case study

Integrating CLTS and PHAST in Kenya

A case study documenting experiences and lessons from Kenya Red Cross Society Guidance for the future of integrated community-based water and sanitation software programming

Locally constructed household latrine in Arumrum community, Isiolo district

Water, sanitation and hygiene promotion has long been a key sector of interest for the Kenya Red Cross Society (KRCS), both in emergency contexts and longer term development programs.

The KRCS is auxiliary to the Government of Kenya and is a key partner in contributing towards the realization of the Government's sanitation and water targets.

Kenya loses 27 billion Shillings (approximately 300 million USD) annually due to poor sanitation (World Bank, 2012). The United Nations estimates that **approximately 50% of all hospital attendance in Kenya is due to preventable sanitation, hygiene and water related diseases.** When people fall sick, local economies suffer through lost productivity and children stay home from school.

In 2011, the Government of Kenya (GoK) launched a National Sanitation Strategy dubbed "Open Defecation Free (ODF) Rural Kenya 2013". The strategy includes a directive to use Community Led Total Sanitation (CLTS) with no subsidy as the key approach for eliminating open defecation. Both the National Environmental Hygiene and Sanitation Policy (2007) and the country's constitution outline the commitment of the GoK toward achieving the target of 90% of the population using a hygienic, affordable and sustainable latrine facility by 2015.

Despite these commitments and positive steps, major challenges remain. The most recent statistics indicate that as much as 14% of the Kenyan population, or **almost 6 million people continue to practice open defecation (JMP, 2013).**

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Purpose of this document

This case study captures key experiences of KRCS in implementing a community-based water, sanitation and hygiene (WatSan) project in Samburu East, Isiolo and Garbatulla districts, where a hybrid CLTS and PHAST approach was the backbone of WatSan software activities.

The lessons and recommendations outlined below are relevant for KRCS, the GoK and non-governmental organisations working in sanitation and hygiene in rural and semi-arid areas of Kenya. This case study is also intended to provide guidance for other National Societies in the region (along with Partner National Societies and the IFRC), who may be looking to implement similar programmes in the future or who are looking to improve the effectiveness of existing WatSan interventions.

Technical information and guidance on CLTS and PHAST are well documented and therefore are not discussed in detail in this case study.

Methodology

This case study focusses solely on WatSan software aspects included in the project. Initially, a desk-top review of key documents was conducted. Data collection tools were developed collaboratively by a team of IFRC, KRCS and Danish Red Cross (DRC) counterparts.

A field visit was conducted to two districts (Samburu East and Isiolo), where three focus group discussions (two with communities groups; one with PHAST volunteers), eight key informant interviews (KRCS project officers, project coordinator, GoK Public Health Officers) and direct observations in two communities were conducted.

Overview and background of the project

The KRCS received funding in May 2011 from the European Union and the DRC under the EU-ACP Water Facility to implement a 45 month project entitled 'The Isiolo Water, Sanitation and Hygiene Community Project for Drought Prone Arid and Semi-Arid Lands'.

The overall project objective is to contribute to the MDGs, improve health status and reduce vulnerability of rural communities living in arid and semi-arid lands of Kenya. The project targets vulnerable rural, predominantly pastoral, communities in Isiolo, Merti, Garbatulla & Samburu East districts of Northern Kenya.

The project integrates hygiene sensitisation, increased sanitation coverage and access to safe water through a continuous community process and targets the entire rural population of the four districts (approximately 156,736 people or 33,129 households). Key project partners include the DRC, the Ministry of Water, Ministry of Health, Ministry of Education and the Northern Water Services Board.

What WatSan software approach and methods were used?

KRCS adopted a combined CLTS and PHAST approach as the backbone of WatSan software activities.

First, CLTS triggering activities (generally ½ to 1 full day in length) were facilitated by GoK Public Health Officers (PHOs) with KRCS project staff playing a quality assurance role. By leading triggering activities, the PHOs developed a closer relationship with communities and it is envisaged this will help to improve sustainability following project completion. Activities using "shame" as a motivator were replaced with those using "shock" – specific activities undertaken include mapping and transect walk to open defecation sites, analysis of medical expenses and story of health problems in the community.

Following triggering, an adapted version of PHAST was implemented in communities over a 3 to 4 month period, facilitated by KRCS volunteers. The standard PHAST methodology was shortened and only steps 3 to 7 were implemented. Step 4 (selection options) focused mainly on latrine super-structure options.

Digging tools were provided to communities (as target communities are pastoralists not farmers, and there were not appropriate tools available). Once a household had dug a pit, they were provided with a dome shaped slab and gunny

bags for pit lining (as project areas have weak collapsing soils), as an incentive to continue constructing the superstructure and begin using the latrine.

Technical guidance was provided on latrine construction through KRCS project staff and volunteers, role models (volunteers, CHWs or community champions/leaders) and PHAST sessions.

Follow-up on PHAST activities and monitoring of latrine construction and coverage was conducted regularly by KRCS volunteers and staff. GoK PHOs also conducted visits to communities approximately every month (however this was very dependent on transportation and availability) as well as being involved with follow-up through the Community Health Workers (CHWs) who reported to them every month.

The project was designed to have a six month start-up phase for community entry and planning, and then implementation commenced. However, partway through year 1 a number of logistical and implementation difficulties were faced in the widely spread and vastly scattered target communities. Subsequently, the 70 sub-locations were divided into three 'community lots' consisting of project sites adjacent to each other.

From year 2, successive implementation of activities in these three 'community lots' began. Software and hardware activities were implemented over a 6 month period in one 'community lot', before proceeding onto the next. The fourth year of the project will focus on institutional consolidation, follow-up, and evaluation, along with completion of hardware and software activities.

Social pressure and positive reinforcement was provided through community role models (generally KRCS volunteers and/or CHWs), and other methodologies incorporated into project design included the model home concept (linked to role models), Participatory Education Theatre (PET) and social marketing events.

To date, approximately 450 latrines have been constructed in Samburu East, however it is estimated that between 100 and 150 were not being used. Data from other districts was not available. Project implementation is ongoing and a mid-term review is planned for 2014, where data on open defecation rates (including relapse), latrine coverage statistics and hygiene practices will be collected.

"When you combine CLTS and PHAST there is more positive change, than CLTS alone. For behaviour change you need a longer time and to keep working together with community. With PHAST the communities have the chance to ask the volunteers for more details or information."

Lucy, KRCS Project Officer (Software) in Samburu

Examples of cultural perceptions, beliefs and practices in target communities

- Semi-nomadic communities are hesitant to build a permanent latrine structure.
- The "Morans" (young Samburu warriors) cannot be seen entering a latrine (least of all by women) and they cannot share latrines with their in-laws.
- An open pit (with no slab or covering) is said to be associated with (or inviting) death and hyenas into the manyatta.
- Latrine construction and use is not part of traditional culture or practices (for some this was their first experience of constructing a latrine).
- Latrines are perceived to be a similar structure to a house; people are hesitant to defecate inside a latrine structure.

Factors promoting and hindering latrine use

The key factors that either hinder or promote latrine construction and use in Samburu East, Isiolo, Merti and Garbatulla districts are:

	Barriers or disabling factors	Barriers or disabling factors
Policy and programming	• Inadequate capacity of Government to take lead role in implementing the Kenya Sanitation Road Map (limited human and financial resources, and technical staff capacity) • Challenges in information flow between district and national level Government officers (despite Govt. officers participation in project design and implementation, the initial approach taken was contradictory to GoK policy and re-design of approach and activities part-way through implementation was a huge challenge) • No flexibility in GoK approach, for the vastly different communities and contexts within the country • Lengthy, expensive and centralised ODF certification and verification mechanisms • Lack of consultation and involvement of community in decisions on latrine technology options and slab type	• Clear national policy statement and sanitation targets that are becoming widely known • Increasingly established Community Health Worker structure, linked the Community Health Strategy initiative and community level action planning for improvements in health • Large number of partner organisations supporting sanitation improvements in Kenya (numerous agencies working toward the same goal) • Buy-in and commitment from local leaders (and to some extent local politicians) • Use of "smart subsidies" as incentives for community contribution and achievement
Community	• Strong cultural perceptions, beliefs and traditions around sanitation (see box above) • Semi-nomadic pastoralist communities (who move periodically to find new pastures and water) meant there were no digging or construction tools readily available, and heavy concrete slabs would be left behind • Scarcity of water and locally available materials for construction of slabs led to slow pace of manufacture by local artisans, demoralised communities and slow conversion rate from open pits to latrine with complete superstructure • "Dependency syndrome" and perceived poverty of communities • Women were the main attendees at CLTS triggering events and in PHAST groups, however they are not decision makers at household level • Results and impact are highly dependent on volunteer and/or CHW motivation, activeness and facilitation	• Positive local leaders and 'champions' who act as role models for others • Existing capacity, strengths and knowledge within communities • Social marketing activities for hygiene promotion were well received by a wide audience and were context appropriate (few radios and TV, only men listen to radio) • Community initiated forms of "penalty" for open defecation in some areas (e.g. bringing people to elders, imposition of small fines etc.) • Existing community unit structures, CHWs and community health strategies which can be utilised to form basis of project activities in each community

Key lessons and recommendations

Drawn from Kenya Red Cross Society's experience with their WatSan project in Northern Kenya, these key lessons and recommendations are applicable for future community-based health, water and sanitation, and disaster risk reduction programs.

There is no "one size fits all" CLTS approach

In communities in semi-arid and arid lands of Northern Kenya, such as in the project studied, there are a variety of cultural, resource and geographic constrains that lead to significant challenges in project implementation, latrine construction rates and elimination of open defecation.

Factors such as a lack of digging tools, semi-nomadic communities, lack of background or technical knowledge on latrine construction, strong cultural beliefs and practices and no local supply chains for sanitation materials should have been accounted for and project activities modified accordingly. The pure 'CLTS' approach may be appropriate in some communities, but not others.

Key enabling factors and barriers for the target communities in terms of sanitation uptake should be closely examined in the project inception and assessment phases, and informed decisions taken regarding the specificities of CLTS to be used (e.g. smart subsidy or microfinance required, difficult technical context requiring additional guidance and support for construction).

CLTS and PHAST both have limitations, but can complement each other

All people interviewed expressed their preference for the hybrid CLTS and PHAST approach. Common reasons cited were that while CLTS focuses only on eliminating open defecation and motivating people, PHAST offers additional avenues of improving latrine facilities (moving up the sanitation ladder), improving hygiene behaviours (particularly household water storage and use and environmental sanitation), gives a range of technical options to suit the context, community planning for themselves, gives them ownership and empowers them toward ultimate goal of diarrhoea prevention.

Specific and appropriate steps borrowed from PHAST, can complement CLTS, and can strengthen components of technical guidance on latrine options and construction, hygiene promotion, community ownership, empowerment and follow-up.

Do not under-estimate the importance of technical guidance (especially in areas with difficult terrains) and sound assessment of acceptable latrine technology options

Non-durable latrine superstructure materials (soft wood eaten by termites, weak grass or mud walls which cannot withstand attack from animals, wind and rain) led to latrines becoming quickly dilapidated (at times 2 - 3 weeks after construction). This de-motivating experience discourages people from repairing or re-constructing latrines in the future.

Rocky ground and sandy, collapsible soils mean that additional technical advice on pit lining for example, are required in the project area. The dome shaped slabs were perceived to be inferior and weak due to a lack of steel reinforcing bars. Some had cracked and broken and many community members were afraid of falling into the pit.

A thorough assessment and/or piloting of sanitation technology options that are both appropriate and accepted by the target communities (given their beliefs and perceptions) should be mandatory during project planning and inception phases. Information on the variety of technical sanitation options available to the community, as well as guidance on construction techniques should be provided.

"People did not understand the technical design of latrines. There is a lack of 'know-how' on how to build them because people here are not used to it. Initially the community used locally available materials, but the latrine superstructure quickly became dilapidated within 2 to 3 weeks. Some people dug pits that were very shallow or were too wide. We need more technical guidance."

Jonah, CLTS community champion and Community Health Worker, Samburu East

Focus on quality facilitation and true implementation of PHAST activities – otherwise risk ineffective programming and wasted resources

Over the years the mentality around PHAST and its implementation have become one of "business as usual": without adaptation of toolkits and activities to community or project contexts, large inconsistencies in perceptions of what PHAST really is, and use of traditional subsidies.

Strong concerns were noted around the quality of PHAST facilitation (both at ToT and community-level) and the lost emphasis on facilitated participatory activities with community groups (replaced instead by 'teaching' or 'hygiene education' activities using picture cards). However, due to timing of and issues with ongoing activities it was not feasible to specifically address them in this project.

For each project context, KRCS should review the shortened PHAST methodology and toolkit to be used, so that the activities are relevant and focussed to key needs. ToT level CLTS and PHAST trainings should be centralised, with a strong focus on quality of facilitation rather than quantity of trainings (or number of people trained).

Take advantage of and work within existing Government and community structures

The success from direct involvement of community unit leaders and CHWs in CLTS and PHAST activities was demonstrated in Matakweni community. A high number of latrines were constructed and were being used in the community over a short-time frame of several months, which was attributed to this comprehensive and complementary community approach.

Existing Government and community structures (such as the Community Health Worker scheme, and community units formed under the Community Health Strategy initiative), should form the basis of involvement, decision-making and planning at community-level for sanitation and hygiene activities. Existing CHWs should be utilised as project volunteers (and potentially volunteer mentors or 'coaches'), along with existing and/or new KRCS community-based volunteers.

A strong assessment which includes attitudes and motivating factors is key, and should be used to guide project activities (not just for measuring project success)

In this project, a baseline survey and initial assessment were completed in order to be able to measure change and impact from project activities. However, if the assessment had included more emphasis on cultural beliefs and attitudes, and if findings were used to guide the sanitation and hygiene behaviour change related activities, a much greater level of impact and effectiveness could have been achieved.

Privacy, pride, convenience, health of family or children, money and status can all be very strong motivators. These factors should be investigated in the project planning and assessment stages, and then used to guide the messages and channels for hygiene and sanitation promotion activities.

Explore sanitation marketing and micro-finance for sanitation

Aspects of sanitation marketing should be explored and incorporated into future WatSan project design. After creation of demand for sanitation, efforts should be geared toward strengthening local supply chains of sanitation and hygiene items, as well as establishing and building relationships between communities and sanitation suppliers.

"Since we started triggering in 2010, about 31 out of 129 villages consider themselves as ODF - however only one community is fully certified to be ODF by the Government. Around three quarters of latrines constructed after trigger events 'collapse'. Some of the places that used to be ODF, are not any more. In some places the pits have filled up and people have gone back to defecating in the open. CLTS can be successful, but only if you have the funds and personnel for frequent follow-up after triggering (around 2 to 3 times per week)."

Public Health Officer, MoH, Isiolo

Micro-finance options for sanitation and hygiene items (through Red Cross branches, local suppliers, mobile phone payment methods directly to beneficiaries etc.) offer numerous other innovative options which should be analysed for suitability and appropriateness in each project context.

Focus on project "economies of scale" and continue to advocate with donors for longer-term funding options for greatest impact

Large scale sanitation and hygiene programs should focus on "economies of scale". During project development, careful consideration of level of needs, project areas, logistical realities and cost implications should be mandatory and an indicative mapping completed where greatest impact can be achieved.

The establishment of community lots (in similar geographic areas) and sequential implementation as part of the project in focus contributed some way toward improving cost effectiveness of project activities, but still posed logistical challenges. A similar mechanism should be utilised for future large scale projects, with context-specific adaptation and an extended contact time with communities.

Follow-up with communities is a 'make' or 'break' factor

Weak follow up and monitoring of project activities (due to logistical capacity and vastness of project sites) in some areas led to poor uptake of sanitation and hygiene practices and affected overall community buy-in.

Key follow-up activities should be budgeted and planned for in detail from the initial stages of project proposal development and planning.

Responsibility for follow-up, monitoring and review of activities and results, should be clearly outlined and ideally documented in a formal agreement with the Ministry of Health and/or other key Government partners.

Community member in Arumrum, Isiolo district, with his latrine (dome shaped slab and super-structure made from locally available materials) and deep rubbish pit for household waste.

Clarify ODF verification and certification process (responsibility, cost and timeframe)

Currently in Kenya, the verification and certification process for ODF status consists of three levels: community CLTS/health committee (level 1); district MoH Public Health Officers (level 2); and third party certification from a nationally endorsed certifier .

There are high costs associated with level 3 certification, and uncertainties about who holds responsibility for initiating and funding certification. The GoK have clearly outlined sanitation objectives and policies (e.g. the Sanitation Road Map), however they are not matched with adequate funding or incentives for district Government officers and there is a heavy reliance on partners.

Woman in Samburu East district next to her household latrine (super-structure made from locally available materials).

Only one district in Kenya (Nambale) has been declared ODF to date. In Isiolo, out of 20 communities that have achieved ODF status, just one has been officially certified to level 3. To improve efficiency of level 3 certifications, it is recommended that third party verification and certification be de-centralised to county level and that specific guidelines (outlining costs, timeframe and expectations for partners) be developed.

Way forward

The Government of Kenya has made a commitment toward ensuring all citizens have access to a hygienic sanitation facility by 2015, with a policy decision to use CLTS as the approach for eliminating open defecation.

The KRCS should continue to advocate for and use a hybrid approach of CLTS followed by a shortened, adapted and high quality PHAST process.

This integrated and comprehensive approach is seen as a way forward for community-based sanitation and hygiene programming in rural areas in Kenya. A 'grey area' currently exists regarding the provision of subsidies, as this is a direct contradiction of the GoK policy.

Greater policy direction, acknowledging the wide variety of community contexts, is required. The role of sanitation marketing in generating demand for improved latrines and strengthening local supply chains should be explored.

"I would choose the two approaches [CLTS and PHAST] combined, in future projects. In CLTS the community sees the importance of having a latrine. PHAST complements this because it is more general and includes hygiene, information on types of latrine and other things like household hygiene and waste management."

Justus, KRCS Project Officer (Software), Isiolo district

Kenya Red Cross Society
P.O.Box 40712 – 00100 GPO
Nairobi, Kenya
Phone: +254 20 6003 593
Email: info@kenyaredcross.org
Website: www.kenyaredcross.org

IFRC Eastern Africa and Indian Ocean Islands Regional Representation
Woodlands Road, PO Box 41275 – 00100
Nairobi, Kenya
Phone: +254 20 2835 000
Email: regional.eastafrica@ifrc.org
Website: www.ifrc.org