Original Article
ISSN (Online): 2582-7472

ShodhKosh: Journal of Visual and Performing Arts
June 2024 5(6), 3146–3153

EFFECTIVENESS OF INFORMATION SOURCES IN TAKING THE 'SWACH BHARATH MISSION' TO TRIBALS IN INDIA: AN AWARENESS CHECK ON ZERO SANITATION AMONG 'JENU KURUBA WOMEN

Dr. Nandini Lakshmikantha[1]

[1]Senior Research Fellow, ICSSR, Center for Educational Social Sciences, Bengaluru.

DOI
10.29121/shodhkosh.v5.i6.2024.3638

Funding: This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

ABSTRACT

Open Defecation Practice(ODP) poses a serious threat to public health. In India, efforts are being made to spread awareness among the public regarding the importance of hygienic and safe sanitation. According to the World Health Organization reports-2022 a major portion of the world's OD population belongs to India. In its efforts to face the challenges, and to achieve Sustainable Development Goals 2030 (SDG), India initiated the 'Swacch Bharath Mission'(SBM) in 2014, a program to make India Open Defecation Free (ODF). In its decade-long behavioural change movement, India has tasted success. Encouraged by the success the Government relaunched SBM-Grameen (SBMG) as Phase II program (2019-2014). As we reach the last leg of Phase II, it is important to check the effectiveness of the information sources in taking the message to the target group. The present study conducted among women belonging to 'Jenu Kuruba' community one among the two Particularly Vulnerable Tribal Groups(PVTG) who have been relocated from the forests of the Western Jenu Kuruba community, details us that 'war is not over'.It is observed that women do not have access to any form of mass media, and largely depend on sustainable, repetitive effective interpersonal communication in bringing in the desired changes.

Keywords: Swach Bharath Mission Grameen, Open Defecation Free, Jenu Kurubas, Particularly Vulnerable Tribal Groups

1 INTRODUCTION

Sanitationfacilities are a fundamental requirement and are considered one of the parameters that measure the development of a country. Safe disposal of human urine and faeces is important in the fight against poverty, disease and death. Proper sanitation can reduce the burden of disease and death as Open Defecation (OD) leads to many health concerns like diarrhoea, worm infections, pneumonia, measles, and malaria among others. In addition to the health concerns, OD causes humiliation, mental stress, threat to privacy and concerns towards safety among women. In its fight against OD and to meet the parameters set by Sustainable Development Goals -2030, India, has initiated various schemes, to provide "Health for All". Understanding cleanliness as the first step towards improving health status, India came up with the 'Swachha Bharath Mission' in 2014 under the leadership of Mr Narendra Modi, the Prime Minister of India.

We understand from the pages of history about the advanced Indian civilisation that existed on the banks of the Sindhu River. It had a systematic drainage and sanitation facility, which waslost over a period of time. It is unfortunate that even after 75 years ofattaining independence around 157 million people in India still practice open defecation. According to

the data obtained from WHO and UNICEF even in 2022 approximately 11% of the population defecates in the open, for example by the side of street gutters, behind bushes or into open bodies of water. Defecation is an important system for every living being, and for human beings adopting ' a privacy, safety and hygiene defecation system is necessary. Accordingly, "improved toilets are the ones that are not shared between households and where the excreta are safely managed either in-site or offsite"**(https://www.who.int/publications/i/item/9789240030848)**is the message that needs to reach the entire population.

India has taken wilful initiatives to arrest the practice of OD for at least the last two decades. With its Health Index (HI) at 145/195 the Government of India has always faced a tough challenge in traversing the road map of health due to its population size, behavioural practices and negligence of the people towards hygiene practices (https://sustainabledevelopment.un.org/content/documents/2537IDR2018). The country has taken several steps to create awareness of the health and social problems posed by OD. Among the major programs focussing exclusively on improving OD status in India, 'Nirmal Bharat Abhiyan' (1999 -2017) (NBA) is probably the first. This program proposed under the Millennium Development Goals(MDG) (2001-2015) accepted by the leaders of the world, set a goal to eradicate OD practice in the country by 2017. At the end of MDG the United Nations reported that 568 million people practised OD of which 90 per cent were from South Asia, and 50% of the global population belonged to India. Nirmal Bharat Abhiyan primarily focussed on providing proper sanitation facilitiesin rural India whichpractised pit latrines without slabs, open pits or hanging latrines which are not considered healthy or hygienic sanitation methods.

During the last two decades, the other major program that focused on sanitationhealth and safety was the Water, Sanitation and Hygiene (WASH) program initiated by UNICEF. The program highlighted the importance of clean drinking water made available to children at schools in addition to sanitation and hygiene. The WASH (Water, Sanitation and Hygiene) initiative has been taken by various countries in order to provide safe drinking water, proper sanitation facilities and a hygienic environment and livelihood to its people

In addition to the initiatives, taken bythe government, the efforts ofDrBindeshwar Pathak, a founder of Sulabh International Social Service Organizationare worth recording. Dr Pathakinitiated efforts to promote proper sanitation facilities for the poor by building public toilets. Pathak's work also took a step towards eradicating manual scavengers and rehabilitated them as they faced discrimination in society owing to their work of cleaning latrines. (https://www.sulabhinternational.org/founders-profile-dr-bindeshwar-pathak/)

2 INITIATION OF SWACCH BHARATH MISSION

"Swacch Bharath Mission", (2014) was conceptualised when Sustainable Development Goals-2030 was accepted universally. Goal 6 of SDG-2030 stresses the need to keep the surroundings clean, waste segregation and build hygienic toilets at every home. Phase I of the Swacch Bharath Mission(2014-2019) gained momentum andmobilisedthe nationwide participation of the public. It also brought massive behavioural change among the people of India. This massive undertaking according to the official records by 2019, celebrated the construction of over 100 million individual household toilets, in addition to declaring more than 6 lakh villages ODF, this probably isthe best tribute to Mahatma Gandhi on his 150th birth anniversary.

In the second phase of Sustainable Development Goal (Grameen) (2019-2025), Swachh Bharat Mission -Grameen the purpose is to achieve '*Sampoorna Swachhata'* - zero sanitation.SBMG focuses its attention on not only on sustaining the ODF status but also managing solid and liquid waste by 2024-25. To transformall the villages from ODF to ODF Plus Model, the need is that in addition to the ODF, it demands solid, liquid and waste management and visual cleanliness i.e.minimalising of litter, plastic and stagnationof wastewater, as part of the program(https://swachhbharatmission.ddws.gov.in/about_sbm).

Accomplishing the road map to fulfilPhase II of SDGG, i.e.propagating the thought of safe and hygienic sanitationto rural parts of India by 2025 is a challenge. As India gears up a huge challenge of taking the message of zero sanitation before 2030, (Jain A et.al)it has tapped multiple sources of information to successfully and effectively take the message to the 'masses'. A big bandwidth of information resources, in addition to the various formats of mass media, other effective platforms comprising of ASHA and Anganwadi workers, 'gram panchayat' members, Non-Governmental Organizations, medical professionals of Public Health Centres, opinion leaders, officials of various government departments, are playing an important role in taking the message to the grassroots level. The challenge gets doubled up while reaching the settlements of tribes belonging to Particularly Vulnerable Tribal Groups(PVTGs) as a majority of the members of these

communities are still struggling to get acclimatised to mainstream life. It is important to note here that while it is difficult to convince the people who are already in the mainstream of life concerning sanitation and hygiene to adopt a zero sanitation behavioural approach, the difficulty level taking a bigger leap while reaching the tribal community who are still struggling to locate themselves in the mainstream of life is not surprising. The observations made in a study conducted on OD by Coffey D. et.al (2015) observed that "in a majority of households, members have continued defecating in the open despite the household owning a toilet. This could be largely related to the behavioural issue of deep-rooted cultural and religious beliefs". Another study conducted by Hathi P Spears and CoffeeyD(2016) highlights the "reinforce the conceptualisation of open defecation as a behavioural issue rooted in cultural and religious notions of purity and pollution", strengthens the contemplations regarding consciousness towards toilet hygiene practised among Indians.

India comprises atribal population which tallies about 8.6% of its population. Among the 700-plus tribal communities, nearly 75 of them were identified as Particularly Vulnerable Tribal Groups (PVTGs), in 2006, by the Government of India. Some common characteristics of PVTGs are'being typically homogeneous communities with small populations, often living in remote and isolated areas. Their social institutions are simple, these groups tend to experience change at a slower pace compared to other communities'(Roy S, et.al, 2015). In Karnataka, the southern state of India, the government has identified two of the tribal communities as PVTGs, namely the Jenu Kuruba and Koraga tribes. The Jenu Kuruba tribe, among whom this study intends to focus its attention originate from the districts of Mysore, Chamarajanagar, and Kodagu.

3 REACHING THE UNREACHED

The *Jenu Kurubas* also known as "KattuNaikar" has about a population size of 36,076. In Karnataka, they are traced in the districts of Mysore, Kodagu and Chamrajanagar. The members of this PVTG rarely mingle with other tribal communities. The Jenu Kurubasoriginally lived inside deep forests and were rehabilitated to the settlements called 'haadis' aroundfour decades ago under the Forest Conservation Act, 1980. Experts in honey collecting skills, the Jenu Kurubasderive their name from theinherited skill. Being inhabitants of forests even today their life and belief system centres around the forest. The community living in the settlements near the border of forests enters forests to gather honey, medicine, fruits, vegetables, tubers, firewood and other forest products. (https://www.survivalinternational.org/tribes/jenu-kuruba) (https://www.sppel.org/jenukurubadoc.aspx).Most of the Jenu Kurubamen and women work as daily labourers in market areas, or agricultural labourers in ginger, and paddy fields. They also migrate to coffee plantations in the Coorg district during the season. They communicate in Kannada and use Jenu Nudi to communicate among themselves.

In the settlement, finding people belonging to three or four generations is common. The first generation after rehabilitation has stayed away from formal education, among the second generation a majority of them are middle school dropouts. We observe three-dimensional efforts by the government, parents, and pro-active NGOs to keep the third generation in school. For the entire population of Jenu Kurubas, the number ofgraduates could be one to five. According to the 2011 census, the literacy rate among the Jenu Kuruba tribe in Karnataka is around 56.1% with a male literacy rate of 59.1% and a female literacy rate of 53.1% (https://pib.gov.in/PressReleasePage.aspx?PRID=1657743#:~:text=As%20per%20Census%202011%2C%20literacy,73%25%20at%20all%20India%20level.). Each of the settlement has a head-man and a ritual head. In recent years a member from the Jenu Kuruba community has been representing the Gram panchayaths in their respective regions. "They believe in magic, sorcery and witchcraft. Neither polygamy nor polyandry is practised (Nanjunda DC, 2010**)** Unlike many other communities whose interactions with nature have evolved, the Jenu Kurubas maintain a deeply rooted connection to the land that is both spiritual and practical. Their traditional knowledge of forest ecosystems is legendary, passed down through oral traditions and experiential learning, rendering them invaluable custodians of biodiversity in their ancestral territories (Dr Nagendra N; 2024).

The efforts of making Jenu Kurba womenaware ofsafe, healthy and hygienic practices are challenging. Despite more than four decades of relocation, the interest towards formal education, acquiring knowledge about the issues with a majority of settlements have lanes of 'kuccha' houses made out of bamboo, mud and the bark of the plants,and awareness on safety and hygiene toilets remains a distant dream. Before they build a toilet there needs to be a big procedure of documentation process, for them to create a 'pucca' house. Keeping this knowledge in the background, this study focuses

its attention only onunderstanding the reach and awareness of healthy and safe sanitation conceptsamong the Jenu Kuruba women. As we can recollect, this government program which has been functional for the past decade, in addition to providing household subsidies as a way to increase sanitation supply, has also focused heavily on investing in information, education, and communication (IEC) campaigns as a way to spur demand for sanitation (http://swachh bharatmission.gov.in/sbmcms/).

With a majority of the studies conducted on Jenu Kurubas focus on issues concerning their rehabilitation and socio-ethnographic graphs, in this decennial year of "Swacchata Abhiyan Mission", it is important to understand if themessage built towards improving their health status disseminated by both government and private missionaries has effectively reached the target group - Jenu Kuruba women. This study is important not onlyfor achieving SBMG as part of goal six of SDG-2030 but also for creating awareness among women for their own health and safety purposes. The outcome of the study regarding the awareness level among womenliving in remote areas, daring the challenges of nature in addition to their biological and social life, can help the policymakers, in taking the next steps related to the projects. The results obtained may also support the policymakers in completing the 'Swacch Bharath Mission Grameen, phase II of the SBM by the end of 2025.

4. METHODOLOGY

Studies on Jenukurubas observe that this community remains "deprived of social benefits" despite the numerous government and non-government-sponsored programs to uplift the community". Jenu Kurubas, are one of two identified PVTGs in the state. A field visit to 'haadis' and interactions with Jenu Kuruba women was conducted using the lens of zero-sanitation but also from the awareness received regarding the importance of building a healthy and hygienic toilet.

The visits to the settlements of JenuKuruba were undertaken when women were available at home. There are around 18 settlements near HD Kote, Mysore district. Kolavige, Dasanapura, Anemala, Damanakatte, and Golur'haadis' were chosen for the visit based on the convenience sampling method. Interactions with the women were based on a structured schedule, comprising questions based on ODF Sustainability Guidelines notified by the Ministry of Drinking Water and Sanitation, Swacch Bharath Mission(Grameen) and their reference to the source of income. In the study, the mean age of women who participated was 33.69±4.01. Considering the age group distribution of respondents whose lower limit was 18 and the highest was 45.

In the relatively visually clean 'haadis' of Jenu Kurubas, effects of Diffusion of Innovation Theory, can be observed in the behavioural pattern among the 'haadi' members. The Diffusion of Innovation theory popularised by Everett Rogers in 1962 explains how new ideas, technologies, or products spread through the community members and the behavioural patterns of people in accepting the propagated idea**(https://www.techtarget.com/whatis/feature/Diffusion-of-innovationsjournals.lww.com)**. Applying the theory to the concept of adapting to hygiene, health and safe sanitation we can bifurcate the settlements as early adaptors, 'early majority', 'late majority', and 'laggards'.

5. ANALYSIS AND DISCUSSION

The government of India has initiated various health schemes for the welfare of public. Various departments like Health, Social Welfare, Women and Child tribal communities, execute the projects. To reach the tribals effectively the Ministry of Tribal Affairs, and the National Commission on Scheduled Castes and Scheduled Tribesinitiated various projects. In addition to the huge network of medical professionals and the services by the Public Health Centres Anganwadi workers and ASHA workers play a vital role in taking the projects to the last person. It is important to observe here that the schemes initiated by the government will reach the target group only if the channel of communication is effective and dedicated.In the communication process, particularly health, the 'source' i.e. the sender of a message, plays a significant role as he/she will not just deliver the information but also make an effort to bring the desired change. The communication will be effective only when the source constructs the message suitable to the understanding ability of the receiver, thus avoiding all the barriers that interrupt the process of communication**(https://www.techtarget.com/whatis/feature/Diffusion-of-innovationsjournals.lww.com)** **(**https://www.ou.edu/deptcomm/dodjcc/groups/99A2/theories.htm). In the following paragraphs perceptions and understanding of Jenu Kuruba women regarding the safe and healthy sanitation system is presented.

Dasanapurahaadihas around 68 houses. The highest quailed respondent had gone to school till 7th standard. In case of any health problem women visit nearby government hospital nearby, making their own transport facility. The settlement has built houses in a neat row and a majority of them are pucca houses and have kept their surroundings clean. Mobile hospitals run by NGOs visit the settlement once in a fortnight. Skin allergies are common among women.

Nearly 55 (81%)houses have made provision for toilets in their house with the support received from the government. Out of which 30 (44.11%) houses have functional toilets with unbroken toilet, water and electricity, ventilation, easy and clean flushing facility and among the remaining houses one or other requirement is missing and the house owners are eager to rectify the issues soon. The houses that do not have toilets have understood the requirement of documents and are in the process of updating their records.

Among the information sources, women do not have any access to newspapers or radio. The settlement has around 100 women population, and only 5 (5%) say have access to TV and they watch teleserials in the evening. Every house has a mobile phone but that largely remains with the husband.

Women can speak but not read or write Kannada. A majority of them have learnt to sign their names. Jenu nudi is their language of communication. More than anganwadiworkers all the respondents depend on NGOs whom they address Brother or Sister (*anna* or *akka*) for preparing their application and documentation ready for application. They do not remember having interacted with any government officials, nor medical professionals have explained the health concerns that may arise out of OD. It is the project of the government and they should procure it, which appears to be the mindset. They could not recollect the program title or scheme under which they were identified as beneficiaries. None of the respondents are aware of health complications that may arise out of OD, and the respondents feel happy and proud to display their toilets. The settlement has built toilets based on the 'pit' system. Hence we can observe that there is a spread of awareness regarding the importance of safe and healthy sanitation, but zero sanitation has not been achieved. The people of this settlement can be classified as early adaptors as they have accepted the idea of sanitation.

Kolavigehaadihas around268 houses, with a woman population of about 450. The highest quailed respondent had gone to school till 7th standard. In case of any health problem, women visit a nearby government hospital nearby, making their transport facility. The settlement has a combination of some pucca houses and the remaining houses are temporary sheds. Kolavige being one of the largest settlements of Jenu Kurubas has its representative in the gram panchayath. The surroundings of Kolavigeare relatively clean. The settlement has water and electricity facilities. Girijana Ashram School, built as early as 1988 is within the vicinity of the haadi. Mobile hospitals run by NGOs visit the settlement once a fortnight. Skin allergies are common among women. Chewing tobacco and betelnut is observed largely among women above 50 years.

Nearly 100 (37.31%) houses have made provision for toilets in their house with the support received from the government. Out of which 30(30%) houses have fully functional toilets with unbroken toilets, water and electricity, ventilation, and easy and clean flushing facilities. In the remaining houses, 15(15%) toilets do not have proper doors, 22(22%) have no water facility and the remaining are under construction. Availability of funds appears to be the reason behind the present status of half-constructed toilets. The women in the settlement come around the NGOs requesting them to help in completing the formalities required for the procedure which indicates that there exists awareness among women.

Among the information sources, women do not have any access to newspapers or radio. The settlement has around 450 women population, and 20 (4%) say have limited access to TV and they watch teleserials in the evening. Women do not have any control over their mobile phones and "nammaphonenalli video kanodilla" meaning we cannot see any video on our (husband's) mobile phones.

Women can speak but not read or write Kannada. Around 223(50%) of them can sign in Kannada on the required documents. Jenu nudi is their language of communication. They listen to their 'Haadi Nayaka', and gram panchayat members' words. However, they depend on NGOs whom they address Brother or Sister (anna or akka) for all the support and thus can be considered primary and dependable sources of information. They have not interacted with any government officials. They recollect that theircommunication with medical professionals is onlywhenever theyneed medical support.

The respondents understand that toilet construction is a project sanctioned by the government and have no further knowledge regarding the project. They are not aware of health complications that may arise due to unhygienic sanitation practices. Women who do not have toilet facility at home OD behind the bushes nearby. A majority of the respondents (98%) do not recollect the title of the program or scheme under which they are enjoying the benefits,nor medical professionals have explained the health concerns that may arise out of OD. It is the project of the government and they should procure it appears to be the mindset. They were not able to recollect the title of the program or scheme under which they are identified as a beneficiary. Regarding the procedure, the respondents opine that it is good to talk to the NGOs as their neighbour's knowledge may not be any better. The toilets are built based on a pit system. Kolivigehaadi, being one of the largest settlements, has a progressive approach. Based on the awareness and eagerness towards completing the half-built toilets, the women belonging to the settlement can be largely distributed between the early majority and late majority.

Golurhaadihas around 105 houses except one or two nearly most of the Jenu Kurubas have constructed huts/sheds by themselves. The huts are made of mud and bamboo sticks, sheds are made of sheets. Most respondents are school dropouts at the primary level of education. Women refuse to talk to visitors or strangers. In the entire haadi, there is only one family which has built a toilet. All others use nearby fields or enter the forest nearby for OD purposes. In case of any health problem, women visit a nearby hospital run by an NGO. Skin allergies are common among women.

It is almost four decades since the people moved out of the forest, yet people are struggling to accept the exposure. Women feel the exposure has done more harm to their children as a majority of their men have turned into alcoholics. The women respondents agree they will receive the benefits provided by the government only if they submit the required documents. Only one house has a television connection. Newspapers or Radio have not entered the haadi. Communication with any source of information other than the NGOs is very minimal. The women work in the nearby fields, they receive ration kit supplied by the central government. They do not show any interest in talking about the sanitation facilities. They can be classified as laggards.

Damanakattehaadiis in the Kakanakote reserve forest region and near the Karnataka - Kerala border. The settlement has around 70 houses and the women's population is around 197. As the settlement is inside the Reserved Forest Area, vehicular movement is controlled after six pm every day and life becomes still here. Elephants are regular visitors to this settlement in addition to other wild animals. The settlements consist of huts made out of bamboo and mud and some of the houses are sheds.In the settlement, there are hardly any permanent construction except for the Anganwadi centre and a school building. The Anganwadi centre has a functional toilet. The houses have no toilets and women do not come out to communicate with strangers. Intercommunity communication is also very minimal.

None of the houses have fully functional toilets and interestingly women do not mind ODP nor seem to be interested in building a toilet.They enter forests for firewood and to gather other forest products like honey, herbs and fruits to make their living.

Anganwadi and ASHA workers visit the 'haadi'regularly but the women make no mention of them. NGOs also visit these 'haadis' and help the members with their medical complications.

Women respondents have no access to any form of media. Cellular network connectivity is not available in this region. The 'haadi' people visit the nearby hospital when they are sick.

Women have the least awareness regarding health complications and are ready to take the challenges. Their status of awareness and acceptance to the 'idea' can be categorised as laggards.

Anehalhaadiis in the Kakanakote reserve forest region and nearthe Karnataka - Kerala border. The people created their own lives in this smallest settlement with just 40 plus houses. They gather forest products and make their living. The government has provided the haadi with a water supply. Electricity provision is also made. As the settlement is inside the Reserved Forest Area, vehicular movement is controlled after six pm every day and life becomes still here. Elephants

are regular visitors to this settlement in addition to other wild animals. Huts are made out of bamboo and mud. Children study in the primary school built near the vicinity. Women and men migrate to Coorg and regions of Kerala for almost three months to work in the coffee plantations. They enter forests for firewood and to gather forest products like honey to make their living. ASHA worker visits the haadi but the women make no mention of her. None of the houses have a toilet facility, nor do they seem to be interested in building one. For the question "Don't you feel scared to go out at night", women say they "have got used to the living conditions and they do not want to come out of the forest".

They have no access to any form of media. Cellular network connectivity is not availablein this region. The haadi people visit the nearby hospital when they are sick. They rarely communicate with NGOs. Women have the least awareness regarding health complications and are ready to take on the challenges. Their status of awareness and acceptance to the 'idea' can be categorised as laggards.

6. CONCLUSION

In its effort to improve the sanitation process, an important SDG 6, that needs to be universally achieved by 2030, the government of India initiated the Swacch Bharath Mission in 2014 to commemorate the 150th birth year of Mahatma Gandhi. The Mission focussed on making the country ODF, by laying stress on zero sanitation. Inspired by the incredible success of Phase I, the government relaunched the program as SBM Grameen in Phase II (2019-2024). The prime focus of the project was to make rural India ODF. Here it is important to remember Indiafaces tough challenges in taking its projects to people due to its diversified and huge population, to the PVTG community, in particular, which has largely remained unreached. Multiple channels of information sources were used to execute the SBM program effectively in India. Along with Media, Anganwadi workers, ASHA, Medical Professionals appointed at PHC, Government Officials, and NGOs are some of the sources who are in regular contact with the masses. At this time, it is important to understand the effectiveness of the information sources in taking the message to the unreached.

The present field study was conducted among the Jenu Kurubas, one of the two PVTG communities in Karnataka. Swacch Bharath Mission Grameen highlights zero sanitation - a new concept that needs to be spread across India. The message of safe, healthy and hygienic sanitation should be commonly disseminated both in urban and rural India sewage treatment plants are not facilitated even in most cities. The results obtained from the study detail different behavioural patterns among the women belonging to different 'haadis'.The Diffusion of Innovation theory popularised by Everett Rogers in 1962 explains how new ideas, technologies, or products spread through the community members and the behavioural patterns of people in accepting the propagated idea.Based on the concept of theory the key players under the study are categorised as 'innovators', 'early adopters', 'early majority', 'late majority', and 'laggards' **(**https://www.ou.edu/deptcomm/dodjcc/groups/99A2/theories.htm). Accordingly the women in Kolavige and Dasanapura 'haadis' can be considered as 'early adopters', women respondents belonging to 'Golur, Damanakatte and Anehal' can be seen as laggards.

The results clearly indicate that media, medical professionals and government authorities have not been considered as influencing factors in accepting the change. Persistent and repetitive interpersonal communication byNGOsappears to be more effective when compared to government-recruited Anganwadi or ASHA workers. The results indicate that effective and persuasiveinterpersonal communication with the women and encouraging beneficiaries to talk about the advantages of owning a toilet or effective'haadi' 'Nayaka' can bring in the desired change at the earliest.

CONFLICT OF INTERESTS

None.

ACKNOWLEDGMENTS

None.

BIBLIOGRAPHY

A.Coffey D, Gupta A, Hathi P, Spears D, Srivastav N, Vya S. Culture and the health transition: Understanding sanitation behaviour in rural north India. International Growth Centre. Ref No. F-35114-INC-12015.

B.Hathi P, Spears D, Coffey D. Can collective action strategies motivate behaviour change to reduce open defecation in rural India? Waterlines. https://practicalactionpublishing.com/article/2781/

C.Jain A, Kumar A, Kim R, Subramanian SV. Prevalence of zero-sanitation in India: Patterns of change across the states and Union Territories, 1993-2021. J Glob Health. 2023 Jul 28;13:04082. doi: 10.7189/jogh.13.04082. PMID: 37497738; PMCID: PMC10373110.

D.Dr Nagendra N;2024; Socio-Economic Status of Jenu Kuruba Tribal Community of Karnataka; Shikshan Sanshodhan: Journal of Arts, Humanities and Social Sciences, Monthly, Volume - 7, Issue - 03, ISSN(o): 2581-6241).

E.Nanjunda DC ; 2010 ;Ethno-medico-botanical Investigation of Jenu Kuruba Ethnic Group of Karnataka State, India; Bangladesh Journal of Medical Science; Vol.09 No.3 Jul'10

F.Roy S, Hegde HV, Bhattacharya D, Upadhya V, Kholkute SD. Tribes in Karnataka: Status of health research. Indian J Med Res. 2015 May;141(5):673-87. doi: 10.4103/0971-5916.159586. PMID: 26139788; PMCID: PMC4510769.

G.https://www.ou.edu/deptcomm/dodjcc/groups/99A2/theories Accessed on 16.7.2024

H.https://pib.gov.in/PressReleasePage.aspx?Accessed on 15.5.2024

I.https://www.sulabhinternational.org/founders-profile-dr-bindeshwar-pathak/ (14.1.2024)

J.https://sustainabledevelopment.un.org/content/documents/2537IDR2018_FULL_REPORT_1.pdf (date accessed 12.01.2024)

K.https://swachhbharatmission.ddws.gov.in/about_sbm. (date accessed 12.01.2024)

L.https://www.techtarget.com/whatis/feature/Diffusion-of-Accessed on 16.7.2024

M.https://www.survivalinternational.org/tribes/jenu-kuruba)(Accessed on 15.5.2024

N.https://www.sppel.org/jenukurubadoc.aspx. Accessed on 15.5.2024

O.https://www.who.int/publications/i/item/9789240030848 Progress on household drinking water, sanitation, and hygiene 2000-2020: Five years into the SDGs. Geneva: World Health Organization and the United Nations Children's Fund; 2021. Accessed on 22.2/2024