

# Crossfire: ‘Does hygiene promotion risk making people feel more ashamed about their poverty and poor living conditions?’

*NJOROGE KAMAU and ANDY PEAL*

*Dear Andy*

Hygiene promotion does not aim at making poor people ashamed of their poverty or poor living conditions. As a matter of fact, it restores poor people’s pride when they realize that they have the power to change their own lives and those of others around them by taking up health promotion initiatives. There are many examples where hygiene promotion initiatives have improved the health status of people in difficult economic situations.

For instance, in a child survival project implemented by Plan International, poor rural communities in Kilifi district, Kenya, living on less than a dollar per day have taken up the challenge of latrine construction in order to reduce the rates of diarrhoea in the community. In a period of less than two years, over 3500 latrines have been constructed in the district and 18 villages attained 100 per cent sanitation coverage thus eliminating open defecation. These latrines have been constructed using locally available materials, each household according to their

capability. In essence, even the poor households are now proud owners and users of a latrine. This intervention among others has led to a drastic reduction in the childhood diarrhoea and a significant reduction in child mortality, preventing 989 child deaths in 5 years as computed using the lives saved calculator (Plan International, 2009).

It is important to point out that shame has a role in promoting and sustaining healthy behaviours. Sometimes public health interventions use shame and stigma to encourage healthy behaviours, for instance in health promotion projects where cigarette smokers are subjected to stigma. The mere notion of a smoker being tagged a ‘spoiled identity’ that ‘has the effect of cutting him off from society and from himself so that he stands as a discredited person facing an un-accepting world’ (Goffman, 1963; Musyoki, 2009) makes him more willing to conform to the non-smoking state. The same strategy has been utilized by community members in parts of Kilifi by blowing a whistle whenever they encounter

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In health promotion projects cigarette smokers are sometimes subjected to stigma

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someone defecating in the open in their village (Musyoki et al., 2009) In some parts of Homa Bay in Western Kenya, those caught defecating in the open are forced to scoop the faeces and carry it to a latrine (Tatiana, 2010). This is in a bid by the community to shame those deviating from the agreed norm of using latrine to dispose human waste. Health promotion creates awareness of the bad consequences of a prevailing health behaviour. In this case even without whistle blowing, the very knowledge that open defecation may cause a child to die creates a feeling of guilt in the offender, causing him or her to adopt the targeted health promotion intervention.

Health promotion is based on models, one of which is the Health Belief Model where health promotion messages target a condition based on perceived susceptibility and severity of the disease, the benefits and barriers to taking up a health behaviour and uses cues to action e.g. posters to urge for change. Could shame be used as a cue to action? Yes but extreme care should be employed not to annoy the target population and lose an opportunity for engagement. It is therefore prudent to assess where they stand on the five stages of behaviour change; pre-contemplation, contemplation, preparation, action and maintenance (Prochaska, 1992). People at the *preparation* stage are on the verge of

taking appropriate health action so shame could be used to aid them make a decision. Is it ethical to 'persuade' people to take up healthy behaviours? According to Mill's Harm Principle, this is justified if restraining one's liberty protects others from being harmed by the individual's behaviour. This is also justified in that the collective good of the population overrides the individual interest (Upshur, 2002).

However, there are times when shame and stigmatization works against the public health goal. For instance stigmatization of communicable diseases like tuberculosis and HIV results in fewer people seeking health hence further transmission of the disease. Therefore a health promotion campaign has to take cognizance of the two possible consequences.

*Yours,  
Njoroge*

*Dear Njoroge*

Whilst I agree with you that discouraging poor hygiene practices and encouraging good ones is important I do wonder whether we need to go beyond looking at just the health benefits which you cover so well in your letter. The hygiene and sanitation sector has found out the hard way that it is simply not enough to 'educate' people about the health benefits of changing behaviours and there is published research to back this up. For instance the 2006 *Human*

*Development Report* contains a chapter by Marion Jenkins and David Sugden on this subject; it includes a long list of stated benefits of hygiene and sanitation compiled from various case studies and project reports (which were in turn based on household interviews, surveys and group discussions in many different settings).

The research found that alongside increased dignity and higher social status were increased comfort, increased privacy, increased convenience, increased safety for women (especially at night) and for children. These benefits all came well above any sort of health benefit or link to reduced illness; so I would always recommend that shaming people into change needs to include more than just focusing on whether the individual and the community will benefit from improved health but it should also highlight the range of other possible benefits. In this way more members of the community are likely to be encouraged to adopt the new behaviours – or to put it another way, you are more likely to reach not only the ‘low-hanging fruit’ but the fruit at the top of the tree as well.

Shame is a transitory state and it requires people to have some degree of pride in the first place and this is where, as you point out, understanding and assessing where an individual or community is in their behaviour change process is very

important. I wish that more projects and programmes would take time to consider and understand this before intervening and interacting. Much precious public and private resources have been wasted on communities because this was not considered before the intervention started.

Indeed, human behaviour is very contextual and I would suggest that there are and will be instances where applying the ‘shaming technique’ may not be appropriate. From my own experience, in Ticho town Ethiopia, WaterAid found strong resistance from the community when they tried using a ‘pure’ Community-Led Total Sanitation (CLTS) approach. The community expressed their displeasure at having to use the ‘crude and shocking’ (sic) language of CLTS. They stated that they felt insulted, that their dignity had been removed and they publicly refused to engage with the facilitators. By listening and then adapting their language WaterAid was still able to ‘trigger’ the community and achieve 100 per cent coverage in the town.

On a larger scale, UNICEF and the Government of Nepal have successfully adapted the CLTS approach for use in schools. The approach which is known as School-Led Total Sanitation (SLTS) uses a ‘strength-based appreciative’ approach to promote hygiene and sanitation at a local level. Importantly, it

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Many benefits such as dignity and safety are valued more than the perceived health benefit

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The community considered the language of CLTS ‘crude and shocking’

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uses a 'praise walk' instead of a 'shame walk' as an ignition tool in which school teachers, students and local community people walk together appreciating those who have installed and are using toilets – this then motivates others to emulate the early adopters. The approach has been so successful that SLTS has been incorporated in the Nepal Sanitation Master Plan and the Government of Nepal is replicating the SLTS programme nationally. I am sure there are other examples from around the world of when shaming an individual or community into change has not been appropriate and that this has led them to feeling more ashamed about their poverty and their poor living conditions; such scenarios are most unlikely to result in a positive outcome and/or sustained hygiene and sanitation behaviour change.

I would argue that these two examples illustrate that improved understanding, listening to the views of the target group and adaptability are the keys to success. These characteristics will correspondingly lead to the 'hard-to-reach fruit' at the top of the tree being picked as well as the more accessible 'low-hanging fruit'.

*Yours,  
Andy*

*Dear Andy*

As you rightly point out, just mere education of communities on hygiene may not be the way

to encourage people to adopt healthy behaviours. Education has its place but it has its limits as well; it has been tried before and resulted in mixed outcomes. General consensus is that communities should be at the forefront of making their lives better.

Health practitioners had this foresight way back in 1978 when Alma Ata Declaration put communities squarely in the driver's seat of their health destiny but it was watered down in implementation with a call for various vertical packages instead of comprehensive care. It has taken policy makers 30 years to see the wisdom of Primary Health Care (WHO, 2008). The idea here is to facilitate communities to realize their potential in turning their lives around using local resources and where applicable through their colleagues who have adopted the targeted behaviour. This has worked well in malnourished children rehabilitation through Positive Deviance Hearth (PD-Hearth). This is akin to the method you described in Nepal where conformers/adopters are praised to encourage the 'wait and see group' to conform as well.

Sanitation and Hygiene promotion projects have many benefits including increased dignity; higher social status; increased comfort, convenience and privacy; and increased safety for women and for children as you have pointed out. These benefits are realized along the way as the

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community seeks better health, which is the ultimate goal of both the project workers and the community. For instance, it is possible to have a latrine nearby where all household members can access it with ease and safety (even at night), but if it does not have aperture cover, it will breed flies which risks the household's health. The same would happen if a hand-washing facility is not available and constantly used during critical times. In these examples, the household will still have the dignity, comfort, privacy and safety but not enjoy the health benefits of their investment.

Adaptability and flexibility is key when it comes to community-based programming. There is no such a thing as 'one size fits all'. This calls for deeper understanding of the community that one is dealing with. Good facilitators who are keen to study the community's norms, values and behaviours often succeed in community projects. For instance, no community will take kindly to being told that they are ingesting faeces. I would take offence if a stranger had the audacity to tell me that. However, the reaction would be different if the facilitator analyses the problem at hand and eventually the community realizes and actually say that they are ingesting faeces. It is therefore prudent that facilitators learn and skilfully use various participatory qualitative methods in such assignments.

In my experience in the field in Kenya, when communities come to realize the harmful effects of their actions for instance open defecation, they immediately come up with an action plan on how to stop open defecation. This has led the Ministry of Public Health and Sanitation in the country to institutionalize community dialogues (Ministry of Health, Kenya 2006). In these dialogues, health workers facilitate sessions where community analyse a particular health problem in their midst. For instance, community dialogues have been held in a part of Kilifi district where neonatal tetanus (NNT) was reported. After these dialogues, the community came to appreciate NNT is a problem in their area and that immediate action needed to be taken. Without prompting from health workers, they requested health outreach to vaccinate women of reproductive age with tetanus toxoid (TT) and thereafter ensure that all pregnant women attend the Antenatal Clinic where TT vaccine is routinely given.

*Yours,  
Njoroge*

*Dear Njoroge*

You certainly have a broad range of experience with knowledge of primary health care as well as sanitation and hygiene interventions. My experience is focused around the latter only but I am always interested to learn about other sectors, especially when it

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is related to the critical issue of behaviour change.

Returning to our crossfire question, I think I would have to agree that in general hygiene promotion does risk making people feel more ashamed about their poverty and living conditions. In fact, it runs many risks, all communities are different and all individuals within a community are different so there are a great many possible 'initial' outcomes. Some would argue that particular approaches are more likely than others to cause the participants to experience emotions of shame and embarrassment (and hopefully joy and happiness too); and they would no doubt add that some approaches are more effective than others in achieving rapid and widespread change.

However, what I hope that they would all agree on is the point you make – that good facilitation is very important and that it is essential that facilitators learn and skilfully use participatory methods. Regardless of which hygiene promotion approach is adopted, training of facilitators is crucial and I am interested in not only the amount and quality of training that practitioners receive, but also how much of it is field-based. It is important that facilitators are properly equipped before they are 'let loose' in the field.

Some behaviour-change approaches, such as the Community-led Total Sanitation (CLTS) approach, advocates

that all facilitator training be done in the field. The benefit of not limiting training to the classroom is that it allows the trainees to encounter real issues and problems and be forced to come up with real-time solutions. The trainees then see at first hand the effect that the CLTS approach has on the individuals within a community. For instance, if an activity has the effect of making a community (or maybe just a few householders from within a community) very ashamed of their level of poverty and living conditions it may cause the community to withdraw from the dialogue. It is then very important that the facilitators have the tools to deal with the situation. With careful facilitation the community can still be triggered to adopt a new, improved hygiene and/or sanitation behaviour which will in turn enable them to start on the road out of poverty; if the facilitators do not have the required skills then it is unlikely that the targeted behaviour change will be adopted. So whilst shame might be the initial emotion it is important to understand that it is only one of a number of possible steps along the process.

We should not forget that other factors influence people's ability to adopt new hygiene behaviours. Communities need markets and supply chains so that they can purchase water containers, soap, sanitary pads, pipes, latrine platforms (san-plats) and other hardware items.

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When such items are both accessible and affordable then it is easier for a community to get onto the sanitation and hygiene ladder and so feel less ashamed of their situation. Hygiene and sanitation professionals have developed other approaches which focus on improving accessibility to such markets as well as approaches which enable communities to access finance to purchase the products. Meanwhile, some approaches focus purely on self-help rather than requiring the beneficiaries to purchase any items at all – learning new skills and building their own facilities brings with it the emotion of pride in their own achievement.

But perhaps there is no ‘magic bullet’ to solving the hygiene and sanitation crisis; it is a very complex problem requiring innovative and flexible solutions. With so many interesting approaches to bringing about change in people’s hygiene and sanitation behaviours we should not allow ourselves to get bogged down trying to make *one approach successful* when it is *achieving the one goal* we should be concentrating on – reducing the number of people without access to sanitation.

Or to put it another way – perhaps it is those of us who have toilets who should feel more ashamed ...that 2.6 billion people are still waiting!

Yours,  
Andy

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Perhaps there is no  
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## References

- Alma Ata Declaration* (1978) The International Conference on Primary Health Care, Alma Ata, available from URL: [www.who.int/hpr/NPH/docs/declaration\\_almaata.pdf](http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf) [accessed 22, July 2010].
- Burris S. (2008) ‘Stigma, ethics and policy: A commentary on Bayer’s “Stigma and the ethics of public health: Not can we but should we”’, *Social Science & Medicine* 67: 474.
- Goffman, E. (1963) *Stigma: Notes on the management of spoiled identity*, Englewood Cliffs, NJ: Prentice-Hall.
- Ministry of Health (2006) *National Health Sector Strategic Plan II: Reversing the trends – Taking the Kenya Essential Package for Health to the Community*, p4, Ministry of Health, Kenya.
- Musyoki, S. et al., (2009) ‘World Toilet Day’, available from: <http://www.communityledtotalsanitation.org/resource/world-toilet-day-let-s-talk-about-sht> [accessed 1 July 2010].
- Plan International (2009) ‘KIDCARE Child survival Project Evaluation’ available from URL: [http://pdf.usaid.gov/pdf\\_docs/PDACP101.pdf](http://pdf.usaid.gov/pdf_docs/PDACP101.pdf). p15 [accessed 28 June 2010].
- Prochaska, J. (1992) ‘In search of how people change: applications to addictive behaviors’, *American Psychologist*, 47: 1102–1114.
- Tatiana T. (2010) ‘Impressions from Homa Bay visit’, available from URL: <http://www.communityledtotalsanitation.org/resource/impressions-homa-bay-visit> [accessed 1 July 2010].
- Upshur, R. (2002) ‘Principles for the justification of public health intervention’, *Can J Public Health* 93: 101–103.
- World Health Organization (2008) *World Health Report: Primary Health Care: Now more than ever*, WHO, Geneva.