CLTS in fragile and insecure contexts

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This article presents the experience of using the Community-Led Total Sanitation (CLTS) approach in a recent programme in Somalia and explains some of the adaptations that were necessary to adjust to the specifics of a fragile and insecure context. The article goes on to explore the applicability of CLTS in fragile and insecure contexts more generally, using examples from South Sudan, Chad, and Afghanistan, and argues that in some ways it is an ideal approach for overcoming some of the challenges of working in these areas. During more than 20 years of civil conflict in Somalia, sanitation interventions were mostly limited to construction of latrines for affected populations or education on sanitation and hygiene (using the Participatory Hygiene and Sanitation Transformation (PHAST) approach) followed by fully subsidized latrine programmes for selected households. There is little evidence that these interventions achieved any real results, and recent surveys in Somalia show that sanitation access has actually decreased between 1995 and 2012. Open defecation levels are very high with correspondingly high levels of diarrhoea and frequent outbreaks of cholera. This is exacerbated by the high costs associated with construction of improved latrines due to logistical difficulties in transporting construction materials through insecure areas to remote communities, which discouraged many actors from carrying out comprehensive sanitation programmes in the past. With this background and encouraged by experiences in Afghanistan and other post-conflict contexts, UNICEF and partners decided to experiment with CLTS. These experiments came at a time when other water and sanitation actors were exploring the broader applicability of more demand-driven approaches in fragile and post-emergency situations.

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DURING MORE THAN 20 YEARS of civil conflict in Somalia, sanitation interventions were mostly limited to construction of emergency latrines for displaced populations or education on sanitation and hygiene (using the Participatory Hygiene and Sanitation Transformation (PHAST) approach) followed by fully subsidized latrine programmes for selected households.

There is little evidence that these interventions achieved the desired results: recent surveys in Somalia show that access to sanitation actually decreased between 1995 and 2012 (JMP, 2013). In Somalia one under-five child dies every hour from

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water and sanitation-related illness. Only 14 per cent of people wash their hands after potentially touching excreta. More than half the population practise open defecation; in rural areas the figure is up to 83 per cent, the fourth highest in the world. In urban areas 30 per cent of people share a latrine and 15 per cent use unimproved sanitation. Overall only 24 per cent of people in Somalia have access to improved sanitation. The effect on infant mortality is clear: Somalia has the third highest infant mortality rate in the world, at 180 deaths per 1,000 live births. There are correspondingly high levels of diarrhoea and frequent outbreaks of cholera, and the transmission of polio in 2013–14 in Somalia was linked to poor sanitation conditions in the affected communities. Somalia's diarrhoea rate among under-five-year-olds is estimated at two in five children.

With this background, and encouraged by experiences in Afghanistan and other post-conflict contexts, UNICEF Somalia decided to experiment with the Community-Led Total Sanitation (CLTS) approach to improve sanitation access in rural areas and small towns.

How CLTS was introduced

In Somalia a feasibility study was carried out in 2011 showing that the approach was viable based on a number of successfully triggered communities, despite reservations from local aid workers. A pilot intervention was implemented in eight communities in relatively stable parts of the country. Communities were apparently very willing to adopt CLTS but hygiene and sanitation staff from NGOs and government public health staff were much more doubtful about the new approach due to perceived religious/cultural taboos on discussing 'shit'. Their scepticism was overcome by wide involvement of sanitation stakeholders in CLTS triggering activities where doubters could see for themselves how enthusiastically the people engaged in the exercises. UNICEF then went ahead with a comprehensive programme of capacity building for partners to develop a better understanding of CLTS and how it differed from the more familiar PHAST. Implementing partners (mostly local NGOs) were invited to Kenya to study how CLTS had been rolled out there. A workshop was held to develop the principles for CLTS in Somalia which subsequently led to the development of a CLTS protocol for the Puntland and Somaliland states (the protocol for South Central is still under development).

The experience emphasized the importance of overcoming resistance to CLTS among stakeholders and institutions and bringing key local leaders on board as agents of change. This 'institutional triggering' was critical to the successful introduction of CLTS in this context.

Challenges

The CLTS programme in Somalia is implemented by local NGOs because of their access to communities even in the conflict-affected areas. Following extensive training local NGOs trained CLTS facilitators and community leaders. The use of

participatory tools was new to many staff who are more familiar with relief work; NGO staff had to be 'reoriented' to work with and empower communities rather than distribute lifesaving relief items.

The ban on public gatherings makes it difficult for local NGOs to facilitate CLTS in areas with strong Al-Shabaab control in South Central Somalia. They are still able to work in areas with less Al-Shabaab control but still considered too insecure for international NGOs and UN agencies. For support and monitoring purposes, the programme has taken a conscious decision to implement first in areas that are easier to reach. These are rural areas where security is good. The programme will then gradually move to difficult-to-reach areas in the rest of South Central Somalia.

The CLTS programmes in Somalia started relatively recently and it has been difficult to conduct surveys to measure the sustainability of open-defecation-free (ODF) status and specifically the sustainability of latrine outputs. It is expected that considerable efforts will be needed to strengthen the market for sanitation products if expected demands for latrine upgrades are to be met. This is complicated by a difficult logistical context but experience in the water sector has shown that these constraints can be overcome through engagement with the strong private sector in Somalia.

Review and reinvention

By late 2013 it became clear that scaling up was not yet possible. Implementing partners were themselves 'slipping' back to more traditional approaches. Reporting on numbers of latrines, rather than ODF communities, non-existence of spontaneously triggered villages, extremely high cost per village of triggering and no reports of non-triggered villages were all indications that the process was not going as desired. Site visits verified these concerns, with evidence in some cases of subsidized latrine construction. So, in October 2014, UNICEF held a second CLTS training, this time in Somalia, with the support of the CLTS Foundation, led by Dr Kamal Kar. Seventy-four participants from government, NGOs, and UNICEF attended. Many of the participants had been involved in the initial CLTS programme, and by the end of the five days, all agreed that the approach so far had not been correct, and there were probably no proper ODF villages in Somalia.

Participants observed many gaps in their previous approach, and planned to change their whole CLTS methodology. There were many barriers in the process prior to October 2014, commented on by the participants in the training. Some of the main issues were as follows:

- Children did not have separate triggering activities and they quickly became bored; they were not triggered, did not understand, and had no recall of messages to be agents of change. There were no children's slogans or recall by the children.
- Facilitators 'taught', they talked about CLTS and were doing awareness raising, i.e. teaching and not learning. Technology was prescribed and there was expectation of support.

- Only the lead facilitator did anything, there was no effort by other facilitators to keep focus on the lead, the moment of ignition was not identified, and natural leaders were not brought forward.
- External materials were used (blackboard, noticeboard, flip charts, etc.) and they did not use local materials (ash, chalk, etc.).
- There were no maps or means of monitoring created during the triggering. As a result the post-triggering process was not possible. There was no identification or promotion of local champions and no plan for verification or certification. In addition other agencies 'donated' latrine slabs covertly.

In spite of these observations the training was good enough to convince the participants from government and NGOs that the approach was still viable. The protocols already developed by the two regions were still valid and should help the approach to be scaled up, once proper ODF villages are created. The key learning from this change in course was that the traditional WASH NGOs who 'build' latrines are probably not the best suited to this approach. CLTS requires a long-term commitment to a community, better suited to implementers with a health perspective. In 2015 UNICEF embarked on a programme of training NGOs with whom they already partner to implement health and nutrition programmes. These NGOs typically stay with communities for years and see the benefits of ODF, rather than facilitating the short-term benefit of building latrines (even when built well) and leaving the community once construction is finished. UNICEF has now trained over 170 facilitators across Somalia. The plan is to have at least one facilitator in each district, to assist the WASH sector to scale up the CLTS approach.

Enabling factors in the absence of enabling environment

Going to scale with CLTS is thought to be difficult with weak central government. However a decentralized implementation approach in Somalia has overcome some of these difficulties. Local authorities (both state and non-state) as well as natural leaders can be powerful enablers for CLTS.

Lessons learned and necessary adaptations

- The introduction of CLTS in Somalia has been slow, and has faced many challenges. The key lesson learned is to *implement through health and nutrition partners, rather than traditional WASH construction NGOs*.
- *An integrated, multi-sector approach supports CLTS and improves sustainability*. Programming alongside relevant community-level activities in WASH and linking with other sectors (health and nutrition) through community health workers (CHWs) have improved community acceptance, and potentially the sustainability, of CLTS.
- The development of *adapted, context-specific protocols to guide CLTS programming is essential for effective roll-out in fragile contexts*.

Photo 1 Involvement of traditional leaders is critical to CLTS success in fragile contexts
Source: Photo credit Robert Maletta, 2009

- *A phased scale-up will be more successful than rapidly going to scale*. CLTS programmes should start in areas that are accessible with a plan for expansion to more difficult areas once the approach is well established.
- It is *difficult to overcome the entrenched subsidy culture* so uptake of CLTS will be slow in communities that have for a long time depended on humanitarian support.
- *Institutional triggering is critically important in fragile contexts*. Involvement of key opinion leaders, particularly traditional and religious leaders is critical during triggering and implementation. This will include 'gate-keepers' who have always directly benefited from subsidy latrines and so may not embrace CLTS.
- *The use of mobile phones can support ongoing dialogue from a distance with natural, religious, and local leadership in monitoring and post-ODF activities*.

Discussion of applicability of CLTS in fragile and insecure contexts

Fully subsidized latrine construction as part of emergency WASH programming has failed to have an impact on sanitation in many fragile and insecure contexts. A bold and different approach is needed and WASH professionals should not be afraid to experiment with the use of development tools in a humanitarian context. Research into the impact of Concern's WASH programme in eastern Chad shows an impressive increase in sanitation coverage (from 10 per cent to 81 per cent in 10 months) using CLTS for triggering, followed by PHAST and Barrier Analysis approaches to encourage behaviour change (Bauby and Flachenberg, 2014). Similar successes with flexible application of CLTS together with other approaches and the use of 'smart' subsidies is reported by IFRC in Cambodia (Greaves, 2011) and Tearfund in DRC (Tearfund, 2011). While previous hygiene and sanitation approaches are based on educative learning processes, CLTS is based on a self-analytical, belief-centred approach. Much of the

action is community initiated rather than aid agency delivered and major improvements in sanitation can be achieved with only minimum external input. The approach is therefore ideally suited for situations where access for aid workers is constrained. However there are some emerging lessons on flexibility and adaptation for CLTS in fragile and insecure contexts.

Fears that aid dependency caused by many years of emergency programmes would undermine the CLTS approach were justified and there appears to be a slower progress towards ODF status in some villages in insecure contexts where subsidized or free latrine programmes are the norm. This highlights the need for local leadership and support and encouragement from local organizations, religious leaders, or local authorities (including non-state actors).

The weak or absent government engagement in sanitation in fragile states and insecure environments can be a constraint to going to scale with CLTS. However there are also some opportunities in these contexts. In Somalia the private sector has taken an active role in water and sanitation services which provides a good environment for sanitation marketing. Furthermore the empowerment and capacity building process inherent in CLTS has the potential to raise the profile of local health champions and natural leaders in insecure contexts where leadership vacuums are common.

Scaling up CLTS in fragile states needs to be carefully planned and slowly managed. In South Sudan UNICEF started by implementing a large-scale, 1-year project in Western Equatoria, Central Equatoria, Warrap, Northern Behr el Ghazal, and Eastern Equatoria in 2012–14. Partners included the Ministry of Electricity, Dams, Irrigation and Water Resources (MEDIWR) and the state authorities, as well as international NGOs and community-based organizations. CLTS is endorsed by the MEDIWR WASH strategy and also supported by government policy at national and state levels. The rapid scale up of triggering (over 300 villages in about 6 months) by many partners led to a high number of failures for a variety of reasons including: insufficient resources for follow up; overlap with subsidized sanitation projects; and population movement. A decision was made to only promote CLTS in states that had most favourable conditions for its success and this tends to favour more settled communities in the southern states rather than pastoralist communities. Mass triggering of villages in each state was stopped, and triggering only performed in villages where there are sufficient personnel on the ground for effective follow up. These actions helped to put CLTS on a better footing, and more and more villages attained ODF status.

Standard protocols and steps in the pure version of the CLTS approach need to be adapted in fragile and insecure contexts. In South Sudan the emerging state public health teams have relatively weak capacity and the WASH cluster plays a role in verifying ODF status. The verification process was activated by the implementing organization who informs the county/state WASH cluster. The verification exercise is then conducted by a team, selected through the state WASH cluster, with a mix of representatives from state government and the NGOs working within the county/state. The national government line ministry is also asked to send representatives to participate in the verification. The outcome is an official confirmation of ODF status or otherwise. This reliance on a large team for verification has been difficult

to sustain with limited government staff and especially with many actors engaged in emergency activities related to the civil war. A smaller, cluster-based verification process will be used in future.

In Somalia, public health offices are established in only a few districts in the north. In the rest of the country local or international NGOs are the main health service providers. The steps are therefore modified from a standard CLTS programme to work in the fragile state context in the sense that: 1) third-party verification is still important but is conducted by local NGOs; and 2) post-ODF sustainability plans are built into the certification process in recognition of the fact that post-ODF monitoring by an external agency is unlikely and this role will need to be fulfilled by the community themselves. This has led to problems with quality of the outputs and verification has not been reported honestly in some cases. A more robust third-party verification process is required, possibly using remote monitoring tools.

CLTS alongside community health programmes at scale has potential to make a significant contribution to strengthening resilience in communities at risk through the empowerment process for community action and impact of improved hygiene and sanitation on human capital. Where CHW programmes are being rolled out at scale as part of the resilience programming in Somalia, the monitoring of ODF indicators as part of ongoing district routine health monitoring helps to strengthen the sustainability of CLTS. New remote monitoring using mobile to web technology could potentially make this monitoring feasible even in the most insecure and inaccessible areas in future. Implementing CLTS as part of an integrated programme which focuses on demand-led, livelihoods-based activities and outcomes has increased its success in countries like Afghanistan and Sudan (Tearfund, 2012).

There are still some valid concerns about the risks of using CLTS in a context where conflict is recent or still ongoing and peace is fragile. In South Sudan, there was stiff resistance from many WASH agencies and actors in the country. Their main arguments for resisting CLTS were that the approach was inappropriate for a country like South Sudan that was still struggling to recover from the trauma of war. They argued that triggering methodology of CLTS which they understood used shame, disgust, and fear to ignite behaviour change could easily provoke the communities and result in an escalation of conflict. They further argued that because of the fragile nature of the communities, where the prolonged war had created dependency and devastating poverty, it will be impossible for the communities to embrace a no-subsidy approach to household sanitation. Broad engagement of stakeholders and the relative success of the pilot programmes helped to overcome these arguments; however this experience confirms evidence from other countries that suggests that a highly conflict-sensitive approach is required in these contexts (Wild and Mason, 2012).

Conclusions

- CLTS has been successfully introduced in Somalia and South Sudan as well as other fragile and insecure contexts. However reviews have highlighted difficulties in quality assurance and the need for adaptations and flexible application in these contexts.

- There are indications of wider outcomes of CLTS such as strengthened community cohesion, reduction in diarrheal disease, and strengthened resilience, but these can only be measured through comprehensive evaluation which is difficult in insecure environments.
- CLTS is ideally suited for situations where access for aid workers is constrained since much of the action is community initiated rather than aid agency delivered.
- The weak or absent government engagement on sanitation in fragile states and insecure environments can be considered as a constraint in taking CLTS to scale but in an adapted CLTS the sustainability of ODF can be planned and ensured through community norms without relying on external support.
- Post-ODF interventions that could support sustained behavioural outcomes such as improved monitoring, coaching, or sanitation marketing need to be explored for their potential applicability in these contexts.

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