when we left at 1600. As we drove to the place where the ceremony was to take place we passed scores of colourfully clad women and children parading through fields and on the country roads with placards (Illustrations 9,10). I was told the placards were full of slogans such as: "Our village is open defaecation free", "In our house we have a toilet, we are proud", "We are civilized we do not open defaecate".



Illustrations 9, 10 “Walk of pride”

When we arrived close to the place where the ceremony was to take place we waited under the shade of a tree, in the intense heat of the Terai, for at least an hour waiting for the musicians to arrive. Musicians are generally Dahlit people and are assigned the job of providing music for various occasions. Whilst waiting we were pasted with tikka, on our foreheads and given garlands of flowers. When the musicians arrived the dancing began (Illustration 11) and we were lead in a procession into the place where the ceremony would take place.



ODF Placards



Illustration 11: ODF Ceremony – dancing begins



Illustration 12: ODF Official Ceremony

On arrival at the ceremony grounds we were greeted, once again, with a tikka ceremony, and along with project staff we were lavished with more tikka and garlands. We were lead into grounds that had a large tarpaulin with at least 300 people, we were escorted to the shade of a tree where a makeshift podium had been erected. Then the waiting began, we waited for up to four hours for the arrival of dignitaries, inclusive of local politicians and members for the District Development Council (DDC). During the waiting time a few speeches were made by various people involved in the prevention of OD campaign. The crowd were visibly tired, fidgety, with faces that were not hard to read, they were becoming bored. Once the dignitaries arrived, the official ceremony began, with drama and dance (Illustration 12). The crowd were transformed into an active, enthusiastic and cheerful one. Most striking was the impact of the drama. It certainly demonstrated visibly the principles of “narrative theory”. A drama was performed by a group of young people. It involved the story of local people, including a local drunk, traditional healer, as well as health workers and an issue of open defaecation (Illustrations 13,14). The audience reaction was remarkable, they became lively, riveted on the drama and full of laughter. Despite my lack of Nepali, it was clear that the audience connected with the story and the characters in the story, they were completely absorbed in what was happening on the stage.



Illustrations 13, 14: Children - Agents of change

I have no doubt that of all the activities that happened that day the narrative told through the medium of a drama had the most impact and would have the greatest recall. The audience

was “carried away” and I am sure the most talked about event of the day will have been the drama.

3.3.4 GENERAL IMPRESSIONS

Overall, the impression I had of RWSSP-WN health promoters practices was that they are highly motivated and convinced about the effectiveness of the CLTS approach. They seem to be implementing this approach in a manner that reflects a high level of awareness of local views and conditions in the communities they target. The reception given, by the several communities we visited, was warm and welcoming, a good indicator of the way in which the practices of these people is being received.



Illustration 15: Wall in Pahadi Village, Terai

The three weeks I was able to spend in Nepal, despite the first week having to contend with the nationwide *Bandh*, were able to be spent productively. The RWSSP-WN had willingly organized and facilitated not only visits to communities (Illustrations 15, 16, 17), but a number of interviews, FGDs and the distribution of the questionnaires. The health promoters were eager to share their positive experiences using the CLTS approach and were certainly very convinced of its effectiveness and appropriateness. The manner in which they interacted with people from all levels,

community members, officials at both the District Development Committee (DDC) and Village Development Committee (VDC) level displayed a high level of sensitivity, willingness to listen and an eagerness to learn from these people.



Illustration 16: FGD Rupendehi



Illustration 17: Madhesi Community

3.3.5 RWSSP-WN Project Staff:



Chhabi



Sangita



Eva



Chhabi visiting a village recently declared ODF

CHAPTER 4: DISCUSSION

In the discussion findings in the literature will be compared with findings in the fieldwork in Nepal, and where appropriate convergence and divergence will be addressed. Headings used in the discussion reflect the structure used in the literature search and in the fieldwork and research questions. Main discussion points will fall under the following headings, Anthropological and sociological perspectives, Community participatory approaches, Characteristics of health promoters, Knowledge, attitude and sociocultural awareness of health promoters, Disgust, and Sensitivity. The section will finish with conclusions and recommendations.

4.1 ANTHROPOLOGICAL AND SOCIOLOGICAL PERSPECTIVES

‘Matter out of place’

Anthropological literature affirms that defaecation practices are inherently related to notions of dirt. Mary Douglas’s concept of dirt defines it as ‘matter out of place’. She also offers an analysis of the way dirt works and asserts that people’s efforts to shun dirt should be understood as an attempt to create social order (1966). Ortner explores pollution practices of the Sherpa and makes the observation that pollution practices serve as a charter for the caste system (1973). Beall described the dynamics occurring between the different classes or castes and how they provide a means to reinforce social positions (2006). Elaborating on this notion, Das describes the way social classes and categories enforce rules that dictate inclusion or exclusion (2006). Van der Geest addresses the ‘social character of dirt’ and describes it as a social phenomenon that provides information about the status and social position of its producer (van der Geest 2007). Anthropological perspectives on dirt firmly assert the symbolic significance inherent in this concept.



Evidence of the social significance of dirt was evident during my short field trip to Nepal. One of the most vivid impressions reflecting this was during a visit to the home of a young Dahlit (outcast) woman who had recently built a latrine in her home (Illustration 18) . It was clearly inferred by one of the project leaders during that visit that her social status in the village had increased significantly since she built the toilet. Although she

Illustration 18: No longer an 'outcast'

would remain a 'Dahli' due to her birth, her status had changed considerably and she would no longer be 'shunned' by the community.

This was also echoed in the FGDs and in-depth interviews where a large number of respondents replied affirmatively to a question about whether or not people's social status had increased since building latrines. One of the answers given in the questionnaire, in reference to the practice of OD, stated, "The people who do have knowledge about it and they want to introduce themselves as a high quality person of the community ...". When interviewing Eva, the Junior Technical Advisor to the RWSSP-WN, about latrines and social status, she had the following to say, " ... if you go to the village you will always find that the richest person in the village will definitely have a toilet .. so it is kind of a status symbol even in the villages ..."

Habitus and 'Habitual'

Bourdieu's concept of 'Habitus' describes the impact of personal histories and the way these histories determine particular practices and at both an individual and collective level. He went on to say that personal history can end up being more influential in our 'practices' than formal rules explicit norms (Bourdieu 1990). He described the way 'practices' of people provided a 'relational analysis' of social tastes, inferring that people's practices can be 'markers' of people's social status. Habitus he asserted, doesn't function in a strict sense as a set of rules, but rather operates at a subconscious level .



and

Illustration 19: 'Taken for Granted'

Observations made during my brief visit to Nepal and from the literature reflect a lot of what Bourdieu was referring to here. Indeed the very fact that people refer to the 'practice' of open defaecation infers that this is something that occurs without deliberation (Illustration 19). He proposes that the orchestration of habitus, where people's lives and experiences are harmonized, results in the production of a 'common sense world' giving rise to the term 'taken for granted' (2008:80). Results from the questionnaires, responses in the in-depth interviews and in the FGDs frequently referred to the practice of open defaecation being a 'habit' or a traditional family practice. Of the 37 questionnaires that were completed, no less than 22 responded this way. Some of the answers were as follows, "It is a practice that can

change”, “*A habit that can change*”, “*Generations before have done it, so why not me?*”, “*It’s a traditional belief*” and “*A traditional way of thinking of defaecating in the jungles*”. A few other responses alluded to Bourdieu’s inference that ‘practices’ serve as ‘markers’ of social position, when they responded that “*toilets or latrines are seen an unnecessary luxury*”.

Symbolic meanings of dirt and disorder

Important lessons can be drawn here with regard to health promotion efforts, as van der Geest asserts, “Dirt and cleanliness have a wide cultural significance, including respect and moral implications. Avoidance of dirt cannot be reduced to rational medical action ... this does not mean ... that dirt is unrelated to health and sickness” (2009:184). Obviously, dirt continues to take a central role in explanations of illness and sickness, however, the broader significance and socio and economic implications inherent in attitudes to ‘dirt’ and sanitation and hygiene practices need to be carefully considered in health promotion efforts.

Reference was made in the literature review to a study undertaken in Pakistan to address dynamics involved in waste management. Findings revealed the powerful way notions of dirt and pollution serve to reinforce social positions and in particular the way the execution of ‘impure’ tasks by one group of people serves to maintain the purity status of another (Beall 2006). During the writing of this thesis there was a nationwide strike of waste disposal workers in The Netherlands and the situation clearly echoed the findings of the study in Pakistan, illustrating how dynamics involved in waste management reflect symbolic meanings of dirt and disorder (Beall 2006). Lower class’ waste workers were in a position where they are able to reverse occupational roles in terms of exercising control and power. This reflects the threat of ‘disorder’ imposed by matter out of place, rubbish should be in bins and disposed of, not left lying around train station platforms. Although this discussion has to do with waste management, it reflects the dynamics and social and cultural implications of ‘dirt’ to which defaecation is inherently connected. Because of this ‘dirt’ being ‘out of place’ and deliberately left in places that would offend and ‘disgust’ people, power was being exercised by ‘lower class’ workers that usually are rendered powerless in their working environment by people holding ‘higher class’ positions.

Using my experiences in Nepal to illustrate this, I would like to share part of a discussion in one of the FGDs. The FGD was being held with ‘triggerers’ from one of the Terai districts. The topic in the discussion turned to a village that wanted to be declared ODF. One of the women in the discussion came from this village and became very angry with another

member of the group from a neighbouring village. She accused people from the neighbouring village for sabotaging the chances of her village being declared ODF as she believed villagers from there were coming and deliberately open defaecating in her village. It was one of the rare occasions in one of the FGDs where there was such a visible display of anger. The accusation demonstrated the impact and role that 'dirt' and 'pollution' beliefs have on social relations.

Actor Network Theory

Actor Network Theory (ANT), developed by Latour and Callon, addresses the simultaneous relationship that exists between 'things' and 'concepts'. Using the example of a laboratory, and the relationship that develops between the laboratory and 'others', he shows how it is potentially affected by the destabilizing role of microbes. What is striking in relation to this research is the way Latour demonstrated important principles relevant to one of the tools being used in the programme. The tool is the 'glass of water' technique and was stated by the majority of respondents as being the most effective tool to trigger behaviour change. This technique involves a group from the community standing around and watching a thread of hair being passed through some faeces and then dipped in a glass of water. The observers are then asked to drink the water, even though the water 'looks' clean, no one wants to drink it. When asked what they believed was the best way to teach people to stop OD, responses included the following: "To show them they are eating shit" ... *"To teach that we are unknowingly eating our faeces" ... "Eating faeces seeing or without seeing" ... "Make them realize they are eating shit and the health effects of it" ... "By pouring water in the glass and giving it to drink then dipping a hair in faeces and again dipping it into the water of the glass and giving it to drink will be the best way"*.

What Pasteur accomplished, according to Latour, was the ability to make events happening in his laboratory relevant to others worlds. By using the 'glass of water' in a 'public sphere', people are confronted with issues that were previously invisible. Not only the 'contamination' effect of the faeces in a physical sense, but social relations were being brought into play. People engaged in OD are now perceived as not only contaminating themselves but others in the community. Talking of raising community awareness about the impact of OD, Sangita put it this way "... if one person, they don't have a house only that person will suffer ... (but) if one house doesn't have a toilet ... all community will suffer that OD ... and this is the community pressure for that household to build the toilet".

4.2 CULTURAL APPROPRIATENESS OF SANITATION AND HYGIENE PROGRAMMES

Community participatory approaches

From what I have been able to ascertain from the literature, the CLTS approach has stemmed from efforts within programmes to increase the level of community participation. The community participatory approach in many ways testifies to the dissatisfaction that has been felt with programmes that have had a bio-medical approach. Sociology has been one of the major drives behind this critique. The belief being that these programmes have ignored factors in the environment and conditions in which people live, that contribute to the health status of people. Additionally, sociology has been critical of the 'medicalization' of many areas of life, inclusive of pregnancy and birth, alcohol abuse, crime and immigration issues. Discourse within health promotion encourages an assessment of 'raw material' being worked with in programmes that aim for behaviour change. 'Raw material' refers to finding out what people mean by health, perceptions about its impact on lives, and beliefs about what they can do about it. The assertion is that it is important to establish knowledge of these factors before behaviour change can be facilitated (Thorogood 2002). Certainly in the literature reviewed for this research and from the impressions I gained in Nepal there seems to be an increasing level of sensitivity of health promoters towards people in programmes aiming to prevent the practice of open defaecation. This was evidenced in the diverse reasons health promoters gave for this practice.

Community participation as means to achieve behaviour change, however, is not without its critiques. In practice no matter how laudable the intentions are, this ambition is seldom reached. An important challenge to community participatory approaches concerns the 'dynamics of the various players' that are involved. Most community participatory programmes fall under the umbrella of a 'development project' and there are frequent power struggles at play among the different stakeholders, not least the outside agencies (Merzel and D'Afflitti 2003). It seems almost a contradiction in terms to promote community ownership when the 'outsiders' have their own agenda to meet, inclusive of the targets that they have set. Eva the RWSSP-WN junior technical advisor put this very well, "*... and for me what I am always thinking is that whether this is a tool ... (CLTS) ... that you can actually apply in a project ... cos we have our targets and everything ... and we are under pressure*

... and sometimes I think that might be the problem also that is not community led sometimes cos we are thinking about our own targets and we are not actually giving the community space ... space that they should need ... like the CLTS says in the guidelines that if the community is not triggered ... if they are not excited then you should just leave it ..."

Another caution extended to the Community Participatory approach concerns the potential for the situation to be politically manipulated. Madan, cited in Linda Stone's article "Cultural Influences in Community Participation in Health" goes so far as to say "Community Participation can be employed to describe euphemistically the manipulation of people by politicians, bureaucrats and technocrats for the purposes which are believed to be for the people's good – and may well be so – but which are conceived by these others in a manner that objectifies and infantilizes people" (Stone 1992). This resonates with the analysis given by James Ferguson of 'development' projects in Lesotho, where he alludes to the creation of problems, or manipulating poverty, as a means to open the door for technical solutions (Ferguson 1994). The challenge boils down to development workers needing to carefully consider 'whose needs are being met', those of the 'community' or those of the 'development agency'?

This finding was reflected in Nepal in the FGDs with Water and Sanitation and Hygiene (WASH) reporters. Translated by Chhabi "*He is saying some of the NGOs working in the district they are declaring the ODF even there is no stopping the OD because they want to show their result but still people are doing the OD ... and this is the situation ... it is not happening in reality but they want to show the result ... in some areas they have put the ODF board, but still in this place we can find the OD area ..."*

Community Led Total Sanitation

The anti-subsidy approach promoted by CLTS is one of the main driving principles and certainly the principle that was most widely cited reason for its success according to most of my respondents in Nepal. The reasons given for its success seem to be particularly pertinent to sanitation projects and in particular the issue of latrine construction. Reasons for the support of an anti-subsidy approach include the fact that a sense of ownership is heightened if people have had to pay for a product, experience has shown that maintenance and use of the product is better if it has been paid for by the user, and that subsidies are often vulnerable to capture by the 'elite' (Kar 2006). This approach finds some support by Easterly, where he claims if poor people make even a modest contribution to the provision of health

services, it results in more accountability and better quality care. This claim is based on the belief that if poor people have had to make a financial contribution, they will certainly put the pressure on to make sure their demands are met (Easterly 2006). This claim of Easterly's was challenged by a Public Health specialist and health economist working for the Royal Tropical Institute in Amsterdam. He says there is increasing criticism for this 'fashionable' talk of out-of-pocket expenses for poor people. Apparently, from a health financing perspective it is evident that out-of-the-pocket expenses are found to be regressive as poor people are not coming forward for treatment at all and is widening the gap between the rich and the poor (Personal Communication, Post 2010).

It seems, however, that when it comes to sanitation projects and especially the provision of 'hardware' that the anti-subsidy support has a lot of support and not least because of it ensuring proper use of latrines. Whilst in Nepal there were numerous accounts given in the FGDs and in interviews of situations where subsidies were given previously and it resulted in latrines being misused. Some latrines were used for storage, some were not even used. Sangita told the following story in an interview with her, "*...and we start to find they are not using the toilets properly ... while they build and they don't use the toilet ... and they are putting all in there sometimes ... and the other problem is that giving incentives they will get some money and they will build the toilet ... and they don't use the toilet ...*"

Another finding in both the literature and in Nepal in regard to the spin off effects of preventing the practice of open defaecation, is that it was helping to prevent some of the dangers women were having to face. The risk was not only due to safety issues of having to walk long distances and in the dark to defaecate, but also due to some cultural expectations. Amongst some of the communities in the Terai, it was reported that women, particularly newly married women, are not allowed to defaecate during the day. This has obvious negative implications for their health as due to this restriction they are severely restricting their intake of food, which results in a number of illnesses related to poor nutritional status. This was repeatedly mentioned in FGDs and in some of the in-depth interviews. The spin off effect is that it has been proposed that the construction of latrines is preventing women having to take these long distance treks from their homes and may help prevent the pressure to wait until it is dark.

There was, however, a divergent view also expressed about this from a Nepali friend of mine, Bina. Bina has extensive experience working as a child and women's rights activist. When I talked with her about the finding in the FGDs and interviews that many women were

practicing OD as they were not permitted to use the same latrine or toilet as men, she offered an insightful explanation. She said that it was a reasonable choice as it is not uncommon for sexual abuse of women to take place in toilets and latrines, so she could understand that for some women OD seemed a safer option.

The principle of using children as agents of change was evident in Nepal. I was opportune, during a visit to a village in the Hills to have a rather elaborate looking latrine pointed out to me. I was informed that it had been constructed by the 12 year old son of a widow living in the village. He constructed the latrine very soon after some 'triggering' activities had happened in his village.

4.3 CHARACTERISTICS OF HEALTH PROMOTERS

Very little description was given in the literature that was reviewed to characterize health promoters in sanitation and hygiene projects. The general 'tone' of the literature read, however, suggested that health promoters are increasingly aware of the need to be sensitive to local views and conditions. It needs to be noted, however, that there is still a tendency in many health promoting projects to medicalize sanitation and hygiene and push for increasing awareness about faecal oral contamination. This focus appeared more important than finding out as much as possible about local views and conditions that contribute to this practice. There were few explanations about the practice of OD in the literature. The most I learned was gathered during my time in Nepal, demonstrating that in Nepal there appeared to be a higher level of sensitivity than what was evident in the literature. Health promoters in Nepal appeared to have looked for underlying reasons for this practice and this effort I believe testifies the openness and sensitivity of these health promoters.

4.4 KNOWLEDGE, ATTITUDE AND SOCIOCULTURAL AWARENESS OF HEALTH PROMOTERS

Endeavouring to find out about existing knowledge attitudes and awareness of health promoters, amongst other findings, lead to literature that described new perceptions of 'place'. What was particularly striking about the findings in the literature, compared to findings in Nepal relates to the 'dynamic nature' of place, and that it is constantly changing and being reformed due to the flows of capital, culture and people. One of our visits in Nepal took us to a village in the hills, the very impressive village with all the

rubbish baskets, plastics nailed to tree's and almost one hundred percent coverage with latrines. As we were walking through the village, one of the RWSSP-WN health promoters made the comment that there were many men from the village who were migrant workers. Most migrant workers from Nepal go to the Middle East to work. Although, I am not sure of the sanitary conditions in the places where they work, I am quite sure it would be vastly different from the hills villages, that until recently had no latrines at all. The implication, in the statement made by the health worker, was that these migrant workers were not only affecting the economic status of the village, but that they were returning with new ideas about living standards, inclusive of sanitation and hygiene behaviours.

Included in the section about knowledge, attitude and awareness of health promoters was an article that brought attention to the influence of historical legacy, on people's interaction with others and current health status of people. This was reflected in Nepal in accounts of the history of tensions between the Madhesi and the Pahadi. From what I could gather many Madhesi feel excluded or further discriminated against due a history that has witnessed Pahadi coming into the Terai from the hills and dominating the Madhesi people. Bina shared a poignant story to illustrate the dominance of the Pahadi over the Madhesi. She recounted a story told by her father, that the Pahadi would come into the Terai and make an agreement with Madhesi, that they could have land to plant pumpkin, and whatever land the pumpkin covered would become Pahadi land. The insinuation in the story, was that the Pahadi were clever and cunning and able to trick the Madhesi, who in their 'ignorance' did not know the rapid rate of growth of pumpkin, and unknowingly conceded to giving away hectares of land. There is little doubt that this legacy is having an impact on the current status of the Madhesi and perceptions of them as being 'backward', 'ignorant', 'more resistant to change', and 'less educated'. Health promoters need to be sensitive to historical influences that are obviously contributing to negative perceptions of this group of people.

4.5 DISGUST

There is little doubt that the pivotal mechanism driving the CLTS approach is the eliciting of disgust. From an anthropological perspective this tool is very interesting in regard to the way disgust and disgust sensitivity is connected to culture and social norms. It therefore becomes a powerful 'behaviour change tool'.

An unusual demonstration, related to the power of disgust, in the literature review concerned the "Dirty Protest" in an Irish prison and the use of disgust to symbolically express messages.

Through smearing faeces on walls messages about the British perceptions of the 'shitty Irish' were being conveyed. This struck a cord with me in terms of findings in Nepal, although completely opposite messages were being conveyed through the use of symbols. When we visited some villages that had been declared ODF, most of the latrines that had been



constructed, had blue flags erected above the latrines (Illustration 20). These flags made visible feelings of pride and modernity associated with the construction of these latrines.



**Illustration 20: Blue flags above toilets
- symbol of pride**

4.5 SENSITIVITY

There is no doubt that it is important to convey respect for another's views, but how should this 'respect' be conveyed if the views held by another have been proven to be detrimental to their own health and that of others? Perhaps, this is what makes the CLTS approach very interesting, as the aim is not to 'preach' or even 'teach', but rather to confront people with their defaecation practices and hope this confrontation, leads them to a place where they pass their own judgment on the practice.

The important lesson to be learned, in regard to the sensitivity required in sanitation and hygiene projects, is that health promoters avoid 'medicalizing' problems. I believe there is a parallel here in regard to Ferguson's analysis of development projects in Lesotho. Unintentionally, development projects can create problems that require 'solutions'. As Ferguson portrayed in Lesotho problems were created that required 'technical solutions'. In much the same way there is a danger in medicalizing some hygiene practices creating

problems that require solutions that only the sanitation experts can provide. The practice of open defaecation is persisting in many instances for very sound reasons, inclusive of it being a good form of fertilization, a much cleaner option for many people and a safer option and these need to be taken seriously.

4.6 CONCLUSIONS AND RECOMMENDATIONS

Efforts to prevent the practice of open defaecation demand that health promoters are sensitive to local views and conditions. This is evident in the literature and has been confirmed in my findings in Nepal. Literature widely supports and promotes the use of participatory approaches in sanitation and hygiene as well as other health promotion efforts. Inherent is the assumption that active participation from community members in programmes enhances chances that interventions are tailored to meet the needs of the community and reflect the perceived needs of the community. Complementary to community participation, seems to be the support being attributed to the use of Community Health Clubs. Additionally, community participation is believed to enhance a sense of ownership and in doing so increases the chance of efforts being successful and sustainable.

There were, however, tones of caution in the literature that 'community participation' per se, is no guarantee that efforts will be successful. Success, in addition to community participatory approaches, is believed to be dependent on the extent to which formative research is carried out and an emphasis on changing social norms.

The challenge to reconsider the concept of 'place' and its influence on health behaviours is important when considering 'social norms'. It was pointed out that 'place' is not something static nor physically bound, but involves mutual and reinforcing relationships between people and place, and is influenced by the impact of 'flows' of people and capital that in turn constantly reshape social norms.

Other emergent themes, and some surprising ones, drew attention to issues such as the historical legacy of disadvantaged communities and the impact of child care practices on the hygiene and sanitation status of communities. Additionally, the need to solicit political support often determines levels of success in programmes.

The basic assumption of this research is that sensitivity of health promoters to local views and conditions will enhance efforts to prevent the practice of open defaecation. It is important to stress the word 'enhance', it is very clear from both literature and impressions that I gained

in Nepal, that there is no 'blueprint'. Health promotion efforts to change health related practices, frequently concern health issues that are also 'social diseases' and this is why anthropological and sociological perspectives caution against the tendency to 'medicalize' approaches.

To be culturally sensitive, is no guarantee for success, in fact Farmer argues it may be a hindrance as people strive to be 'culturally sensitive', they may miss the mark in terms of meeting the needs of 'destitute' sick (Farmer 1997).

Sensitivity needs also to be exercised in regard to conditions in which people live, inclusive of physical, social, historical and economic factors. Additionally, health promoters need to be acutely aware of their own 'baggage', inclusive of their own cultural, social and political perceptions.

In regard to Nepal, I believe the CLTS approach being used there demonstrates a high level of sensitivity of health promoters, particularly the RWSSP-WN staff. Not only did they demonstrate an awareness of local views and conditions, they actively respected the people they were working with and appeared to have an awareness of the influence of their own cultural perceptions about the practice of OD.

I believe, however, there is a need in the 'difficult' areas of the Madhesi communities that both the content and delivery of messages be more culturally appropriate. Given the history between the Madhesi and the Pahadi it is clear that messages and programme activities need to be more sensitive to existing tensions. From what I could gather many Madhesi feel excluded or further discriminated against as much of the material used or case studies given are Pahadi oriented. I have reservations about the formal ODF declarations and would be a little concerned that these may in fact reinforce tensions as most villages that have achieved ODF status to date are Pahadi. Although, a certain degree of competitiveness may be healthy to generate behaviour change, caution needs to be exercised to ensure this does not backfire.

Open defaecation is a practice that has persisted for generations for multiple reasons, it is often a cleaner, easier and logical option, especially for poor people living in rural areas. Despite the reasons for this practice persisting, there is ample evidence that it contributes to the high levels of morbidity and mortality of children due to the contraction of diarrheal diseases. It is a practice that needs to be prevented where possible.

I would like to conclude with a quote from van der Geest, “The anxiety and discomfort felt about excrement, combined with their attraction and fascination, represent a crucial anthropological paradox: the curious cultural taming of what appears to us as wild and uncontrolled ... we should not underestimate the disciplinary power that culture produces” (van der Geest 2007:321). I believe indeed it is the ‘disciplinary power’ of culture that provides so much impact in the radical CLTS approach. If culture did not exercise such discipline this approach would have no impact. It is through eliciting of disgust the CLTS method is able to tap into cultural mechanisms, particularly disciplinary power, that will enhance the chances of behaviour change.

Finally, I am very grateful I had the opportunity to visit Nepal and the RWSSP-WN project there, as without this I would not have been able to deduce much from the literature and certainly would have made much less sense of what I was reading.

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APPENDICES

Appendix 1:

QUESTIONNAIRE FGD PARTICIPANTS

PERSONAL

Age:

Sex:

Marital Status:

Ethnicity:

Religion:

Highest level of education:

Occupation:

1. List three words below that you believe describe your personality:

2. Can you please tell me something more about yourself in one sentence.

3. Please tick the sentence below that best describes the way you feel about your work in the programme:

- I think the most important thing is to find out who is practicing open defaecation and where they are doing it and then do all I can to stop this happening.
- I think the most important thing is to find out as much as I can about the people in the villages where I work and what the reasons are for them practicing open defaecation.

PROJECT

4. Can you please write below what you think is the most important aspect of the training you are giving:

OPEN DEFAECATION

5. Which of the following describes best what you believe about the practice of open defaecation (OD) (you can tick more than one answer)

6. Can you please describe below the way you feel about people who practice OD

7. Can you tell me something about the practice of hand washing with or without soap among the people you work with in the villages:

- a.
- b.
- c.
- d.

8. Please list, in order of importance, the reasons why you think OD happens:

9. Can you please tell me why people OD happens:

VILLAGE AWARENESS

10. Using the space below can you please describe the most important things you know about the villages in which you work.

HEALTH MESSAGES

11. Please write below the most important message you believe needs to be given to people who practice OD

12. What do you believe is the best way to teach people to stop OD? Why?

Please add any comments that you believe are important for people to know about the CLTBC programme?

Your help in this research is very much appreciated, many thanks, Fiona

QUESTIONNAIRE RWSS-WN PROJECT STAFF

PERSONAL

Age:

Sex:

Marital Status:

Ethnicity:

Religion:

Highest level of education:

Occupation:

1. List three words below that you believe describe your personality:

2. Can you please tell me something more about yourself in one sentence.

3. Please tick the sentence below that best describes the way you feel about your work in the programme:

- I think the most important thing is to ensure the 'triggers' find out who is practicing open defaecation and where they are doing it and then do all they can to stop this happening.
- I think the most important thing is that 'triggers' find out as much as they can about the people in the villages where they work and what the reasons are for people there to practice open defaecation.

PROJECT

- 4. Can you please write below what you think is the most important aspect of the RWSS-WN CLTBC project:

OPEN DEFAECATION

- 5. Can you please write three sentences below that best describes what you believe about the practice of open defaecation (OD) (you can tick more than one answer)

- 6. Can you please describe below the way you feel about people who practice OD

- 7. Please list, in order of importance, the reasons why you think OD happens:

8. Can you tell me something about the practice of hand washing with or without soap among the people you work with in the villages:

9. Can you please write below three reasons that you think prevent the people from the practice of washing hands at critical times:

VILLAGE AWARENESS

10. Using the space below can you please describe the most important things you know about the villages and the people in the villages where the 'triggers' are working.

HEALTH MESSAGES

11. Please write below the most important message you believe needs to be given to people who practice OD

12. What do you believe is the best way to teach people to stop OD? Why?

Please add any comments in the space below that you believe are important for people to know about the CLTBC programme?

Your help in this research is very much appreciated, many thanks, Fiona

IN-DEPTH INTERVIEW QUESTION GUIDELINE

<i>DATE</i>	<i>IDI</i>	<i>THEME</i>	<i>QUESTION</i>	<i>VERBAL RESPONSES</i>	<i>NON VERBAL RESPONSE</i>	<i>OTHER COMMENTS</i>
		PROFILE OF PROJECT STAFF	What can you tell me about yourself? - What can you tell me about the various cultures of the people you are targeting in this programme? - Why did you join this programme? - Can you tell me about your beliefs concerning OD? - Have these beliefs changed since you joined the programme? - What do you believe is your most important role in the programme?			

		TARGET AUDIENCE PROFILE?	<p>Can you tell me anything about the way the village/s work/s?</p> <ul style="list-style-type: none"> - Who are the most important people in the village? - Why are they important? - What influence do they have in the village? - What are the most important difficulties people face in this village? - What are the most important issues going on for people in the village? - To what extent do you think these problems/issues affect the aim of CLTBC to prevent OD? - Can you tell me about any beliefs they have about defaecation? And OD? 			
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		OPEN DEFAECATION	<ul style="list-style-type: none"> - What can you tell me about the practice of - OD? - Are there any patterns with regard to who goes where, at what time and with whom, etc - Are there major differences between men/women/children/elderly/adolescent s, etc - Can you tell me any stories that relate to defaecation and especially open defaecation in the villages in which you work? 			
		CLTBC	<p>What can you tell me about CLTBC?</p> <ul style="list-style-type: none"> - What do you believe is the most important thing in CLTBC programmes? Why? <p>What is the main priority of the programme?</p> <p>What is your main priority in the programme?</p> <p>If you were to be in charge of this programme is there anything you would change?</p>			
		GENERAL	Is there anything else you would like to tell me that you think will help me in my research?			

IF TIME PERMITS

- To what extent does OD or latrine use reflect social dynamics? – may be use some diagrams – ask the group to draw a map of the village and indicate places of OD and say something about who/when/why – any potential dangers?
- Social lives of latrines? If they could imagine being latrines having a social life – how would they describe them?
- What methods of training/teaching/communication do they think are the most effective? Why?

FOCUS GROUP DISCUSSION INTERVIEW QUESTION GUIDELINE

<i>DATE</i>	<i>IDI</i>	<i>THEME</i>	<i>QUESTION</i>	<i>VERBAL RESPONSES</i>	<i>NON VERBAL RESPONSE</i>	<i>OTHER COMMENTS</i>
		PROFILE OF 'TRIGGERS'	<ul style="list-style-type: none"> - What do you people have in common? - What do you believe is your most important role in the programme? 			
		TARGET AUDIENCE PROFILE?	<p>Can you tell me anything about the way the village/s work/s?</p> <ul style="list-style-type: none"> - Who are the most important people in the village? - Why are they important? - What influence do they have in the village? - What are the most important difficulties people face in this village? - What are the most important issues going on for people in the village? - To what extent do you think these problems/issues affect the aim of CLTBC to prevent OD? - Can you tell me about any beliefs they have about defaecation? And 			

			OD?			
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		OPEN DEFAECATION	<ul style="list-style-type: none"> - What can you tell me about the practice of OD? - Are there any patterns with regard to who goes where, at what time and with whom, etc - Are there major differences between men/women/children/elderly/adolescents, etc - Can you tell me any stories that relate to defaecation and especially open defaecation in the villages in which you work? - Can you tell me about your beliefs concerning OD? - Have these beliefs changed since you joined the programme? 			
		CLTBC	What can you tell me about CLTBC?			
			<ul style="list-style-type: none"> - What do you believe is the most important aspect of CLTBC programmes? Why? - What is the main priority of the programme? - What is your main priority in the programme? - Do you believe this programme helps villages in other ways? Ie increasing school attendance, increasing productivity, etc 			

			- If you were to be in charge of this programme is there anything you would change?			
		GENERAL	Is there anything else you would like to tell me that you think will help me in my research? My main research question is ...			

IF TIME PERMITS

- To what extent does OD or latrine use reflect social dynamics? – may be use some diagrams – ask the group to draw a map of the village and indicate places of OD and say something about who/when/why – any potential dangers?
- Social lives of latrines? If they could imagine being latrines having a social life – how would they describe them?
- What methods of training/teaching/communication do they think are the most effective? Why?

Appendix 2: Literature Search – Results

KEYWORD/ CONCEPT	DATA BASE	Field	Boolean	Ltd to	Hits	Select	Reason for exclusion
“Open Defaecation”	PubMed (PM)	All			0		
”	Web of Science (WoS)	All			0		
“	Cochrane Library (CL)	All			0		
“	Science Direct (SD)	All			44	21	Title irrelevant
“	ERIC	All			0		
“Sanitation and hygiene”	PM	All			0		
			And behaviour		279		
			And Diarrhoea		74		
			And Community		30		
“	WoS	All			549		Title irrelevant
				And behaviour	47	30	
“	CL	All	And behaviour 3		14	5	Title irrelevant
“	SD	All	And behaviour 255	Social science 362	9,251		
	ERIC	All			152		

KEYWORD/ CONCEPT	DATA BASE	Field	Boolean	Ltd to	Hits	Select	Reason for exclusion
			And behaviour/behavior		13	0	Titles irrelevant
Diarrhoea And Health promotion And Health education	PM	All			142		
“	PM	Abstract			43		
“			Not breast feeding		22	5	Title irrelevant
“	Web of science	Topic			22		
“	Cochran e Library	All			18	1	Title irrelevant
“	Science direct	All			5.925		
“	Science Direct	All	And cultural Not health care,woman,primary health,western medicine, health status,breastfeeding,h ealth service,infant feeding,psychological distress, child mortality,infant mortality,maternal education,community	Social science	383		

			health,oral rehydration				
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KEYWORD/ CONCEPT	DATA BASE	Field	Boolean	Ltd to	Hits	Select	Reason for exclusion
Diarrhoea And Health promotion And Health education			And Sociocultural and behavioural		57	3	Title irrelevant
“	ERIC				1	1	
Faecal oral contamination	PM	All			197		
			And Health education		8	2	Titles irrelevant
	WoS	Topic			44		
			And health education		2	1	
	CL						
	SD			SS	33	9	Titles irrelevant
	ERIC				0		
Designing health messages	PM	All			85		
			And diarrhoea		0		
			And cultural		19	6	Titles irrelevant
	WoS	Topic			49	25	Titles irrelevant
	CL	All			25		
	SD	All			6	3	Titles

KEYWORD/ CONCEPT	DATA BASE	Field	Boolean	Ltd to	Hits	Select	Reason for exclusion
Designing health messages	ERIC	All			10	4	
Behaviour change	PM	All			73644		
			And latrines		2		
			And latrines and diarrhoea		3	3	
	WoS				45233		
			And latrines		8	8	
			And latrines and diarrhoea		2	0	Duplicates
			And defaecation		0		
	CL				1179		
			And latrines		1	1	
			And latrines and diarrhoea		0		
			And defaecation/defecation		0		
	SD				4183		
			And latrines		26	11	
	ERIC				11		
Defaecation practices	PM	All	Or defecation		78	31	
	WoS	Topic	Or defecation		8	0	Duplicates
	CL	All	Or defecation		0		
	SD	All	Or defecation		34	17	Duplicates or irrelevant
	ERIC	All			0		

KEYWORD/ CONCEPT	DATA BASE	Field	Boolean	Ltd to	Hits	Select	Reason for exclusion
“Cultural sensitivity in health education”	PM	All			553		
			Not MRSA Not Clinical Not Care		174	33	Title
	WoS	All			0		
	CL	All			0		
	SD	Topic			2	0	Irrelevant
		All	“Cultural sensitivity” And “Health Education”		84	13	Title
	ERIC	All			22	11	Title
Attitude and health workers	PM	All			0		
	WoS				7	7	
	CL	All			0		
				“Health workers” And Attitude	21		
	SD	Topic			62	10	Journal title article title

KEYWORD/ CONCEPT	DATA BASE	Field	Boolean	Ltd to	Hits	Select	Reason for exclusion
Attitude of health workers	ERIC				0		ERIC
			Health workers And Attitude		31	1	
Latrine acceptance	PM				0		
			Latrine and Acceptance		10	5	
	WoS				0		
			Latrine and Acceptance		0		
	CL				0		
	SD				359		
			Not water supply Not World Bank Not World health Not schistomiasis	Social science and medicine Habitat international Public Health Transactions of the Royal Society of Tropical Medicine and Hygiene	41		
			Not refugee Not art Not AIDS Not postpartum amenorrhea		37	13	Title
	ERIC				0		

KEYWORD/ CONCEPT	DATA BASE	Field	Boolean	Ltd to	Hits	Select	Reason for exclusion
"Toilet habits"	PubMed	All			114		
			And belief		3	1	Title
	Web of Science				0		
	Cochrane Library				5	0	Title irrelevant
	Science direct				182		
					Social Science and medicine Science of the total environment	135	3
	ERIC				28	4	
Defaecation/ defecation	PubMed		And beliefs		73		
			Not irritable, psychiatric, shigellosis, drugs		56	11	
	Web of science		And beliefs		3	0	Title irrelevant
	Cochrane library				17	0	

KEYWORD/ CONCEPT	DATA BASE	Field	Boolean	Ltd to	Hits	Select	Reason for exclusion
Defaecation/ defecation	SD		And beliefs		99		
				Social Science and Medicine Habitat international Public Health World Development	66		
			Not hook worm, nappy changing, quadrant, obstetric practice, parasitic disease, personalised relation, port dickson, prescribing behavior, problem related		25	25	
	ERIC		And beliefs		0		
Cleanliness and beliefs	PM				93		
			Not nurses, bacteriological		83		
			Not hospitals		77	14	Titles irrelevant
	WoS				0		
	CL				0		
	SD				0		
	ERIC				0		

KEYWORD/ CONCEPT	DATA BASE	Field	Boolean	Ltd to	Hits	Select	Reason for exclusion
Excreta disposal	PM		And disposal		126		
			Not ascariasis, parasitic, schistomiasis, pentachlorophenate, shigella		103	42	Title
	WoS				0		
	CL						
	SD				0		
	ERIC				3	0	
Dirt	PM		And Culture		41	11	Titles
	WoS		And culture		30	6	Titles
	CL		And culture		1		
	SD		And culture	Social sciences	0		
				All journals	0		
	ERIC		And culture		6	0	
Health workers	Library of congress		And relationship		0	0	
					17	4	Titles
	PM				84017		
			And relationship		4543		
			And relationship and performance		210		
			And culture		17	2	Titles

KEYWORD/ CONCEPT	DATA BASE	Field	Boolean	Ltd to	Hits	Select	Reason for exclusion
Health workers	WoS	Title/ keywords /abstract			27238		
			And relationship		1950		
			And relationship and performance		146	8	Titles
	CL				421		
			And relationship		162		
			And relationship and culture		25	3	Titles
	SD				3938		
			And relationship		2450		
			And relationship and performance		760		
			And relationship and performance and culture		412		
			NOT world bank, family planning, reproductive health, mental health, nurse	Social science and medicine Public Health Habitat international International Journal of intercultural relationship International Journal of Educational development	91	29	Titles

KEYWORD/ CONCEPT	DATA BASE	Field	Boolean	Ltd to	Hits	Select	Reason for exclusion
Health workers	ERIC				4742		
			And relationship		926		
			And relationship and performance		71		
			And relationship and performance and culture		5	0	
Total behavioural change (TBC)	PM				0		
				Total to date	239552		
“Community led total behavioral change”	PM	All fields			1	0	
“Community led total behavioural change”					0		
Community led total behavioural change (not as quote)					1	0	
Community led total behavioral change (not as quote)					23	6	
“Community led total behavioural/ behavioral	WoS				0	0	

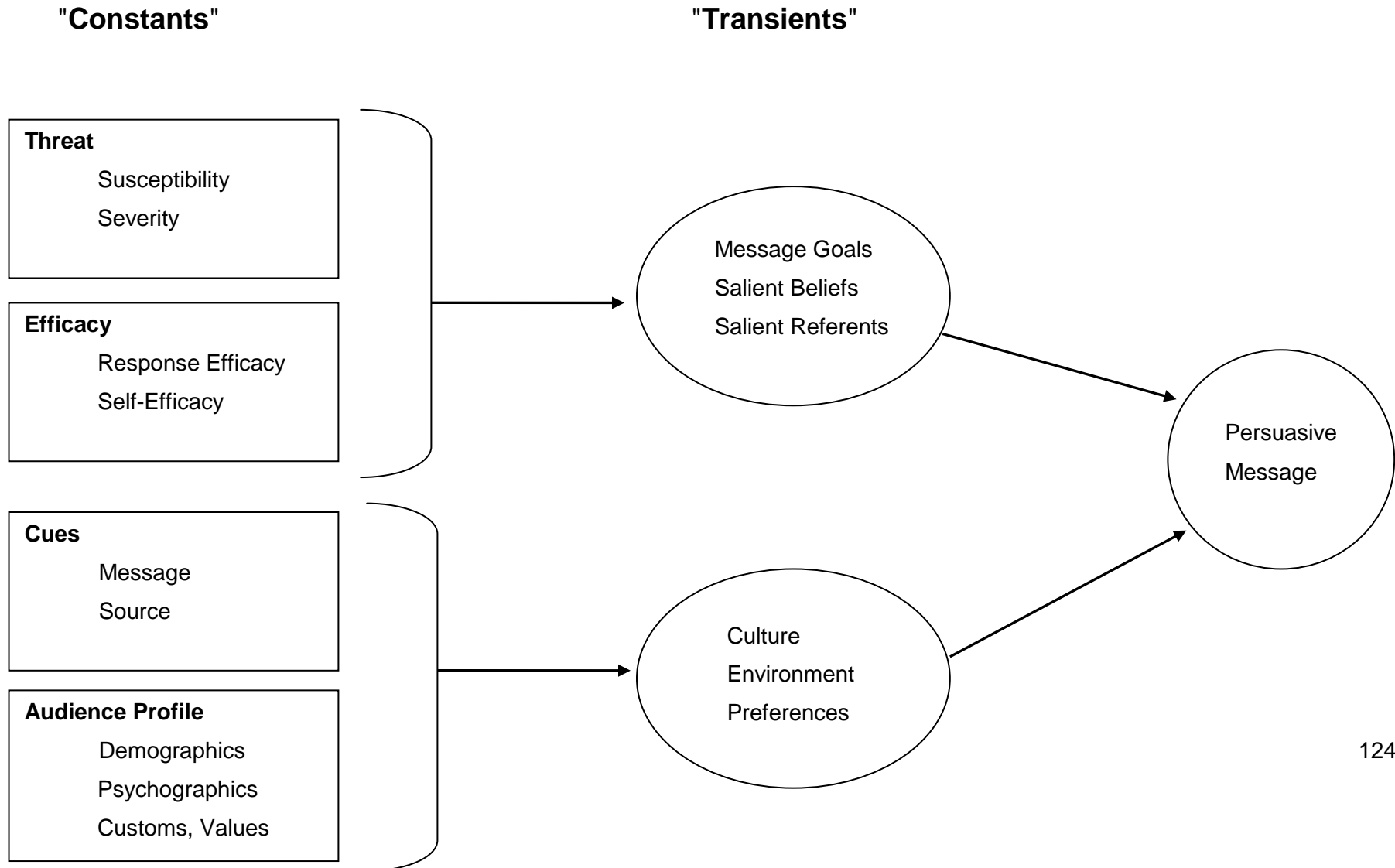
change”							
“Community led total behavioural/ behavioral change”	Cochrane Library				25	4	
KEYWORD/ CONCEPT	DATA BASE	Field	Boolean	Ltd to	Hits	Select	Reason for exclusion
Community led total behavioural/ behavioral change”	SD				0		
	Library of congress				0		
	ERIC				1	0	
	Library of congress				0	0	
	PM						
				Total	277196	453	

Appendix 3: Countries where CLTS has been Implemented (copied from IDS Working Paper 298 – 2008, Deak, A.)

Asia
Bangladesh (Plan, Care, WaterAid, VERC, DIsari, NGO Forum, WSP) India (Government of Maharashtra, Haryana, Himachal Pradesh, WaterAid, WSP) Indonesia (Ministry of Health WSLIC, PCI, AusAid, WSP) Cambodia (UNICEF, Concern Worldwide) Nepal (Plan, WaterAid, NEWAH, UNICEF), Pakistan (IRSP Mardan NWFP, RSPs, WSP) (China (Plan) and Mongolia –unsuccessful)
Africa
Plan RESA (Kenya, Tanzania, Zimbabwe, Uganda, Malawi, Sudan, Zambia, Egypt) Ethiopia –Southern Nations Nationalities and People’s Region (WSP, Health Department, Vita, Plan) Nigeria – WaterAid – they are also planning to roll out in Ghana, Mali, Burkina Faso Interest from Chad, Sierra Leone
Latin America
Bolivia (initial workshop in Dec 06 was also attended by participants from Peru)
Middle East
Yemen – (Yemeni) Social Fund for Development

Appendix 4 : A Framework for Developing Culturally Specific Persuasive Health Messages

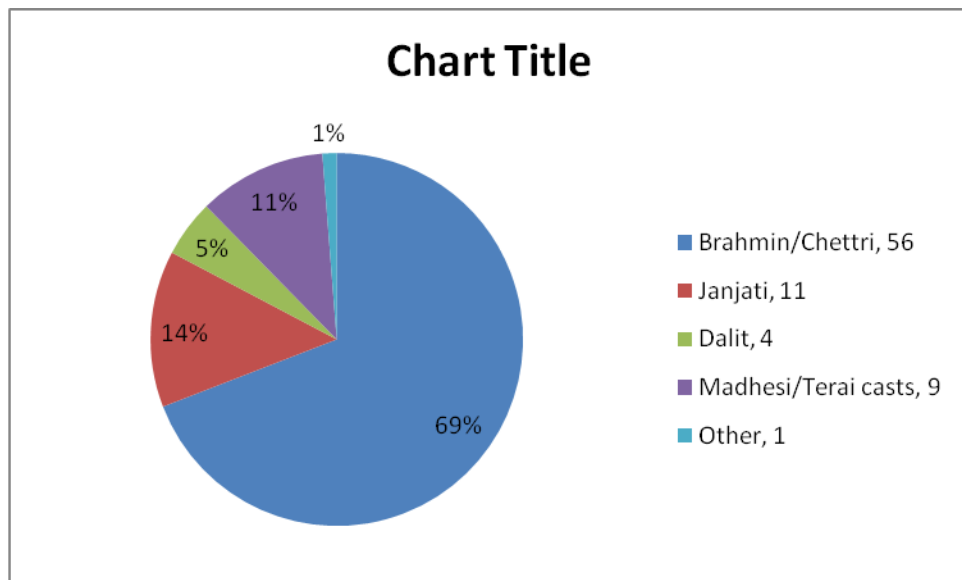
(Source: "Fishing for Success: Using the Persuasive Health Message Framework to Generate Effective Campaign Messages" 1995, Witte, K. in "Designing Health Messages: Approaches from Communication Theory and Public Health Practice")



Appendix 5 : RWSSP-WN Project Staff Composition

Staff	Total	Female No. %(%)	Ethnicity/dalit No. & %	Madeshi No. & %
PCO	4	2(50%)	2(50 %)	0
PSU(Sp.)	8	2(25%)	1(13%)	0
DSA	11	2(18%)	1(9%)	3(27%)
Support Staff	6	3(50%)	3(50%)	0
Drivers	4	0	4(75%)	0
Total	33	9(27%)	11(33%)	3(9%)

Appendix 6 : Composition of LTBCFs



I have been informed the female/male ratio is 48% male 32% female.