MINISTRY OF HEALTH

Protocol for implementing CLTS in Kenya

November 2013

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ACRONYMS

CLTS: Community Led Total sanitation

INGO: International Non-Governmental Organization

LNGOs: Local Non-Governmental Organization

MOH: Ministry of Heath

MDG: Millennium Development Goals

NGOs: Non-Governmental Organization

ODF: Open Defecation Free

WASH: Water, Sanitation and Hygiene

FOREWARD

The development of this CLTS protocol has come at a critical time when all efforts are being made to implement the ODF rural Kenya campaign roadmap 2013 by all the actors in the water, sanitation and hygiene sector. The roadmap launched by the Ministry of Health in the year 2011 has ambitious targets to be achieved namely to create an enabling environment to sustainably expand improved sanitation and hygiene practices, to support improved hygiene behavior to achieve the use of 2.5 million latrines and handwashing facilities by 12 million people in 269 districts of rural Kenya and to support improvement in their sanitation practices to ensure they reside in open defecation villages.

The Ministry of Health recognize the fact that these targets cannot be achieved through efforts of one agency alone, but through the concerted efforts of all stakeholders, be they governmental, non-governmental or private sector actors. Furthermore, the communities themselves also have a major role to play in this process, as it is only through their determination and actions that Kenya will become and remain open defecation free.

With the many actors from different backgrounds, working in different parts of the country, there is a danger that this variability may result in different outcomes that will be achieved through what essentially the same CLTS process. This protocol will therefore, provide the standards that will guide the various stakeholders on how to implement CLTS effectively.

Even though this protocol has been developed through a participatory and consultative process under the leadership of the division of Environmental Health in the Ministry of Health, a broad spectrum of other actors also gave their inputs through their membership of sanitation and hygiene promotion working group which was tasked with the development of this protocol. More importantly, the protocol was also validated by the Interagency Coordination Committee on water, sanitation and hygiene in Kenya before being released for use by the general public.

It is my belief that this protocol will be a useful reference material for CLTS practitioners, trainers, policy makers, researchers and community members as it clearly provides what is required for a community to attain ODF status and the processes and milestones to get there.

I commend the dedication of the staff of CLTS Hub in the Ministry of Health for their efforts in the preparation of this protocol. UNICEF Kenya Country Office contributed generously towards the preparation and production of this protocol. It is our hope that this protocol will guide and strengthen our efforts to bring us closer to attaining ODF rural Kenya by the end of the year 2013. Together we can reduce the burden of disease in our country.

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MoH

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Ministry of Health

1.0 INTRODUCTION

Kenya is one of the pioneer countries in this region to declare a national strategy for elimination of open defecation and developing a road map for achieving this goal through Community Led Total Sanitation (CLTS) approach. Approximately one million new users of improved sanitation are attributable to this approach.

Community Led Total Sanitation (CLTS) is an innovative methodology for mobilizing communities to completely eliminate open defecation (OD). Communities are facilitated to conduct their own appraisal and analysis of open defecation (OD) and take action to become ODF (open defecation free). CLTS is the strategy adopted by the Kenya Governments' Ministry of Health to achieve Open Defecation in rural areas of Kenya by the year 2013. At the heart of CLTS lies the recognition that merely providing toilets does not guarantee their use, nor result in improved sanitation and hygiene. Earlier approaches to sanitation prescribed high initial standards and offered subsidies as an incentive. But this often led to uneven adoption, problems with long-term sustainability and only partial use. It also created a culture of dependence on subsidies whereas open defecation and the cycle of fecal–oral contamination continued to spread disease.

In contrast, CLTS focuses on the behavioral change needed to ensure real and sustainable improvements – investing in community mobilization instead of hardware, and shifting the focus from toilet construction for individual households to the creation of open defecation-free villages. By raising awareness that as long as even a minority continues to defecate in the open everyone is at risk of disease. CLTS triggers the community's desire for collective change, propels people into action and encourages innovation, mutual support and appropriate local solutions, thus leading to greater ownership and sustainability.

There is a well-structured national and regional coordination mechanism in Kenya for CLTS including an information/knowledge management hub to create an enabling environment for achieving the road map of an Open Defecation Free, Kenya. More and more implementing partners are joining this movement working at the community level in close collaboration with the Ministry of Health. Hence it becomes important to have harmonized country-wide implementation of a strategy with commonly understood elements of CLTS and also recognition of the path beyond ODF for sustained behavior change in hygiene practices once communities have eliminated open defecation.

2.0 NEED FOR PROTOCOL

CLTS has been and continues to be recognized by partners as an important strategy that can be turned into a social movement using social norm that has great potential in addressing sanitation and hygiene issues in the country. Some villages in Kenya have been triggered following formal CLTS training while others have taken particular interest and self-initiative as a result of the influence of natural leaders and other committed community members from neighboring triggered villages, to stop open defecation.

While CLTS approach is being adopted in various parts of the world including in Kenya, there has been varying understanding to some of the issues that confronts the sustained behavior change and adhering to certain quality that ensures that the change in sanitation and hygiene practices would be irreversible. Some of the issues that are commonly encountered and need to be addressed are as below:

i) Common understanding of CLTS and consistent implementation: Various stakeholders have varying understanding and perception of CLTS; rightly so, given the communities' culture, affordability and response to change. The change could be gradual and in steps and the challenge is to capture these critical milestones leading to an ODF community with clean environment with clear indicators defining them. At the same time, there is an issue of coherence in implementing the approach, complementarity and leveraging synergies between partners, assuring quality and adhering to agreed upon standards.

ii) A process for identifying communities: Though it is recognized that Kenya ODF roadmap envisages universal coverage and a vision of ODF community; it is also important that initiating community consultation from a village which provides a favorable condition may help in getting quick win that in turn will also enthuse the champions and the neighbouring villages to embrace the strategy. It is important from practicality point of view in implementing and not to create any sort of inequity as the health benefits of ODF will not accrue if ODF is not achieved covering villages one after other. This entails carefully selecting communities where to start implementing CLTS. Some key characteristics which might lead to failure or success of triggering are noted. For example, history of subsidies for sanitation, soil formations can be a big impediment to a successful elimination of OD. Timing is also considered such that key processes related to pre-triggering and triggering are carried out when total participation and engagement with the community can be secured. Also, cultural barriers, existing practices and beliefs are assessed to form a baseline for determining success.

iii) Developing baselines

The ODF Kenya roadmap has clear targets in terms of the districts in rural Kenya to be reached. The roadmap also indicates the population targeted and the interventions they will put in place at the household level to improve their hygiene and sanitation situation. What is not clear in the roadmap is the number of villages in the targeted rural areas and their OD status before the intervention. It will therefore be necessary for any partner implementing CLTS to collect baseline data on the total number of villages in the area targeted, their triggering status and post ODF status.

iv) Better understanding of triggering process: Triggering and follow up are important elements of CLTS strategy comprising various exercises leading ultimately to communities abandoning open defecation. As such, it is critical that triggering focuses on behavior change rather than simply awareness creation and sanitation promotion. Quality of facilitation and follow up are critical elements in an at-scale CLTS program. The challenge is to initiate and support the triggering through quality facilitation and follow up which has bearing on the outcome. Based on experiences of triggering as to what has worked will provide guidance to mobilizing teams involved in triggering process and help them to self-assess if the process is going in the right direction.

v) ODF Claim, Verification, Certification and Celebration: While ODF strategy motivates the community leaders for a collective action, there are temptations of short cuts by some communities in terms of declaring their villages ODF before they are truly ODF. There is also need to clarify where and who they make their claims to and how the information is conveyed upto the DPHO. A system which has reasonable assurance to ensure the reliability of attainment of ODF status will bring credibility to the reporting mechanism and will also help in planning for further intervention. Considering that CLTS is being rolled out in all parts of the country, it is anticipated that many villages will be claiming ODF simultaneously in different parts of the country. This will require a network of verifiers and certifiers to apply uniform criteria in their mandate areas.

vi) Post ODF support: As the ODF entails a sustained behaviour change which is irreversible, ODF attainment can be seen as intermediate milestone and the community may need support post ODF period as well. It is critical that these needs are articulated and understood by implementing partners for them to plan the initiatives. It is required to have a common understanding of what this means and what it entails.

With expansion of ODF initiatives and large number of partners engaged in CLTS roll out, it becomes critical to have a protocol which would contribute to developing common understanding about the critical aspects of CLTS and the key processes entailed which in turn would ensure the quality of interventions as well as adherence to agreed standards of ODF.

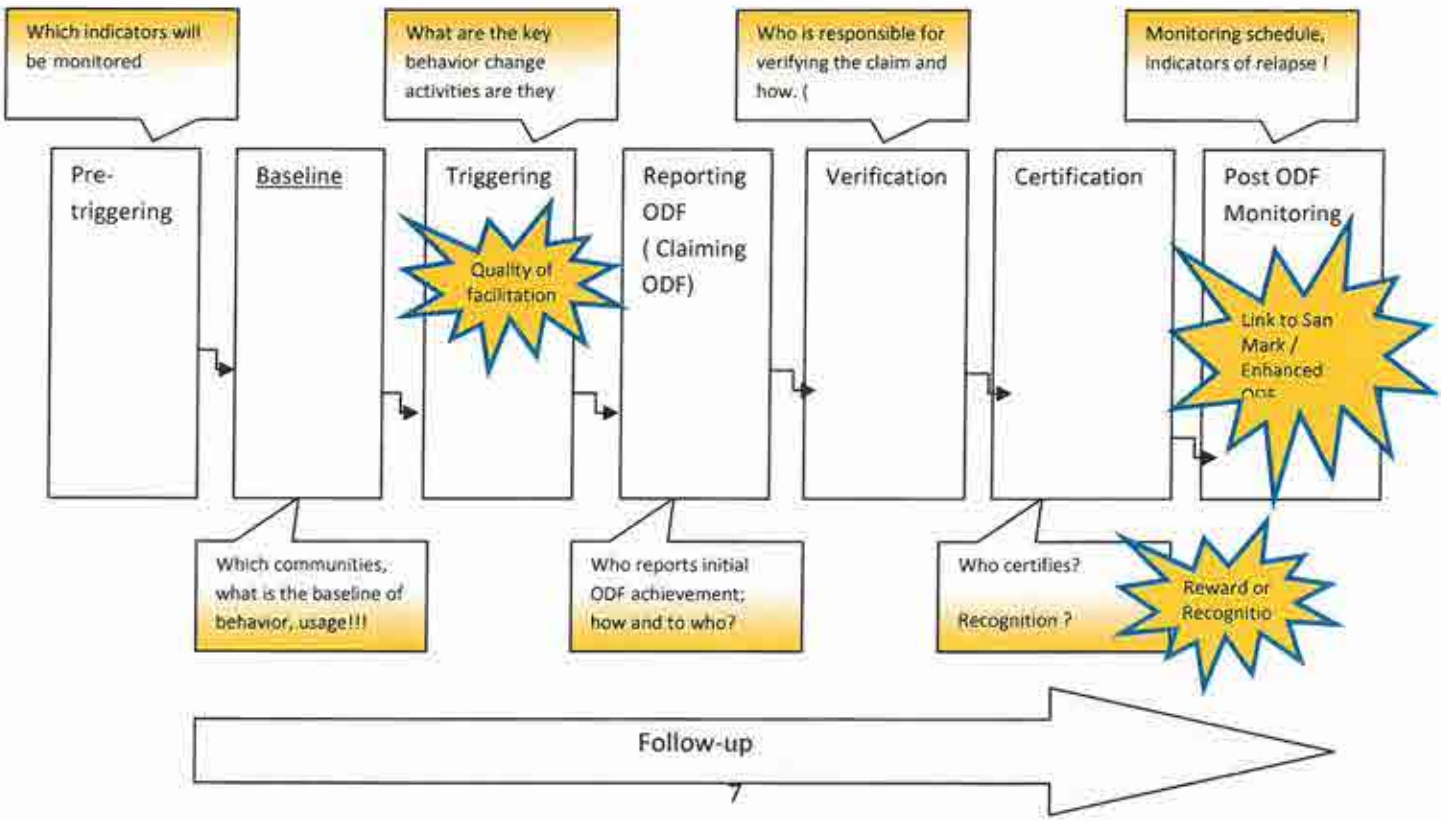
Kenya has adopted the devolution of governance and sanitation and hygiene is one the services which have been devolved. With this arrangement, county governments would be implementing CLTS on their own and will be required to allocate resources and manage the programme at local level. A protocol will help in adopting a common approach and also ensuring that minimum agreed standards are followed/maintained.

A protocol, therefore, would clarify the issues mentioned above and bring about a common understanding of the approaches, the monitoring indicators and also the way forward after a community achieves open defecation free status.

The protocol is expected to be used by implementing partners engaged in CLTS implementation that includes NGOs/CBOs/CSOs and officials at County level and the national level. The Protocol will also provide a reference document for community level facilitators (CHEW and natural leaders) and will be used by the ODF certifying agencies and professionals.

3.0 PROTOCOL FOR CLTS:

Before delving on the elements of the protocol, it is important to understand key elements and processes involved in ODF initiative through CLTS strategy. The flow diagram indicated below illustrates critical steps in rolling out CLTS.



Protocol 1: Pre- triggering

Community entry and mobilization: Rapport building (pre-triggering)

The following aspects need to be considered for an effective triggering:

Who can do facilitation?

Health promoters, health staff, including CHWs and CHEWs, WASH officers, community leaders, religious leaders, women and youth leaders, persons with disability, children and other emerging facilitators from the communities.

NB: Preferably Individuals with community mobilization (communication/ facilitation) skills and have understanding of community dynamics

Protocol 2: Key element for triggering: Triggering is the critical element of CLTS strategy and has bearing on the outcome to a great extent.

i) Some of effective tools for triggering communities for behaviour change

- Social mapping
- Transect walk
- Shit calculation
- F diagram (may be useful to discuss hand washing, reduction of flies and smell, solid waste)
- Medical expenses **and loss of time/unproductivity**
- **Participatory** Community action plan towards ODF
- **Participatory** Community monitoring

ii) How do we know that triggering and facilitation is effective

- Participation level of community members
- Participatory Community action plan is developed
- Triggered/ODF communities/villages
- Whether community still demanding subsidies
- High Level of participation of women and children
- High CLTS uptake in the prescribed period (3 months)
- Emergence of
    - Natural Leaders (NL) / ambassadors
    - active ODF committee
    - community solidarity
- Spill over to other villages

Protocol 3: Definition of ODF

Stage 1: Complying for ODF Certification. The key indicators:

Non-Negotiable

- No exposed human excreta within the community/households (this means a complete absence of exposed faecal matter that can be accessed by houseflies, whether in toilet facilities, chamber pots, surrounding bushes/shrubs or refuse dumps etc).
- All households have access to a toilet (individual or shared) which should not facilitate faecal-oral transmission:
- The squat hole should be covered
- The floor should be free of faeces and Urine
- Superstructure that provides privacy
- All households have a hand washing facility near the latrine with soap/ash and water
- Continued use of toilet by Household owner

Desirable

- Use of ash being put over faeces in pit after defecation (reducing contact of flies and smell) promote but do not make it mandatory

Stage 2: (post ODF): The key indicators:

- Schools/Health centres/ **Pubic places** with functionality/use of WASH facilities (drinking water plus hand washing plus toilet for girls)
- **A system of maintenance of WASH facilities in schools in place with involvement of CEC teachers and children.**
- Safe storage/handling of drinking water and point of use water treatment (as needed) – (covered vessel with hand not dipped while taking out water)

Stage 3: A Total Sanitation environment

The key indicators:

- A system developed at community level by community to stop OD in /around village (**Formation of sanitation and hygiene committee to oversee community systems to stop ODF are followed).**
- Village being visibly clean (no garbage stagnant water, debris)
- Safe storage/handling of food (free from flies)
- Personal hygiene

Protocol 4: ODF Claim /VERIFICATION/ CERTIFICATION of ODF: (The ongoing concept note on third party verification to be suitably incorporated)

The reporting, verification and certification should be done by separate bodies/agency to ensure reliability. Factors to be considered and suggestive officials and agency who could carry out the specific functions are provided below

Step 1: Community self-assessment process (ODF reporting/Claim)

The first step in the ODF certification process is an internal process of community self-assessment. A community that has been triggered and believes it has achieved ODF status according to the stipulated criteria, conducts a self-assessment which is facilitated by the Public Health Officer. Having assessed that the community complies with the ODF requirement as defined above, the community will claim for being declared ODF.

Step 2: Verification

Verification will be undertaken through a peer review process that will be supervised by a district team. Verification should be done within one month after community self-assessment yields an ODF claim by a team of **three persons** drawn from i) The District Public Health Officer ii) Trained Natural leaders and Community leaders iii) NGO representatives working in the area.
The members from categories ii) and iii) above will be drawn out from Divisions (ward) other than the area to which they belong to or work for. This is to avoid any conflict of interest and ensure objectivity.

Step 3: ODF certification

Certification will be carried out by a trained county level certification team constituted at the county level and not directly involved in implementation ensuring an element of objectivity. Certification should be carried out two months after verification.

Composition of county level certification team

The county certification team will be drawn from credible institutions/ organizations i.e. NGO's, CBO's, FBO's etc. or from individuals who have demonstrated skills and expertise in CLTS. They will be identified through a shortlisting process coordinated by the Hub and trained on the 3rd party certification training will be conducted by an institution accredited by the Ministry of Health. The Hub will compile the list of organizations and individuals accredited to be county certification teams and provide this to the implementing agencies. The implementing agencies will engage the county certification teams directly.

Quality Control of certification

Quality of ODF certification will be ensured by sample check of randomly selected 10% of villages certified by county level teams. This exercise would be carried out by accredited independent institutions/organizations that have previous experience in sanitation – CLTS and have capacity in ODF Certification. The certification will be notified only after the validation by quality assurance carried out as above.

A flow chart of work process for certification process is provided in the figure 2

RECOGNITION (at local level/ Regional level/National level)

- Public celebration with local and outside guests
- Billboards, flags
- Involve media – TV, radio and newspaper
- Certificates to be issued during celebration

Implementing NGOs and individuals including community leaders who have contributed to the ODF should duly recognized through community felicitation. The recognition may be in form of certificates/memento etc . **Recognition should not involve cash award**

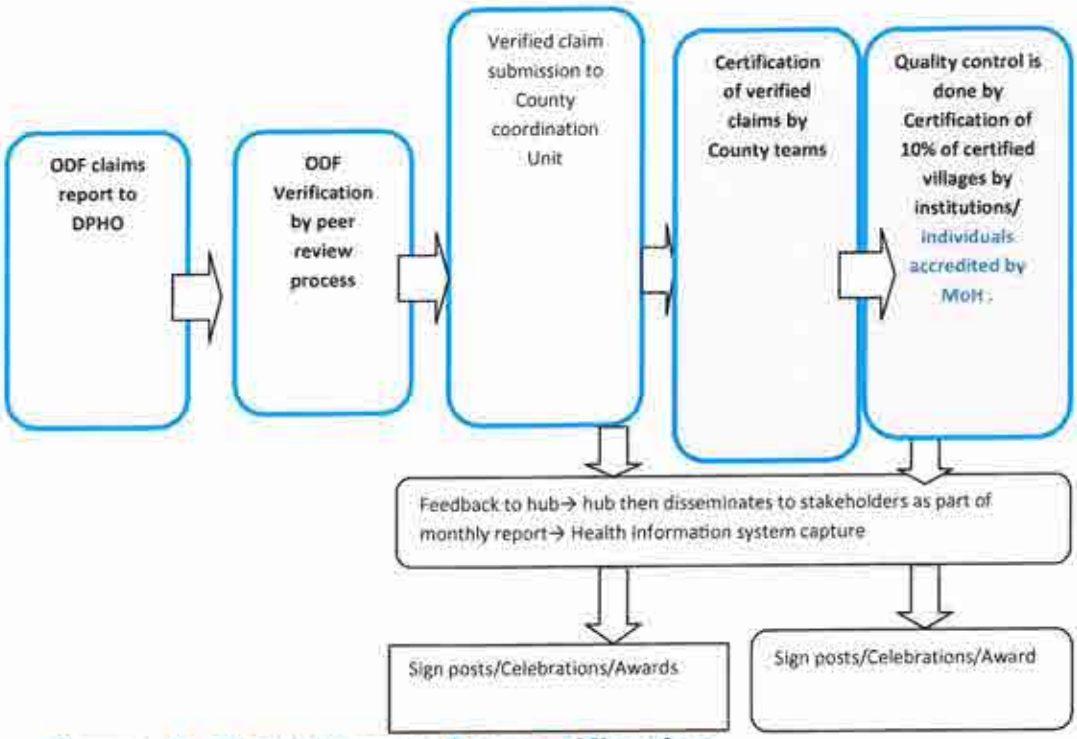


Figure 2: Workprocess for certification

Protocol 5: POST ODF Social Mobilization and Monitoring It is important that the community receives support even after certification of ODF. This is especially critical to ensure that they do not revert to open defecation. Families who are using shared toilets should be motivated to have their own toilets and any new families branching out or new house constructed or any additional population settling in, should also conform to the open defection free status. Families may like to upgrade the toilet facility to JMP standard/Kenya standard; from basic toilet[1] to improved toilet as applicable supported by appropriate supply chain. These may require handholding support, mobilization and behavior change communication. Community Health strategy are also being implemented in various districts. The community units provides a platform for community interaction and promoting hygiene practices.

The above mentioned objectives could be supported through following activities:

- ODF Community should develop a POST ODF Sustainability plan as part of Certification requirement (to be developed between verification and certification)

[1] Basic toilet is defined as a toilet which does not facilitate faecal-oral transmission and has following features: i) The squat hole should be covered ii) The floor should be free of faeces and Urine and iii) Superstructure that provides privacy

- Follow up to ensure that the supply chain is strengthened in the area where triggering has been completed and it complements the community level commitment. The operationalization of supply chain is established such that it is not too long and expensive.
- Monitor villages achieving post ODF indicators. This could be done through the network of Community Health Workers and may be linked to Health Management Information System (HMIS).
- Reorientation/retraining of Health workers to support community in post ODF stage to motivate them to adopt total sanitation. (Refer protocol 4.3)
- Promote appropriate disposal system of solid and liquid waste
- Establish linkage with community initiative including those by other sectors such as Community Health Strategy. The solid waste disposal could be linked to composting for improved agriculture or small farming. Community Dialogue process may be used for monitoring post ODF sustainability. Counties could be motivated to assign periodic Sanitation Days across the county for turning sanitation as way of life and develop performance contracts that include the sustainability aspects of ODF.