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**SUSTAINABLE WATER AND SANITATION SERVICES  
FOR ALL IN A FAST CHANGING WORLD**

**Mainstreaming inclusive sanitation into  
community-led total sanitation in Kenya**

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**BRIEFING PAPER 1925**

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*Access to water hygiene and sanitation services is a human right. Full participation and enjoyment of the right to sanitation services by people living with disabilities depend on accessibility and use of sanitation facilities. Attempts to increase coverage of water and sanitation services have excluded the needs of people living with disabilities or those too weak to use them. WASHplus, a five-year USAID-funded project, is piloting a rural sanitation program that supports the Ministry of Health to integrate inclusive sanitation in their Community-Led Total Sanitation (CLTS) program, or CLTS+. The program encourages simple innovations—small doable actions that caregivers of people with physical or visual impairments can adopt to facilitate household access to sanitation facilities. WASHplus trained over 30 public health officers on inclusive sanitation. These facilitators have supported CLTS implementers including community health workers and natural leaders to promote use of improvised supportive devices to assist individuals with physical or visual impairments to access sanitation facilities.*

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**Introduction and background**

In Kenya, an important proportion of disease burden is sanitation-related, with approximately 19,500 Kenyans, including 17,100 children under the age of five years, dying each year from diarrhoea – nearly 90 percent of which is directly attributed to poor water, sanitation and hygiene (WASH) (GoK, 2012). According to the Joint Monitoring Programme 2013 report, approximately 14 percent and 31 percent of Kenyans are practicing open defecation and using unimproved latrines respectively. About 17 percent of the population practicing open defecation lives in rural areas. In 2008 the Ministry of Health (MOH) and its stakeholders adopted Community-Led Total Sanitation (CLTS) to accelerate access to basic sanitation by millions of Kenyans in rural areas. CLTS is an innovative methodology for mobilising communities to completely eliminate open defecation. Communities are facilitated to conduct their own appraisal and analysis of open defecation and take their own action to become open defecation free (ODF) (Kar and Chambers, 2008).

Even if the CLTS approach achieves increased sanitation uptake in the rural communities, it is likely that the better informed, better connected and physically able are the ones who gain access to the available services or facilities in the society. This further marginalises the less informed, less connected and the physically and visually impaired members of the society. Mere concentration on just overall numbers will only serve to increase the gap between the haves and the have-nots. (Patkar and Gosling, 2011).

In Kenya, the overall disability rate is currently estimated at 4.6 percent; of this, the largest proportion is physical impairment (1.6 percent) followed by visual impairment (1.4 percent) (GoK, 2008). People living with disabilities face various challenges in the course of pursuing their daily activities because of activity limitation or restrictions. This includes limitations in access and use of sanitation and hygiene facilities made with standard designs. In addition, elderly people, pregnant women, and people with chronic illness such as HIV and AIDS face similar challenges of impaired mobility due to advanced age or their present physical or health condition. Equity and inclusion therefore involves recognizing that people are different and require specific support and measures to overcome the impediments that block their ability to access and use services sustainably, in this case safe sanitation and hygiene practices (Patkar and Gosling, 2011). The National Environmental Sanitation and Hygiene Policy states that as a basic human right, “All Kenyans

should enjoy quality of life with dignity in a hygienic and sanitary environment.” Furthermore, sanitation is now a constitutional right in Kenya. The right to sanitation embodies: availability, accessibility, quality and use (GoK, 2010).

## **Project overview**

The WASHplus rural sanitation pilot program in Kenya, funded by USAID/Kenya, works closely with the Ministry of Health and USAID-funded bilateral health projects (APHIAplus projects) to increase sanitation uptake in rural areas through the government-led CLTS program. WASHplus introduced a “*plus*” component to CLTS, called CLTS+, which included a more focused emphasis on hand washing with soap and inclusive sanitation, focusing on sanitation needs for people with impaired mobility such as the elderly, physically and visually disabled, and children, which is often not adequately integrated into CLTS programs. The program encourages households to embrace “small doable actions” to design improvised supportive sanitation devices for individuals with mobility restrictions. WASHplus is working with the Ministry of Health to pilot the plus component interventions in Nairobi, Migori and Nakuru Counties.

## **Program context and approach**

Recognising that CLTS alone was not enough, WASHplus wanted to build on lessons learnt from other partners to support the MOH increase sanitation uptake in the rural communities while attempting to address the issue of inclusive sanitation, which is lacking in the current CLTS approach. The program built capacity of public health officers and CLTS implementers including community health workers and natural leaders on inclusive sanitation. The CLTS+ program encourages implementers to negotiate and support households with physically or visually impaired individuals to embrace the small doable action approach in improvising supportive devices that would facilitate access and use of sanitation facilities at the household level. The program began by training public health officers on CLTS+. The content of the training included sessions on basic principles of sanitation, introduction to CLTS approach, equity and inclusion (WASH) using the social model of exclusion, triggering for behaviour change, monitoring and evaluation. The small doable action approach was emphasised throughout the training and demonstrated during the practical sessions. Training materials used included the training manual for CLTS in Kenya, a guide for training community health workers in WASH-HIV integration and the equity and inclusion in WASH training materials produced by WEDC and WaterAid. Trainers included WASHplus staff trained on equity and inclusion during the 36<sup>th</sup> WEDC International Conference held in Kenya as well as MOH national CLTS master trainers. The public health officers and WASHplus staff then rolled the CLTS and the inclusion component down to the community health workers (CHWs) and natural leaders who implement CLTS+ at the village level. During the CLTS triggering sessions the community health workers and natural leaders sensitise villagers on the need to consider persons with disabilities while constructing latrines. Following triggering sessions, baseline data are collected by CHWs and natural leaders on sanitation and hygiene facilities status in a particular village. WASHplus in collaboration with the MOH made additional indicators in the CLTS monitoring and evaluation tools to capture baseline data of households with people living with disabilities in the project pilot sites. In addition, during the home visits and follow up sessions for CLTS, CHWs and natural leaders identify people living with disabilities, the elderly or chronically ill, or even pregnant women dealing with difficult pregnancies and negotiate with the households various sanitation supportive devices options on a case-by-case basis using the small doable action approach. CHWs and natural leaders have been provided with job aids that have photos and illustrations of supportive devices and disability-friendly latrines. In some cases the natural leaders or CHWs demonstrate or work with the household to make supportive devices such as commodes, support bars and guiding ropes among others.

## **Results**

To date more than 530 CLTS implementers including over 30 government county public health officers, 202 community health workers and over 300 natural leaders have been trained on inclusive sanitation. The community health workers and the natural leaders are putting their new skills into practice by negotiating and demonstrating to the households how to make supportive devices to address sanitation needs for individuals with disabilities using the small doable action approach. To date, the trained CLTS+ implementers have reached approximately 100 villages in the pilot sites. About 46 people living with disabilities have supportive devices such as commodes, support bars and guiding ropes constructed for

them using locally available materials. With lessons learnt and scale up activities by the MOH, the program is primed to reach 379 more villages by end of the year in the intervention sites.

## Lessons learnt

Below are highlights of the lessons learnt to date:

1. While implementing sanitation programs, public health officers have at one time or another interacted with households with individuals with special sanitation needs; however, before being orientated on inclusive sanitation they could not advise households with family members with physical, visual or other impairments. Now trained MOH and natural leaders have embraced the new concept and have begun to integrate inclusive sanitation in the national CLTS approach.
2. The WASHplus program and the MOH have recognised how small actions can change lives of families with individuals with physical and visual impairments. Care givers are now free to engage in other productive activities while they know that persons under their care can use the toilets easily with the help of an improvised supportive device. As an example of a successful small doable action, a young man who depended on the family members and sometimes toddlers to take him to the toilet now uses a string to guide himself from his house to the toilet.
3. The CHWs and natural leaders implementing CLTS at the village level identify households that have individuals with physical or visual impairments and target such households on a case-by-case basis. The implementers work with the household to help them design improvised sanitation supportive devices including bedside commodes and the setup of strings for individuals who are blind to use to guide themselves to the toilet.
4. Even though Kenya is committed to providing universal access to sanitation for all, the current national sanitation policy and strategy does not address the issue of inclusive sanitation. WASHplus is informing national policies based on its experiences in the pilot sites

The CLTS+ pilot program on the ground is having an immediate impact, but for longer term health and equity gains and sustainability of this approach, WASHplus understands the need to effect policy change. Toward this end WASHplus co-chairs the Government of Kenya's hygiene promotion technical working group and is also a member of the sanitation technical working group and the national CLTS steering committee, and in this capacity participates in reviewing relevant policy documents and suggesting ways to insert inclusive sanitation. WASHplus also plans to share experiences and lessons learnt to inform the ongoing National Environmental Sanitation and Hygiene Policy review process.

### **Community health strategy and CLTS monitoring and evaluation indicators - with additional indicators for inclusive sanitation**

- Number of households with functional latrines
- Number of households with functional hand washing facilities
- Total population of the elderly (60+ years)
- Number of person with mobility impairment (disabled)
- Number of bedridden women receiving menstrual hygiene care



**Photograph 1. FHI 360.**  
**Danson, who is blind, demonstrates how he uses a nylon string to guide himself from his house to the toilet**



**Photograph 2. FHI 360.**  
**A bedside toilet made from a plastic chair and a bucket for an elderly person who is mobility impaired**

### **Project success story: simple string solves problem for blind youth**

Three years ago Danson Ndung'u was a popular mechanic and driver in Nairobi's biggest slum, Kibera. Today he can neither drive nor fix cars. The 20-year-old's career ended when a violent mob beat and blinded him during post-election year violence in 2010. The attack changed Danson's life forever, ending his promising career, independence, and ability to support his mother and four younger siblings.

After three months in the hospital, he struggled to adapt to the fast-paced lifestyle of home and moved to a quieter rural area, Sision Village in Maai Mahiu, Nakuru county, to live with his married elder sister. In the serenity of the village, Danson slowly began to cope with life as a blind person. He enrolled in a knitting course at Thika School for the blind.

Whenever he came home for holidays, Danson felt robbed of his privacy. He felt helpless having to depend on somebody to get him to the toilet, just a few meters from the house. Even though he has learned to use a white cane, he still finds it hard to move around outside his home because of the rocky terrain.

Peter Maina Njoroge, a WASHplus-trained volunteer (CLTS natural leader), visited Danson's home and heard about the challenge Danson faced reaching the toilet. Using knowledge he gained during a training conducted by the MOH staff, they quickly came up with a solution. They tied a red nylon string running from the house to the toilet to guide Danson. This simple modification worked. Two months later Danson reports, "I can now go to the toilet alone even when there is no one around. Before I used to wait for them to come from the farm so that one could come and help me."

Although he still faces many challenges in moving around his village, the simple string has eased his life and given him back his privacy. To him it is a step toward regaining the joyful life he once had.

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