

Salima district can be used as a case study on the effects of integrating CLTS into routine Health Surveillance Assistant (HSA) work (the extension staff for the health department); the success of the program there is a promising sign for the rest of Malawi. This study presents findings on how HSAs currently work on CLTS in Salima and potential iterations on this model which could make it scalable to all of Malawi. Action research was conducted at the Maganga rural Health Centre. HSAs were shadowed to gain first-hand experience on the challenges they face in their day to day duties and with CLTS implementation. Interventions were co-developed with HSAs and piloted to address key bottlenecks observed. These led to several recommendations which have potential to improve CLTS implementation in Malawi.

## Findings & Recommendations

### 1. Integrate CLTS responsibilities into routine HSA work

In Salima, CLTS was found to be fully integrated into routine HSA work (whereas in other districts this is not the case, and CLTS is seen as a project instead of another approach for conducting routine, sanitation work). At Health Centres in the district, HSAs as well as HSA managers, Assistant Environmental Health Officers (AEHOs) and Senior HSAs, were conducting CLTS activities as part of their regular duties. HSAs saw CLTS as their responsibility, integrating it into their monthly work plans and devoting significant amounts of time to sanitation promotion.

**Recommendations:** It is recommended that CLTS be incorporated into routine HSA work. Integrating CLTS, which is not dependent on external funding, into routine HSA work in Salima was very successful in creating a self-sufficient system within the district to deliver sanitation services. Implementing CLTS in this way avoids the pitfalls of delayed or inconsistent services due to lack of funding and little ownership by HSAs over the program, a challenge associated with donor-funded projects. A potential way to scale up CLTS integration into HSA work is to share the “CLTS for HSAs, by HSAs” guide developed during this study.

### 2. Focus on CLTS management training as well as field staff training

It is important for management level stakeholders to be involved and active in changing processes for implementing CLTS. This is because they have the positioning to motivate and support HSAs, as well as hold them and Health Centre management staff accountable to performing CLTS duties.

**Recommendation:** Holding management trainings on motivation and accountability structures for AEHOs can help bring managers into change projects. AEHOs and other district managers should be trained on how to motivate and hold their employees accountable. This training would also benefit activities other than CLTS since the same structures can be applied to different duties. Designing CLTS interventions and interventions in general in partnership with AEHOs & HSAs are also beneficial for sustained change since these partners feel a significant amount of ownership and pride over creating the intervention.

### 3. Incorporate CLTS goal setting into all levels of government and conduct ODF celebrations to increase motivation and accountability

HSAs have many duties and CLTS activities can be easily delayed or neglected if there are no incentives or accountability structures in place to ensure they're conducted. In Health Centres, the duties which are most often prioritized are those that have tangible outputs or clear consequences as a result of non-performance are prioritized. This makes it easy for hard working HSAs who push to include CLTS activities in their work and not be rewarded or recognized for their efforts.

**Recommendation:** Goal setting for CLTS should be incorporated into districts, Health Centres and HSA workplans. Goal setting should include not only the number of triggerings but also ODF villages and follow-ups. HSAs should be held accountable to meeting the CLTS goals for their Health Centre as well as their own workplan goals. Those who

are able to perform all their duties, both CLTS and non-CLTS related, should be rewarded with public recognition. Villages should also be encouraged to hold celebrations for themselves when they achieve ODF status to emphasize the ownership that they have over their sanitation and overall health. Not only do ODF villages benefit from the celebrations but the HSA and the Health Centre benefit as well from this, as a motivation to continue working on CLTS.

#### 4. Increase attention on follow-ups

It was found that not enough focus was placed during trainings or by management on follow-ups. HSAs are not taught how to conduct follow-ups properly, or given the forum to discuss challenges and tips on the follow-up process. It was observed that the lack of follow-ups prevents villages from achieving ODF because communities are not given the adequate support and encouragement needed to reach this goal in the timeframe that was decided at the CLTS triggering; therefore, follow-ups are crucial to the CLTS process. Good follow-up practices which are efficient and effective are unavailable, and if best practices do exist, they are unknown to HSAs.

**Recommendation:** More critical thinking and creativity needs to be applied when conducting follow-ups. For example, instead of visiting every single household in a village at each follow-up, the lagging households can be identified by the Natural Leaders and only those are visited, making more efficient use of the time spent on this activity. This would also help to ensure each village's unique challenges are being addressed.

#### 5. Explore cost-effective ways of training all HSAs in Health Centres

HSAs are still in the process of being trained. On average, only about one quarter to one half of HSAs at Health Centres in Salima were found to be trained in CLTS. The absence of trained staff within Health Centres puts increased pressure on the currently trained staff available to trigger and help with follow-ups to villages in untrained HSA catchment areas. Trained staff are helping trigger in other catchment areas, which takes them away from their own work at their catchment. This also leaves staff who have not been properly trained in CLTS in charge of follow-ups to the triggered communities in their catchment areas (since most trained staff are unable to follow-up on villages outside of their catchment), which was observed to be ineffective due to lack of CLTS knowledge in general.

**Recommendation:** Trainings should be piloted at Health Centres, as opposed to the district capital, to determine if this can reduce budget costs and improve CLTS extension services to the Health Centre catchment areas. Ideally this should be piloted in at least three different areas to determine scalability.

#### 6. Increase focus on hygiene with campaigns and the involvement of religious leaders

It was observed that hand-washing facilities (HWF) and drophole covers (DHC) took significantly more time to adopt than latrine use in all communities. Coverage of HWF was especially hard to achieve in Muslim communities. Often this prevents communities from achieving ODF status in areas where ODF status is defined as including 100% HWF coverage.

**Recommendations:** In areas where ODF criteria include HWF and DHC coverage it is important to have a separate and specific focus on promoting these behaviour change indicators. Possible campaign ideas include hosting hand-washing days at primary schools and exchange visits between Health Centre staff to share best practices. It is also important to leverage all possible options to encourage the adoption of HWF and DHC, including the use of religious leaders. Involving more members of the community in the CLTS process is a good way to create a norm around washing hands and good hygiene practices.

### Conclusion

HSAs and Health Centre staff have the capacity to be the main proponents of CLTS with the appropriate support. CLTS can be scaled up through them in a cost effective manner. Their work on CLTS can also have positive spill over effects on their other duties. CLTS can be seen as a tool for building capacity and as a leverage point for empowering individuals to be critical thinkers and solve problems as they come.

