Formative research report

Child faeces management

Beyond the Finish Line, Sustainable Sanitation and Hygiene for All (SSH4A)

Bhutan
How to use this report

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Section cover page
Click on the sub-section e.g., Current status, to go directly to the sub-section.

Inside pages
Click on Contents to return to the Contents page.

Click on the section e.g., Programme context, to return to the section cover.
Abbreviations

BCD  Behaviour Centred Design
BFL  Beyond the Finish Line
CFM  Child faeces management
CUS  Children under 5
DFAT Department of Foreign Affairs and Trade
FGD  Focus group discussions
HA   Health Assistant
KII  Key informant interviews
LSHTM London School of Hygiene and Tropical Medicine
MICS Multiple Indicagory Cluster Surveys
MoH  Ministry of Health
PLWD Persons Living With Disability
PHED Public Health Education Department (PHED)
RSAHP Rural Sanitation and Hygiene Programme
UNICEF United Nations Children’s Emergency Fund
WASH Water, Sanitation and Hygiene
WSP  Water and Sanitation Programme
SNV is a not-for-profit international development organisation that makes a lasting difference in the lives of people living in poverty by helping them raise incomes and access basic services. We focus on three sectors and have a long-term, local presence in over 25 countries in Asia, Africa, and Latin America. Our team of more than 1,300 staff is the backbone of SNV. For more information: www.snv.org

The Public Health Engineering Division (PHED) under the Ministry of Health is the lead agency for the Rural Sanitation and Hygiene Programme (RSAHP). Its goal is to promote sustainable sanitation and hygiene to bring about improved health and quality of life for the rural population through access to a sanitary toilet, hygienic use of toilet and adequate facilities for handwashing with soap. It is also responsible for environmental health, occupational health, and water, sanitation, and hygiene (WASH) in health care facilities.

Upward Spiral specialises in designing and delivering effective behaviour change interventions to create social impact at scale. It has worked in the WASH sector across Asia and Africa. It is currently piloting the Behaviour Design Hub for SNV, a new model for program design. Under the hub, programme managers learn to design effective interventions through a ‘learning by doing’ approach.

Water for Women is the Australian Government’s flagship WASH program and is being delivered as part of Australia’s aid program, investing AUD 118.9 million over five years from 2018 to 2022. It is supporting improved health, gender equality, and wellbeing in Asian and Pacific communities through socially inclusive and sustainable Water, Sanitation and Hygiene (WASH) projects. For more information, visit: www.waterforwomenfund.org

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Contact:
Kencho Wangdi, WASH Sector Leader, SNV in Bhutan | kwangdi@snv.org
Nipa Desai, Upward Spiral | nipa@upwardspiral.in
We are happy to share with you the findings from the formative research on child faeces management conducted in Bhutan as part of the Beyond the Finish Line–Sustainable Sanitation and Hygiene for All Programme. The formative research had to be postponed several times because of the COVID-19 pandemic. However, with proper safety protocols, we were able to complete the field work by March 2021. We hope this report offers insights for designing child faeces management interventions in Bhutan and elsewhere.

This research is part of the Behaviour Design Hub, an innovative approach to design behaviour change programmes simultaneously across countries. As part of the hub, five SNV country teams across Asia and Africa went through a ‘learning by doing’ process i.e., learning the Behaviour Centred Design framework, while designing the intervention.
We would like to thank the following people and organisations for their support:

**The District Health Officers and Health Assistants of Punakha Trashigang District** for coordinating and guiding us for the focus group discussions (FGDs) and key informant interviews (KIIs).

The FGD and KII participants from the communities of Punakha and Trashigang for making themselves available, despite their busy schedule.

Public Health Engineering Division (PHED) for informing and sending out formal letters to the relevant districts.

Sonam Pelzom, PHED for leading and coordinating the team and Sherab Gyaltshen and Yeshey Choden who successfully completed the note taking.

Adam Biran from the London School of Hygiene and Tropical Medicine (LSHTM) for his inputs and support throughout the process.

Asahel Bush (CBM Australia) and Tshering Choden (SNV Bhutan) for guiding us in conducting research among people with disabilities.

Gabrielle Halcrow (SNV) for championing the Behaviour Design Hub pilot among the five participating countries and for being available from the initial stages through to completion of the project.

Kencho Wangdi (Country Representative/WASH Sector Leader), Ugyen Rinzin (Project Leader) and Tashi Dorji and Raj Kumar (WASH Advisors) for their valuable comments and support.

Australia’s Department of Foreign Affairs and Trade (DFAT) and the Water for Women Fund for supporting the training and research activities.

Write to us at kwangdi@snv.org or nipa@upwardspiral.in

Let’s keep the child faeces management conversation going!
Programme context

Bhutan’s national Rural Sanitation and Hygiene Programme (RSAHP) is a district-wide government led approach to achieving universal access by 2022. Based on SNV’s Sustainable Sanitation and Hygiene for All (SSH4A) Programme programme model, it focuses on strengthening Water, Sanitation and Hygiene (WASH) governance; engaging local stakeholders, including government and private; sanitation demand creation (using adapted Community Development for Health Workshops) with households; behaviour change communication (BCC) for hand washing with soap and hygienic usage; supply chain development, monitoring, and learning; and sustainability monitoring. Though children’s faeces play a key role in diarrheal disease transmission, it hasn’t received attention so far. This formative research aims to inform a behaviour change intervention that addresses this critical link in the disease transmission chain. It covers eight districts and is a result of the partnership between Australia’s Department of Foreign Affairs and Trade (DFAT), Water for Women, Bhutan’s Public Health Engineering Division (PHED) and SNV as part of the Beyond the Finish Line (BFL) Programme (2018-2022).

In the Performance Monitoring Survey 2020, for child faeces management (CFM), we found that 70% of households with children under three disposed faeces unsafely. Our vision is to influence safe disposal of child faeces by an additional 10% of caregivers by the end of 2022. However, we first need to arrive at a clearer understanding of what we mean by safe disposal of child faeces in the context of rural Bhutan, particularly for diapers, as approaches vary.

Programme goals

Disposal of Faeces

<table>
<thead>
<tr>
<th>Method</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Picked up and deposited in garbage</td>
<td>18%</td>
</tr>
<tr>
<td>Uses diaper, rinsed into toilet then deposited in garbage</td>
<td>5%</td>
</tr>
<tr>
<td>Child uses potty, rinsed into toilet</td>
<td>47%</td>
</tr>
<tr>
<td>Safe</td>
<td>30%</td>
</tr>
<tr>
<td>Unsafe</td>
<td>70%</td>
</tr>
</tbody>
</table>

1Performance Monitoring Survey 2020
Approach

Behaviour Centred Design
We used the Behaviour Centred Design (BCD) framework, developed by Robert Auinger and Valerie Curtis of London School of Hygiene and Tropical Medicine. There are five steps in the BCD process: Assess (existing knowledge), Build (through formative research), Create (the intervention), Deliver (the intervention), and Evaluate (process and impact). This formative research report is an output at the end of the second step – Build.

Behaviour Design Hub
This research is part of the WASH Behaviour Design Hub initiative comprising of five SNV country teams: Mozambique (latrine construction), Tanzania (solid waste management), Bangladesh (faecal sludge management), Bhutan (child faeces management) and Lao PDR (hand washing with soap). The objective of the hub is to design and deliver effective behaviour change interventions and, in the process, also enhance capacities of the programme teams.

Research design
We used qualitative research methods such as key informant interviews (KIIs) and focus group discussions (FGDs). The research was conducted in Punakha and Trashigang, based on levels of safe and unsafe CFM.

Geography

<table>
<thead>
<tr>
<th>District</th>
<th>% of households practising safe CFM²</th>
<th>% of households using diapers²</th>
</tr>
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<tbody>
<tr>
<td>Punakha</td>
<td>28.5</td>
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<td>52.2</td>
<td>19.6</td>
</tr>
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</table>

Within each district, we chose the sample based on three criteria: behaviour, income, and inclusion. We looked at the two behaviour segments: infants (tools – cloth, diaper), toddlers (scoop, child potty, toilet).

We ensured representation in terms of income and persons living with disabilities. We also interviewed government stakeholders, health workers and shopkeepers. The data was collected in March 2021.

<table>
<thead>
<tr>
<th>Key Informant Interview</th>
<th>Focus Group Discussion</th>
<th>Market Study</th>
<th>Government</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total: 37</td>
<td>Total: 16</td>
<td>Total: 14</td>
<td>Total: 15</td>
</tr>
</tbody>
</table>

²Baseline Survey Report 2018
Target behaviour

Key finding
Most caregivers use diapers and dispose of them into garbage. Some caregivers use the child potty to help the child move towards use of toilet, but don’t always dispose of faeces safely. Toilets are available but often uncomfortable for young children who struggle with using pit toilets and toilets that are far away.

Children with disability may also use diapers as toilets are inaccessible.

Recommendations
- We need to clarify the definition of safe disposal of diapers in the context of Bhutan.
- We could promote the child potty to accelerate the movement from diaper to toilet, with messaging on safe disposal.
- We could consider promoting child-friendly and disability-friendly toilet designs to help all children access toilets more easily.

Executive brain

Key finding
There is no messaging on CFM by the RSAHP or health workers. Child faeces are perceived to be less harmful than adult faeces, and the link with disease transmission exists but is weak.

Recommendations
- We could design messaging to address CFM behaviours and perceptions. This could be integrated within the RSAHP or health worker outreach.

Social environment

Key finding
Mothers are very invested in ensuring proper growth of the child and see themselves as experts in caring for children. They reject the idea of men taking over childcare activities.

Recommendations
- We could explore ways to include men in CFM that would be acceptable.

Motivated brain

Key finding
Mothers are strongly driven by nurture and look for convenience for CFM. They would like to have affiliation with others and aspire for modernity.

Recommendations
- Nurture, convenience, and affiliation could be used to motivate caregivers along with modernity, while disgust should be avoided.

Touch points

Key finding
Most people in the village own a TV. Mothers visit the Out Reach Clinic (ORC) once a month. Most mothers own a personal smartphone and use WeChat.

Recommendations
- We could use TV, Inter Personal Communication (IPC) sessions at the Out Reach Clinic (ORC) and create a Mothers’ Group on WeChat to engage mothers.
Programme context

1. Background
1.2 Indicators
1.3 Current status
1.4 Goals
Background

The Rural Sanitation and Hygiene Programme (RSAHP) from the Ministry of Health (MoH), with support from UNICEF and SNV, aims to improve the overall sanitation and hygiene practices in rural Bhutan. Through its integrated approach, it has successfully promoted toilet construction and hygienic usage reaching in all 20 districts as part of its national scale up plans. Though children’s faeces play a key role in diarrheal disease transmission, it hasn’t received the same level of attention as toilet construction or hand washing. The current project aims to develop an intervention that addresses this critical link in the disease transmission chain.


**Indicators**

The safest way to dispose of a child’s faeces is to help the child use a toilet or latrine or, for very young children, to put or rinse their faeces into a toilet or latrine (WSP and UNICEF, 2014). During the SNV Performance Monitoring Survey on Child Faeces Management in 2020, the disposal methods are referred to as ‘safe’ in the table below, whilst all other methods are considered unsafe.

<table>
<thead>
<tr>
<th>Unsafe CFM</th>
<th>Safe CFM</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Picked up and deposited in garbage</td>
<td>• Buried</td>
</tr>
<tr>
<td>• Uses diaper, rinsed into toilet then deposited in garbage</td>
<td>• Picked up and deposited in toilet</td>
</tr>
<tr>
<td>• Uses diaper, deposited in garbage</td>
<td>• Child uses toilet</td>
</tr>
<tr>
<td></td>
<td>• Child uses potty, rinsed into toilet</td>
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</table>

An additional level of analysis can consider whether the faeces is deposited into an improved toilet (including a shared but otherwise improved toilet) which is termed ‘improved child faeces disposal.’ In the sector, there is an inconsistency between Multiple Indicator Cluster Surveys (MICS) and the core questions (WHO/UNICEF, 2016) relating to whether buried should be considered safe; the latter includes it as such.

There is also debate about the safety of disposal in the garbage but limited evidence on risks. The Joint Monitoring Programme led an expert consultation to explore this issue in 2015 - the findings and a summary article are now available from the journal ‘Waterlines’.

The study found ‘strong consensus among experts that the two practices investigated (disposal of stools with solid waste and burial of stools) should not be considered as “safe,” or “improved”, consistent with the analytical approach used in MICS reports’.

This needs further discussion within the RSAHP and what it means in the Bhutan context.

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1[www.wsp.org/childfecesdisposal](http://www.wsp.org/childfecesdisposal), also includes a list of country profiles covering many of the SSH4A programme countries
1.3 Current status

*Disposal of Faeces*

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*Performance Monitoring Survey 2020*

1.4 Goals

The RSAHP vision is to achieve an additional 10% safe disposal of child faeces by the end of 2022. However, we first need to arrive at a clearer understanding of what we mean by safe disposal of child faeces in the Bhutan context.
Approach

2.1 Behaviour Centred Design framework

2.2 Behaviour Design Hub
2.1 Behaviour Centred Design (BCD)

We used the BCD framework, developed by Robert Aunger and Valerie Curtis from London School of Hygiene and Tropical Medicine. BCD is built on the latest insights from evolutionary and environmental psychology, marketing, and neuroscience. It has been applied successfully to behaviours ranging from handwashing, to oral rehydration, food hygiene, child and maternal nutrition, and post-operative exercise.

**Links**

- [The BCD resources page](#) on the LSHTM website has many free resources that dive deeper into the BCD framework, including the following:
  - Behaviour Centred Design, towards an applied science of behaviour change
  - Aunger and Curtis, Behaviour Centred Design - towards an applied science of behaviour change, Health psychology review, 2016

**Books**

- [Gaining Control](#) Robert Aunger and Valerie Curtis
- [Don’t look, Don’t touch](#) Valerie Curtis
- [Reset](#) Robert Aunger
BCD defines behaviour as a functional interaction between a body and its environment, designed to help an organism to get what it needs to survive and reproduce. At the individual level, the framework proposes roughly three regions in the human brain, related to three different types of behaviour:

**Automatic brain** produces unconscious behaviours. These include reflexive behaviours such as flinching in response to contact with a flame and habitual behaviours such as driving a car.

**Motivated brain** produces sub-conscious behaviours to achieve goals. One of the unique features of the BCD framework is that it has identified 15 fundamental, universal motives that drive all human behaviour.

**Executive brain** produces conscious behaviours. It chooses the behaviour to perform and also plans for the same. While most of the health messaging is targeted at this brain, most of the behaviours are produced in the automatic or the motivated brain.

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**Environment**

It proposes three levels to the environment that an individual interacts with during the performance of the behaviour. The physical, the biological, and the social environment.
The motives pyramid

Fifteen fundamental, universal motives that drive all human behaviour, as outlined in the BCD framework.

Justice

Status

Affiliate, Nurture, Attract, Love, Hoard

Play

Create

Curiosity

Fear, Disgust, Comfort, Hunger, Lust

Body

Environment

Brain

Human

Primates (e.g., monkeys)

Mammals (e.g., cats)

Invertebrates (e.g., insects)

The stage of evolution at which these motives first evolved.

The aspect that is primarily modified by achieving a goal related to that motive.
The BCD process

BCD provides a process for designing behaviour change interventions - ABCDE. Each letter explains one of the key steps in the process as seen below.

**A** Assess
- Gather what is known and identify what is unknown about goals, resources, determinants, and touch points through desk research, expert interviews, and workshops with stakeholders.
- Post-assess BCD checklist capturing ‘what is known’.
- Research questions noting ‘what is unknown’.

**B** Build
- Conduct formative research using BCD research tools to find answers to ‘what is unknown’ and explore hypotheses about the likely drivers of change.
- Formative research report.

**C** Create
- Design the intervention through an iterative design process where creative ideas are refined through research with the target group.
- Design brief to guide the Create phase.
- An intervention package of surprising and relevant materials and activities designed to cause the desired behaviour change.

**D** Deliver
- Implement the intervention package through relevant touch points such as community events and mass media.
- Monitor this process to ensure on-going learning and adaptation.
- Project monitoring reports and learning documents.

**E** Evaluate
- Measure the outcomes and evaluate the processes along the theory of change. Learn what has worked and what has not to inform future programmes.
- Evaluation report of outcomes and processes.
During the Assess and Build phase of the project, we understand the causal links from the state of the world to behaviour to brain-body to environment. Based on this understanding, the intervention is created, delivered and evaluated.

**Theory of change**

1. **Surprise**
   - The first task of the intervention is to create a surprise so that it gets noticed.

2. **Revaluation**
   - The second task is to cause the target behaviour to be revalued so that it is likely to be chosen.

3. **Performance**
   - The third task is making sure the target behaviour gets selected and performed.

**Intervention**
- (e.g., a film)

**Environment**
- (e.g., shown in a group meeting)

**Brain-Body**
- (e.g., hand washing with soap is good manners)

**Behaviour**
- (e.g., wash hands with soap)

**State of the world**
- (e.g., less incidence of diarrhea)
The Behaviour Design Hub

This project is part of the WASH Behaviour Design Hub created by Upward Spiral for SNV. The Behaviour Design Hub proposes a new model of programme design and management for multi-national foundations that wish to create social impact on a global scale.

Its objective is to design and deliver effective behaviour change interventions and, in the process, also enhance capacities of the programme teams.

**Effective Interventions**
As it is rooted in the BCD framework, country teams can follow a robust design process and identify the behaviour determinants that help create effective interventions.

**Experimental Learning**
It takes a ‘learning by doing’ approach. By designing effective behaviour change interventions, country teams also learn the design process.

**Cross-Country Learning**
Country teams follow the same processes, which helps managers and country teams learn and work more effectively and efficiently with each other.

**Optimisation of Resources**
Experts are engaged by the group instead of individual teams, and tools are shared. Costs and efforts are optimised for everyone.
The Behaviour Design Hub (WASH-SNV)

It comprises five countries, with each country focused on one specific WASH behaviour.
Research design

3.1 Process
3.2 Research questions
3.3 Research contexts and methods
3.4 Sample design
3.1 Process

The respondents listened to the purpose of the study and gave their signed consent for use of data collected, including photographs. All researchers read and signed the SNV Child Protection Policy.

Iterative Approach

The iterative approach helps answer new questions that emerge during the formative research and thereby helps move closer to strategic insights. Based on analysis of data from the Punakha district, we modified the research for Trashigang.

Ethical Consent

The process took longer than expected because of COVID-related travel restrictions.
During the Assess phase, we identified the gaps in knowledge and organised them as key research questions. These formed the basis for designing the formative research.

3.2 Research questions

<table>
<thead>
<tr>
<th>Target</th>
<th>Brain</th>
<th>Environment</th>
<th>Touch Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are we promoting only routines or also specific tools?</td>
<td>What are the cues and rewards related to CFM practices?</td>
<td>What will reduce the barriers to practicing safe CFM, in the physical environment, for people living with disability?</td>
<td>What are the most effective and efficient channels to reach our target audience?</td>
</tr>
<tr>
<td>What is the safe way to dispose of diapers in the village context?</td>
<td>What motive/s (nurture, disgust, convenience, affiliation, fear, hoard) can cause the shift from unsafe CFM to safe CFM practices?</td>
<td>If they believe, ‘child faeces are not harmful’, how does it affect behaviours around CFM?</td>
<td>What is the social support people living with disabilities need to perform the behaviour?</td>
</tr>
<tr>
<td>Are we promoting only routines or also specific tools?</td>
<td>What can motivate family members to support CFM practice by people living with disabilities?</td>
<td>Are the perceived norms in favour of or against CFM?</td>
<td>What are the most effective and efficient channels to reach different segments of people living with disabilities?</td>
</tr>
</tbody>
</table>

Research design
3.3 Research contexts

Focus Group Discussion (FGD)

Key Informant Interview (KII)

Note: We had planned to conduct rapid ethnography. However, it was shelved due to COVID-related safety concerns.
### 3.3 Research methods

Formative research in BCD is different from that which is usually conducted in a number of ways; it is designed to carefully answer questions that will help us to construct a Theory of Change for behaviour. It focuses on behaviour and not so much on what people say about their behaviour, as many of the drivers of behaviour are non-conscious and so cannot easily be explained by the people involved.

To know more, please refer to BCD - Formative Research Protocols document.

<table>
<thead>
<tr>
<th>Three Wishes</th>
<th>Motive Stories</th>
<th>User Imagery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Respondents get to make three wishes to improve their life or an aspect of their life (e.g., children’s life). This helps us understand overall motives in life, not necessarily related to the behaviour.</td>
<td>Respondents react to stories that link motives to the target behaviours. This helps us understand motives specific to the target behaviour.</td>
<td>Respondents imagine the profiles of those who perform the target behaviour and those who do not. This helps us understand motives, social norms, and sanctions related to the target behaviour.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Site Observation</th>
<th>User Journey</th>
<th>Behaviour Demonstration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Researchers observe the site and then interact with the community member to know more about what was observed. This helps us understand aspects of the physical environment, reasons for choices, and rewards.</td>
<td>Respondents narrate their experience of performing the target behaviour (e.g., latrine construction) as a story. This helps us understand the factors that influence different stages of the user journey.</td>
<td>Researchers observe the demonstration of the behaviour (e.g., washing hands) and then interact with the persons living with disabilities to know more about what was observed. This helps us understand routines, tools used, and challenges to performing the behaviour.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Touch Point Mapping</th>
<th>Product Concepts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Researchers map the different touchpoints to reach the target persons. This helps us understand access and nature of engagement with potential touchpoints.</td>
<td>After exposing respondents to product and service ideas, researchers elicit reactions to them. This helps us understand target behaviour preferences, motives, knowledge, and willingness to pay.</td>
</tr>
</tbody>
</table>
Sample design

The research sample was selected based on three criteria:

1. **Behaviour**
   The development stage of the child and the nature of tools and infrastructure used results in different routines. Therefore, we looked at the following behaviour segments: infants (tools – cloth, diaper), toddlers (scoop, child potty, toilet).

2. **Income**
   We consciously looked for a good mix of rich and poor households within our sample design.

3. **Inclusion**
   We were looking to recruit caregivers, irrespective if it was women or men. However, we found that the caregivers for infants and toddlers were primarily women. We also conducted specific interviews with caregivers of people living with disability.

District selection

The districts were selected based on their levels of safe and unsafe CFM. We looked at one district with a greater percentage of households practicing safe CFM (Trashigang) and one district with a lower percentage of households practicing safe CFM (Punakha). It is interesting to note that the use of diapers seems to have a negative correlation with safe CFM (see table below).

<table>
<thead>
<tr>
<th>District</th>
<th>% of households practising safe CFM&lt;sup&gt;5&lt;/sup&gt;</th>
<th>% of households using diapers&lt;sup&gt;5&lt;/sup&gt;</th>
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</tbody>
</table>

<sup>5</sup>Baseline Survey Report, 2018
Sample achieved

- **KII with caregivers of infants**
  - Punakha: 10
  - Trashigang: 7
  - Total: 17

- **KII with caregivers of toddlers**
  - Punakha: 8
  - Trashigang: 7
  - Total: 15

- **FGD with caregivers of infants and toddlers - touch points**
  - Punakha: 4
  - Trashigang: 4
  - Total: 8

- **Market study**
  - Punakha: 10
  - Trashigang: 4
  - Total: 14

- **KII with caregivers of persons living with disability**
  - Punakha: 3
  - Trashigang: 2
  - Total: 5

- **FGD with caregivers of infants and toddlers**
  - Punakha: 4
  - Trashigang: 4
  - Total: 8

- **Government: Gup (Village official), Health Assistant (HA), Village Health Worker (VHW), Environment official, Physio official**
  - Punakha: 9
  - Trashigang: 6
  - Total: 15
Research findings

4.1 Target behaviour
4.2 Target personas
4.3 Determinants
4.4 Touch points
Target behaviour

At the end of the Assess phase, we were clear that 70 percent of households with children under 5 (CU5) practise unsafe child faeces disposal, as defined by the Water and Sanitation Programme (WSP) and UNICEF: ‘The safest way to dispose of a child’s faeces is to help the child use a toilet or latrine or, for very young children, to put or rinse their faeces into a toilet or latrine’.

However, we were not clear about the exact behaviours, tools, routines, and determinants that contribute to safe CFM behaviours for CU5. So, we wanted to clarify the target behaviours for safe CFM across the stages of development of CU5. To do that, we wanted to understand the tools and routines used to dispose of faeces of CU5. We also needed to identify the determinants of CFM behaviours i.e., the physical and social environment, and the different levels of the brain of the caregiver. Also, as diaper usage accounted for the majority of ‘unsafe’ behaviours, we wanted to focus on identifying the safe way to dispose of diapers in the rural context. In addition, we explored the motivators and barriers for caregivers of children with disability.

Key research questions

Would we like to promote only routines, or also specific tools?

What is the safe way to dispose of diapers in the village context?
For infants, caregivers use a cloth nappy, for the initial two or three months at least. As the baby grows, caregivers start using diapers. Once the child starts walking, she may also defecate in her pants or in the open. Caregivers may then dispose of the faeces safely or not. Some caregivers may use a child potty. All caregivers ultimately train the child to use the toilet.

Caregivers use different tools and routines to manage faeces as the child grows.
Caregivers often use multiple tools at different stages of the child’s growth.

The combinations can be: nappy + diaper; diaper + potty; diaper + toilet and potty + toilet.

'We don’t use only one until the baby grows. We use a nappy sometimes, sometimes diapers and sometimes a potty.'

Caregiver
Research findings

Behaviour - Cloth Nappy
Caregivers may store the soiled nappy or wash it straight away in a pour-flush toilet or the tap stand located outside the toilet. The water from the soiled nappy may run off into public pathways or water if washed at the tap stand.

Behaviour - Diaper
Caregivers seem to be careful about disposing used diapers at home and even when travelling. They reported disposing of diapers in the household or communal pits for solid waste management, as mandated by the Government. Some caregivers also reported burying the used diapers or putting them in a pit and burning them.

Caregivers who are living in communities located near towns hand over the diapers, along with other solid waste, to the garbage truck; or dispose of in the designated dumping ground.

‘Baby’s diapers should be brought back home, if we throw in other places, people will spit on it and it will bring bad luck to baby, making the child sick.’

Caregiver

Behaviour: Child Potty/Open Defecation/Toilet
As the child starts walking, caregivers may continue to use diapers, especially at night or when travelling, until the child is able to use the toilet. They may use the child potty or directly start toilet training. The child uses the toilet with support and eventually on her own.
Research findings

**Child Potty**
Caregivers use the child potty to start the transition to use of toilet. Sometimes they dispose of faeces in the toilet. They may also throw faeces into the bushes or in the drain, when tired or busy, at night, or if the toilet is at a distance.

**Open Defecation**
Caregivers allow the child to defecate in the open when outside, to avoid holding it and to avoid soiling of pants. They use a hoe or sticks to move the faeces from the ground. They may also throw faeces into the toilet or the bushes or leave them for dogs to eat. They may also cover faeces with soil. Sometimes, caregivers may just leave it in the open.

**Toilet**
The child starts using the toilet under supervision of the caregiver first and ultimately by herself. This process is often difficult and takes some time.

The caregiver may have to support the child to use pit toilets or toilets that are located far from home, especially at night.

'We help her at night because the toilet is outside, and she feels scared.'

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**Caregivers of children with disability**
CFM is a very small part of their overall situation.

Children with disability are often unable to use the toilet at all, so their caregivers use diapers, often for life, which is quite expensive.

Disposal of diapers is into individual or community pits.
Target personas

Target personas bring together important facets of a target segment, such as life context, motives, and relationship with the target behaviour. Seeing them rolled into a single persona makes it easier for us to relate to the target persons when designing interventions.
Sonam became a mother about six months ago. She was both excited and nervous. She was excited to see the newborn baby, but she also felt like she had a big responsibility on her hands. She was not sure if she was capable.

Thankfully, her sister visited during her pregnancy and told her all that she needed to know, from how to breast feed the baby to how to burp him in case of indigestion. Even now, if she has a doubt, she calls her sister to check. She is most happy to see her baby grow. Every little thing, from making new sounds to turning over for the first time, is a moment of excitement for her. Even when she is very tired, just seeing her baby’s smile cheers her up. Sonam is constantly looking for signs to know if her baby is doing okay, or if something is ailing him. Since the baby can’t speak, she needs to keep a check through whatever means. For instance, she observes his faeces very closely every day to check if there is something wrong.

For the first two-three months, she used nappies. Her sister advised her not to use diapers initially because the baby will then grow up bow-legged. Washing the many nappies was a lot of work, but she didn’t mind doing it, as it was best for her child. After three months, she started using diapers. She mostly uses them at night so that the baby can sleep comfortably. In the day, she still uses nappies as they are softer on her baby’s skin.

At the primary health centre, the health assistant told her to dispose of the diapers in the garbage pit. She has been doing that. Anyhow, she didn’t want to throw them anywhere else. What if someone spits on her baby’s diaper? It will make him sick, and she definitely doesn’t want that.

I had certain fears of raising a child, so many questions in my mind like, if I could be a good mother, what if something happens to my child.

Sonam, Caregiver of an infant
Yeshe has two daughters, the elder one is three years old and the younger one is just a few months old. Everyone thinks when you have two children you should be doubly happy. That is true for Yeshe to some extent, especially when she sees her child grow, or start talking and walking. Then she is really happy.

But she also knows that when you have two children, you also have double the work. Instead of one mouth, you have two mouths to feed, two sets of clothes to wash and so on. Besides, she also has the shop to look after.

When she is at the shop, she feels like she is not taking care of her daughters properly. And when she is at home, she feels her sales at the shop are being affected. Her husband does help a bit now and then, but she thinks it is primarily her responsibility. Anyhow, she wouldn’t trust her baby with her husband all the time. He doesn’t know all that much about babies.

Yeshe can’t wait for her elder daughter to grow up and do some things by herself. But she is still very much dependent on her, always calling out to her for this or that. She has been trying to get her to use the toilet, but it is a real struggle. She stands with her the entire time, holding her hands. She wishes there was a faster way to teach her daughters to use the toilet. Picking up the poo, throwing it away and then washing her daughter many times a day is a lot of work.

Though her life does feel tough, with one baby strapped to her back and another one holding her hand, she also feels it is worth it. She wouldn’t have it any other way. There is no joy like motherhood.
Ugyen has three children: two sons and a daughter. Her daughter, who is seven years old, has cerebral palsy. Taking care of a child itself is a big responsibility but taking care of a daughter with cerebral palsy is a bigger one. She has to help her with everything from eating, to bathing, to using the toilet.

When she sees other children her daughter’s age run, play, and go to school, it makes her sad. She wishes her daughter could lead a normal life like them. But she knows that won’t be possible. She constantly worries about what will happen to her daughter after she dies. She is not sure if her sons would care for her daughter as much as she does.

She gets most worried when her daughter is constipated. She will try some home remedies, like soaking her in herbs and water. If it lasts a few days, she will carry her to the primary health centre. Nowadays, she follows a proper diet plan so that her daughter doesn’t have constipation.

She learnt most things about taking care of her daughter by herself, including managing her toilet habits. Through the day, she keeps checking if she has pooped or peed, because her daughter can’t signal. If she has, she will carry her to the toilet, which is becoming more difficult as her daughter is getting heavier.

She prefers to use the diaper, as that will make sure her daughter is not sitting in her own faeces and she doesn’t need to be carried to the toilet.

But diapers are quite expensive, and she would need to use them for the rest of her life. Ugyen wishes for financial support from the Government to purchase diapers for her daughter.

As long as I live, I am here to take care of her but what will happen to my daughter if I die before her?

Ugyen, Caregiver of a child living with cerebral palsy
Determinants

In this section we present findings related to the determinants of behaviour change. We have gathered insights, from the perspective of child faeces management, around five determinants:

4.3.1 Automatic brain
4.3.2 Motivated brain
4.3.3 Executive brain
4.3.4 Physical environment
4.3.5 Social environment

Brain - Key research questions

**Automatic**
What are the cues, routines, and rewards related to CFM practices?

**Motivated**
Which of the following motive/s can trigger the target behaviour most effectively—affiliation, hoard, disgust, comfort, convenience, nurture, and any other?

**Executive**
What are the gaps in knowledge and skills related to tools and routines?
If they believe, ‘child faeces are not harmful’, how does it affect behaviours around CFM?

Environment - Key research questions

**Physical**
What will reduce the barriers to practicing safe CFM, in the physical environment, for people living with disability?

**Social**
Are the perceived norms in favour of or against CFM?
Are there any social sanctions around unsafe CFM?
To what extent is it possible to change gender roles around CFM?
What is the social support people living with disabilities need to perform the behaviour?
The CFM routine varies widely based on the tools and infrastructure used. While cloth nappies are washed and reused, diapers are usually stored and disposed of. In some cases, diapers are reused as a panty, after removing the gel layer.

**CFM cues and routines for infants**

1. The caregiver checks the baby if it smells or cries or makes a strange face.
2. The caregiver removes the nappy or diaper and cleans the baby’s bottom with unsoiled parts of the nappy or diaper.
3. The caregiver puts on a fresh nappy or diaper.
4. The caregiver collects the soiled diaper in a plastic bag or a gunny bag or a basket.
5. The caregiver disposes of the diapers in an old toilet pit or the waste pit.
6. The caregiver washes hands with soap (claimed) during the day.

**Finding**

For both diaper and cloth nappy

4. The caregiver washes the nappy at the tap stand or stores it to wash later.
5. The caregiver dries the nappy in the open and stores it for future use.

For only cloth nappy

6. The caregiver washes hands with soap (claimed) during the day.

For only diaper

4. The caregiver collects the soiled diaper in a plastic bag or a gunny bag or a basket.
Potty – Cue and Routine:

Child indicates to the caregiver that she wants to defecate.

Caregiver puts child on the potty.

Child may defecate or just play with the potty for some time.

Once the child has finished, caregiver takes child to the toilet and washes the bottom with water. The caregiver may just wipe the bottom with toilet paper if it is night-time or winter.

The caregiver disposes of the faeces in the toilet and washes the potty. Sometimes, the faeces may be tossed into the bushes or drain nearby and the potty is then cleaned. The potty is then kept in a corner of the home or yard for next use.

The caregiver may wash their hands with soap at the end of the routine.
Caregivers don’t seem to offer any rewards to the child for using the toilet. However, there are punishments, and toilet training is a difficult time for the child.

**Toilet-cue and routine:**

Young child undergoing toilet training indicates to the caregiver that she wants to defecate.

Caregiver takes the child to the toilet and helps remove pants and may help the child squat.

Once the child has defecated, the caregiver may support in anal cleaning.

**Toilet-rewards and punishment**

Caregivers don’t seem to offer any rewards to the child for using the toilet. However, there are punishments, and toilet training is a difficult time for the child.

Often, the caregiver scolds or beats the child to get her into the habit of using the toilet. The child may cry or run away at first, as there is fear of the dark or falling into the toilet.

As the caregiver keeps persisting, the child starts using it regularly. The caregiver may still need to assist the child at night or if the toilet is outside.
Mothers are strongly driven by nurture and work hard to care for the child. They find deep fulfillment and joy in watching the child grow.

'It is extra work and responsibility but also gives me happiness, I think there is no love greater than this.'

Caregiver

'It is a great experience to see your child grow, and when they grow, when they don’t have delays in development, that makes me feel better. My daughter started crawling when she was eight months, and at one and a half she started to walk, it feels so good.'

Caregiver

Mothers worry about protection of children - from illness, accidents, injury, etc. They do what it takes to keep them safe and comfortable, even if it means more work.

'Recently my youngest had a problem, she was not able to poop for days. I instantly took her to the hospital. I leave everything behind and make sure I take them to the hospital. I get so scared that something might happen to them.'

Caregiver
Caregivers are not disgusted by faeces of their own child.

Mothers experience strong disgust with adult faeces but less with children’s faeces. The smell and size of adults’ faeces is more disgusting as adults eat chilli, meat, alcohol, etc., while children’s faeces smell less and are less disgusting as they eat limited items.

Mothers clearly and strongly rejected the idea of disgust with their own child’s faeces. They expressed a sense of distance and disconnection with any mother that feels disgust at her child’s poo.

‘I have never seen any mother who is disgusted with her own baby’s poo. We don’t have such mothers in our village. Maybe some mothers in Thimphu, who are modern and have babysitters.’

Mothers are often busy balancing childcare with housework and activities such as farming or running a shop. They look for ways that make CFM convenient in a way that also works for the child.

**Finding**

**Diapers over nappies**

‘I use diapers for the convenience. I am at the shop mostly and using diapers helps me get my work done, especially when there are a lot of customers. I don’t have to keep changing. I can change it after few times of pee or when there are no or less customers.’

**Use of child potty**

‘My friends told me to use a potty. They said it is convenient and you can just keep in one corner of the house and use it whenever the child needs to pee.’

**Use of toilet**

‘Life has become so convenient with my children being able to use the toilet. The time I put into dumping the diapers and, changing them can now be diverted into other work.’
Caregivers worry that others would disapprove of improper faces disposal.

“If a household does not take care of the used nappies, neighbours often complain, the mothers are considered irresponsible, and people talk badly about her.”

Caregiver
4.3.3 Executive Brain

Finding

Caregivers do not receive any formal support/training on CFM.

CFM is a blind spot, neither focused on in sanitation messaging, nor in pre/post pregnancy care at Primary Health Centre (PHC) or hospital. Current messaging on sanitation refers to adults, not to child faeces. The training at the PHC and hospital pre/post-delivery relates to overall health of the mother and baby and does not include CFM.

‘PHCs and hospitals teach new mothers how to breast feed our baby and healthy diet we have to follow when we are breast feeding.’

Caregiver

Finding

The only mention of CFM is the mandate of safe disposal of diapers: no littering or burning; to be buried in a pit at individual or communal level. Mothers figure it out on their own or learn from the other mothers around them.

‘With regard to poop, no one taught me, I learned it myself. We do have questions, but the more you do it the more you get used to it.’

Caregiver

Finding

Caregivers would like to receive training on childcare and CFM.

Mothers, especially when they have their first child, have fears and anxiety about childcare, including poo and pee habits. They have questions and doubts and would like to receive training on how to handle CFM.

‘Trainings on how to take care of newborn babies and their poop would be helpful for new mothers who do not have support from mothers/sisters/mother-in-law/sister-in-law.’

Caregiver

‘If there was training, it would greatly help. Trainings such as what products to use for a certain age, how to wipe poop and pee, what to do when your child has rashes....’

Caregiver

Research findings
Caregivers have beliefs about diapers that influence their usage.

Mothers use a cloth nappy for newborns as they believe that using a diaper will cause the child to become bow-legged.

Finding

Many mothers believe that their child will have bad luck if diapers are thrown around.

‘If you throw your baby diaper, people curse and eventually it brings bad luck for your child.’

Caregiver

Caregivers believe that child faeces are not as harmful as adult faeces.

There is clear and strong awareness that adult faeces can cause diseases such as diarrhoea, cough, cold, sore throat, headache, stomach pain and vomiting. The connection between children’s faeces and disease was weaker: mothers were vaguely aware of possible diseases, but unsure of what they might be.

‘Since the olden days, people used to say that “Child poo is not harmful” so I don’t think it will spread disease. Adults eat everything so it is more disgusting and spreads more disease.’

Caregiver

‘Trainings on how to take care of newborn babies and their poop would be helpful for new mothers who do not have support from mothers/sisters/mother-in-law/sister-in-law.’

Caregiver
Caregivers struggle with toilet training.

Mothers figure out their own way to train the child to use the toilet or potty or learn from other mothers.

‘The transition to using a toilet was difficult in the beginning, but I kept taking them to the toilet and after few times they were OK. You need patience and consistency.’

Caregiver

Punishments such as scolding and beating were mentioned, but no rewards.

‘It was quite a challenge when I was training her, she used to cry so much. [She] didn’t sit down and kept running away. We managed it somehow, after scolding her and sometimes hitting her also.’

Caregiver

The potty is seen as a good option to make the transition from diaper to toilet easier.

‘A woman in the next village, her son is five and still not toilet trained. I told her to use the potty first and then toilet.’

Caregiver
4.3.4 Physical Environment

New infrastructure and products have made childcare easier.

There has been overall improvement in infrastructure in the past years – roads, electricity, water, toilets, etc.

‘Electricity came to our village not so long ago. Before that there were mothers who had a difficult time managing their kids. They were not able to heat water and wash the nappies, now with diapers things are so much better. Some didn’t even have cloth nappies; babies were wrapped in old cloths.’

‘With development, we are introduced to different products such as diapers, creams, oils, etc. Compared to before everything is convenient. It was difficult for the mothers in the olden days but now it is easier for mothers, we also have Education and Early Childhood Care and Development centers (ECCDs) and also new products for child faeces.’

Caregiver

Caregiver
4.3.4 Physical Environment

Finding

Toilets are available but difficult for some children to access.

Most households have access to toilets and an increasing number have pour-flush toilets as a result of intensive work on sanitation promotion in villages. More homes have toilets that are attached or closer to home.

“You don’t see poo in the open these days, almost all the houses own a toilet.”

Caregiver

Young children struggle with pit toilets and toilets located far away from home. Pour flush toilets and toilets attached to or close to home are easier for children to use by themselves. Children living with disabilities also struggle with the design and location of ‘regular’ toilets.
We learnt that caregivers choose tools depending upon the stage of development of the child, as well as features of the tools.

Key features of tools used to manage child faeces are:

- comfort and health of child
- containment of faeces and urine
- ease of use for the caregiver
- cost and durability - affordable or reusable
- availability - at home or in nearby market.

### Finding

**Caregivers choose tools by trading off different features.**

Caregivers use cloth nappy for newborns, for the initial two to three months, as it is soft for baby’s skin and doesn’t cause rashes. They are also cheap and can be reused many times. However, it is more work for the caregiver as there is more laundry, which becomes more difficult when travelling and in the winter. Also, the cloth nappy leaks easily and doesn’t hold much.

**Tool – Cloth Nappy**

‘In the day time I change a cloth nappy around four to seven times. Whereas a diaper is just once a day (only one for the whole night).’

Caregiver
Caregivers prefer the diaper because it contains poo and pee very well and is disposable, so no laundry, which is very convenient. It is easily available at nearby markets but expensive compared to cloth nappies.

The diaper keeps the baby dry and allows baby to sleep through the night but might cause rashes.

*Tools – Diaper*

‘It is advantageous for both the mother and the child, it keeps the child dry without disturbing their sleep and for the mother also, she can have a good sleep. She is responsible for almost everything at night so she deserves a sound sleep!’

— Caregiver

*Tools – Child Potty*

It contains faeces and pee well and is convenient for the caregiver as it can be used anywhere and at any time. At around 450Nu, it is affordable, durable, and available in markets nearby. Caregivers don’t have to worry about the child falling into the toilet. Some children like it, some don’t; it may be cold to sit on in the winter.

‘Potties are better than diapers actually, they can be used again and again, and you are teaching your child to use the toilet in the long run. It is also good for the environment as it goes straightaway to the tank.’

— Caregiver
Caregivers are keen for the child to use the toilet as they become independent and it is less work for them. Toilets are excellent for containment of faeces and pee, and there is no additional cost as the toilet is always available at or near home. Toilet designs that are friendly for children living with disability are needed but rare.

"It is scary for me since I have a pit toilet and I feel he might fall in the pit."

- Caregiver

Open Defecation

Caregivers allow the child to defecate in the open when a toilet is not available as it is better for the child than the discomfort of holding it in. There is no cost, but caregiver may have to work to move or cover the faeces or may even leave them in the open. There is poor containment of faeces and pee and it is the most unhygienic option. Space/social sanction for open defecation for children is not an issue.

"My child pees and poos wherever he likes sometimes, I pick it up with a hoe and throw it in the bush (especially when I have a lot of work, it is easier that way)."

- Caregiver
The community views open defecation negatively.

Most households have toilets so open defecation has become a thing of the past.

'We don’t see people poop or letting children poop in the open now, so the hoe is also not commonly used.'

Caregiver

If faeces are seen in the open, it is seen to be a negative thing and there might be bad-mouthing or gossiping.

'People comment and spit on the diapers if we throw them around in the village, which will make our baby sick.'

Caregiver

Caregivers of children with disability prefer diapers but find them expensive.

Caregivers of children living with disability find diapers very convenient, as their children can’t signal and they need to carry the child to the toilet. However, they find diapers quite expensive and would like some financial support on that front.

'It would be easier if we were given some amount of money or other support by the government. It is an additional expense when you have a disabled child.'

Caregiver
Mothers were resistant to changes in gender roles.

The mothers seemed well adjusted to the current arrangement of roles based on gender. If men were to take on ‘female’ i.e., indoor roles, then females would also be expected to take on ‘male’ i.e., outdoor roles. This would not work well for either gender in the village context.

‘It might change in the town but not in the village; village work is a lot of physical work, if men do not do it, who will? If we exchange, we will be the ones doing most of the physical work and we won’t be able to.’

Mothers responded negatively to the idea of changes in gender roles in general, and for childcare in particular, as males are not seen to be as good as the females in taking care of children.

‘We don’t see these roles changing in the near future, it has always been like this, and it always will be. Mothers and grandmothers are much better as compared to the fathers or grandfathers.’

Young children are usually looked after by the mother, who relies on close female relatives - mother, mother-in-law, sister-in-law - and close friends who have brought up children, for support and advice.

‘Mothers help in teaching their daughters with their new-born. They teach how to feed, bath, to change their nappy, and feed nutritious meals.’

Mothers see themselves as the experts on childcare and think that fathers are not as good at it.

‘There are some men who help with the chores, but the boss is always the mother or the grandmother.’

Mothers were resistant to changes in gender roles.
4.4 Touch points

We specifically explored effective touch points to reach our target segments through FGDs among men and women. We also explored effective ways to reach persons living with disabilities. We share here our findings on the reach and engagement of different touch points.

Key research questions

What are the most effective and efficient channels to reach our target audience?

What are the most effective and efficient channels to reach different segments of people living with disabilities?
### Mass media

#### Radio

**Reach**
Radio is usually listened to on the phone. Very few people listen to the radio – mostly the elderly.

**Engagement**
Not much time is spent listening to the radio and there is no specific time to listen.

#### TV

**Reach**
Most people in the village own a TV, even the not so rich families. The few without a TV, visit other households to watch TV.

**Engagement**
Most people watch TV every day in the evenings after seven PM. The most Popular Channel is BBS (Bhutan Broadcasting Service).
## Interpersonal media

### Mothers Group

**Reach**
There is no mother's group in the village. Mothers usually meet when their children are being immunised.

**Engagement**

### Village Health Worker (VHW)

**Reach**
There is one VHW per village, who lives in the village itself. She does not conduct meetings or do household visits.

**Engagement**
People go to her when they are sick, and she gives medicines.

### Out Reach Clinic (ORC)

**Reach**
Visit once a month.

**Engagement**
Mothers spend between two hours to half a day at the ORC. Currently, the message from the HA is on child health and nutrition, there are no messages on CFM, except on diaper disposal.

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### Research findings
Reach
Most mothers own a personal smartphone. Only elderly people have basic phones.

Engagement
Usage is limited because of the data costs. Most popular forum for mothers is WeChat. There are no mother’s WeChat groups at the moment, but they would like to have one.
Conclusions
**Target behaviour**

<table>
<thead>
<tr>
<th>Key finding</th>
<th>Recommendations</th>
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<tbody>
<tr>
<td>Caregivers use different and multiple tools to manage faeces at different stages of the child’s development: nappy, diaper, potty, and finally the toilet.</td>
<td>We could promote all the tools that can be used for safe CFM, along the different developmental stages of the child.</td>
</tr>
<tr>
<td>Caregivers put used diapers into individual or communal Solid Waste Management (SWM) pits, or bury them. Littering is rare, as mandated by Bhutan Government guideline.</td>
<td>Use of diaper seems to imply safe disposal as per guidelines of Bhutan Government, although not by WSP/UNICEF definition. We need to further clarify this.</td>
</tr>
<tr>
<td>Some mothers use the child potty to help the child move towards use of toilet. However, they may sometimes also dispose of the faeces unsafely after use.</td>
<td>The child potty seems to be a good tool to accelerate the transition from use of diaper to toilet. However, it doesn’t seem to guarantee safe disposal of faeces by itself. This can be promoted, with some training for caregivers on safe disposal of faeces.</td>
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**Conclusions**

**Key finding**

<table>
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<tr>
<th>Recommendations</th>
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<tbody>
<tr>
<td>Toilets are available but are often not comfortable for young children who struggle with using pit toilets and toilets that are far away, especially at night.</td>
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<td>It seems that some OD is likely to persist, especially when children are outside of home with caregivers.</td>
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<tr>
<td>Many caregivers, including those of children living with disability, prefer diapers as they are very convenient to use, although expensive in the long run. The use of diapers is only likely to increase with time and does not appear to need any promotion.</td>
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<tr>
<td>Soiled nappies are washed in pour flush toilets or at public tap stands.</td>
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**Motivated brain**

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<tr>
<th>Key finding</th>
<th>Recommendations</th>
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<tr>
<td>Mothers are strongly driven by nurture, as they are very invested in their</td>
<td>Nurture, convenience, and affiliation could be used to motivate caregivers</td>
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<td>children and work hard to care for the children.</td>
<td>along with modernity, while disgust should be avoided.</td>
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<td>They look for convenience when it comes to CFM, as they juggle multiple</td>
<td></td>
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<td>activities.</td>
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<td>They would like to have affiliation with others in the community and aspire</td>
<td></td>
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<tr>
<td>for modernity.</td>
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<tr>
<td>Mothers reject the motive of disgust for CFM.</td>
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</tbody>
</table>

**Executive brain**

<table>
<thead>
<tr>
<th>Key finding</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a gap when it comes to CFM messaging, as it is neither addressed</td>
<td>Messaging around CFM could be included in sanitation programmes as well as pre/post</td>
</tr>
<tr>
<td>in sanitation programmes nor pre/post pregnancy care.</td>
<td>pregnancy care initiatives.</td>
</tr>
<tr>
<td>Caregivers know the Government guideline about disposal of diapers into</td>
<td>Messaging could be provided around the health impact of child faeces - that they</td>
</tr>
<tr>
<td>pits and believe their children will get bad luck if they are littered,</td>
<td>are indeed as harmful as adult faeces - to drive home the importance of safe</td>
</tr>
<tr>
<td>leading to safe disposal as defined by the Bhutan Government.</td>
<td>disposal of child faeces.</td>
</tr>
<tr>
<td>While caregivers know that the toilet is the best way to dispose of child</td>
<td>Caregivers would benefit from training on CFM, particularly training on use of</td>
</tr>
<tr>
<td>faeces, they perceive child faeces as not as harmful as adult faeces. This</td>
<td>child potty and toilet training that is child friendly.</td>
</tr>
<tr>
<td>leads to unsafe CFM behaviours, especially for children that don’t use the</td>
<td></td>
</tr>
<tr>
<td>toilet.</td>
<td></td>
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<tr>
<td>Caregivers and children struggle with the transition from diaper to toilet,</td>
<td></td>
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<tr>
<td>as there is no training around it.</td>
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</tbody>
</table>
**Social environment**

<table>
<thead>
<tr>
<th>Key finding</th>
<th>Recommendations</th>
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</thead>
<tbody>
<tr>
<td>There is nearly universal availability of toilets and open defecation is seen as outdated and on its way out, with the exception of children. Open defecation by children, while it is not the norm, is more acceptable than by adults.</td>
<td>Messaging on sanitation can include children, so that open defecation by children becomes as unacceptable as open defecation by adults.</td>
</tr>
<tr>
<td>The current social norms seem to be in favour of safe CFM, and there is negative social response to unsafe CFM.</td>
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</tr>
<tr>
<td>Mothers are the primary caregivers and seem well adjusted to the role of caring for children. They are very invested in their children and see themselves as experts on childcare. There was a negative reaction to the idea of men taking over the role of caring for children.</td>
<td>Ideas on how men can be included in childcare in general and child faeces disposal in particular need to be explored.</td>
</tr>
</tbody>
</table>

**Touch points**

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Mass media</strong></td>
<td>Very few people listen to the radio. Most people in the village own a TV, even the not so rich families. The few without a TV visit other households to watch it.</td>
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<tr>
<td></td>
<td>We could use TV as it has good reach and everyday engagement. IPC sessions at the ORC could be possible and effective.</td>
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<tr>
<td><strong>IPC</strong></td>
<td>There is no mother’s group in the village. There is one VHW per village, who lives in the village itself. She does not conduct meetings nor do household visits. Mothers visit the ORC once a month.</td>
</tr>
<tr>
<td></td>
<td>WeChat would be useful as reach and engagement is high. We could create and moderate a mother’s group on WeChat.</td>
</tr>
<tr>
<td><strong>Digital Media</strong></td>
<td>Most mothers own a personal smartphone and use WeChat.</td>
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Annexure

Research guides and tools