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TRANSFORMATION TOWARDS SUSTAINABLE
AND RESILIENT WASH SERVICES

Capacity-building village sanitation committees accelerates and sustains communities open defecation free status

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Since 2016, Amref Health Africa has been implementing the Kenya Sanitation and Hygiene Improvement Programme (K-SHIP) funded by Water Supply and Sanitation Collaborative Council (WSSCC) through the Global Sanitation Fund (GSF). The K-SHIP[1] has formed and trained 6480 village sanitation committees (VSCs) on community-led total sanitation (CLTS). However, early to mid-2016, there was slow pace delivering villages ODF because VSCs` capacity-building was not emphasized and streamlined. To accelerate the pace, the programme innovatively resorted to capacity-build VSCs which enabled the K-SHIP to achieve more ODF villages (149 in 2016 and 410 in 2017). This is after ensuring key competencies are acquired by VSCs through a 2-day training and on-job-orientation on CLTS incorporating Sanitation Marketing and Equity & Inclusion during follow-ups. This paper aims to emphasise that to improve CLTS efficiency, sustainability and hence health outcomes and building up strong socio-economic-ODF-slippage-free communities, proper capacity building to VSCs is necessary.

Introduction

Sanitation is a human right and access to it contributes significantly to improved Public health outcomes (Kenya Constitution 2010). According to the Joint Monitoring Programme, only 32 percent of the rural population had access to improved sanitation of which 72 percent predominantly consisted of simple pit latrines providing varied degrees of safety, hygiene and privacy. Open defecation is still practised in Kenya despite the government's ambitious Open Defecation Free (ODF) Rural Kenya 2013 Campaign Roadmap. Overall, the national open defecation rate is about 14 percent, which masks massive regional disparities. In some counties, open defecation remains the norm with the northern counties hardest hit with Turkana (82.2percent), Wajir (76.7 percent) and Samburu (73.4 percent). Even in counties with lower rates of open defecation, children's faeces are often not contained, due to parental perception that children may fall in latrines, and also the perception that children's faeces are harmless. Some adults also continue to routinely defaecate in the open at night and during the rainy season. Therefore the true rates of open defecation may be higher. (KESHP 2016 – 2030). The situation concerning access to basic sanitation in Kenya is not appealing with approximately 8 million people defecating in the open (OD). This led to the Government of Kenya in 2011, to launch Community Led Total Sanitation (CLTS) as official approach for scaling up rural sanitation with the aim of achieving 100% open defecation free (ODF) communities by 2015. The progress has been very slow since by 2016 only 5,434 (8%) were ODF out a total number of 69,299 (100%) villages in Kenya. This leaves a gap of 63,865 (92%) villages in Kenya not ODF. This according to the UNICEF December 2016 will cost Kenya a whooping KES 1,857 billion. UNICEF, in realising open defecation free rural Kenya – achievements and the road ahead – December 2016).

The gap

The journey of attaining improved sanitation coverage has been slow since 2007 when CLTS was introduced in Kenya. The 1st Counties to benefit from this approach were Siaya County – Siriwo village in 2007, Homa Bay County – Manera village 2007, Kilifi – Jaribuni village in 2007 and Kisumu County

Kochogo village in 2008. The four villages went on to become ODF between 2007 – 2010. Since then not much has been achieved. It was expected that subsequently, the wards and Sub counties where this first villages were triggered would have quickly progressed on to becoming ODF long time ago. However, in 2018, we are still talking of a minimal number of villages that have accelerated the improvement in sanitation.

The question is what could be wrong? Could it be the approach? UNICEF, in Realising an Open Defecation Free Kenya 2016, gives a grim picture of the situation by indicating that the pace of villages progressing from triggering to ODF is too slow. In 2015, a total of 4,144 villages were triggered in Kenya and only 13% managed to attain ODF status in that year while in 2016 a total of 5,849 villages were triggered and only 35% became ODF (UNICEF 2016). It then means that at this pace, attaining an ODF Kenya will take a significant amount of time.

The 11 Counties where K-SHIP is operating aren't spared either since when the K-SHIP came on-board the Kenyan WASH sector in 2015, it experienced challenges in following up the villages to ODF because the VSCs orientation was not emphasised and streamlined then. At the end of 2016, the KSHIP managed to deliver a cumulative 149 villages ODF in all the 11 target counties. This showed a slowed progress in achieving set targets (200) for the 2 years. As a mitigation measure, the programme innovatively decided to effectively train VSCs for 2 days so that they competently understand the content. In 2017, the KSHIP enjoyed grass-root programme support from the VSCs. This was achieved through proper selection of committed VSCs oriented for 2 days on CLTS processes incorporating Sanitation Marketing and Equity & Inclusion. In 2017 alone, the programme achieved 410 ODF villages as compared to 2016. This is after ensuring key competencies are acquired by VSCs through training and on job orientation by Public Health Officers (PHOs) and local implementing partners (LIPs) staff during follow-ups and on day to day implementation of programme activities.

The cost of training all the VSCs (approx. 6,000) in 2016 and 2017 in the 11 target counties amounted to approximately 24 Million Kenya Shillings which is 4.8% of the entire budget. This led to reduction in unit cost of delivering a village by near half since the amount used to deliver 149 villages ODF in 2016 is estimated to be almost the same as the amount used to deliver 410 villages ODF in 2017.This was attributed to competently trained VSCs hence ensuring effective follow-ups leading to less time taken to deliver the villages ODF. The village sanitation committees can also double up as members of water committees in their villages. Still, VSCs can also play community health volunteers (CHVs) roles in their villages.

The proposed intervention – "the way to go"

Based on Amref Health Africa's K-SHIP implementation approach, VSCs are formed and organised in such a way that they follow-up on the triggered villages to attain ODF and keep track of improved sanitation thereafter in an endeavor to climb up the sanitation ladder. The village sanitation committees are also the main players to rally around to ensure sustainability of the acquired behavior change. The followings are key in ensuring competent VSCs:

- 2-day orientation
- Regular VSC meetings (Weekly)
- Village visits to do follow-ups while using village diaries
- Escalating and innovating approaches that proof to work
- Involving communities in income generating activities (IGAs)
- Ensure equal representation (Equity & Inclusion, Gender)
- Monitoring and Evaluation plans
- Walking the journey with the VSCs (Close Supportive Supervision).

Early 2017, the K-SHIP in collaboration with one of her local implementing partners (LIPs), Community Social Networking Improvement Organisation (COSENIO), empowered VSCs through Capacity building to accelerate sanitation improvement in South Mugirango of Kisii County. The approach was able to achieve 21 villages ODF in just one and a half month. The strategy worked very well. In the 11 target counties, the KSHIP has so far formed and oriented 6480 village Sanitation Committees to date which translated to 559 ODF villages and 737 others under follow-ups, claims and verification stages.

Training curriculum and delivery method

The training curriculum involves a one day class work to build a background of Water sanitation and Hygiene for VSCs as well as share the local sanitation situation for them to appreciate the magnitude of the

problem, a one day field exercise to help the participants develop hands on skill to help the Households negotiate for improved sanitation and Hygiene practices and also to analyse the field learning exercise and thereby developing a community action plan (CAP) based on the information gathered during the field learning.

The training content is outlined below:

- Water, Sanitation and Hygiene (WASH) situation in the home county,
- Introduction to sanitation & its components,
- The F – Diagram & blocking faeco-oral transmission routes,
- Sanitation ladder & negotiation skills for households behavior change,
- Brief introduction to CLTS process & parameters,
- Introduction to focused follow up using the CLTS and other approaches,
- Reporting & certification tools & parameters for both,
- Introduction to equity & inclusion,
- Demonstration on proper hand washing & water saving techniques; tippy tap, leaky tins and toilet hole pit lid cover,
- Demonstration on how to make affordable sanitation facilities to address disability, Sustainability, equity and inclusion: -
  - Commodes
  - Re- usable sanitary towels
  - Simple hand rails
  - Analysis of the field learning & emerging learning points
  - Community monitoring, evaluation & social norms to address sustainability of the acquired behavior change
- Action plan & way forward.

Training schedule overview

Table 1.

Time	Mode	Where	Purpose
Day 1	Theory	In class	Lay the background for the VSCs to understand sanitation in relation to their roles, carry out a practicum on hand washing and prepare for the field learning the following day
Day 2	Field Learning	In a selected village	To practically relate what was learnt in theory & reality on the ground, analyse and develop a way forward based on the experience gained from the field learning The VSCs will develop a way forward, Community Action Plans (CAPs)

VSCs Terms of References (TORs)

- Once the village sanitation committee has been formed, TORs will be shared with the members.
- The VSC will keep the record of base line profile of the village.
- The VSC will develop the community action plan for the village which will identify that how the village will achieve ODF status.
- The VSC will allocate responsibility to each house hold for fixed point defecation and social mobilisation to climb up on sanitation ladder.
- The VSC will encourage the linkages among the masons, entrepreneurs, mart owners, community-owned resource persons (CORPs) and natural leaders.
- The VSC will prepare their village level WASH road maps and will coordinate with community unit level authority to develop plans for total sanitation.

VSC members role and responsibilities

The national health sector strategic plan 2 (NHSSPII) under the Kenya Essential Package for Health (KEPH) identified the critical role played by the community. This led to the structuring of health services into Cohorts and Levels of Service. Level Health Unit otherwise called the Community Unit (CU) which is

manned by the Community Health Workers / volunteers was formed. This cadre of personnel forms a key linkage between the community and the formal health services delivery.

In CLTS approach, after triggering, the resultant Villager Sanitation Committees is oriented and form part of this important team and hence ensures ownership, sustainability and replication

Some of their roles are as follows:

- Able to identify issues and then highlight to address the sanitation issues as a priority.
- Ensure the participation of all community members including men, women, youth and children in development of community.
- To raise awareness and provide timely two-way information to the related households.
- To participate in all development projects and make efforts for their sustainability.
- To perform his/her activities while being accountable to the community members.
- To give his/her own opinion and provide opportunities to others to express their point of views in all the decisions of the organisation.
- Record Register for VSC Meetings, date, time, venue, total members who have participated, name of the participants & contact details, agenda of the Meeting, proceedings (resolutions, minutes etc), what was decided and who is responsible, monitoring of activities, next meeting date, time and venue.
- To play his/her active role in the betterment of the social situation of the village.
- Be able to make collective decisions.

VSCs governance structures

These roles can be further defined as per requirements of VSC. The governance structure of village sanitation committee within a community can be:

- The organisation will have 5 members selected from the triggered village at the time of triggering. These are the members who come out from the triggering session as natural leaders and commit themselves to the process.
- Each member will represent at least 10 households.
- These selected members will elect their chairman, vice chairman, general secretary, finance secretary and linkages building secretary.
- It will be preferable that parallel structures must not be organised in the targeted village. If multiple forums exist within the community like Community Health Workers or Community Health Volunteers etc, then their representatives can be members of the Village Sanitation Committees.

Conclusion

VSCs are the cornerstone of delivering and sustaining ODF status of communities. Empowering VSCs will not only reduce the cost of delivering a village from triggering to ODF, but will also reduce the period taken to deliver villages ODF. This is why it is feasibly imperative to effectively train VSCs, one of the community structures, to create a sanitation and hygiene movement among communities which fast-tracks interventions as well as ensuring sustainability. This in the end improves health outcomes and hence building up strong socio-economic communities that will not fall back to Open Defecation status.

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Note

K-SHIP is the Kenya Sanitation and Hygiene Improvement Programme. The K-SHIP is funded by the Water Supply and Sanitation Collaborative Council (WSSCC) through the Global Sanitation Fund (GSF). Amref Health Africa in Kenya is the executing agency (EA) for the K-SHIP and implements the programme

through 17 Local Implementing Partners (LIPs) in the 11 Counties in Kenya. The K-SHIP targets to reach over 1.92 million people with appropriate sanitation and hygiene interventions through the use of appropriate participatory sanitation and hygiene promotion approaches primarily Community Led Total Sanitation (CLTS) among others with the overarching goal to reduce the burden of disease resulting from poor sanitation and hygiene and improve the health outcomes of target communities.

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