EFFECTIVENESS OF COMMUNICATION CAMPAIGNS IN THE SUSTENANCE OF OPEN DEFECTION-FREE SOCIETY: A STUDY OF UGEP COMMUNITY IN CROSS RIVER STATE

BY

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Abstract
This paper focuses on the role of communication campaigns in sustaining an open defecation–free community. The population was drawn from the four wards in Ugep Local Government Area of Cross River State. Questionnaires were administered to 80 respondents and eight volunteer health communicators were interviewed. Findings showed that most of the respondents attended sensitisation programmes which led to some community members abandoning the practice of open-defecation; and that many of them have toilets and do not defecate in the open, while about a quarter of the respondents still defecate in the open because they lack information on the dangers of such practice. The study recommended that continuous communication campaign should be used to sensitise the public on the need to stop open defecation; while volunteer health communicators should sensitize children on the dangers of open defecation since the study showed that many of them still engage in this act.
Keywords: Campaign, communication, open defecation, sensitisation, Ugep.

Introduction

The state of man's health, to an extent, is dependent on his environment. Human activities and practices are often not nature-friendly and may result in an unhealthy and dirty environment. Evolution has led to certain changes of man's practices; some are modified while others are eliminated. However, the pace of development and modification of certain human practices are not the same globally. For developing nations, they are lagging behind in the global fight against unhealthy human practices like open defecation, female genital mutilation and a host of other unwholesome practices. It is, therefore, not far-fetched why international non-governmental organisations often send aids to these nations.

Furthermore, developing nations are plagued with poverty, lack of social amenities, improper healthcare delivery and other unwholesome practices that have led to the continuous outbreak of deadly diseases as a result of constant exposure to infections. Africa is a continent that is synonymous with diseases such as cholera, diarrhoea, dysentery, etc. In Nigeria, since the beginning of 2018, there have been a total of 5,607 suspected cases of cholera reported in nine states of the Federation. Odikamnoro, Ikeh, Okoh, Ebiriekwe, Nnadozie, Nkwuda and Asobie (2017) identify typhoid as one of the infections that is caused by poverty and which leads to serious negative health impact. This implies that poverty is the cause of many infections and diseases in Nigeria. A global report of research on infectious diseases from poverty reveals that the scourge comes into view and chronic condition clusters and continues wherever poverty is widespread. It is a known fact that lack of good food, potable water, shelter and

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proper healthcare delivery can lead to an epidemic. Poverty can also lead to non-provision of toilet facilities in homes, thereby leading to open defecation, which can cause outbreak of infectious diseases. A study in India by Kotian, Sharma, Juyal and Sharma (2014) confirms this connection in its conclusion that prevalence of infection was higher in population practising open defecation than people using latrine.

Open defecation is a practice that is common among rural dwellers in Nigeria. Gupta, Hathi, Khurana, Srivastav, Vyas and Spear (2014) describe the practice as defecating in an open environment rather than using toilet facility. Open defecation can be done in bushes, forest, canals, ditches, streets, etc. Statistics reveal that rural dwellers constitute the highest population of open defecators. Multiple Indicators Survey of 2017 as revealed by UNICEF (2018) shows that 46 million people still practise open defecation in Nigeria and 33 million of this figure are rural dwellers. According to the United Nations Children's Fund (UNICEF), many approaches introduced were aimed at eliminating open defecation but all these have failed to attain a sustainable latrine usage, which has led to Nigeria becoming one of the nations with the least level of access to good sanitation (UNICEF 2018). Indeed, as observed by President Muhammadu Buhari, the country ranks number two globally in open defecation (Vanguard Newspaper, 2018).

Health communication campaign plays a significant role in influencing certain behaviours that are detrimental to human health. Many practices that are harmful to human health are entrenched in human culture, and beliefs. Sood, Corinne, and Sengupta (2006) opine that health promotion campaigns in developing nations influence knowledge and encourage interpersonal communication that promotes pro-social behaviour. Health communication campaign does not only create awareness and social change but serves as a springboard for interpersonal communication among members of a given community concerning a behavioural issue. Health communication campaign can be described as a process of applying integrated strategies to deliver messages designed directly or indirectly to inform, influence and persuade target audiences attitude about changing or maintaining healthy behaviours (Kauppi 2015). Health communication messages can be transmitted through various channels of communication, which include television, radio, newspaper, internet, social media, brochures, posters, workshops, community forum and interpersonal interactions.

Open defecation-free campaigns have been ongoing in Nigeria and particularly Cross River State. These campaigns have, to a large extent, recorded a level of success within some rural areas and towns having been declared open defecation-free. It is a great achievement for the members of the community, policy makers, and non-governmental organisations that have been at the forefront in achieving this success. Proschaska, Krebs and Norcoss (2011) assert that in stages of change model, individual progresses from one level of change to another based on persuasive messages that have been disseminated. They further explain that when a change occurs, certain efforts are required to maintain the change that has occurred in order to avoid a relapse. Constant and persistent exposure to persuasive messages on behavioural change can help in completely eradicating the practice of open defecation. The aim of health communication campaign is to influence and change health behaviour of individuals and communities in a positive way. Newson, Lion, Crawford, Curtis, Elmada, Feunekes, Hicks, Vanliere, Lowe, Meijer, Pradeep, Reddy, Sidibe and Uauy (2013) explain that majority of the health challenges faced by man are preventable and the solution is in behaviour change. It is worthy to note that typhoid, cholera and dysentery that are caused by open defecation can be prevented when there is a behavioural change. This study primarily focused on assessing the effectiveness of communication campaigns in the sustenance of open defecation-free society in Ugep, Cross River State in order to avoid any form of relapse.

Statement of the Problem

Open defecation is a practice that is common in developing and under-developed nations. Despite its numerous disadvantages and negative impacts, it has remained a prevalent practice in these nations, particularly Nigeria. Open defecation is a practice that has remained persistent over the years despite constant campaigns and health promotions. It is believed that the major cause of open defecation is lack of toilet facilities, culture and values tied to the practice. Open defecation causes environmental pollution and various diseases such as cholera, typhoid, dysentery, etc. Falaju (2016) explains that experts have warned that when large numbers of people defecate in the open, it is almost impossible not to ingest human waste. Open defecation leads to contamination of not just the environment but also food and water. No wonder, the Nigeria Centre for Disease Control (NCDC, 2018) warns against open defecation, especially during the rainy season, which it says can lead to deadly infections such as cholera, dysentery, and diarrhoea.

Recently, the anti-open defecation campaign and sensitisation programmes have been successful and some communities in Cross River State were declared open defecation-free, which implies that members of these communities no longer defecate in the open, and traces of human faeces cannot be found in such communities. Ugep was declared open defecation-free in April 2018, thus connoting that there are no traces of faeces found in an open space and that children, most especially, have stopped defecating in the open. It is important to state that open defecation is a practice and a way of life of the people; but due to modernity and development, rural communities are urged to abandon it and other life-endangering practices.

Since the practice of open defecation has not been outlawed by the government, can a community that has been declared open defecation-free still keep up with the newly acquired habit or will it experience a relapse by simply reversing to its old lifestyle? Are open defecation-free communities truly free of open defecation? Can the practice of open defecation be completely eradicated through continuous sensitisation campaigns? These are some of the questions this study had set out to answer.

Research Questions

1. How effective are the communication campaign strategies adopted in sustaining open defecation-free communities?
2. What are the challenges of health communicators who are saddled with the responsibilities of sensitising the communities on open defecation?
3. What are the communication challenges that can lead open defecation-free communities to experience a relapse?

The Role of Communication in Influencing Behavioural Change

According to the United Nations Children Educational Fund Regional Office for South Asia (2005), behaviour change communication is a research-oriented consultative process of addressing knowledge, attitudes, and practices through well-defined strategies using an audience-appropriate mix of interpersonal group and mass media channels, including participatory method. It is the use of communication to change behaviour. It works at multiple levels of system which are individuals, family, community, service delivery, and an enabling environment. Behaviour change communication is not only focused on individual but on families, communities and socio-cultural factors that possibly lead to the behaviour that is detrimental to an individual and the community at large. It can be viewed as a development process, which is aimed at educating and enlightening individuals and communities to change for the better.

Furthermore, Adewuyi and Adefemi (2016) explain that behaviour change communication is an offshoot of health communication that is primarily concerned with the study and application of communication strategies for promoting positive health outcomes. Similarly, Briscoe and Aboud (2012) describe behaviour change communication as non-linear in nature but rather, a participatory process aimed at encouraging positive health behaviour change in individuals and communities through the strategic application of targeted messages. Behaviour change communication is individual and community-oriented. This kind of communication is usually tailored in a manner that can be easily understood amongst members of the community. It is a strategic kind of communication, identified by Okwumba and Onyiaji (2018, p. 12) as purpose-driven which "has the capacity to create awareness and change attitude."

Behaviour change communication messages are transmitted through various channels of communication, and when transmitting a message to a community, it is advisable to adopt the channel that is most efficient. Behaviour change communication is a two-way flow – health communicators listen to members of the community and while in the process of dialoguing, this enables the communicator to develop culturally appropriate and easy-to-understand strategies that will aid in addressing the challenges. This form of communication can be transmitted in several ways. One of the characteristics of behaviour change communication is that it can be transmitted through any means of communication. It could be through interpersonal communication, counselling or group discussion, performing art, fine art, folk tales, dances, etc. The role of behaviour change communication is to influence and change individuals from behaviours that can be a threat to the individual and the society at large.

Cultural Background, Health and Environmental Implications of Open Defecation

Open defecation can be described as the act of defecating in the open, be it in the river, bush, canal, roadside, etc. The practice of open defecation has been directly linked to poverty, lack of toilet facilities, etc. It was a generally acceptable practice in Nigeria till it became a national issue due to the health concerns raised by international organisations concerning it. Open defecation is regarded as a cultural norm in most rural areas, where people engage in indiscriminate defecation in the open without any form of sanctions (Ngwu, 2017). This practice is culturally bound, although poverty and lack of toilet facilities could be some of the reasons it is prevalent. However, when a practice is intrinsic on cultural belief, changing the behaviour of the culturally-bound practice of the people will require an effective communication strategy. Due to its link with the cultural beliefs of the people, open defecation is still prevalent in some urban areas. Development and urbanisation have not changed the perception of the people. The problems of open defecation, poor sanitation as well as the socio-cultural side effects of poor sanitation have been the focus of many health and nongovernmental organisations. Sadly, there is inadequate academic research in the area of open defecation. Most of the available literatures are, therefore, reports generated by international agencies and nongovernmental organisations.

Furthermore, open defecation creates an inhabitable and unhealthy environment, and is the major cause of cholera, diarrhoea and dysentery. Spears, Ghosh, and Oliver (2013) explain that open defecation has been found to cause stunting and malnutrition. Health experts also claim that open defecation increases the risk of polio infection among children since the faecal-oral route is regarded as a pertinent pathway for the transmission of virus (Saliu, 2016). In most rural areas in Nigeria, there are significant challenges to the provision of environmental services such as water, sanitation, solid waste management and drainage; and most of the rural dwellers are not aware of the dangers that are associated with open defecation.

According to the Ministry of Water Resources in Nigeria, diarrhoea, which is the second largest killer of children below five years, is caused by poor management of human excreta. The negative impact of open defecation is often perceived from the aspect of health. It is worthy to note that open defecation also has its impact on the economy of a nation. Gius and Subramanian (2015) explain that the economic cost of inadequate sanitation facilities in India in 2006 was 53.8 billion Rupees. Similarly, the Ministry of Water Resources in Nigeria revealed that Nigeria loses 455 billion Naira or 3.6 billion Dollars annually due to poor sanitation.

Godana and Mengiste (2017) assert that unhygienic dumping of human faeces and other forms of unhygienic conditions are the main contributors to diarrhoeal disease. Based on their study, unhygienic disposal of human faeces and other unsanitary human behaviours contribute to 88 percent of diarrhoeal disease and a major cause of mortality among infants and adult. Similarly, Uthira and Babu-Suresh (2017) aver that the World Health Organisation report of 2011 shows that 0.7million deaths occurred as a result of infectious diarrhoea. They further reveal the process in which open defecation can lead to water and food pollution which is the major cause of typhoid, diarrhoea, cholera, hepatitis, polio, and trachoma. Faecal pathogens are transmitted to water and this leads to water-borne diseases.

Open Defecation-Free Policies in Nigeria

The Nigerian government has formulated policies that are aimed at promoting sanitations in the country, and some of them, at ending the practice of open defecation. So far, there have been four policies – National Water Supply and Sanitation Policy formulated in 2001, National Environmental Sanitation Policy in 2005, National Health Promotion Policy (2006), and the Strategy for Scaling up Rural Sanitation and Hygiene – which were to meet the Millennium Development Goals (2007). The water and sanitation policy was developed by the Federal Ministry of Water Resources and was primarily focused on sanitation and hygiene which include the proper disposal of liquid and solid waste. The main objective of this policy is to ensure that Nigerians have access to affordable sanitation through the vigorous involvement of all levels of government, communities, households and individuals. The fight to achieve a proper disposal of liquid and solid waste does not only lie on the government, but also on the willingness of individuals, households and communities to adopt a proper means of disposing solid and liquid waste. The National Task Group on Sanitation is a group that is made up of both government and nongovernmental agencies, which are the Ministries of Water Resources, Environment, Housing, and Urban Development, Health, Education, and Women Affairs, National Orientation Agency, Millennium Development Goals Office, National Planning Commission, National Agency for Food, Drug Administration and Control, UNICEF, Water Aid, European Commission, Department For International Development, and World Bank. This national task group approach was not successful as it failed to create a community based approach to meet the needs of the rural dwellers.

In a bid to increase sanitation due to poor results of other approaches, the Nigerian government adopted a community-led total sanitation approach which is primarily aimed at empowering communities through evolving exercise to expose the problems that are linked to open defecation and also encouraging communities to take collective actions to solve the challenges that are associated with the achievement of improved health and well-being of the people. This policy is community-oriented as it focuses on establishing a behavioural change in sanitation. One of the strengths of the policy is that it is not just focused on building toilet facilities for communities but more on achieving a change in sanitation behaviour because providing toilet facilities with no change in sanitation behaviour cannot solve the issue of open defecation. Toilet facilities can only be used if there is a change in behaviour. Community-led total sanitation (CLTS) can be described as a participatory methodology for mobilising

communities to eliminate open defecation. Communities are given the mandate to carry out appraisal and analysis of the practice and take necessary measures to become an open defecation-free community. A community can only be declared open defecation-free when all members of the community defecate in latrines and there are no traces of faeces in the community and such community is verified as open defecation-free by a third party (Njuguna, 2016).

However, studies have shown that communication campaign serves as a tool in combating open defecation and enhances the implementation of these policies. A study by Abubakar (2018) highlights some threats of the practice on human and environmental health and recommends facilitating ownership of latrines by households and communities, as well as stepping up campaigns aimed at behavioural change as ways through which the practice can be eliminated in Nigeria. Open defecation is a common practice in most communities; and building toilets for members of this community is a stepping stone to end open defecation. However, for a total eradication of the practice, members of the community must be sensitised on the need to abandon their old practice. Ngwu (2017) avers that this is deeply rooted in the tradition and culture of some Nigerian rural communities, and recommends that eradicating open defecation requires behavioural change communication because simply supporting communities to build latrines may be insufficient to make them use the facilities. Studies by Gertler, Shah, Alzua, Cameron, Martinez and Patil (2015) and Gross and Gunther (2014) reveal that behavioural change communication should not be a secondary approach: it must be fundamental to the community-led total sanitation programmes in Nigeria, as there is substantial evidence that campaign programmes focusing on behavioural change foster latrine adoption and significantly reduce open defecation in many developing countries.

Devine and Kullmann (2011), in their study, reaffirm that behaviour change communication is very essential and it enhances the implementation of polices that are aimed at ending open defecation. They recommend community-led total sanitation (CLTS) and behaviour change communication (BCC) as useful adjuncts because, while CLTS focuses on changing community practices, BCC is on changing individual or household behaviours. Hence behaviour change communication can be used to sustain and supplement community-led total sanitation in motivating individuals to adopt open defecation-free practice and sustain this behaviour over time. Perez (2012), in a research carried out in Bangladesh to examine the long-term sustainability of sanitation behaviours and facilities in areas that were declared open defecation-free, observes that the BCC campaign directed at households to stop practising open defecation was very extensive: campaign messages were communicated through various channels and settings including messaging by members and officers of the local Union Parishad (the smallest rural administrative unit) at meetings, rallies, over loudspeaker announcements, and through household visits by Union Parishad member.

Research Methodology

Research design, according to Burns and Grove (2003), is a plan for carrying out a study with the highest control over factors that may interfere with the validity of the findings. Parahoo (1997) sees it simply as a blueprint or an outline that is primarily aimed at describing how, when and where data are to be collected and analysed. It also means how the researcher intends to provide answers to the research questions and the hypotheses formulated.

This study adopted a descriptive survey design, which is used to quantitatively describe specific areas of a given population. This type of research design is apt for this study because, according to McIntyre (1991), it can be used to obtain information or data from large samples of a given population and it is very suitable for gathering demographic data, and can be used to describe the composition of the sample of a population.

The population of this study is Ugep town in Yakurr Local Government Area of Cross River State. According to the Local Economic Empowerment and Development Strategy for Yakurr Local Government Area (YAK-LEED 2, 2013), the population of Ugep is projected at 103,220 and it has the highest population density in Yakurr Local Government Area. Apart from its high population, the town was preferred for this study because it was declared open defecation-free in April 2018. Also, its choice allowed the researchers to ascertain if open defecation-free communities have truly abandoned their old practice.

The respondents were drawn from the four wards in Ugep town which are Ijiman, Ijom, Ikpakapit, and Biko-Biko. One village was randomly selected from each of the wards: Aneja from Ijom, Ntamkpo from Ikpakapit, Ijiman from Ijiman ward, and Ibenda from Biko-Biko, bringing the total to four villages. Each village was progressively divided into five zones and one respondent was picked from each of four houses randomly selected from every zone. Thus, 20 copies of questionnaires were administered through stratified sampling, making a total of 80. A purposive random sampling was used to choose and interview defecation-free volunteer health communicators in each of the villages, and a total of eight volunteer health workers were interviewed respectively.

Instruments used in collecting data were questionnaires, unintentional observation and interview. The data were analysed using simple statistics.

Theoretical Framework

There are many theories which can be used to explain human behaviour. In this study, the Stages of Change model, also referred to as Trans-theoretical model was used. Developed by Prochaska and DiClemente, it evolved through studies examining the experiences of smokers who quit on their own and those who required further treatment to understand why some people were capable of quitting on their own. According to Norcross, Kreb and Prochaska (2011), the model represents time as well as set of tasks needed for movement to the new level. It proposes steps that can lead to behavioural change through the following stages:

1. **Pre-contemplation:** This is the first stage identified in the stages of change model. At this stage, individuals involved do not have any intention of changing their behaviour since they are not aware of the dangers their behaviour poses.
2. **Contemplation**: The individuals involved in this stage are aware of their behaviour and the problems that arise as a result of the behaviour. Contemplators struggle with their positive evaluation of the dysfunctional behaviour and perceived consequences of abandoning their behaviour.
3. **Preparation:** At this stage, based on series of campaign and strategic communication, individuals intend to take action on some behavioural changes. Those that practise open defecation have been exposed to campaigns against open defecation and are prepared to stop the practice. These behavioural changes are minimal at this stage and the individuals may aim at trying to reduce the number of times they defecate in the open.
4. **Action:** At this stage, individuals adjust their behaviour and environment to overcome the problem. This can be achieved by building toilet facilities in order not to defecate in the open. It is believed that individuals that have been able to desist from a practice like open defecation for a period of six months can be classified as being in the action stage.
5. **Maintenance:** This is a very crucial point in the change model. The maintenance stage is simply working to avoid a relapse or reversion. This shows that achieving a behavioural change is not enough but maintenance determines the sustainability of the change.

Stages of change model is integral for this study. It explains how effective behaviour change communication is influencing and changing social behaviour. Behaviour change can take place when strategic communications are properly disseminated. In the stages of change model, pre-contemplation is the first stage in the change process. It shows that without behaviour change communication, individuals cannot change. Stages of change model illustrates the level of success achieved in influencing and changing an individual or a community. With that understanding, communicators are able to understand the level of success achieved and the right strategies to adopt that will bring about a sustainable change. Health communicators listen to members of the community and while in the process of dialoguing, this enables the communicator to develop culturally appropriate and easy-to-understand strategies that will aid in addressing the challenges based on the different stages of change. It is on these bases that the stages of change model was adopted for this study.

Presentation and Analysis of Data

Out of the 80 questions distributed, 78 (97.5%) were returned and found usable for this study. This number was considered adequate to represent the population. The presentation and analysis of data obtained were based on the 78 copies of questionnaire returned and used.

RQ1: How effective is the communication strategies adopted in sensitising communities on open defecation?

Table 1: Effectiveness of communication strategies adopted for open defecation campaign

QUESTION	RESPONSE				
	YES	%	NO	%	TOTAL
1. Have you attended any open defecation sensitisation programme?	68	87.2	10	12.8	78 (100%)
2. Are the sensitisation programmes in a language you can understand?	59	75.6	19	24.4	78 (100%)
3. Since your communication was declared open defecation free, has there been any sensitisation campaign on why and how to sustain this status?	13	16.6	65	83.4	78 (100%)
4. Do you defecate in the open?	58	74.4	20	25.6	78 (100%)
5. Do you own a toilet?	53	67.9	25	32.1	78 (100%)
6. Do you find children defecating in the open?	44	56.4	34	43.6	78 (100%)

From the data presented in Table 1 above, the findings can be summarised thus: item 1 shows that 87.2% of the respondents had attended open defecation sensitisation programmes; for item 2, 75.6% of them were at sensitisation programmes organised in a language they could understand; item 3 shows that 83.4% of them had not attended any sensitisation campaign since the community was declared open defecation-free; item 4 depicts that a large number of them (87%) are no longer engaged in the act of defecating in the open; 75.6% of the respondents have toilets as shown in item 5; while item 6 shows that 56.4% of children still defecate in the open.

From these findings, it can be seen that communication, which is sensitising the community, took place and in the language they could understand. Based on the stages of change model, contemplation is the second stage of the model: members of the community begin to contemplate if they should accept the campaign message, and thereafter evaluations are made based on the message content received. Without communication, contemplation cannot occur. After evaluating the advantage and disadvantage of open defecation in the community, members of the community will decide if they should desist from or continue with the practice.

Unfortunately, since the community was declared open defecation-free, intensity of the sensitisation campaign had dwindled. This runs counter to one of the stages of change, which is maintenance. In the stages of change, communication campaigns are aimed at maintaining and sustaining the behavioural change to avoid a relapse. When there is no continuous campaign on open defecation, members of the community can experience a relapse. Therefore, a continuous communication campaign aimed at sustaining the behavioural change of the members of the community is very crucial.

As found out in the study, 87.2% of respondents have stopped defecating in the open. This further proves that communication campaign strategies adopted to sensitise the villages against open defecation was effective. It implies that communication campaigns influenced the members of the community and has led to a behavioural change. This finding is, therefore, in line with the study carried out by Devine and Kullman (2011) in which they recommend community-led total sanitation and behaviour change communication (BCC) as useful adjuncts because, while community-led total sanitation focuses on changing community practices, behaviour change communication focuses on changing individual or household behaviours. Also, a study by Ngwu (2017) suggests that eradicating open defecation requires behavioural change communication because simply supporting communities to build latrines may be insufficient to make them use the facilities.

From the findings that 75.6% of the respondents had toilets and that based on the sensitisation programmes, members of the community were aware of the benefits of owning a toilet and 75.6% of the respondents now have toilets, there is the implication that the 24.4% percent of the respondents who do not own a toilet either defecate in the open or make use of public-owned toilets. This, therefore, raises the fear that there are traces of open defecation in these villages; and this fear is confirmed by the finding that 56.4% of children defecate in the open. This shows that open defecation-free campaigns have been more effective on the adults in the Ugep community than with the children. It also implies that it is generally acceptable among the people for children to defecate in the open whereas adults are forbidden from doing so. It is pertinent to note that waste of both adult and children causes the same negative health challenges. Therefore, as noted by Omoloso, Ahmed and Ramli (2017, p. 58), "identification and understanding of the target audience have significant implications for the production of culturally sensitive and relevant health promotion messages capable of achieving effective outcomes." This is why the campaigns should also be directed at the children while parents should be sensitised on how they can properly guide their children to defecate in a toilet instead of defecating indiscriminately in the open. Children faeces are also capable of causing cholera, trachoma, typhoid and a host of other diseases.

RQ2: What are the challenges of health communicators who are saddled with the responsibilities of sensitising the communities on open defecation?

Table 2: Challenges of health communicators engaged in sensitising the communities on open defecation

QUESTION	RESPONSE				
	YES	%	NO	%	TOTAL
1. Are you given incentives or motivated for the work you do?	8	100	0	0	8 (100%)
2. Are you satisfied with the incentives given?	0	0	8	100	8 (100%)
3. Are the members of the community hostile towards volunteer communicators?	8	100	0	0	8 (100%)

Items 1 and 2 in Table 2 above show the responses obtained from the interviewees. From responses, all of them (100%) agreed that they were given stipends or incentives for being volunteer

workers but that they were not satisfied with the amount of stipends they were paid. According to them, the stipends were meagre compared to the cumbersome responsibilities they handle.

From item 3, it can be seen that volunteer health communicators are saddled with the responsibility of carrying out sensitisation programmes and the community taskforce that tries to ensure that people do not defecate in the open are exposed to the hostility from community members.

RQ3: What are the communication challenges that can lead open defecation-free communities to experience a relapse?

Table 3: Communication challenges that lead open defecation-free communities to experience a relapse

QUESTION	RESPONSE				
	YES	%	NO	%	TOTAL
1. Can you defecate in a nearby bush when there is an urgent need to defecate?	70	89.7	8	10.3	78 (100%)
2. Can open defecation-free campaign serve as reinforcement and continuous reminder of the negative health implications of the practice?	65	83.3	13	16.7	78 (100%)

From item 1 in Table 3 above, 89.7% of the respondents agreed that they would defecate in the open if they had an urgent need to defecate and there was no toilet around. However, as confirmed by responses on item 2, when there is a continuous sensitisation programme on the need to maintain an open defecation-free environment, members of the village will be steadfast in desisting the practice; and a generation that is free from open defecation can be achieved.

Conclusion

The need to achieve an open defecation-free environment is paramount due to its negative health implication to man. The issue of open defecation can be solved by simply desisting from the practice which has led to the deterioration of man's health. However, since man normally clinches to his old habits, communication campaigns play a pivotal role in changing the lifestyle of man. The essence of any communication campaign is for development, and development is regarded as changing for the better. For any form of development to take place, communication is involved. Communication serves as a tool that is used to achieve development. This study concludes that there is need for a continuous sensitisation of the community members especially on how to teach the young ones on the need to use the toilet in order to decrease the number of children who defecate in the open.

Recommendations

From the conclusion of the study, it recommended:

1. That parents should be sensitised and encouraged to train their children on how to use the toilet, and to teach them on the negative health implication of open defecation;
2. That volunteer communicators should be paid better remuneration; and
3. That the target audience of open defecation-free campaigns should be children; with the sensitisation campaign developed in such a way that the target audience will be effectively attracted to it and the campaign message easily understood.

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