

Scaling up CLTS in Kenya: opportunities, challenges and lessons

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Kenyan sanitation context

Over 2.6 billion of the world's population does not have proper toilet facilities. Worse still, even those with proper toilet facilities do not wash their hands properly after **shitting**. In Kenya, about half of the population (20 million people) does not have proper sanitation facilities (Doyle, 2008). They defecate in the open or in a *juala* (plastic bag). The implications? About 80% of Kenyans who go to hospital suffer from preventable diseases such as typhoid, amoeba and diarrhoeal diseases. Diarrhoeal and gastroenteritis diseases are among the highest causes of infant hospitalisation in Kenya today. The situation is worse in rural areas where 55% of the population have no access to sanitation facilities and have to resort to open defecation.¹ Thousands of children miss classes in school as a result of diarrhoea and worm infections among other poor sanitation and hygiene related illnesses. Poor disposal of human excreta is responsible for the

contamination of open water sources and the spread of frequent cholera outbreaks. Poor sanitation and hygiene not only affect economic and social well-being but also result in many infections that lead to the hospitalisation or death of thousands of Kenyans.

Past sanitation interventions

Over the last 20 years, many donor funded sanitation programmes focused on developing affordable latrine models that could be replicated. Yet these efforts have failed to scale up. This is because these programmes are based on two flawed assumptions: firstly, that people do not construct and use latrines because they are too poor; and secondly, that cheap and affordable latrine models are all that are needed to solve the problem. What the programme designers did not realise was that transforming people's mindsets was key. If people appreciate the importance of living in a sanitised and hygienic environ-

¹ WHO/UNICEF Joint Monitoring Programme, 2006.

Photo: Samuel Musembi Musyoki



A simple pit latrine in Vitengeni, Kilifi District, Kenya.



Photo: Samuel Musembi Musyoki

Picture of a permanent toilet block in Siaya District, Kenya. This was taken during a verification exercise.

ment, they will do everything possible within their means to stop open defecation, improve their sanitation conditions and use locally available resources to put up sanitation structures – and with time go up the sanitation ladder without external subsidies.²

For over 15 years the Government of Kenya, Plan Kenya and many other agencies in the sanitation sector have been using the Participatory Hygiene and Sanitation Transformation (PHAST) approach. While PHAST is a very rigorous approach, there have been doubts within such agencies as to whether PHAST can promote sanitation and hygiene at a scale that would significantly contribute to the attainment of the Millennium Development Goals related to sanitation. PHAST is a lengthy process ridden with some subsidy components which have made it expensive and so difficult to scale up in a sustainable manner.

Community-Led Total Sanitation (CLTS) therefore came at a time when agencies in the sanitation sector were searching for innovative approaches that could be used to promote and scale up sanitation and hygiene.

The CLTS journey in Kenya

Community-Led Total Sanitation (CLTS), which has its origins in Participatory Rural Appraisal (PRA), is one of the fastest growing methods in the sanitation sector with documented positive impacts in South and South East Asia (Kath and Kamar, 2005). It is now being practiced in over 20 countries in Africa.⁴ It was first introduced in Kenya in May 2007, following two training workshops in Tanzania and Ethiopia attended by three Plan staff. Working for the Institute of Development Studies University of Sussex at the time, I was privileged to accompany Kamal Kar as a co-

² The 'sanitation ladder' helps people to identify options for improving sanitation in their community and realise that this can be a gradual process. Sanitation may be as cheap and simple as a protected pit latrine or as expensive and complex as a flush toilet with sewerage. The further up the 'ladder', the greater the benefits for people and the environment.

³ PHAST is a participatory training method that uses visuals to demonstrate the relationship between sanitation and health status. It is geared towards increasing self esteem of community members and empowers them to plan environment improvements and own and operate water and sanitation facilities. See PHAST Step-by-Step Guide, WHO 1998.

⁴ Kenya, Ethiopia, Uganda, Tanzania, Rwanda, Zambia, Malawi, Zimbabwe, Northern Sudan, Southern Sudan, Mozambique, Niger, Democratic Republic of Congo, Nigeria, Ghana, Mali, Burkina Faso, Sierra Leone, Senegal, Gambia, Benin, Liberia, Chad and Egypt.

trainer and a participant observer. Though sceptical at the time, my desire was to learn what was different in CLTS as I had had many interactions with Kamal in seminars where he talked about the approach.

As a PRA/PLA practitioner and trainer the main tools used in CLTS were not new to me (i.e. social mapping, transect walks, flow diagrams and action planning). What I found unique in CLTS was its innovative use of **disgust, shame and fear** as a force to change mindsets and trigger collective action (see Pasteur, 2005 and Musyoki, 2007). These require the facilitator to play a very different role and behave differently too. While participatory approaches such as PRA/PLA teach us to be nice and humble, in CLTS our role is required to change to that of devil's advocate.⁵ In this role, we systematically and humorously facilitate a process that enables the communities to analyse their own sanitation profile. This entails drawing up a map of their community, indicating where they defecate, calculating the amount of faecal matter generated (per day, per week, per month and per year). They then indicate where the faecal matter goes to using flow diagrams. They also take a walk (sometimes called the 'walk of shame') to see the magnitude of the problem. We (facilitators) get them to stop at the open defecation sites and discuss what they see. We then carry some shit back to the meeting venue and visually demonstrate how the faecal-oral contamination process happens through water and food. This process called **triggering** usually results in the shocking discovery that the community members have been ingesting each other's or their own shit – resulting in illness, hospitalisation and sometimes death.

At this point of realisation – the ignition moment – we as facilitators thank them for

educating us about their sanitation behaviour, beg to leave and encourage them to continue eating their own shit. Of course, we do not really leave, nor would they allow us to. It is all part of the tricks we use to emotionally push people towards changing their mindsets to take collective action, stop open defecation and ensure good sanitation in their community.

CLTS bushfire

Following the training in Tanzania, Plan Kenya decided to pilot CLTS in three districts: Kilifi (Coast Province), Homa Bay (Nyanza Province) and Machakos (Eastern Province). The three pilot triggering sessions took place between July and October 2007.

In Kilifi district, where the first village was triggered in July 2007, the response has been remarkable. Since the first Open Defecation Free celebration (19th November 2007), communities in over 150 villages have demonstrated great ownership of the CLTS initiative. They see the approach as not only improving their sanitation and hygiene situation but also enhancing their human dignity and pride. This was well put by Charo, a village natural leader, when he said:

*We feel proud of our achievement. All the 37 households previously without latrines now have constructed and are using them well. There is no more bad smell in the neighbourhood.*⁶

Some community members in the triggered villages in Kilifi have already started phasing out the temporary sanitation facilities that they hurriedly put up following the triggering. They are now investing in the construction of long lasting and/or permanent structures. There is a sense of compe-

⁵ In common parlance, a devil's advocate is someone who takes a position s/he does not necessarily agree with for the sake of argument. This process can also be used to test the quality of the original argument and identify weaknesses in its structure.

Source: Wikipedia.

⁶ Quote from a case study of Jaribuni Village in Plan Kenya Country Programme Progress Report (CPPPR) 2008.

tion amongst the community members as they work towards improving their sanitation facilities and moving up the sanitation ladder. In areas where artisans had been previously trained by earlier sanitation programmes, they have been re-energised to apply their skills as the demand for sanitation facilities rises. In Kilifi, groups who have attained open defecation free (ODF) status are going on to trigger neighbouring villages. The momentum gained has resulted in groups organising and engaging in other economic activities such as growing herbs, mushroom and fruit tree farming. They have also integrated CLTS with child survival and broader health agendas.⁷ As the Child Survival project coordinator put it, 'there is a realisation that a child who eats shit cannot survive, grow and realise their full potential'.

The achievements in Kilifi provided a good platform for learning. There have been exposure visits organised to showcase what communities can do on their own once their mindsets are changed and they resolve to take collective action. Initially it was not easy to get buy-in for CLTS from professionals in the sanitation sector. However, after seeing what was happening in Kilifi it became evident to them that CLTS had the potential to transform people's behaviour and scale up sanitation coverage much faster than other approaches they had used in the past. As the district public health officer remarked:

*...our obsessions with self ventilated improved pit (VIP) latrine models with a concrete slab, four walls and a dark room had enslaved the communities... see the wonderful variety of designs they've come up with.*⁸

The Ministry of Public Health and

Sanitation (MoPHS) is now convinced and has been at the forefront in promoting CLTS. The launch of the Environmental Sanitation and Hygiene Policy coincided with the introduction of CLTS in July 2007. This opportunity has made it easy to work with the MoPHS. The policy articulates sanitation as human right that all Kenyans should enjoy.⁹ The policy however did not have a clear methodology on how this right would be achieved. Nevertheless the Kenyan government introduced a performance contract which required the entire ministry to set targets against which staff would be assessed. For the Ministry of Public Health and Sanitation, the contract had a target to increase sanitation coverage and use by 5% annually. Government staff in Kilifi therefore had an incentive to engage in CLTS. Using CLTS, MoPH staff were able to far surpass this target. Within a period of 18 months from when CLTS was first introduced, they increased latrine coverage and use in Kilifi from 301 to 4551.

From one open defecation free (ODF) village (Jaribuni) in Kilifi in November 2007, numbers have risen to about 100 ODF villages in May 2010. As Dr Tsofa, District Medical Officer of Health in Kilifi put it, 'CLTS is spreading like bushfire'. Reflecting on the success of CLTS in Kilifi, he added:

I attribute the achievements to the stewardship from Senior District Health Management Team members and the fact that the trained public health staff had taken up CLTS with such enthusiasm.

Kilifi is now working towards becoming the first ODF district in the coastal region and Kenya. However, the district public health officer in Kilifi acknowledges that monitoring and keeping track of the trig-

⁷ Plan International Kilifi District Coastal Area Replication and Evolution (KIDCARE) Child Survival Project, 2004–2009.

⁸ Kilifi District Public Health Officer during the World Toilet Day Celebration transect walk in Jaribuni Village (19th November 2007).

⁹ See National Environmental Sanitation and Hygiene Policy (GOK, 2007).

Photo: Samuel Musembi Musyoki



A man in Ngamani village in Kilifi demonstrates to a government public health officer his handwashing facility made from a leaking plastic container. This was during the World Toilet Day Celebrations 2008.

gered villages and households building and using new latrines is a challenge. The staff are few and cannot keep up with the speed at which communities are moving.

The success in Kilifi has come with its demands. The District Health Management Team and natural leaders in Kilifi are bombarded with requests to train their peers in the neighbouring districts.¹⁰ In collaboration with Plan they have been able to respond to these requests and are now playing a key role in scaling up CLTS in the Coast Province. They have been able to train facilitators and trigger communities in the neighbouring districts of Kwale, Kinango, Msambweni, Kaloleni and Malindi. There is a good synergy between government staff, NGOs and natural leaders in the triggered communities which is contributing immensely to lateral spread and up-take of CLTS.

At the national level the MoPHS, the lead agency in sanitation, has shown a high level of commitment to scaling up sanitation efforts using the CLTS approach. As the deputy chief public health officer from the ministry put it:

...we see it as complementing both the Government of Kenya policy on environmental sanitation and hygiene and the Community Health Strategy launched in 2008.¹¹

Celebrating achievements has been an opportunity to trigger more communities. For the third year running Plan Kenya has worked with the MoPHS and other partners to mark World Toilet Day (19th November) at village level. In 2009 alone 20 villages in Kilifi celebrated World Toilet Day to mark their attainment of open defecation free status. One of the villagers in Katsemerini said, *'Tumeamua kuacha kula mavi yetu na ya wengine'*. This translates literally as, 'We have decided to stop eating our own and other people's shit!'

These celebrations have been instrumental in showing **professionals** in the sanitation sector what communities are able to do once their mindsets are transformed. They have also played a pivotal role in publicising the CLTS approach and influencing communities in neighbouring villages to take up action to improve their sanitation. There are more organisations joining the growing CLTS movement as a result of seeing what has been achieved so far. These include UNICEF, Agha Khan Health Services, Network for Water and Sanitation (NETWAS), World Bank Water and Sanitation Programme (WSP), SNV (The Netherlands Development Organisation), World Vision and Oxfam UK, Human Rights Cities Nairobi, Community Cleaning Service, SC Johnson, Starehe and Kasarani Youth Network and Pamoja Trust among others.

Challenges exist too

While I am so excited and inspired by the successes in Kilifi, I am disturbed that the fire of CLTS is not burning at the same rate across the country. Even in districts where

¹⁰ Natural leaders are activists and enthusiasts who emerge and take the lead during CLTS processes.

¹¹ Source: MoPH Chief Sanitation Officer keynote address during a CLTS regional training in Kilifi, July 2008.

Plan Kenya works uptake has been slow. While CLTS was introduced at the same time in July 2007, in the Coast, Nyanza and Eastern Provinces, the response and the outcomes have been different. The uptake is faster on the Kenyan coast (Kilifi, Kwale, Kinago and Msambweni), while it has been much slower in Nyanza. Only Homa Bay, among the three districts in Nyanza where Plan Kenya works, has remained focused and committed to CLTS. As of May 2010, almost three years since CLTS was introduced, only 20 villages have attained ODF. This has only happened in the last few months. In the Eastern Province (Machackos and Tharaka) which is arid and semi-arid, sparsely populated and with relatively high latrine coverage and use (80%) there seemed not to be much motivation and we decided to go slow until a later date. In these areas, it is likely that CLTS would be most relevant in small towns and markets where there is a high concentration of settlements and evidence of mass open defecation.

The most challenging of all the regions has been Nyanza Province. While the region exhibits most of the favourable conditions for CLTS (Kar with Chambers, 2008), it has been a huge challenge to accelerate the process. Challenges in the region are more institutional than socio-cultural. These can largely be attributed to a lack of passionate committed leaders and champions for CLTS. There have been about five hands-on training workshops and exposure visits to Kilifi and Kwale. This means that more than 100 CLTS facilitators have been trained in Nyanza. Though about 50 villages had been triggered between July 2007 and December 2008, only one village had attained ODF by December 2009 in Plan working areas. The first ODF celebration in Nyanza was held in Manera village on 25th February 2010. As a result there is renewed commitment by the MoPHS which has resulted in 19 additional villages attaining ODF as of May 2010.

In Siaya district (a non Plan working area), however, a youth group that brought five participants to a training conducted by Plan in Bondo in December 2008, managed to trigger 21 villages in one sub-location. All of them attained ODF within eight months of triggering. On the contrary, 10 villages triggered at the same time in Bondo by Plan and government staff do not seem to have made progress. Neither Plan staff nor MoPHS seem to have kept track on what progress has been made as there has been no effective follow-up to the communities.

Anecdotal evidence from our internal follow-up revealed that there had been difficulties between our Plan office and MoPHS staff in Bondo. The reason? Allowances. Though at the end of the training MoPHS staff had developed very elaborate action plans on how they would roll-out CLTS in Bondo district, this was based on the assumption that they would be 'facilitated' to implement it. In fact, they saw the task as an assignment for Plan and demanded confirmation that we would pay them to undertake the assignment. On learning that we (Plan) would not change our position, they dropped the ball and said unless we '*gonyo*' them, which literally translated means 'untie us' (the code for asking for payment) they would not be part of the process.

Unfortunately, we had very few staff in Bondo. With the entire CLTS strategy based on the assumption that the government personnel would be triggered and see the added value of CLTS in their work we had hit a dead end. We had got it wrong. Although the CLTS training was demand driven, it appeared that the MoPHS personnel in the region at the time were in it for money and did not share our vision. We had not taken enough time to trigger and identify institutional champions within Plan Bondo and MoPHS as we had done in Kilifi.

The experience in Plan Homa Bay was similar. However, because there was a

champion who had a clear vision and commitment, the failure of government officers to collaborate did not deter him and the team to move on. Philip Otieno of Plan, who has now earned himself the designation of Eastern and Southern Africa Region CLTS Trainer, was quick to change the approach in Homa Bay. They worked with local chiefs and youth instead of relying on the MoPHS as the only partner. This strategy led to the new achievements in Homa Bay with about 20 villages becoming ODF and a few others increasing latrine coverage to 95%. Homa Bay celebrated its first ODF village in February 2010. It attracted the participation of Ministry of Public Health and Sanitation staff in Nyanza Province – not just the Homa Bay district – and the Ministry Headquarters in Nairobi. There is no doubt that the ODF celebrations in Manera village will lead to renewed support for CLTS in the entire Nyanza Province.

The practice of demanding allowances is a common practice in the region. As a senior Ministry of Public Health and Sanitation official put it:

... this is a problem that has been created by INGOs working on HIV and AIDS in Nyanza Province who have a lot of money and do not know how best to invest it other than in meetings/workshops and paying allowances.

Nyanza Province is saturated with NGOs and most of them pay very high allowances to government staff. Therefore, the latter did not see why Plan should be different on this particular initiative. While it was clear to us that CLTS is a non-subsidy approach and this principle needed to be applied even during the training and follow-up, our partners who had known Plan to pay allowances for other activities did not see why CLTS should be any different. The practice of not paying allowances needed to be applied not only to CLTS but

to all collaborative projects we were undertaking in partnership with the government.

Key lessons for the future

Creating the right institutional culture is important for effectively implementing CLTS. This calls for identifying champions who understand the philosophy behind CLTS and are able to monitor and support frontline staff to observe them. We realised that we had assumed that since we had decided as an institution to adopt CLTS that the vision was shared by all – and this would therefore ensure congruence in practices. However, we learnt this was not the case and there was a need for harmonisation. For example, in Kilifi while the practice of not paying allowances to government officers was being applied across the board, this was not the case in some of the other regions where Plan Kenya works.

Even in Kilifi, where Plan and MoPHS leadership were committed to supporting CLTS from the onset, we realised that capacity was limited. We have learnt that there is need to free up staff who are passionate and have them work full time to support CLTS processes. For effective follow-up support, monitoring, evaluation and documentation post CLTS triggering, we have learnt there is need to set aside resources and time. Even for Kilifi District which is on track towards becoming the first ODF district in Kenya, this might take longer if left only to the MoPHS and Plan. There is a need therefore to use different entry points with multiple players and not rely solely on the MoPHS. The teams in Kilifi and Homa Bay have decided to work with staff from other line ministries, the local administration (chiefs and village elders), community health workers, youth and children to take the lead in triggering more villages and to undertake follow-up, monitoring, evaluation and simple documentation.

We have also learnt that with success comes increased demand for going to scale. From our experience we have, however,

realised that there is a need to be more strategic and systematic if CLTS is to be scaled up with quality. This requires setting up support structures at different levels (national and district) and designating specific staff and resources (including functions such as coordination, monitoring, evaluation research and documentation). We need to build strategic partnerships with relevant players at different levels as opposed to working through a loose, sporadic arrangement that leaves CLTS scaling up to isolated individuals. Through such a systematised and deliberate approach CLTS scaling up will not be left

to chance but to committed institutions. This will ensure that CLTS evolves to a self-facilitated and spreading movement or practice that can be sustained within the existing structures. In this regard Plan Kenya is in the process of setting up a small CLTS Unit (with a minimum of three staff) whose mandate includes advocacy, hands-on training (including mentorship and coaching), monitoring, evaluation and research and documentation. The unit will also play a key role in networking and partnership building to facilitate sharing and learning among practitioners in Kenya, regionally and globally.

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