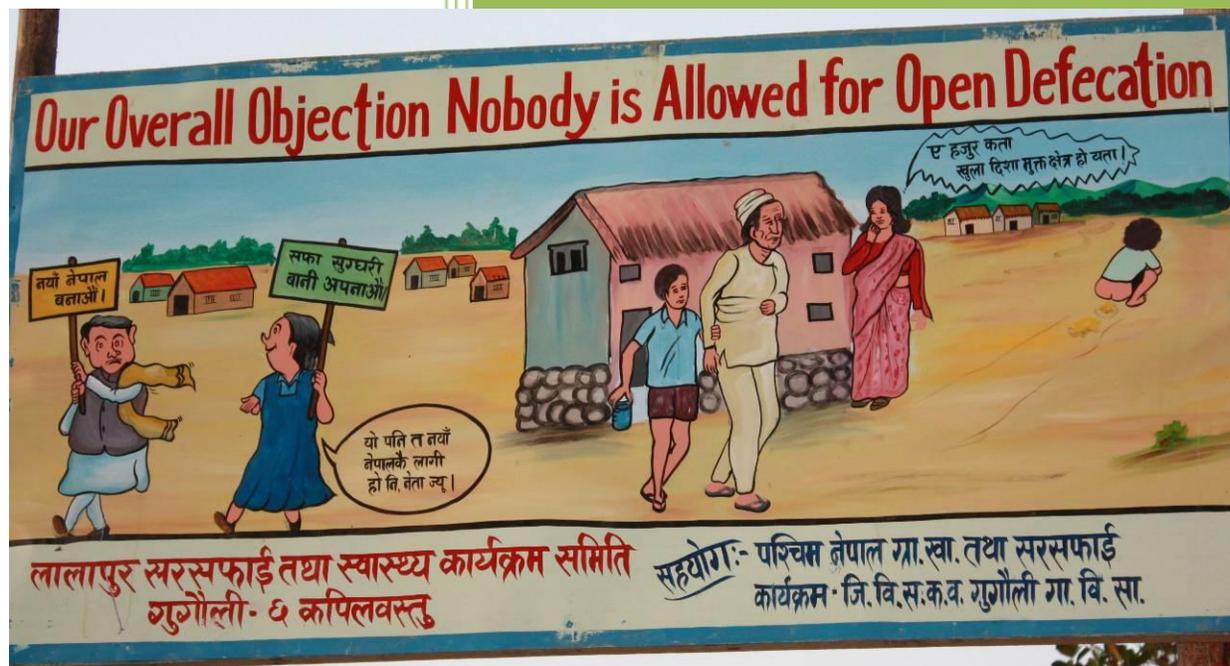


EFFORTS TO PREVENT THE PRACTICE OF OPEN DEFAECATION

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
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 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, within this project, to local views and conditions and compare these to findings in literature.

The approach for this research has been from an anthropological and sociological 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.

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, encouraging those wanting to sell a product or an idea, to build up a profile of their target audience. This profile should include audience demographics, information about such matters as age

distribution, ethnicity, gender, income and education. It also encourages a profile of audience psychographics, information about such matters as prevailing attitudes, beliefs and values.

An anthropological perspective is deeper than this, in its search for 'meanings' of such behaviour, never-the-less the integration of techniques that endeavour 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 and respect for 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 also apparent among the administrative level of the RWSSP-WN.

Much of what was said about this practice 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, believing that subsidies 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 that this approach is having a major impact. It also 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 as well as the 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 will end with my conclusions as well as recommendations to support the notion that sensitivity of health promoters to local views and conditions will enhance efforts to prevent the practice of open defaecation.

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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. Due to loss of earnings because of ill health or needing to care for others this 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).

Therefore, the perspective taken in this thesis is one that will search for meanings underlying the behaviour and practices of people engaged in these programmes.

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, I believe it is important that the reader has some understanding of my own 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 certainly made an impact on my perceptions of sanitation and hygiene practices.

Leprosy historically has been a highly stigmatized disease that, 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 with people affected by Leprosy 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 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 in Nepal. It was my involvement with this course that led to my introduction to the Rural Water Supply and Sanitation Project in Western Nepal (RWSSP-WN). The project was using 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?

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. The period in 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
 - LTBCFs
 - Triggerers
- Informal interviews with Nepali friends whom I believed would have a good knowledge of this topic
- FGDs 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
 - WASH reporters (general 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 all possible because of the enthusiastic support of the RWSSP-WN project 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 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. An initial selection of 49 articles was made. Articles were selected through the following process (Appendix 2):

- i. English only
- ii. Reading the title and abstract
- iii. Reading the entire article

- iv. Eliminating articles without a focus on central themes of interest (Open defaecation, behaviour change, health promotion, design of health messages, context sensitivity)
- v. Reading and analyzing the final selection
- vi. Latterly, bibliographies of these were referred to for further articles
- vii. 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
- viii. 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 be taken 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

As a result of the initial literature review, 49 articles were selected for this study, which were categorized in the following sub-headings:

- Anthropological and Sociological Perspectives;
- Health Promotion;
- Community Participatory Approaches and Community Lead Total Sanitation (CLTS);
- Sanitation and Hygiene Programmes;
- Health Communication and Behaviour Change;
- Disgust;
- Developmental Discourse.

During the course of the review the initial selection expanded and has continued to expand during the process of writing this thesis.

The review will be structured under themes inherent in the research questions and relevant impressions gained in Nepal will be incorporated . 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.

'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 also 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 these people.

Sjaak van der Geest in his ethnographical account "Children and Dirt in Kwahu, Ghana" provides a perspective that highlights the symbolism inherent in concepts of dirt and sanitation. Drawing on Mary Douglas's concept 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 goes on to propose that it is from this vantage point that ideas about health are derived, hence the reference to the term 'disorder' in health discourse (van der Geest 2009).

Moving on from this van der Geest begins to address the 'social character of dirt' and in doing so 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 can become an interpretative tool. The description gives a detailed 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.

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. It became evident that this obsessive concern with cleanliness accounted for why people were reluctant to build toilets in their homes and ensuring they were located on the edge of town (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 is essentially describing the way our personal histories determine particular practices, both individually and collectively, and end up being more influential in our 'practices' than formal rules and explicit norms (Bourdieu 1990).

Bourdieu was also concerned with 'classes' and factors that determined different behaviours of people or more precisely, the practices of people within the various classes. He created a framework that would help 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 may even 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 went on to explain that habitus does not function in a strict sense, 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 even 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 other issues that are relevant to this research. Firstly, although Naipaul is here referring to India, he points out that indeed open defaecation is a widespread practice. Secondly, the places in which it is practiced are also 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 many 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. If, as Douglas asserts, practices such as defaecation are considered 'dirty' or 'polluting' when they happen out of place they may well 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 village.

Symbolic meanings of dirt and disorder

An ethnographic study undertaken among Christian street sweepers in Faisalabad, Pakistan addressed the dynamics involved in waste management. The dynamics occurring between groups of people 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.

To take another perspective on the symbolism inherent in issues related to defaecation and dirt it will be helpful to turn to a study undertaken in Benin. A qualitative study involving 40 households was conducted to determine what motivated people 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). The study was undertaken in rural areas and sought to challenge the consistent 'health related' framing of messages in sanitation programmes. In particular, the study wanted 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). Symbolism that is associated with ownership of objects relates to the connection that exists between 'things' and 'concepts' and will be discussed in the following section.

Finally, in this account the central role that perceptions of dirt and hygiene have in socially marking people is made clear, particularly in terms of position and social relationships. This is most demonstrably evident in the low social rank that 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).

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.

Anthropological contribution to sanitation and hygiene projects

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 this study indicated the more programmes learn about target communities ensures they can be tailored to fit the target audience. Techniques used in the research such as the 'structured walkabout' enabled structured observation of the community.

One major finding of the above study 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). This was reflected in results of the questionnaire given to RWSSP-WN community level staff. Six of the ten respondents cited the fact that faeces are considered good fertilizer, as a major reason for the practice of OD. The study also mentioned socio-cultural taboo's that would dictate who could or couldn't share the latrine and these dictates were determined by social categories, such as in-law relationships (Almedom 1996).

Reflected frequently in the literature is that hand washing practices were 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). These studies 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.

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).

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. This relates to a phenomenon labeled the 'Prevention paradox' which 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 then the lesson is that programmes need to target everyone and avoid targeting only the more selective 'at risk groups'.

A longitudinal study in rural Bangladesh was conducted to address the impact of a behaviour change intervention on cleanliness, diarrhoea and growth of children. The intervention was to adopt a community-based approach and compare this with non-community based approaches (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. In comparison to the community based approach where solutions had been recommended by the community.

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).

Implementation of CLTS involves the training of 'Lead Total Behavioural Change Facilitators' (LTBCFs), these are usually selected by a local governing body at district level. LTBCFs are taught to train people, within the targeted communities, to become 'triggerers'. These triggerers then work with the community with the aim to create behaviour change in sanitation practices, inclusive of the prevention of OD.

The CLTS is characterized by its use of ignition-processes using Participatory Rural Appraisal (PRA), in the RWSSP-WN they call these 'triggering activities', and 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. In Nepal this is known as the 'walk of shame'.
 - ✓ 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. In Nepal it was frequently stated, "*Nepali people eat on average two kilos of shit a year*". 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.
- ✓ Interestingly, children have been identified as key agents of change, and reasons for this are varied. Perhaps most significantly, they have the most energy and have been found to initiate the digging of pits to start the process for latrine construction. I was opportune to witness this principle in action in Nepal, where a rather elaborate looking latrine was pointed out to me, and 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.

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 models all 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). Indeed, following its inception in Indonesia it was observed that it did support 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 overnight, it was reported that "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, the fact that it has been implemented widely in such 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 this runs in contradiction to CLTS principles where 'demand' is essential. Another finding has been the fear 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 has drawn from a number of different disciplines. The core disciplines are 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, inclusive of demographic information, varying beliefs and attitudes, interests and concerns of targeted communities.

It has been difficult to deduce from literature much about the character of health promoters and exactly 'who' they are. However, it has been possible to find some evidence of their beliefs about OD and the people who practice it, however, most evidence of this came from the short time I had in Nepal.

What I have decided, therefore, to share from the literature is something about narrative theory, as I believe this 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 and as a result creates cultural meaning, a sense of belonging and provides guidance. Narrative theory proposes that through narratives not only can expression be given to 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, cited 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).

Another significant aspect of narrative is that it is believed to have considerable ‘spillover effects’. It is believed that as people are affected and respond to narrative the more they are likely to 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" and 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 2006). 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 2006). 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.

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?

The applicability and transferability of any health promotion activity is very much 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).

A refreshing perspective, on a notion inherent to context, is that of 'place' and has been offered by Cummins. 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). Acknowledging that there has been a wealth of research on the influence of 'place' and its effect on health, 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, he 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 such matters as 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.

The vast majority of 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 image that has built up over the years has had considerable impact on the perceptions of others as well as on the conditions in which they live.

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).

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 when considered within a cultural context, 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, then in relation to local conditions, it is not these specific child care practices, but rather the circumstances that contribute to these behaviours happening in the first place, that lead to sanitation related ill health.

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).

The other interesting observation, and one that resonates with much of the literature, is the issue of political will. The observation is that often the level of success of programmes is determined by the extent of political will (Atkinson 2002; Kar 2006; Ngondi, et al. 2010; Peal 2010; Stone 1992; Wang 2006).

This was also evident during my field trip to Nepal, a frequent remark in regard to the effectiveness of the LTBCFs, was that this was often determined at local government level, as they were the body that would dictate selection of these people. Effectiveness or not of health promotion activities was therefore influenced heavily by political influence as this was the body that would select people that would have a huge impact on the effectiveness or not of project efforts. There is little doubt that the effectiveness or not 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 where a study established that increase in latrine coverage was attributed to the political commitment of local government and intensive community mobilization (Ngondi, et al. 2010).

The use of Community Health Clubs (CHC) 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). They have been promoted in Zimbabwe within sanitation and hygiene programmes and have been found to be an effective way of creating new norms within communities. In much of Africa, sanitation and hygiene programmes were making use of an approach called Participatory Hygiene and Sanitation Transformation (PHAST). Although this approach was widely recognised as good practice, it did not result in well-supported programmes. Problems with the approach were that it was perceived as too time consuming, required too much input, and its success was determined by the personality and confidence level of the trainers (Waterkeyn 2005).

Sanitation and hygiene programmers were still convinced about the value of participatory approaches. Rather, however, than focusing on traditional leadership, the focus shifted to promoting membership of clubs and promoting 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 more pleasure in the clubs but indeed improvements were happening 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).

A workshop for Hygiene Practitioners was held in Bangladesh, in February 2010. 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. There was criticism of previous approaches used in sanitation and hygiene that have been perceived as top-down and a call was made to push for more bottom-up approaches (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).

Participatory approaches were recognized as being popular and well used. Peal asserted that the frequent use of mass mobilization, also known as social marketing, was also recognized as being effective (2010). The creation of 'social norms' was highlighted, as well as the emergent tool of disgust, which is being widely used in the CLTS approach. The notion of children as change agents was also raised and the call to ensure schools are targeted 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, they affirm what other literature has been saying, that for the intervention to be effective, it requires a supportive political environment, as well as some degree of harmony with existing social norms (Wang 2006)). Other contributing factors have to do with the existing epidemiological situation, the stage of an epidemic, incidence, prevalence, geographical distribution and population groups. Of course capacity for implementation in terms of available resources, local skills, as well as organizational factors all affect the intervention.

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 2006). 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 indeed because of the various perspectives of the players in the health field, in particular health programmes that fall under the umbrella of 'development work'. Linda Stone observes that nearly 20 years ago, Robert Chambers noted 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, and in particular 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' that serve to provide some political intelligibility for their existence and keep them functioning (Ferguson 1994). This political intelligibility or 'rationale' for the existence of development projects is worthy of note when considering the sensitivity that health workers have to local views and conditions in the places in which they work. This is not to negate the importance of workers being sensitive but rather to demonstrate the complexity of this ambition and permit a broader view of what is taking place.

Kamal Kar, when talking of CLTS describes it as 'local initiatives' to prevent the practice of open defaecation. Although he has labeled them this way, they are in fact a specific approach to change hygiene and sanitation practices that initiated in Bangladesh in 1999. This approach is now being implemented in several different countries and, as has been described earlier, is based on the premise of no-subsidy, and was developed in response to sustainability issues (Kar 2006). 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). Cultivating such a dependency culture in some ways reflects the notion of political intelligibility. Inherent in this 'political intelligibility' is the idea that poverty can be reduced to a 'technical' problem requiring technical solutions to be provided by development agencies.

The CLTS approach advocates that evaluations of sanitation programmes should be based on evidence of no open defaecation rather than on the number of latrines constructed. Kamal Kar alludes to the notion of Fergusons 'side effects' of development projects when he talks of the fact that subsidies may be counter-productive. To illustrate this he refers to a situation whereby a project using the CLTS approach applied to a donor agency for money. The money would be used for training and the donor agency, in their over enthusiasm, contributed nearly 6 times the amount that was asked for, the result was that the project increased their staff levels threefold. The new staff were not the right people to implement the project as the people that were needed would come from the targeted communities and would not command such a high wage.

Experience has shown that projects are much less effective when they follow a subsidized approach. Experience with the CLTS approach in Indonesia lends weight to this anti-subsidy approach, where 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, they established that the provision of subsidies resulted in even greater disparity between the powerful and less powerful in the targeted communities. They failed to recognize socio-economic differences and cultural factors that contribute to the practice of open defaecation and better off households ended up receiving the subsidies, and never those most in need (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).

2.5 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) (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' involves 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.

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.

2.6 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.

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.

2.7 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, offers a useful definition of 'cultural sensitivity' where he relates it to both 'surface' structures and 'deep' structures, there is an implication that to be sensitive requires knowledge not only of another's culture, but the 'conditions' in which the other lives (Resnicow K. 1999).

Of course having knowledge of another's views and conditions in which they live, does not necessarily translate as 'sensitivity'. Sensitivity demands that one not only seeks to understand, but also affords a certain respect for another's view, and refrains from passing a judgment of right or wrong.

2.8 CONSUMER MARKETING

Health promoters are increasingly aware that there are few successes in programmes trying elicit behaviour change. An aspect of this awareness is that increasing knowledge does not necessarily result in 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). A similar study to the one in Benin that sought to

establish motivating factors for latrine adoption, 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. These 75 districts comprise a total of 3915 village development committees (VDCs). 85% of the population lives in villages, with about 70% of the population dependent on agriculture. Rural unemployment is very high and this is thought to be directly associated with high levels of landlessness. The landless status of many people is believed to be directly responsible for high levels of poverty in Nepal. 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 (Action 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 (Action 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 DO was not practiced and were transporting some of these ideas back to the village.

Linda Stone researching Primary Health Care (PHC) in Nepal addresses the relationship between particular sociocultural factors and PHC activities (1986). PHC is an approach to health care for poorer segments of countries and emphasizes community participation (Stone 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 to be 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 full access to sanitation facilities by all in 2017. The RWSSP-WN operates in nine of Nepal's 75 districts, eight of which are in the Western region and one in the 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 three main geographical areas in which they work are the mountains, hills and the lowlands of the Terai. During my visit, I was only able to visit the hill region and the Terai. 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 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.



Illustration 1: RWSSP-WN Logo

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. This meeting with Arto 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 target population.

When I went back to Nepal for my fieldtrip the visit coincided with ongoing political tensions and the nationwide *Bandh*. To complicate matters further, Arto was unexpectedly admitted to a local 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



Illustration 2 : Bandh Pokhara

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 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 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 laughingly 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. 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: Welcome ceremony - Rote Village

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. 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



Illustration 5: Rote Village

factors to account for this, it could have been 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



Illustration 6: Rote Village

explanations, it was truly impressive. Responses given in

the mass meeting will 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 in-depth interviews, FGDs, questionnaires and direct observation. Although most information collected came from project staff of the RWSSP-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.

3.4 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 within the RWSSP-WN. There seemed to be four main groups, those at an administrative project level; those selected to become what are known as Lead Total Behavioural Change Facilitators (LTBCFs); Water Sanitation and Hygiene (WASH) officers; and Triggerers (people from the community trained by the LTBCFs) to conduct triggering exercises in the community. Obviously, given the short time frame I had in Nepal it is not possible to build an accurate picture, but enough to gain some impressions, from both interactions with these people as well as responses to the questionnaires.

Project level staff

The project administrative level staff 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 Expert for the programme.

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, however, due to local government politics. The community led approach demands that local community people should be in lead positions, especially with regard to training being undertaken within the project. The appointment, however, of LTBCFs is often taken by local government officials and results in appointment of people that are not always the most sensitive to local views and conditions. Due to the sensitive political situation, project level staff is unable to override such decisions and intervene by appointing more appropriate people to these lead positions. Certainly, interviews with staff at this level indicated a high degree of 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 ..*

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.

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 one of these officers, he was the only RWSSP-WN staff I met that worked in the mountain regions. 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 mountain regions, 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 of CLTBCEs 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 very vocal and lively in their participation. Many have been selected as 'triggerers' due to the natural leadership qualities they possess.

In terms of the ethnic or caste affiliation of the 37 RWSSP-WN who were given the questionnaire, aside from 2 Finnish respondents, the respondents classified themselves as the following:

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

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 and 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 Kapilvastu district. It was a relatively lively FGD with a number of fairly 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 *Dahlit*. 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.

3.5 KNOWLEDGE, ATTITUDES AND SOCIOCULTURAL AWARENESS OF HEALTH PROMOTERS

Most of the health promoters within the project 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 why should it 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: Triggers 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 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.

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 administrative staff and LTBCFs were that the Madhesi communities are more 'backward', 'less educated', 'landless' and 'living in crowded conditions'. The prevailing attitude toward the Madhesi were 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'.

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

3.6 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 levels of staff, namely the 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 more 'task' oriented and 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 in the RWSSP-WN, 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. This is because the CLTS approach encourages 'ignition' and 'triggering' of behaviours through its confrontational method of 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. Clear messages were coming through the literature search that health education and increasing knowledge about health impacts of poor hygiene has little effect on hygiene behaviour. What I witnessed in Nepal seemed to contradict this finding. Education regarding health was taking place, however, in a completely non-conventional way. The 'form' of education was confrontational and innovative, 'lectures' were not taking place, rather active, participatory methods inclusive of mapping exercises, the 'glass of water' technique and transect walks. Seemingly, the more people were aware of the contamination effects of 'shit' the more they were willing to change their hygiene practices.

Despite the difficulty encountered in trying to assess the 'content' of health messages within the RWSSP-WN programme 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 CLTBCFs, she pointed out the difficulty the programme has in recruiting these people. Not only do too few Madhesi apply to be CLTBCFs, 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 opportune 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 was 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. 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:: ODF Parade



ODF Placards

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 Dalit 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 and we were lead in a procession into the place where the ceremony would take place.

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 before the 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.



Illustration 11: ODF Ceremony the dancing begins



Illustration 12: ODF Official Ceremony

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. 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. 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.

3.7 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

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, 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.

Illustrations 16, 17 : Chhabi and Chhabi



CHAPTER 4: DISCUSSION

In the discussion findings in the literature will be compared with findings in the fieldwork in Nepal, and where appropriate convergent 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.

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' 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 Dahliṭ (outcast) woman who had recently built a latrine in her home. 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 would remain a 'Dahliṭ' due to her birth, her had changed considerably and she would no longer be 'shunned' by the community.

**Illustration 18: No longer an
'outcast'**

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 and 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 .



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. 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 groups 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) as developed by Latour and Callon addressed the simultaneous relationship that exists between 'things' and 'concepts'. Using the example of a laboratory and the relationship that develops the laboratory and 'others' 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. Even 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 a 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.

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 projects 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 Madhesi coming into the Terai from the hills and dominating the Pahadi 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 as whatever land the pumpkin covered would become Pahadi land. The insinuation in the story, is 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. 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 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 the solutions 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.

CONCLUSIONS AND RECOMMENDATIONS

“**T**he 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). This statement reflects much of what has been found in this study, and illustrates that health promoters, aiming to prevent the practice of open defaecation, need to be sensitive to local views and conditions. 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 that will enhance the chances of behaviour change.

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. "... social disease(s) ... transcend the traditional medical approach ... its understanding demands that the impact of social and economic factors on the individual be considered as much as the mechanisms by which ... bacilli cause damage to the body" (Dubos, in Farmer 1997:348).

It seems that what is required is for some middle ground to be reached in health promotion efforts aiming to achieve behaviour change. To be culturally sensitive, is no guarantee for success, in fact Farmer argues it may be a hindrance. He responded to findings in a study about a TB-Control programme, where it was proposed that the programme failed as clinics did not have enough knowledge about local culture, that "It could more easily be argued that TB-Control programs ... have failed not through cultural insensitivity but rather through lack of commitment to the destitute sick" (Farmer 1997). This is not to say that cultural sensitivity is not important, but rather it is not the full solution. There is more to health promotion than being culturally sensitive. Sensitivity needs also to be exercised in regard to conditions in which people live, inclusive of physical, social, historical and economic factors.

In regard to Nepal, I believe 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 of tensions between the Madhesi and the Pahadi it is clear that messages and programme activities need to be more sensitive to these 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 existing 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.

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