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**LOCAL ACTION WITH INTERNATIONAL COOPERATION TO IMPROVE AND
SUSTAIN WATER, SANITATION AND HYGIENE SERVICES**

**Lessons learnt from implementation of outcome linked
community led total sanitation intervention in Busia Kenya**

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The financial inclusion improves health in Kenya (FINISH INK) is a public private partnership project funded by the Dutch Government implemented in Busia and Kilifi Counties of Kenya. The aim is to increase access to sustainable sanitation for rural communities through micro-credit initiatives. The project has three components namely: sanitation demand through community led total sanitation plus (CLTS+), sanitation supply side development and financial inclusion. The project has decomposed demand creation into two social marketing strategies namely; community led total sanitation (CLTS) and direct sanitation marketing all which are which linked to sanitation loaning.

In Busia, an intensive CLTS intervention was implemented based on three key innovations namely: targeted capacity building schemes; harnessing the existing local social and administrative governance structures; and development of localized low cost sanitation technologies. A combination of these strategies led to achieved of open defecation free status for the rural population in the entire county.

Introduction

About 32 per cent of the Kenyan population have access to improved sanitation (UNICEF/WHO, 2015). Inadequate sanitation coupled with rampant open defecation has been associated with negative social economic and health outcomes. Diarrhea diseases mainly due to poor sanitation practices kill children three times more than HIV, TB and Malaria (Boschi-Pinto et al, 2008). Further, inadequate sanitation has been linked with loss of time spent out of productive labor or seeking a place to defecate leading to overall decreased economic productivity (WSP, 2012). In some Kenyan counties, open defecation rates are greater than 70% of the population representing a significant at risk population. This paper explains the process and the lessons learnt during the implementation of intensive countywide community led total sanitation (CLTS) campaign in Busia Kenya. The paper reflects on critical steps and innovations which other programmes should consider to achieve scale and ultimately universal coverage.

Context

To accelerate sanitation coverage in Kenya, the Ministry of Health adopted community led total sanitation (CLTS) as the mainstay strategy for scaling up sanitation (IDS, 2015). A framework dubbed the ODF rural Kenya campaign was developed to guiding counties to eradicate open defecation by the year 2013 (Ministry of Health Kenya, 2013). This has since been proceeded by the National Environmental Sanitation and Hygiene Policy (KESH) of the year 2016 (Republic of Kenya, 2016) and the national sanitation strategic frameworks whose goal is to guide on the implementation of total sanitation under the devolved governance system as enshrined in the Kenyan constitution (The Constitution of Kenya, 2010).

In 1999, Dr. Kamal Kar developed the community led total sanitation (CLTS) methodology in Bangladesh (Kamar & Robert, 2008). The main tenets of the methodology are creating fear and disgust with the aim of driving community resolve to build their own toilets. The efficacy of CLTS methodology has been proven leading to large scale CLTS intervention by the governments and development partners. Nambale sub-county of Busia County Kenya became the first ever region to achieve open defecation free status in the

country as a result of CLTS promotion. Based on this success, FINISH INK project scaled up CLTS promotion to the rest of the six sub-counties until all achieved open defecation free status.

Objectives

This paper describes the processes, innovations and lessons learnt while implementing community led total sanitation which led to realisation of Busia county open defecation free status the first ever in Kenya. The paper seeks to answer three key questions:

- What were the contributing factors and processes to attainment of large scales ODF status
- What were the immediate and intermediate results
- What were the salient lessons learnt from this process

Materials and methods

Setting

The programme was implemented in Busia County which is at the most westerly part of Kenya and consists of seven administrative sub-counties namely: Busia, Nambale, Butula, Bunyala, Samia, Teso North and Teso South. The county has a population of an estimated 736, 881 people with 621,756 living in rural and 115,125 in urban areas (KNBS, 2009). The intervention focused on the rural population where community health units are well formed. Very little has been documented about the traditional practices in relation to defecation and disposal of faeces in these communities. It is however known that the Bukusu (Luhya) belief that sexually active youth should not touch human faeces which should only be handled by elderly people often considered less sexually active (Emmanuel, 2015).

Processes and procedures

The journey towards open defecation free rural Busia began with commitment by the county government to attain open defecation free county by June 2015. With the support from the FINISH INK project, accelerated large scale CLTS implementation plan drawn by the county beginning March 2015. The implementation plan was based on three pillars namely:

- Structured capacity building and engagement with health staff and communities leaders
- Addressing access to sanitation by sustained demand creation and low cost affordable technological options
- Harnessing local social and administrative governance framework to ensure scale

The capacity building scheme focused on transferring key competencies for community triggering other than theoretical knowledge. The main training methodologies employed included problem based learning, field trails and practical sessions. Administratively, all CLTS trained persons signed a performance contract outlining commitment to deliver at least ten open defecation free villages. Thereafter, primary data on sanitation coverage was actively obtained by conducting a census on each household in the area allocated to the triggering team. Villages were listed by sub-county; the village elders identified and where practicable the local area administrator was informed of the upcoming CLTS activity to gain support in mobilisation of the communities. During pre-triggering, the promoters listed each household indicating situation and these data supported the development of village level triggering micro-plans.

A mass CLTS triggering campaign was initiated closely supported by supportive monitoring by the oversight teams. Monthly review meetings were held to review performance. All villages achieving 90% of documented open defecation free (ODF) criteria were qualified for third party certification with a clear plan on how they would address the identified gaps. Certification followed and thereafter quality control by officials from the Ministry of Health was deployed to re-affirming the completeness of the processes and the accuracy of the data and information provided.

Findings

Factors contributing to the achievement of ODF

Social cohesion among the community members

Social cohesion was a major factor to achieving ODF status. Each community member took responsibility of ensuring neighbors acquired and used latrines. In some instances children played a role in shaming laggards

by raising alarm if any these individuals were caught practicing open defecation. Any community member found not to have deliberately constructed a latrine was guided and supervised to put up a latrine by community elders. Although un-written, communities developed informal norms, laws and standards indicating how each of the members was expected to behave.

Strong leadership from the county all through to the community levels

Strong leadership both from the county level all through to the community level played a major role in realising in institutionalising CLTS processes. The intervention effectively utilised the government administration structures to mobilize both the technical teams and the communities to support CLTS activities. Leadership characteristics varied from community to another and where there was strong leadership, ODF success was higher.

Regular and consistent follow ups by the county government Amref and the community natural leaders

The intervention strengthened post triggering follow up and monitoring to ensure that communities consistently focused on ODF as the ultimate goal. Intensive follow up began right away after the triggering sessions with the aim of hastening the achievement ODF status. In many occasions, the triggering teams made visits to the villages to ascertain the progress made in latrine construction, installation of hand washing stations and elimination of open defecation practices. Every follow up visit offered an opportunity to interact with the community and to understand the constraints and drivers of open defecation practices. Intensive follow ups continued through to verification and certification processes and one of the most important features in the follow up was picking of lessons on how teams would optimise their efforts.

The immediate outputs and outcomes

Community access to latrines

The CLTS campaign contributed to a rapid increase and access to private latrines as well as reducing self-reported open defecation. The baseline data indicated that latrine coverage went up from an average of 62% in the entire county to about 89% over a period of nine month. Nearly all (99%) latrines constructed through this process were unimproved. Further analysis indicated that there was a statically significant increase in the number of the latrines constructed before and after intervention ($P=0.00$). The construction of latrines was at peak three months from the time of triggering a probable indicator of the time required to expect meaningful outcomes.

Institutional arrangements to support CLTS in Busia

Busia embraced CLTS strategy in sanitation institutionalized this approach within the county operations and framework. In the county health act, the county cites CLTS as a mainstream strategy in sanitation promotion and this is part of policy sustainability in the county. The county has provided a coordination forum dubbed 'Busia county WASH coordination forum'. These infrastructures continuously provided leadership and guidance for implementation of the approach throughout the county.

Conversion rate from open defecation (OD) to open defecation free (ODF)

Self report progress monitoring by community health workers and submitted to the county public health officer on monthly basis showed rapidity of the uptake of CLTS processes. The ODF trajectory was almost similar for all the sub-counties with no remarkable differences. Key to the uptake and the conversion to ODF was intra and inter village monitoring.

Reduction of sanitation related morbidities

In the implementation processes remarkable positive social impacts have been witnessed as shown in the box below:

Open defecation free intermediate results

By November 2015, Busia County achieved open defecation free status and was celebrated during the world toilet day. Some of the immediate and intermediate results include:

- 1,118 villages were certified open defecation free
- 15,203 latrines had been constructed
- Prevalence of diarrhea diseases among the under five years children dropped by a margin of 31% within the year

Additional monitoring and follow up is on-going to further describe long term impacts of this intervention.

Lessons learnt

The role of different community leaders in promoting CLTS in rural communities

A combination of leadership played a big role in encouraging communities to adopt open defecation practices. The intervention did not limit itself to the natural leaders who emerged through triggering but went further to engage religious, political administrative and the traditional leaders. This ensured that there was total coverage of information and in many social events the message of achieving ODF was passed. This may have contributed to the rapidity of achieving ODF. Additionally, local administrators were particularly key in ensuring that recidivism did not happen by door to door check on individual household sanitation status. They were also instrumental in enforcement of the rules and the norms.

Varied complexities in different communities

Throughout the CLTS processes, it turned out that although not significantly, the ODF conversion rates were varied. No single factor could be attributed to either a rapid or slow ODF conversion rates but various factors influenced the conversion rates. Notable influences were among others; the zeal of the triggering teams, inter village competition and in some cases, inhibitors such as geophysical constraints.

Discussion and conclusions

The implementation of CLTS activities involved efforts from different players in the community. The strong social cohesions, inclusivity and commitments from the communities and the leaders played the main role in ensuring success of the CLTS processes. This explanation coincides with earlier finding in Kolkota where political support overwhelmingly led to achievement of ODF without subsidies (Robert, 2009).

Before the initiation of triggering activities, triggering teams developed micro-plans and strategies for effective roll out. Such strategies included house to house visit to the laggards and enforcement of the norms through village elders. Although this approach departs from the CLTS protocols which promote persuasion, enforcement of communal norms and self governance proved to be a powerful tool in ensuring that ODF status is realized as corroborated by other authors (Bates, 2001).

High quality CLTS trigger by well trained and supervised teams ensured maximum triggering effect was achieved and this relates to earlier findings by the World Bank water and Sanitation Program (WSP, 2011). The intervention further promoted low cost technologies use of locally available materials and communal labor to build latrines. This approach helps solve both the demand and the supply side gaps described as a major constraint for successful CLTS programme.

Immediately after triggering, community members started building latrines significantly changing the sanitation densities before the intervention ($P=0.000$). This concurs with other findings which note that then well implemented, CLTS has been associated with rapid construction of latrines (UNICEF, 2006).

With regards to reduction of diarrhea diseases a comparison of before and after intervention diarrhea morbidity data collected between January 2014 to December 2015 indicated that there was a significant reduction of diarrheal diseases between those two periods ($p=0.000$). This corroborates earlier findings that lack of household latrines is associated with diarrhea and under-five mortality and the opposite is true (Semba, 2011).

From the onset of the intervention, triggering teams were expected to meet set targets over specific time period and this was tied to a reward. Performance linked CLTS processes may have contributed to the rapid

achievement of ODF status. This strategy borrowed from the reflections of CLTS practitioners' workshop in which one of the recommendations was to have CLTS facilitators under performance based contracts (Institute of Development Studies (IDS, 2011). As enthusiasm to achieve ODF status among the CLTS facilitators and the communities developed, inter-village competition emerged accelerating the ODF transition rates. Self triggering was also witnessed especially in villages whose sanitation densities were high and were neighboring the enthusiastic villages.

This paper concludes that strong coalitions between the community members, local administrators and the CLTS facilitators should be explored as leverage points when implementing CLTS activities. It's further noted that keeping track records of individual village performance helps to identify gaps early enough for effective corrective actions. Further exploration and follow up on the long term effects of such an intervention is require to provide context specific relationship between improved sanitation and demographic dividends such as increased economic potentials and the contribution of reduction of other sanitation related diseases.

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References

- Bates, R. H. (2001). *Prosperity and violence: the political economy of development* 1st ed. New York: Norton.
- Boschi-Pinto, C., Velebit, L., & Shibuya, K. (2008). *Estimating child mortality due to diarrhoea in developing countries*. Bulletin of the World Health Organization, 86(9), 710–717.
<http://doi.org/10.2471/BLT.07.050054>
- Emmanuel, O. (2015). A reality for Uganda: Kampala, 23rd April 2015: *Urine Diversion Dry Toilets for Urban Towns*,. (p. 9). Kampala: National Technology Conference on Urbanization,. Retrieved from <http://bbm.miva.at/wp-content/uploads/2015/08/UDDTs-for-Urban-Towns.pdf>
- Institute of Development Studies (2011). *Taking Community Led Total Sanitation to Scale with Quality- An Executive Summary of the Lukenya Meeting convened by IDS, July 2011*. Brighton: Insitute of Development Studies.
- Kamar, K., & Robert, C. (2008). *Handbook on Community Led Total Sanitation with Kamar Kar*. Brighton, BN1 9RE, UK: Institute of Development Studies.
- Republic of Kenya. (2016). *Kenya Environmental Sanitation and Hygiene Policy*. Nairobi: Government of Kenya. Retrieved from http://www.health.go.ke/wp-content/uploads/2016/05/KESH-POLICY_1-1.pdf
- Republic of Kenya. (2010). *The Constitution of Kenya* 27 August 2010, available at: <http://www.refworld.org/docid/4c8508822.html> [accessed 22 February 2017]
- Republic of Kenya (2009). *Socio-economic Profile of the population, Kenya 2009 Population and Housing census*. Vol. 2. Nairobi: Kenya National Bureau of Statistics
- Robert, C. (2009). *Going to Scale with Community-Led Total Sanitation: Reflections on Experience, Issues and Ways Forward*. (= Practice Paper, 1). Brighton: Institute of Development Studies. Retrieved from http://www.sswm.info/sites/default/files/reference_attachments/CHAMBERS%202009%20Going%20to%20scale%20with%20CLTS.pdf
- Semba, R. D. (2011). *Relationship of the Presence of a Household Improved Latrine with Diarrhea and Under-Five Child Mortality in Indonesia*, American Journal of tropical medicine and hygiene, 443-450. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3042822/>
- UNICEF. (2006). *Case Study of Community-Led Total Sanitation in Nigeria*. New York: UNICEF. Retrieved from <http://www.unicef.org/french/wash/files/NigCLTS.pdf>
- World Health Organisation. (2015). *Progress on sanitation and drinking water – 2015 update and MDG assessment*. Geneva: WHO Press.

World Bank Water and Sanitation Programme. (2012). *The economic impacts of poor sanitation in Africa*. Nairobi: WSP. Retrieved from <https://www.wsp.org/sites/wsp.org/files/publications/WSP-ESI-Kenya-brochure.pdf>

Water Sanitation Program (2011) WATER AND SANITATION PROGRAM: RESEARCH BRIEF scaling up rural sanitation factors associated with achieving and sustaining open Defecation free communities: Learning from east java. Available at: http://www.communityledtotalsanitation.org/sites/communityledtotalsanitation.org/files/Factors_ODF_EastJava.pdf (Accessed: 22 February 2017).

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