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CLTS plus: making CLTS ever more inclusive

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If CLTS is to eliminate open defecation, issues of disability inclusion must be fully addressed. Research in Malawi aimed to discover if WASH practitioners, after a short training, could implement CLTS in a more inclusive way, and whether this made a difference to disabled people in the community, in terms of access to sanitation and hygiene facilities. After a 3-day training, CLTS implementers designed and implemented a CLTS+ Action Plan, in which additional triggering activities were introduced, and more attention paid to households with disabled and older people post-triggering. This CLTS+ intervention resulted in increased awareness among implementers and community members of the access needs of older and disabled people, and in adaptations to improve accessibility of some household latrines. Endline data will tell us whether this has resulted in improved outcomes for disabled and older people. Further piloting will be needed to explore how to incorporate this training into regular CLTS capacity building.

Introduction

It is generally accepted that the MDG sanitation target has not been met, leaving 2.4 billion without access to improved sanitation. Progress has been unequal: the hardest to reach have largely been left out, including the poorest, and particularly disadvantaged groups (WHO & UNICEF 2015). This inequality of progress has led to a strong emphasis in the Sustainable Development Goals on reducing inequalities, and a commitment to 'leave no-one behind' (UN 2015).

Among those most vulnerable to being left behind are people with disabilities and chronic illness, and frail older people, who experience numerous barriers preventing their access to sanitation and hygiene. These include physical barriers such as distance to facilities, lack of support structures, narrow entrances (Jones & Reed 2005; WSSCC & FANSA 2015: 21-22); institutional barriers such as lack of staff awareness and training, inadequate policies, consultation procedures, information and designs; and social and cultural barriers such as negative attitudes and discriminatory practices (Wilbur and Jones 2014). To combat these barriers, solutions to make household facilities more accessible are increasingly available, such as ramps, wider doors, seats and handrails in latrines (Jones and Reed 2005, WaterAid 2012). With user-friendly information about low-cost options (Jones and Wilbur 2014), technologies can be made using local materials to suit individual household needs. They have, however, tended to be implemented in small, high input pilot projects. There have been very few interventions which have actively tried to address institutional and social barriers as well as physical ones. Given the WHO and World Bank (2011) estimate that 15% of the population is disabled, short of mobilising armies to go house-to-house to install adaptations, how can we ensure that these kinds of solutions reach those who need them, on a scale and at a rate that will reach 'all' by 2030?

Instead of relying on separate 'disability' initiatives, would it be possible to capitalise on current widely used sanitation approaches? For example, Community-Led Total Sanitation (CLTS) has 'been demonstrated to rapidly improve sanitation coverage in Asia', and has 'real potential, when scaled up, to make a strong impact in accelerating coverage' (IIED 2010). A more inclusive CLTS programme could potentially reach huge numbers of disabled people who are currently left out. Recent research indicates that households with a disabled or frail older person are more likely to be still practising, or revert back to, open defecation (Wilbur and Danquah 2015). So if CLTS is to completely eliminate open defecation, it is crucial that issues of disability inclusion are given full attention.

In Malawi, 71% of the population still lack access to improved sanitation (WHO and UNICEF, 2015). The Malawi Disability Act (Malawi Government 2012) promotes equal access for disabled people to all services and infrastructure, yet the sanitation status of people with disabilities is unknown and has not been systematically addressed. CLTS in Malawi is supported by a National Sanitation Policy, and an Open Defecation Free (ODF) Strategy (Malawi Government 2008, 2011) and is supported financially through NGOs and the Global Sanitation Fund. CLTS is implemented by Health Surveillance Assistants (HSAs) who are the frontline government community health workers. HSAs' responsibilities include a range of public health topics including WASH, vector control and maternal care. However, they receive relatively little training and tend to have high school level education.

Research purpose and design

This research aimed to find out a) whether it would be possible, after a short training, for HSAs to implement CLTS in a more inclusive way than usual, and b) whether a more inclusive approach brings any benefits to disabled people in the community, in terms of improved access to and use of sanitation facilities.

The research was conducted from April 2013 - March 2016. It was led by the London School of Hygiene and Tropical Medicine (LSHTM), and funded by the Australian Department of Foreign Affairs and Trade (DFAT). The study was carried out in Malawi, in 30 villages in Rumphi District. It was designed in 3 phases:

Phase 1: Baseline data collection to understand the barriers preventing access to water, sanitation and hygiene (WASH) among people with disabilities in the study area.

Phase 2: Randomisation: villages were randomly allocated to control and intervention arms: a) 15 'control' villages received standard CLTS sanitation and hygiene promotion; b) training on inclusive WASH was provided to the HSAs implementing CLTS c) 15 'intervention' villages then received a modified form of CLTS (henceforth referred to as CLTS+), from the trained implementers.

Phase 3: An endline survey to repeat data collection on WASH access, in control and intervention villages, four months after the intervention.

The focus of this paper is on Phase 2 - the training provided to CLTS implementers, and its immediate impact on practitioners and communities. Researchers from Mzuzu University carried out structured observation of all stages of implementation in both the standard CLTS and the CLTS+ villages.

In the standard CLTS arm, 9 out of 15 triggering sessions and 13 out of 75 (17%) follow up visits were observed. While in the CLTS+ arm, six out of 15 triggering sessions and 17 out of 97 (18%) follow-up visits were observed, across 13 villages. Documentation was in the form of written notes, tallies of attendance and photographs. Two focus group discussions (FGDs) were conducted at the end of the implementation. One comprised 6 HSAs who had delivered the standard CLTS program, the other comprised 5 HSAs who had delivered the CLTS+ intervention. Complete endline findings will be reported at a later date.

Training in WASH and inclusion

A three-day participatory training on 'Making CLTS more inclusive' was designed and delivered by WEDC in collaboration with LSHTM, in Rumphi District in April 2015. The content was based on learning materials (WEDC 2015) developed over years of experience of training staff in WASH organisations, most notably with WaterAid (Jansz et al. 2013). The theoretical underpinning of the training was the 'social model of disability' (Jones & Reed 2005:30), which states that the obstacles preventing access to sanitation for disabled people are less to do with their own impairments and limitations, and more to do with physical, social and institutional barriers in the environment.

The core workshop participants were 12 HSAs, 1 staff from a local NGO, Church of Central Africa Presbyterian Synod of Livingstonia Development Department (CCAP SOLDEV), and two representatives from local Disabled People's Organisations who provided invaluable local and contextual knowledge.

Day 1 Context setting: The purpose was to share experience of problems accessing WASH, and identify possible solutions to improve access. This was classroom based, with facilitated discussions and practical activities, including a 'squatting activity' highlighting that different users have different needs, and that consultation with users is crucial when designing facilities (Photo 1 and Box 2). On this first day, participation was broadened to include 10 District Council members, local disability NGOs, additional CCAP staff, and representatives from the media. Inviting this wider audience created broader awareness, ensuring that relevant government decision-makers understood and supported the intervention.

Day 2 Household visits: Days 2 and 3 involved only the core participants, which allowed the training to be as hands-on and as practical as possible. An adapted form of the Accessibility and Safety Audit (WEDC/

WaterAid 2014) was introduced and practised by participants during visits to households with disabled people. This tool helps to pinpoint any physical barriers that prevent users accessing and using the latrine and handwashing facility, while also identifying appropriate solutions.

Day 3 Participatory processes & action planning: On the last day the focus shifted from hardware to software solutions: attitudes, behaviour and service delivery processes. Small groups discussed local case studies, and a role-play provided practice in making community mapping as inclusive as possible. Finally, participants produced a CLTS+ Action Plan, drawing on their learning. This outlined what HSAs would do differently to make the standard CLTS process more inclusive (Box 1).



Photograph 1. HSA participating in a squatting activity

Source: S. White, LSHTM



Photograph 2. Household visit with Accessibility Audit. Finding ways for a disabled older man to support himself when squatting

Source: H. Jones, WEDC

Box 1. CLTS+ Action Plan

Pre triggering:

1. When communicating to the village leader about the triggering meeting, people with disabilities and elderly people should be invited
2. The location of the triggering should be close to where disabled people live if possible;
3. Disabled people to be assisted to come to the meeting if needed.

Triggering:

4. Invite people with disabilities to sit in front, e.g. people who are blind or with low vision, those who are deaf or hard of hearing, and those with physical disabilities.
5. On the community map, add symbols for HHs with disabled family members. This should be done in a supportive way not in a discriminatory way.
6. Add the squatting demonstration exercise to triggering activities
7. Provide information about low-cost technologies to improve access to WASH, e.g. support rails, strings for guidance, seats. This can be done through description, images, use of available objects, demonstration.
8. Look for people with disabilities to include as natural leaders and on the WASH committee.

Post-triggering follow-up:

9. Encourage the community to construct user friendly toilets for people with disabilities.
10. Visit people with disabilities in their homes – carry out accessibility audit with them.
11. During monitoring visits, ask the question: "Can everyone in the family use the toilet/ handwashing facility?"

Findings

CLTS+ was implemented in the 15 intervention villages by the 12 trained HSAs and CCAP staff by following the usual three CLTS stages: pre-triggering (preparation for triggering), triggering (actions that occurred during the main community event) and follow-up (actions in the 4 months post triggering). Findings are summarised and presented according to Action Points in the CLTS+ Action Plan (Box 1).

a) Did CLTS implementers do anything differently as a result of the training?

Pre-triggering

Action point 1: was consistently carried out: HSAs stressed the need for all villagers, including disabled and older people, to be assisted to attend the meeting. In control villages these groups were not mentioned.

Action point 2: No change was observed to make meetings closer to households or more accessible.

Action point 3: No efforts were observed to assist vulnerable groups to attend the meetings.

Triggering

Action point 4: No facilitators were observed to invite people with difficulty seeing or hearing to sit in front. Facilitators did not appear to know if anyone had hearing or visual impairments.

Action point 5: In some communities, households with a disabled person were identified by circling them on the map with charcoal. A volunteer wrote down the names and particular challenges or conditions of persons identified in this way.

Action point 6 & 7: In every CLTS+ triggering, an additional activity was introduced. Facilitators asked if people knew of any latrines which are user-friendly for disabled or older people in their community. Only a few hands were raised. A squatting activity was then carried out (Box 2). This led to discussions about different needs and how local materials could be used to build the designs.. None of the people with disabilities present participated in demonstrations or discussion.

Action point 8: Disabled people were not verbally encouraged to be natural leaders, or on the WASH committees, as selection was not requested publicly. Identification is done by the HSAs, who mainly select the most outspoken and participatory individuals.

Box 2. Squatting demonstration activity

A circle was drawn on the ground to represent a latrine drop hole, and the facilitator, or a volunteer from the community, was asked to demonstrate how they would 'squat' to use it. The facilitator then asked participants to think how a people with different needs would squat, e.g. a person with a leg amputation, an elderly person, or a pregnant woman. Volunteers or the facilitator would then role-play to demonstrate. Challenges were noted and adaptations to support specific needs were suggested. Materials found lying around were used, e.g. two sticks to demonstrate how handrails could be installed next to the drop-hole, or bricks placed either side of the hole to provide a seat, or a wider entrance for wheelchair users to easily access the toilet.

Source: WEDC & WaterAid (2012)

Post-triggering follow-up

Action point 9: During follow up meetings with village leaders, community members were urged to ensure that households with disabled or older members be assisted to own a user-friendly latrine.

Action point 10: In all CLTS+ villages, one or two households with a disabled person were always visited during follow-up, unlike in standard CLTS follow-up. This involved a 10-20 minute discussion with household members and the disabled person. Although the accessibility audit was not carried out as in the training, the general objective was adapted to the discussion. However, it was observed that in most cases, facilitators still tended to discuss with family members rather than with the disabled person.

Action point 11: Follow-up visits were interactive and used questions to engage householders. However, the question about whether everyone in the family used the toilet and handwashing facility was not systematically asked.

b) Did CLTS+ make a difference, to participation of disabled and older people in the CLTS process, and to the community response?

It was observed (no numbers were recorded) that attendance of people with observable impairments¹ was higher in the CLTS+ than in standard triggering sessions, possibly due to the targeted invitation message.

When the community was asked about other disabled people in their village, it became apparent that there were other disabled people in the community who had not attended the meetings.. Furthermore, attendance should not be confused with participation: active engagement in the meetings by the disabled people present was limited, although facilitators did in some cases actively try and involve disabled people.

Follow-up visits showed progress towards ODF in most standard and CLTS+ villages. In the eight CLTS+ villages where ODF status had been achieved, there was evidence, in terms of what was said by both village leadership and community members, and of adaptations observed, of a strong awareness of the needs of people with disabilities, and the concept of constructing user-friendly toilets. In these communities, community members made an effort to urge the CLTS+ team to visit households with adaptations to improve access to latrines for disabled people, constructed post triggering. Raised latrine seats and guide rails were the most common adaptations observed (similar to images used in the training (Jones and Wilbur 2014)). One unexpected consequence of the intervention was that in the post-triggering period three CLTS+ communities set up local organisations to support disabled people. In the FGDs, HSAs reported that these groups were led by disabled people and had increased the voice of disabled people at a local level.

In both FGDs, HSAs were requested to recall the steps they followed to implement the intervention. HSAs involved in standard CLTS implementation did not mention any attempts to make CLTS more inclusive. They reported that disabled people did not normally attend triggering events and said that as implementers they were not aware of the different needs of disabled people. In contrast the HSAs that had been trained on inclusiveness were able to recall each step in the CLTS+ action plan. These HSAs demonstrated a strong knowledge of disability issues and understood the value of ensuring equal access to sanitation. The endline evaluation will assess whether disabled people are able to access and use latrines and handwashing facilities to the same extent as other family members. As such this data is not presented here.

What were the associated costs of making a CLTS programme inclusive?

The CLTS+ triggering event was easily delivered in a half-day session, taking no longer than standard CLTS triggering. The consultation with disabled people during follow-up visits did take additional time (between 10-30 minutes), but this did not substantially affect the amount of time HSAs spent on CLTS-related work, as there were generally only a small number of households with disability in a community. In total the cost of making CLTS more inclusive through this approach is estimated to be over \$11,000 USD, with almost all the cost associated with delivering the additional training.

Conclusions

The three-day participatory training was sufficient to raise the awareness of CLTS facilitators to the different sanitation access needs in the community (specifically those of disabled people). The training equipped the HSAs, who had little prior knowledge of disability, to design an intervention that was feasible for them to implement, by including simple additional activities in the triggering process, and focusing on households with disabled members during follow-up visits. The CLTS+ intervention was delivered with minimal additional costs and did not significantly alter the time required.

There is evidence of adaptations to improve accessibility of some latrines, however it is clear that not all disabled people in intervention communities benefitted equally from the intervention. Qualitative evaluation at endline will intentionally explore these differences within and between communities.

Learning points and next steps

As far as we are aware, this is the first time that a standard CLTS intervention has actively attempted to address disability and diversity in a structured way. The positive results are encouraging, and the following points worth pursuing further:

- Collective planning of the CLTS+ intervention with active involvement of the HSAs was critical in ensuring the proposed modifications were realistic and do-able.
- The most significant additional cost and time was the three-day training. Further piloting needs to explore how this cost could be reduced by incorporating the disability/ diversity problem-solving elements into CLTS training itself, instead of as an add-on extra.
- Information about low-cost accessibility options needs to be more widely available via different pathways, e.g. posters in health clinics, for CLTS implementers to gain more confidence in advising and adapting to household level.
- Issues of accessibility cannot be addressed by CLTS alone. Supply and availability of accessibility options could be addressed by applying a similar approach to sanitation marketing. A complementary

approach could be explored within the disability sector: Community based rehabilitation (CBR) programmes could be supported to incorporate hygiene and sanitation into their work.

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Note

¹ The main data collection method here was observation. It is therefore possible that people with hidden impairments, e.g. deafness or epilepsy, were present but unidentified by observers.

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