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CLTS in Fragile and Insecure Contexts: Experience from Somalia and South Sudan

INTRODUCTION

During more than 20 years of civil conflict in both Somalia and South Sudan, sanitation interventions were mostly limited to construction of emergency 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 the desired results: recent surveys in Somalia show that access to sanitation actually decreased between 1995 and 2012. Open defecation (OD) levels are very high in both countries with correspondingly high levels of diarrhoea and frequent outbreaks of cholera. Baseline data is unreliable but some studies (JMP, 2013) indicate that OD is as high as 83% in rural communities in Somalia. South Sudan has the worst OD rates in sub-Saharan Africa at 77% nationally (JMP, 2012). The transmission of polio in 2013/14 in Somalia was linked to poor sanitation conditions in the affected communities.

The high cost of constructing improved latrines - due to logistical difficulties in transporting construction materials on poor roads to remote communities through insecure areas - discouraged comprehensive sanitation programmes in the past. With this background, and encouraged by experiences in Afghanistan and other post-conflict contexts, UNICEF WASH teams decided to experiment with Community-led total sanitation (CLTS). In South Sudan independence and the restoration of peace in 2006 buoyed the government and other agencies to consider sanitation approaches that would better serve the long-term needs of the country. This led to the introduction of CLTS on a pilot basis.

This Field Note describes the experiences of implementing CLTS programmes in these fragile contexts with recommendations on where the approach needs to be adapted to be applied in these settings.

KEY POINTS

- ***CLTS has been very successful in Somalia and South Sudan: Somalia has gone from zero ODF (Open Defecation Free) villages to 144 (self-declared) ODF villages in 2 years and South Sudan declared 103 communities, 200,000 people in ODF communities in 2 years.***
- ***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 an enabling factor for CLTS since government support for latrine subsidies has worked against CLTS in other countries.***
- ***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.***

DESCRIPTION OF INTERVENTION

How CLTS was introduced

In Somalia a feasibility study was carried out in 2011 showing that the approach was likely to be successful based on a number of triggered communities and despite reservations from local aid workers. A pilot intervention was implemented in 8 communities in relatively stable parts of the country.

Communities were 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 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.

Triggering at a village in South-Central Somalia

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. 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).

CLTS in South Sudan was initially introduced in all the 10 states in the country with varying success. 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 uses shame, disgust and fear to ignite behaviour change, could easily provoke a backlash within communities. They further argued that the fragile nature of the communities, where the prolonged war had created dependency and devastating poverty, means it will be impossible for the communities to embrace a no subsidy approach to household sanitation. It was therefore imperative that these key institutional stakeholders be brought on board before CLTS could take off. Discussions were held with stakeholders at national and state level workshops. Many were persuaded to give CLTS a chance by the numerous testimonies about the failure of the conventional approach.

Both country offices recognised the importance of overcoming resistance to CLTS amongst 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 these contexts.

Taking the programmes to scale

In Somalia the programme has so far triggered more than 370 villages with 140 self-declaring ODF by August 2014. One of the main successes of the programme has been the training of more than 120 NGOs as implementers. These included nutrition and health partners who are helping to take CLTS to scale through the new community health worker (CHW) programme. Using the high acceptance of CHWs by the communities, usually involved in curative work, the WASH program has leveraged support for CLTS. Joint WASH/Health and WASH/Nutrition partner agreements have been developed that address both integrated community case management (iCCM) and ODF attainment/ sustainability.

The South Sudan WASH team started by implementing a large scale 1 year project in Western Equatoria, Central Equatoria, Warrap, Northern Behr el Ghazal and Eastern Equatoria. UNICEF worked with partners including the Ministry of

Electricity, Dams, Irrigation and Water Resources (MEDIWR) and the states authorities, as well as INGOs and CBOs. 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 the most favourable conditions for its success. Mass triggering of villages in each state was stopped, and triggering only performed in villages where there is 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.

Conditions considered favourable for CLTS in South Sudan included:-

- Stable soil formations
- Homogeneous culture
- Predominantly rural settlements
- Sedentary lifestyles
- Secure land tenure

Development and use of adapted CLTS protocols

Both Somalia and South Sudan developed unique protocols that reflected the specific contexts in the two countries (See Fig. 1 and 2). ODF protocols are not yet standardised across either country but follow similar structures to Eastern African countries, including: a definition of open defecation and description of verification/reporting/certification processes.

Figure 1 – Somalia ODF Protocol

Definition of ODF	• No faeces in open including children's • Access and use of toilet for all • Covered pit + ash
Baseline	• Feasibility study established baseline behaviour
Triggering	• Local or International NGOs and/or CHWs • Each organisation selects most appropriate/effective tools from CLTS toolkit
Reporting	• Self declaration • Community to LNGO/INGO
Verification	• Implementing LNGO or CHW
Certification	• Multi-tiered with 3 stages/flags • Third parties (other LNGOs) + local authorities where possible
Post-ODF Monitoring	• Development of community ODF sustainability plans • Monitoring by natural leaders/community consultants with visits by government/local NGO staff/ mobile phone follow-up

Flexible procedures for verification and certification in Somalia

Public health offices are established in only a few districts in the north of Somalia. In the rest of the country local or international NGOs are the main heath service providers. The steps are therefore modified from a standard CLTS programme to work in the fragile state context and an adapted protocol was designed by practitioners with the help of experienced Kenyan public health officials. The Puntland region of Somalia is the furthest ahead with the CLTS roll out and developed a comprehensive CLTS protocol. This includes procedures for triggering, reporting, verification and certification as well as post-ODF monitoring.

The procedures are flexible allowing for other stakeholders (including local health authorities who may be INGOs or other non-state actors and CHWs) to play key roles in, for example, certification in the absence of government public health officers at local level. The protocol includes a multi-tiered certification of ODF – corresponding to different 'flags' – the development of ODF sustainability plans by the communities themselves, monitored by communities and local officials. The delineation between external (NGO-led) and internal (community health worker) roles was made explicit during the protocol development process leading to the inclusion of sustainability measures to ensure follow-on by communities and health workers post-ODF.

Definition of ODF in Somalia

Stage 1: YELLOW FLAG – Compliance for ODF Certification (non-negotiable)

- No faeces in traditional open defecation area/ street/courtyard
- All households have access to toilets (individual or shared)
- Evidence of use of toilet (footprints to toilet, splash of water in toilet, etc.)
- Children faeces disposed of in toilet
- Toilet to have covered pit and use of ash to cover faeces in pit after defecation (reducing contact of flies and smell)

Stage 2: GREEN FLAG (post-ODF)

- Hand washing facility by each household with availability of soap/ash and water.
- Schools/health centres with functional/use of WASH facilities (drinking water plus hand washing plus toilet for girls)
- Safe storage/handling of drinking water (covered vessel with hand not dipped while taking out water) and household water treatment (as needed)

Stage 3: WHITE Flag (desirable post-ODF)

- A system developed at community level by community to stop OD in /around village.
- Village visibly clean (no garbage, stagnant water, debris)
- Safe storage/handling of food (free from flies)

Self-certification in South Sudan

The National Sanitation Working Group in South Sudan developed the following as a prerequisite for a village becoming ODF:

- Do all households dispose of their faecal matter safely in a latrine?
- Are all the latrines properly maintained? That is: are they clean, no faeces outside the holes, the pits have a cover?
- Are there any human faeces in the environment of the village e.g., in the bushes, plantations and within the compounds of the village?

These are then used by the villagers to certify their own ODF status. These definitions are also adapted into indicators which can easily be applied by the multi-stakeholder team and state officials to verify and certify ODF status where possible.

In South Sudan the process of confirming ODF status is as follows:

- The verification process is activated by the implementing organisation.
- The sponsoring organisation informs the county/ state WASH cluster.
- The verification exercise is 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.

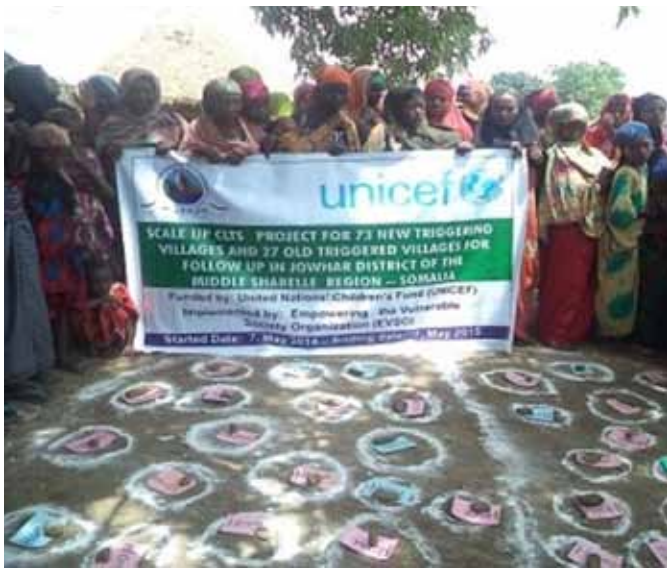
Figure 2 – South Sudan ODF Protocol

Definition of ODF	• Defined by National Sanitation Working Group • No faeces in open or near water sources • Access and use of covered pit
Baseline	• Established during triggering • Insecure land tenure a constraint to latrine construction
Triggering	• INGOs + state government public health officers (where available) • Using PRA tools
Reporting	• Implementing NGO/sponsoring organisation to state health authority & WASH cluster
Verification	• Large team of stakeholders from all levels selected by cluster • Using standard indicators defined by National Sanitation Working Group
Certification	• State authorities • Celebration with local dignitaries
Post-ODF Monitoring	• Follow-up by CLTS committee, chief, state public health offices

Implementation challenges

The Somalia WASH team focused on local NGOs as implementing partners 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 distributing lifesaving relief items.

The ban on public gatherings makes it difficult for local NGOs to facilitate CLTS in areas with strong Al Shabab control in South-Central Somalia. They are still able to work areas with less Al Shabab 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 with more Al Shabab control in the rest of South-Central Somalia.



Mapping during triggering in Middle Shebele, Somalia

There were challenges related to the fragile context in South Sudan that had to be overcome through dialogue, sensitisation and regular follow-up. These included:

- Heterogeneous cultures within single communities that had lingering ethnic suspicions making collective action difficult,
- Land tenure uncertainties creating a reluctance to construct a latrine,
- Poor logistics and neglected capacity development leading to insufficient digging tools and inadequate technical skills for constructing latrines.

The collaboration between the staff from government at the state and county level, INGOs and UNICEF played a key role in surmounting these challenges.

Mobility, a common feature of conflict-affected communities, is a challenge for the sustainability of ODF status. Identified natural leaders in some 'triggered' villages left due to fighting or drought, which negatively affected the construction of latrines. A broad group of natural leaders need to be involved in the CLTS programme to overcome this problem.

Enabling factors in the absence of an enabling environment

In Somalia implementing partners have noted that a number of villages trigger as a result of other activities going on in neighbouring villages. This trend has the potential to partially address the problem of Al Shabab controlled areas where villages who cannot go through a full CLTS programme can still trigger community action to improve sanitation. Improved monitoring of 'self-triggering' will help measure the full impact of CLTS programmes.

Going to scale with CLTS is thought to be difficult with weak central government. However a decentralized implementation approach in South Sudan and 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 LEARNT

- Despite considerable challenges in implementation and opposition to the introduction of a new approach at all levels the introduction of CLTS in Somalia and South Sudan has been successful in attaining ODF at scale.
- An integrated, multi-sector approach supports CLTS. Programming alongside relevant community level activities in WASH and linking with other sectors (Health and Nutrition) through CHWs has improved community acceptance, and potentially sustainability, of CLTS.
- The development of adapted, context-specific protocols to guide CLTS programming is essential for effective roll out in fragile contexts.
- Partnership with local NGOs was an essential component in Somalia. Their facilitation skills and mobility enabled follow-up and support to natural leaders where access for INGOs, UN and government was limited.
- CLTS alongside the CHW programme has the potential to make a significant contribution to strengthening resilience in communities at risk. The empowerment process for community action implicit in CLTS together with the impact of improved hygiene and sanitation on family nutrition and health enhances human capital.
- A phased scale-up was 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.

Next Steps

In Somalia an ambitious target was set to scale the programme to 5,500 villages, of the 12,000 in the country, by end of 2015. The implementing partners are working with state governments to develop a CLTS protocol for Somaliland and other states in South-Central Somalia, with the aim of strengthening institutional support for CLTS within the Government of Somalia. Additional strategies for taking CLTS to scale include planning to achieve ODF Districts by zoning the districts for a maximum of one or two NGOs. UNICEF is developing tools to support post-ODF monitoring: this will be performed by the natural leaders/community consultants with periodic visits by government/local partner staff. New techniques for monitoring through the mobile phone are being explored.

In South Sudan, the programme has slowed down due to the escalation of fighting but where and when the level of conflict is low implementation of CLTS continues, with 100 villages targeted in 2015. More flexible and less cumbersome procedures for verification are being developed.

Child demonstrates handwashing in CLTS village in South Sudan

Enabling and challenging factors for CLTS in Somalia

What has worked:

- Working with local partners where insecurity is a challenge by continually enhancing their facilitation skills.
- Acceptance and support of approach by the government. Decrees issued by Puntland, Somaliland.
- CLTS has been successful to elicit shame and disgust in riverine areas with high OD practices.
- CLTS has typically focused on rural and peri-urban areas where there is a better sense of 'community'.
- Working with relevant community level activities in WASH (household visits) and other sectors (Health and Nutrition) through community health workers has improved community acceptance of CLTS.
- The first two stages of CLTS (pre-triggering and triggering) have particularly been successful. The post-triggering stage has faced challenges.
- Presence of community health workers/ hygiene promoters for day to day activities.

Challenges:

- Identified natural leaders in some villages where triggering was done moved due to fighting or drought affecting the construction of latrines.
- Areas that previously benefitted from subsidized latrine construction by humanitarian organisations makes it difficult to promote the CLTS approach.
- Whilst the facilitation skill base is there, it needs continual improvement based on feedback and documentation of lessons learned.
- Children, women and girls are not involved in major decision making.
- Low cost of implementing CLTS is not popular with some traditional partners and government staff.
- Destruction of excavated latrine pits by heavy rains demoralises households.
- After years of nonfunctional government, there is high level of aid dependency leading to low outputs of CLTS.

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This Field Note is part of the UNICEF Eastern and Southern Africa Sanitation and Hygiene Learning Series, designed to improve knowledge of best practice and lessons learnt in sanitation and hygiene programming across the Region. The series has been funded by the Bill & Melinda Gates Foundation in support of improved knowledge management in the sanitation sector.

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