

case
study



CLTSH in Ethiopia

Experiences and lessons learned from a community-based water and sanitation and disaster risk reduction project
Guidance for future community-based water and sanitation software approaches



Partially constructed household latrine in Senbetge, North Gondar, made from locally available materials.

Water, sanitation and hygiene promotion (WatSan) has long been a key sector of interest for the Ethiopian Red Cross Society (ERCS), both in emergency contexts and longer-term development programs.

The Government of Ethiopia relies largely on the support of external agencies and partners for implementation of the National Hygiene and Sanitation Strategy. As one of these key partners, ERCS contribute toward achieving these goals through their WatSan programs.

Access to improved and appropriate sanitation and safe water supplies are still urgent requirements for many communities in Ethiopia, without which they are left vulnerable to a multitude of preventable diseases and health impacts. It is estimated that 60 percent of the disease burden in Ethiopia can be attributed to poor sanitation and hygiene .

Despite the Government's commitment to ensuring all Ethiopian households have access to basic sanitation by 2015, as outlined in the National Hygiene and Sanitation Strategy 2005 and the Universal Access Plan for Water and Sanitation 2008, the needs and vulnerable populations still remain extremely large. The most recent statistics indicate that only 45% of the Ethiopian population, or over 38 million people in Ethiopia continue to practice open defecation .

The Government of Ethiopia (GoE), through a policy level decision, adopted community-led total sanitation and hygiene (CLTSH) with no subsidy as the key approach for improving sanitation and hygiene in the country. Realising the importance of hygiene in improving total sanitation, the GoE modified the CLTS approach to include hygiene (CLTS became CLTSH). Although this is a positive step, opportunities remain for strengthening the CLTSH approach at implementation level.



Why this document?

This document captures key experiences of the Ethiopian Red Cross Society in implementing a community-based water, sanitation and hygiene and DRR project in North Gonder zone.

The key lessons and recommendations outlined below are relevant for both ERCS and other National Societies in the region (along with Partner National Societies (PNS) and the IFRC), who may be looking to implement similar programmes in the future or who are looking to improve the effectiveness of existing WatSan interventions.

This case study will focus only on the WatSan software aspects of the project. Data was gathered through a desk-top document review and field visit in May 2013 (data collection methods included focus group discussions, key informant interviews and direct observations).

Technical information and guidance on CLTSH and the PHAST methodology are well documented and therefore are not discussed in detail in this case study.

Overview of the project in focus

The ERCS, with support of the Austrian Red Cross, have been implementing a community-based WatSan and disaster risk reduction (DRR) project in North Gonder zone since January 2011.

The 3 year project aimed to reduce the vulnerability of climate related disasters at the community-level through evidence-based advocacy and disaster risk reduction activities integrated with water, sanitation and hygiene components.

The target area of Senbetge kebele, in Wogera woreda, has a population of approximately 8,140 people (or 1,500 households) and is a drought-prone area of northern Ethiopia. In Senbetge kebele there are 25 Gots (communities or household clusters). Significant underlying vulnerabilities exist in the area, including low access to health-care facilities, poor water and sanitation access and practices and food-insecurity.

Project design and implementation experiences

Assessment and monitoring:

Project activities commenced in Senbetge kebele in August 2011 with a vulnerability and capacity assessment (VCA). The VCA focussed on identifying key risks and capacities linked to climate-induced water, sanitation and hygiene related hazards (see overall aim of the project above). Crops, soil erosion, water, sanitation, personal and environmental hygiene, and livestock were identified as key sectors of interest from the VCA, and were included in the comprehensive baseline survey completed in August 2012. An end-line survey will be completed to enable measurement of project impact and success. The ERCS field officer was primarily responsible for community-level monitoring, in collaboration with volunteers, community committees and Health Extension Workers (HEWs).

Software components:

A major challenge in software implementation was the shift in Government policy part-way through the project period from PHAST to CLTSH, and the subsequent delays due to confusion of both local Government and ERCS project staff on which approach to take.

Project activities needed to be revised, even though implementation was already underway, and as a result the cascading of PHAST was not completed to community level and CLTSH and CBHFA (Community-based health and first-aid) were largely conducted as separate activities at field level. This created a certain degree of confusion, duplication and inefficiencies (see section below for key lessons and recommendations for future projects).

52 community-based volunteers were trained in CLTSH (two for each Got within Senbetge kebele) and six volunteers were trained in PHAST, facilitated by Government officers and ERCS staff.

“The government authorities at Kebele, Woreda and Zone level have been involved in the project implementation and found the project addresses the needs in the community and at the same time reinforcing the Ethiopian government plans.”

Mid-term review, March 2013

CLTSH and latrines: The hygiene components of CLTSH include messages on the importance of handwashing at critical times and safe water management. Along with verification of open defecation free status, CLTSH also requires evidence of a handwashing facility and of safe water management at household level.

CLTSH triggering was done by Government officers, using mainly shame and fear as the motivating factors. No subsidy was provided to households (in line with GoE policy), however several model latrines were constructed at central areas.

Traditional pit latrines constructed from locally available materials (wood/trees, rocks) are common in Senbetge. The soil is very rocky and community members had difficulties digging pits. Reports indicate that 1,350 out of 1,400 households have constructed a latrine of some sort (e.g. some do not have superstructure), however the number actually being used is estimated to be significantly less. The majority of these latrines were built as a result of the Health Extension Program (see below). Specific data on latrine construction and use will be captured in the end of project survey, and was not available at the time of this case study.

As part of the CLTSH trainings, a community action plan was developed and each volunteer assigned to a particular Got. The volunteer was then responsible for following up with households on latrine construction, handwashing and environmental hygiene.

PHAST: Cascading of PHAST group sessions was not completed to community level, mainly due to uncertainties around the approach to be taken (Government policy decision to use CLTSH only; conflicting with ERCS experience and capacity in PHAST). The PHAST toolkit used during training was a mixture of pictures from existing toolkits (there are 8 in total in Ethiopia, one for each region) - some pictures from other regions were not appropriate for the target community and were met with disapproval from volunteers and communities.

CBHFA: 34 volunteers were trained on core CBHFA modules, first aid and water, sanitation and hygiene. These were mainly youths, who also established a “CBHFA youth group”. This group are involved in community activities such as dramas, handwashing demonstration, model latrine construction and community clean up days. There were difficulties with accessing and providing volunteers with translated CBHFA tools and manuals to support their activities. The CBHFA component lacked a clear strategy and plan for implementation of activities following training.

Community-based management: Community water committee structures were established (one for each water supply facility / well). The water committees were trained by the local water authority, who continues to liaise with them regarding operation, maintenance and future repairs. At the time of the mid-term review (March 2013), all the completed water points had functional water committees. Females made up approximately one quarter (25%) of the water committee members.

Existing Government initiatives:

In the project area there are two Health Extension Workers (HEW) and one health post. The HEW system was established in 2002/2003 by the GoE. The role of HEWs is to run the health-post, provide first-aid services, and health and hygiene promotion (including latrine construction and use). The two HEWs in the project area were involved in CLTSH, PHAST and CBHFA trainings.

CLTSH verification and certification

The Ethiopian Ministry of Health developed a CLTSH Verification and Certification Protocol in January 2012. The purpose of the protocol was to standardize the verification and certification process in compliance with CLTSH implementation, and to provide simple templates and clear guidance on how to declare ODF status.

There are different levels of verification: village, kebele, woreda, zone, regional and national. A coloured flag system is used at community level as a key motivation mechanism, and also to promote healthy competition between villages. The Protocol can be downloaded from the ‘Relevant Resources’ section here: www.communityledtotalsanitation.org/country/ethiopia

Key lessons and recommendations

The following key lessons and recommendations are drawn from ERCS experiences with their WatSan and DRR project in North Gonder zone from 2011 – 2013, and are applicable for future community-based health, water and sanitation, and DRR programs in Ethiopia.

Strong commitment to WatSan ‘software’ components is essential for success – plan and budget sufficient resources from the beginning

In Senbetge, a variety of WatSan software activities were planned in the project (CLTS, PHAST, CBHFA) however field-level implementation and roll-out of these different approaches and activities was not fully realised or done largely separately. A PHAST training was done, however there was no clear plan or sufficient budget for cascading PHAST sessions to community groups or for implementing hygiene promotion activities. Training should not be done (PHAST or CBHFA or CLTSH), unless a clear plan and budget for bringing activities to community level is in place.

It is recommended that for future projects, ERCS develop a detailed plan of action for hygiene promotion and WatSan software activities (alongside hardware components). Along with the Project Coordinator (branch level), two Project Officers are recommended - one software and one hardware focused (dependant on project context, size and corresponding budget).

National Societies, PNS and donors need to realize the critical importance of well-planned, WatSan software activities with sufficient resources allocated (financial and human), for sanitation and hygiene project success and real impact. Advocacy for scaling-up and improving effectiveness of WatSan software activities should continue at all levels.

Create demand for sanitation through CLTSH; complement it with scaled-up hygiene promotion, community empowerment and technical advice

CLTSH triggering activities can be used as the entry point for project activities, and to motivate individuals to change the sanitation and hygiene situation in their community. Regardless of who will facilitate the triggering event, ERCS should emphasise a strong commitment to use ‘disgust’ and ‘shock’ as motivating factors and not ‘shame’ (for example activities which demonstrate the huge amount of human waste

generated by the community, or the amount of money spent annually on medical expenses related to diarrhoea).

To complement CLTSH and strengthen hygiene promotion, community empowerment and technical advice to communities (particularly in those with difficult technical contexts), specific activities can be borrowed from the PHAST methodology for implementation at community-level. For example, the sanitation ladder activity can be used with community groups (which in fact is included and recommended in the Ethiopia National Hygiene and Sanitation Strategy).

Through extended contact between volunteers and community members during PHAST activities (scaled-up hygiene promotion compared to what is included in CLTSH), additional follow-up support to increase uptake of hygiene and sanitation behaviours, and to improve the monitoring of project activities can be provided (e.g. monthly household visits by volunteers to monitor the number of latrines and handwashing facilities constructed in that period).

The model latrine concept provided positive guidance on latrine design and construction, and should be continued in the Ethiopian context. It is important that demonstration of handwashing facilities are included (tippy tap or other locally acceptable facility).

Acknowledge and plan for inclusion of most vulnerable groups (elderly, disabled)

Elderly and disabled community members in Senbetge were unable to dig their own latrine pit, so other community members were required to help. Extra caution and care is required to ensure that the most vulnerable groups are not excluded or ‘left behind’ due to the lack of subsidy or project design (materials, labour or financial). Vulnerable groups need to be proactively identified (elderly, disabled, single female-headed households etc.), and a collaborative problem solving and planning process undertaken so they are able to construct, use and maintain a latrine.

While household latrines were part of the Senbetge project, the church was not included, despite community members openly defecating when attending mass on Sunday. Public facilities such as schools and health clinics should not be left out, as the services that these facilities provide to the wider community are great.

Streamline community-level volunteer activities and action plans

In Senbetge, both a CLTSH community action plan and a CBHFA action plan were developed, with a separate set of volunteers for each. A complimentary plan of action and agreement on the hygiene and sanitation messages, activities and channels/methods that all volunteers will implement, would reduce duplication and confusion (both of volunteers and the community) and improve impact and effectiveness. A more strategic and complementary outlook during the project planning phase, and delegation of responsibility for implementing and following up on action plans, is required.

Volunteers involved in hygiene and sanitation activities could very well be called the “community sanitation action team” or similar, rather than CLTSH volunteers or PHAST volunteers. In reality, the terminology and name of the approach is not relevant or important for community members.

Volunteer trainings should be integrated and should focus on the key activities that volunteers will actually do in their communities (rather than holding separate CLTSH, PHAST and CBHFA trainings).

An assessment which includes attitudes and motivating factors for sanitation and hygiene is important, and should be used to guide project activities

In the Senbetge project, a cross-sectoral baseline survey and assessment were completed in order to be able to measure change and impact from project activities. However, the baseline assessment did not capture comprehensive information on attitudes, motivating factors or key areas of need in hygiene promotion. Menstrual hygiene, and to some degree maternal health, were only identified as issues during the mid-term review.

If assessment results which also include components of attitudes and motivations are used to guide project activities rather than solely to measure project success, a much greater level of impact and effectiveness can be achieved. Privacy, pride, convenience, health of family or children, money and status as motivating factors should be investigated, and used to guide the messages and channels for hygiene and sanitation promotion activities.

The use of youth groups (established as part of CBHFA activities) to conduct community hygiene promotion and social marketing activities should be continued and strengthened, and the involvement of Health Extension Workers and women’s groups should be scaled-up.

Strengthen and advocate for increased involvement of women

Improving women’s involvement in sanitation and hygiene interventions is critical. Although they may not have strong decision making powers at household or community level, women are often seen as a driving force for improved household health, hygiene and sanitation behaviour change. Including women in project planning, decision making and implementation can greatly improve the ownership, maintenance and sustainability of sanitation and hygiene facilities, as well as contribute to their empowerment and that of their families.

In future projects ERCS should continue to advocate with kebele and woreda local Government structures (as well as with committees established under the project, such as water committees) for the benefits of inclusion of women.

Strengthen and formalise cooperation with local Government structures and initiatives

In Senbetge, a “task force” comprising of key Government stakeholders was initiated who meet regularly to discuss project activities and progress. This initiative generated a good level of interest from stakeholders and strengthened their involvement in the project. Documenting and agreeing upon the roles, responsibilities and expectations of key local Government stakeholders is highly recommended would have ensured agreement on the approach to be used (rather than lengthy discussions, uncertainty and eventual change of the approach part-way through the project, as was the case in Senbetge).

Close coordination, engagement and planning with kebele and woreda (and zone) Government counterparts who are responsible implementation of the National Sanitation Action Plan (Ministry of Health) would enable a stronger CLTSH process at community level with higher chances of success and open defecation free certification. Collective positive pressure from ERCS and key Government counterparts on Got and kebele leaders can bring about change to resistant communities (as experienced in the Senbetge project).



Community members in Senbetge, North Gondar, during a community meeting.

In Senbetge, monthly meetings with the Health Extension Workers was identified as a positive method for coordinating project implementation. However, these meetings and coordination of project activities could be broadened to include existing community leadership structures (such as the Senbetge Women's Association) and existing Government initiatives (such as the Development Army and Women's Development Army).

Way forward

Considering the importance of hygiene promotion in achieving universal sanitation, the Government of Ethiopia took a policy decision to incorporate key hygiene components into the pure CLTS approach. Termed CLTSH, this is the key approach used in Ethiopia for improving sanitation and hygiene practices at community-level.

During the planning and implementation phases of projects, emphasis needs to be placed on hygiene and sanitation promotion and WatSan software components. For successful and sustainable projects, these components need to be strongly integrated into the CLTSH approach.

To further ensure the effectiveness and impact of project investments in sanitation and hygiene behaviour change, components of community ownership and technical guidance can be strengthened by borrowing specific steps from the PHAST methodology.

This complementary approach will strengthen sustainability and effectiveness of community-based sanitation and hygiene projects in Ethiopia.



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