

**A Scoping Study of Existing Health Promotion Strategies  
to promote  
Sustainability, Integration, Self-Supply and Institutionalisation  
(SISI)  
in Hygiene and Sanitation Programmes  
in Sierra Leone.**



The 'Moment of CLTS Triggering' in Kamathoro Village, Biriwa Chiefdom, Bombali District (a Muwodo Project)

**Study Prepared by Africa AHEAD in Collaboration with MoHS**

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## Glossary of Terms

**Community Health Clubs** are voluntary, community-based organisations of 50 – 150 people, who meet regularly for participatory health sessions using visual aids for acquiring information, shared understanding, discussion and the promotion of a sense of ‘common unity’ (i.e. community) of purpose for the sake of improved hygiene practices in order to prevent and manage common communicable diseases in the area.

**Community Led Total Sanitation (CLTS)** uses a one day participatory method of “triggering” communities to achieve Open Defecation Free (ODF) status, through the construction of latrines and other hygiene facilities following their desire to change engendered by their awareness of contamination of food and water by faeces (Unicef, 2010)

**Community Led** means that the actions are based on collective decision-making and by the community that is driven by a sense of collective achievement and motivations that are internal to communities, not by external subsidies or pressures (Kar, 2008).

**Health Belief Model** accounts for the variance of an individual’s behaviour based on their knowledge, understanding, attitudes and belief and therefore advocates for health education to prevent disease. (Stretcher & Roenstock, 1997)

**Health Promotion** is ‘the process of enabling people to exert control over the **determinants** of health and thereby improve their health’ according to the Ottawa Charter (WHO, 1986)

**Hygienic latrine** means any type of toilet that blocks the route of flies from either accessing or leaving the site of defecation, therefore no faeces should be external to the pit, and the squat hole should be properly sealed by water, by a tight fitting cover, or have a fly proof ventpipe as in a VIP latrine.

**Improved sanitation** varies from a flush toilet to septic tank or pit, direct drop pit latrine, VIP latrine

**Mothers Clubs** (MCs) There are 406 in the country trained to ensure all girls and boys go to and stay in school, support for education and the management of village schools, improving nutrition through vegetable gardens, sharing information about reproductive health, HIV/AIDS, immunization, exclusive breastfeeding, and malaria prevention.

**Mother-to-mother support groups (M2M)** There are 1,494 throughout the country as a key mechanism in preventing malnutrition and child mortality through improving the practices around early and exclusive breastfeeding and introduction of nutritious complimentary foods

**Natural Leaders (NL)** – local people who show exceptional initiative at the triggering exercise and who are the nominated to help to lead the process of latrine construction (PLAN, 2010).

**Open Defecation (OD):** the practice of exposing of faeces in the open air without covering, burial or use of a toilet of any sort. A direct pit latrine with no lid is a form of open defecation known as ‘Fixed-Point Open Defecation’ (Kar, 2008).

**Open Defecation Free (ODF):** implies there are no faeces openly exposed to the air and fly contamination. A pit-latrine with a fly-proof lid qualifies as ODF” (CLTS Handbook, Kar, 2008).

**PHAST** means Participatory Hygiene and Sanitation Transformation and is a method of community training using visual aids and activities to improve hygiene behaviour and awareness, in seven steps of needs identification, analysis and action planning which aim to prevent diarrhoeal disease by construction of water and sanitation facilities. (Srinivasin, 1990)

**Sanitation Marketing** is essentially the use of commercial marketing concepts and tools to influence the voluntary adoption of adequate sanitation by households. It is about leveraging market forces for both demand and supply of sanitation products and ensuring availability of supply and options through the market place which are both attractive and affordable to low income populations rather than on subsidies for latrine acquisition.

**Social Planning** is merely a term for interventions that reflect a professional, epidemiological analysis of health problems, in which interventions tend to be expert-driven, task-orientated and based on a rational-empirical approach to problem solving. (Bush et al., 2002)

**Social Marketing Approach** to promote hand-washing with soap is often done through public/private partnerships between development agencies and corporate companies using the same social dynamic as commercial advertising through the media and appeal to status (Borghi et al., 2001).

**Sustainable Sanitation** 'is indicated when the general trend in a community is to go up the sanitation ladder' (Kar, 2008)

**Total Sanitation** includes a range of behaviours such as stopping all open defecation; ensuring that everyone uses a hygienic toilet; washing hands with soap before preparing food and eating, after using the toilet, and after contact with babies faeces or birds or animals, handling food and water in a hygienic manner and safe disposal of animal and domestic waste to create a clean and safe environment (Kar, 2008)

**Unimproved Sanitation** indicates traditional open pit latrine, hanging or bucket latrine.

**Village 2.0** is the evolution of community-based interventions designed to create a transparent flow of support between village needs, government responsibilities and UNICEF interventions. Mothers are partners in the development of their communities, and respected stakeholders in the strengthening of the country, supported by 3 key approaches; learning summits, monitors as social connectors, and creative media support (national superheroes).

**Wi Pikin groups:** There are 1,900 Wipikin groups in the country (a combination of M2M groups and MCs) engaged in subsistence farming, petty trading and have diverse ethnic backgrounds.

### Acronyms

<b>AHEAD:</b>	<b>Applied Health Education and Development</b>
<b>CATS:</b>	<b>Community Approaches to Total Sanitation</b>
<b>CBEHPP:</b>	<b>Community-Based Environmental Health Promotion Programme</b>
<b>CLTS:</b>	<b>Community Led Total Sanitation</b>
<b>CHC:</b>	<b>Community Health Club</b>
<b>DFID:</b>	<b>Department for International Development</b>
<b>DHMT:</b>	<b>District Health Management Team</b>
<b>GoSL:</b>	<b>Government of Sierra Leone</b>
<b>IP:</b>	<b>Implementing Partner</b>
<b>ISIS:</b>	<b>Integration, Sustainability, Institutionalisation &amp; Self-Sufficiency</b>
<b>MDG:</b>	<b>Millennium Development Goals</b>
<b>MEST:</b>	<b>Ministry of Education Science and Technology</b>
<b>MoHS:</b>	<b>Ministry of Health and Sanitation</b>
<b>MoWR:</b>	<b>Ministry of Water Resources</b>
<b>SHC:</b>	<b>School Health Club</b>
<b>SSHE:</b>	<b>School Sanitation and Hygiene Education</b>



## EXECUTIVE SUMMARY

### Background

In 2008, the Ministry of Health & Sanitation (MoHS) decided to actively address the serious shortfall in sanitation coverage across the country which was estimated at 13% (AMCOW, 2010) with a target of reaching 66% by 2015. Through active promotion by UNICEF, many Implementing Partners (IPs) within the WASH sector adopted the methodology of CLTS (or CATS) for achieving 'Open Defecation Free' (ODF) villages and within five years a significant number of unsubsidised household latrines were constructed in over 5,000 communities in Sierra Leone. Relative to past performance this was indeed a positive achievement in sanitation. However it was clear that the CLTS methodology had resulted in little impact on the two equally important arms of health promotion in WASH, namely water and hygiene – there had been little improvement in proper hand-washing in CLTS areas with 90% still not washing hands with soap after defecation and of the 47.5% who had constructed a pit latrine over 60% were uncovered thus causing a health threat from flies (Unicef, 2011). In addition the challenge of safe drinking water continued. Food and water contamination through poor hygiene had not been linked to the CLTS programme in many areas. Of particular concern was that although in some of the highest CLTS coverage areas such as Kenema, where sanitation had increased from 17% to 83%, anecdotal observations by key stakeholders suggested that as many as half of the ODF communities had in fact regressed to open defecation. This is cause for concern as to the sustainability of sanitation through the triggering process of 'Classic CLTC'.

In light of the above, MoHS is seeking to enhance safe hygiene behaviour and evolve the CLTS approach within the national hygiene and sanitation promotion programmes towards achieving a more integrated strategy that will address all transmission routes of diarrhoea and other preventable diseases. To this end Africa AHEAD, the organisation which first pioneered the Community Health Club (CHC) model in 1995, was commissioned to undertake this Scoping Study (funded by UK-Aid and managed by Adam Smith International) in order to ascertain if some key ingredients of the CHC model which have resulted in Sustainability, Integration, Self-Sufficiency and Institutionalisation (SISI), can also be used within the Sierra Leone context. The CHC Model has been developing over the past 18 years and is also a 'community led' approach which results in 'total sanitation' and has demonstrated cost-effective hygiene behaviour change in a range of 50 behaviours in Zimbabwe (Waterkeyn and Cairncross, 2005). A Randomised Control Trial to measure the reduction of disease as a result of the CHC Model is currently being funded by the Gates Foundation in Rwanda where it is being scaled up nationally into every village (15,000 villages) in order to address the national disease burden and poverty due to WASH related diseases.

Building on the achievements of CLTS, AfricaAHEAD was requested to identify opportunities in Sierra Leone to support the MoHS and Implementing Partners (IPs) to 'evolve' the existing programme into a more integrated, holistic and cost-effective strategy. The aim is to achieve hygiene behaviour change and total sanitation through more concrete structures where communities themselves would take greater responsibility for their own health and hygiene, as has been repeatedly done through Community Health Clubs in other countries. Previous experience of CHCs in Sierra Leone that were introduced by Africa AHEAD through CARE International in 2002, have led to many successful Mother's Clubs which are now supported by Unicef through the Wipikin Movement.

### Methodology

This Scoping Study by Africa AHEAD took place between 28<sup>th</sup> January and 19<sup>th</sup> February 2013. The three-week assessment took a 'snap-shot' of NGO activities and government District Health Management Teams (DHMTs) across Sierra Leone in 7 districts.

UNICEF's Evaluation Report of CLTS (April 2011) was used to provide the quantitative data as it was a comprehensive survey of 5,000 households over 13 districts.

A 10-day Rapid Rural Appraisal (RRA) to meet DHMTs and IPs was undertaken that incorporated focus group discussions, key informant interviews, spot observations of hygiene and sanitation facilities, demonstrations of a village CLTS 'triggering' activity, and a Mother's Club.

A consultative workshop provided information on the Health Promotion projects in Sierra Leone as conducted among 13 NGOs and focused on 10 key questions as relate to Best Practices (see Figure 2).

A debriefing workshop at the end of the mission enabled all IPs and MoHS to get feed-back and recommendations as contained in this report.

## General Observations:

In the RRA of the CLTS programmes in 7 districts, the spot observations of over 100 latrines endorsed findings already highlighted in the UNICEF Evaluation Report (April 2011):

- (i) **Sustainability:** Although there has been a rapid response to CLTS with >60% of the >5,000 triggered communities' being declared ODF, around a half of these so-called 'ODF communities' had regressed back to open defecation, usually within two or three years after the initial 'CLTS triggering'. Families claimed to share with neighbours but it is more likely they resorted back to using the bush again. At least 50% of latrines are not being replaced which indicates a lack of appreciation for using latrines.

*CLTS on its own does not manage to sustain improved sanitation behaviour.*

- (ii) **Disease control:** Random spot observations indicated that very few, if any, of the latrines checked could be considered to be 'hygienic' as none had covers that were 'fly-proof' resulting in pit latrines becoming fly-breeding sites.

*The faecal-oral route is not being broken: it is unlikely that diarrhoea is therefore being reduced.*

- (iii) **Hand-washing and Hygiene:** The random spot observations also revealed very little evidence of hand-washing facilities being used at critical times as is required under the broad definition of '**total sanitation**' in CATS. As hand-washing is critical to reduce diarrhoea this further endorses the view above, that diarrhoea is unlikely to be reduced. Furthermore kitchen hygiene was extremely basic, with little evidence of safe food storage. Poor storage practices were unlikely to result in safe drinking water.

*The CLTS training has done little to develop a culture of good hygiene behaviour.*

- (iv) **Women empowerment:** The current CLTS triggering process tends to identify 'Natural Leaders' of which over 90% are male, despite the fact that women are mainly responsible for the health and hygiene of their families. Clearly, if improved family health is the goal, women should not be marginalised as is happening using the current CLTS method of triggering.

*Women are not being empowered by the current triggering method of CLTS.*

- (v) **Monitoring:** There is little or no monitoring of the outcomes of classic CLTS as project officers from most NGOs seldom return once communities have been declared ODF. They tend to rely on MoHS to follow up and the true picture of how many communities have reverted to OD is unknown.

*Without better monitoring the claims of ODF are questionable.*

- (vi) **Resources:** DHMTs were under-resourced and therefore unable to effectively monitor the programme that ultimately they should be responsible for leading in their respective districts.

*No wheels, no monitoring!*

**(vii) Technology:** There is seldom technical assistance given to build permanent latrines or maintain standards as the CLTS Handbook categorically states that technical guidance should NOT be offered! With little know-how, the latrines tend to be poorly constructed using local materials and they often collapse in the first heavy rains whilst the mud and timber floor slabs tend to decay after a year or two from termites thereby leaving potential 'death traps' within the village.

*Poorly constructed uncovered latrines are more dangerous to health and safety than no latrines.*

**(viii) Improved Sanitation:** Whilst the triggered communities have moved from open defecation to basic latrines, the RRA found evidence that few, if any, of the communities that were visited have moved any further UP the sanitation ladder to permanent latrines which can properly be called hygienic.

*CLTS is not providing the impetus for long term improvement in sanitation after the initial triggering.*

**(ix) Water:** Whilst some NGOs continued to provide water facilities this was resented by other NGOs who felt that it was a form of subsidy which made villagers donor-dependent. As a result there is still a critical shortfall of safe water supply.

*A national strategy is needed to incorporate water supply, as sanitation on its own is not sufficient in improving health.*

**(X) Cultural Appropriateness:** Many advocates of CLTS play down the aspects of naming and shaming which, according to the CLTS Handbook (Kar) are necessary to shock community into better behaviour. Our observation is that the overt 'dirty talk' needed for an effective triggering is unnecessary, as the same levels of sanitation coverage can be achieved in a more enlightened approach that provides information and positive peer pressure rather than overt impoliteness to cultural sensitivities.

*An Ethical Code of Standards for Public Health service provision should be developed by government to ensure professional behaviour in the field is consistent with norms of politeness in the local culture.*

## Summary of Key Recommendations

### **(i) INTEGRATION:**

Achieve efficient integration of the four key Ministries of Water, Health, Education and Local Government by building strong DHMTs capable of integrating water, sanitation and hygiene in a more holistic way and by better coordinating and deploying their existing resources.

**Recommended Action: Provide a forum for constructive inter-sectorial dialogue to brainstorm what each Ministry can contribute with a view to designing a national programme (a Roadmap).**

### **(ii) INSTITUTIONALISATION:**

Build on initial discussions with MoHS to develop a practical and low-cost strategy for a fully integrated Community-Based Environmental Health Promotion Programme (CBEHPP) using the CHC Model to evolve the CLTS programme in support of all aspects of WASH.

**Recommended Action: Development of an inter-Ministerial policy 'Roadmap' to inform future direction in Public Health Promotion in Sierra Leone for the next 5 years.**

### **(iii) CAPACITY BUILDING:**

Improve reporting at district level of hygiene behaviour change by increasing the capacity of District Health Management Teams (DHMTs) to take the lead to better coordinate and engage with all Implementing Partners.



**Recommended Action:** A directive from MoHS to ensure that all IPs report through DHMTs as well as contribute towards capacity building of DHMTs through adequate transport to enable effective monitoring, possibly using a web based programme to create a national data base.

(iv) **SELF-SUFFICIENCY (SELF-SUPPLY):**

Ensure appropriate training in water, sanitation and hygiene facilities at district and village levels with no material subsidy but with enough technical support to stimulate communities to construct more appropriate and permanent toilets and affordable water-supply facilities (Upgraded Family Wells).

**Recommended Action:** Develop a Household WASH Technical Manual on how to construct low-cost water and sanitary facilities using locally available and affordable materials with Training of Trainers (and artisans) done at village level.

(v) **HOLISTIC:**

Address all components of Primary Health Care, not just sanitation, so that the CLTS programme adopts a more robust hygiene promotion strategy with a wider focus on all preventable diseases, not only diarrhoea.

**Recommended Action:** Start Community Health Clubs in all villages in a phased scale-up over the next five years as part of a national training programme on primary health and hygiene.

(vi) **MONITORING:**

Use the local school as a focal point with their already existing channels for reporting to the DHMT. Enable communities to self-monitor using the CHC Monitoring Model.

**Recommended Action:** Develop a national CHC Membership Card for training in all communities with key recommended practices which can be monitored at village level with a Household Inventory and uploaded by each district quarterly using ten golden indicators.

(vii) **SUSTAINABILITY:**

Ensure WASH facilities and good hygiene is sustained by ensuring that **women** and **youth** are key stakeholders - making schools the focus of all WASH activities not only of child but also adult health literacy to build a 'Culture of Health and Hygiene' in every village.

**Recommended Action:** Build on the Mothers' Clubs and Wipikin initiatives by instituting a CHC training with standard health promotional activities. Train assistant school teachers as facilitators for community as well as school health clubs.

(viii) **TRAINING MATERIAL:**

Review and adapt existing PHAST training materials to provide and expand existing Participatory Tool Kits to enable roll-out of a national programme for illiterate/ semi-literate communities.

**Recommended Action:** Develop a national Toolkit for use in all communities to enable a full 20 topic training to take place in each village.

(ix) **EVALUATION:**

Ensure policy is based on rigorous research. A study is needed to contrast CLTS achievements with other methodologies such as the CHC Model to maximise possible hygiene behaviour change

**Recommended Action:** Comparative Study done to measure cost-effectiveness, health impact and sustainability of hygiene behaviour change, between the different approaches currently used in Sierra Leone and compare with international levels of behaviour change achieved in CHC programmes.

(x) **SCALING UP:**

To ensure that CLTS is used to its fullest potential, it needs to be evolved to be used within a more structured organisation at village level i.e. Using the CHC Model as an expanded CLTS+

**Recommended Action:** Pilot an evolved CLTS programme that is a fusion of the CHC approach and CLTS and includes appropriate water and sanitation technology options, in two districts with/without CLTS as a control to fine-tune a national programme before scaling up.

**This Report is divided into four parts as follows:**

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# **PART 1: INTRODUCTION**

## **1. BACKGROUND TO HEALTH PROMOTION IN SIERRA LEONE**

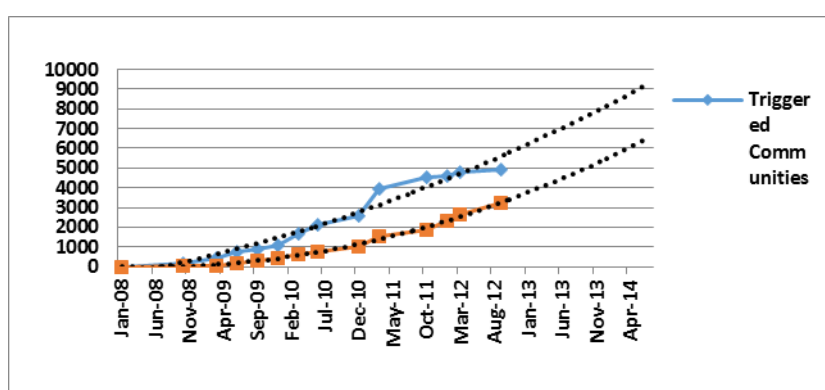
### **1.1. Community Led Total Sanitation**

In an effort to kick start a programme of latrine construction Government of Sierra Leone (GoSL) adopted the Community Led Total Sanitation (CLTS) methodology in 2008 in 8 districts, to encourage the self-supply of latrines and hand-washing with soap at critical times. By June 2010, over 2,000 villages had been triggered through the CLTS programme, and over one third met the criteria of being Open Defecation Free (See Glossary). The 2010 coverage of rural sanitation was by then only 13% with an ambitious MDG target to reach 66% by 2015 (AMCOW, 2012).

In April 2011 an Evaluation of CLTS was commissioned by UNICEF. Out of a total of 2,022 communities or 'sites', 1,167 (58%) had been triggered and of these, 853 had been declared ODF. Selection was done using district, Implementing Partner (IP) and Open Defecation (OD) status and 20% of the communities were sampled (408 sites). Some 5,000 houses were assessed across 13 districts. The impact of the programme was found to be very significant with 'over 70% of houses (4,274 out of 5,597) having toilets as compared to 19% (1,080 of 5,597) before CLTS'. In Kenema, the district with the most intensive CLTS programme, it was found that number of households with latrines had increased from 17% to 83% in communities declared ODF. In communities still in the process of achieving ODF status, the change was still good with a 22% increase, from 22% before triggering to 44% at the time of survey. In addition to the 4,274 with toilets, another 663 (12%) were still in the process of construction. The duration for communities to achieve ODF from moment of triggering ranged from 3.3 months in Bombali to 10.4 months in Koinadugu. The mean number of users per latrine is estimated at 9.3 people, whereas household size is on average 5.9 in Sierra Leone. Therefore it is assumed that there is a lot of sharing of latrines, although this is only reported. This Evaluation of CLTS maintains that there is '*overwhelming evidence supporting hygiene transformation behaviour and the relevance of CLTS.*' (Dalan, 2011), and it is clear Sierra Leonians do not have a cultural resistance to adopting latrines.

By 2013, in the presentation given at the Scoping Study workshop, UNICEF estimated that roughly 5,000 communities have been triggered of which 3,000 are considered ODF. (See Fig.1. below).

**Fig 1: Progress of CLTS to-date (2013) in Sierra Leone (UNICEF presentation)**



The construction of a latrine is a good indicator of 'sanitation consciousness' and there has been a massive response to the triggering with thousands of latrines having been constructed. However, there are still a number of critical gaps and the same report notes: '*Although most recognised 'run belleh' (diarrhoea), vomiting and malaria as serious health consequences, very few made the link between open defecation and these health consequences*'. This indicates that although latrines have been built, the accompanying behaviour change to adopt improved personal hygiene is missing. Until this link is made and the hygiene of communities is thereby improved, achieving ODF through the construction of latrines would have very limited health outcomes and impact.

The same report notes ‘that 52.5 % of rural household still do not have access to a latrine; and of those households who do have a latrine, around 60% use traditional pit latrines with no slab or cover.’ Such basic latrines, still allow access to flies and therefore these rudimentary uncovered pits are unable to break the faecal-oral disease-transmission routes associated with flies transmitting faeces onto food and should therefore not be classified as ODF. Of equally significant concern is the finding that over 90% of the rural population are not practicing hand-washing with soap after defecation (UNICEF, 2012) as they do not have a hand-washing facility and are at risk from diarrhoea and other faecal-oral diseases. This lack of personal hygiene and understanding of public health is likely to account for the fact that Sierra Leone has one of the highest rates of child deaths - an estimated 269 per 1,000 live births (WHO, 2009) with 17% dying of ARI, 23% from Malaria and 12% through diarrhoea every year. Thus ‘Total Sanitation’, as defined by Kamal Kar (the originator of CLTS, refer to Glossary), is clearly NOT being achieved as intended.

The ‘Community Led’ aspect of CLTS is based around WASH Committees (WashComs) that help to drive their respective communities to become open-defecation free (ODF) and are responsible for reporting to the UNICEF monitors who track ODF progress. These WashComs are mandated to also promote good hygiene practices to the communities but their main focus tends to be on ODF attainment (toilet construction, compost facility, pot racks and hand-washing facilities). There is concern that these WashComs have not been sustained over time, especially after the initial drive for ODF status has been achieved. **Therefore the claim that the Model is ‘community led’ is questionable.** At present, very limited efforts are being made in support of community-based development and monitoring after the ODF program has been completed.

## 1.2. Community Health Clubs in Sierra Leone

The Ministry of Health & Sanitation (MoHS) now wants to adapt, expand and evolve CLTS to become **more holistic and integrated** towards achieving national improved preventative health and poverty reduction outcomes. Recent studies indicate that such an integrated approach is indeed possible and one such study (Whaley and Webster, 2001) shows that in Zimbabwe the highest level of sanitation coverage and hand-washing was achieved in areas where “CLTS-triggering” was done within the same communities that were part of a **Community Health Club** (CHC) Programme.

CHCs that were established in Zimbabwe have been found to remain active 10-15 years after the actual WASH project had ceased. Research has shown high levels of behaviour change across a whole raft of behaviour change indicators, and one such study in Matabeleland Province of Zimbabwe showed that 99% of the CHC members achieved ODF within a year, with 42% constructing latrines and the balance of 57% practicing cat sanitation, so ensuring open defecation free areas. This is contrasted to the control group with only 2% latrines and no cat sanitation. In addition, 14 hygiene indicators known to prevent diarrhoea were maintained over a year after the project ended with over 60% of the members adopting 14 indicators of which 10 were adopted by over 80% of members (Waterkeyn & Cairncross, 2005). It has been well demonstrated in countries such as Rwanda, Vietnam and Zimbabwe, where the CHC methodology has been adopted by Government as a national hygiene promotion and health strategy that improved practice can be scaled up to ensure higher hygiene standards throughout the country.

As pioneers of the CHC Approach, the Directors of Africa AHEAD were invited to assess the CLTS programme in Sierra Leone to determine how CHCs might add value and help achieve and sustain ‘total sanitation’ (see Glossary for definition). CHCs are not a new concept in Sierra Leone as the methodology was first introduced into the country in 2002 by Africa AHEAD working through CARE International in Bo and Moyamba districts. CARE has since adapted the idea of a ‘Health Club’ to become a ‘**Mother’s Club**’ (MC, see Glossary) and produced a manual (2005) that provides a broad range of community training including WASH-related hygiene, targeting pregnant and lactating mothers and care givers. This same Care project is currently being implemented in Koinadugu and Kambia. However it is still at a small scale with only 10 MCs per year. A review is soon to be completed and preliminary findings indicate that it may have been highly effective. There are now nearly 2,000 groups under the **WiPikin** umbrella (see Glossary) that are proving to be successful in empowering women but these concentrate on mainly school support, good parenting and sustainable livelihoods rather than water, sanitation and hygiene (WASH) related activities. UNICEF is supporting **School Health Clubs** that have been established under the SSHE approach.

## 2. SCOPING STUDY OF EXISTING HEALTH PROMOTION STRATEGIES

With the limited time and scope for this assessment it was not proposed to go into detail of the Value for Money (VfM) i.e. cost effectiveness, of the different approaches; nor to measure the health impact which would require a far more in-depth research study. Nor was it expected to produce detailed project proposals but rather to lay the ground work for such activities in future by providing information through a Rapid Rural Appraisal at practitioner level. This document reports on observations, as well as opportunities, to incorporate different options of 'community-led' programmes currently being implemented within Sierra Leone. This assessment will provide the MoHS and the WASH sector with immediate findings taking a snapshot of projects across the country and comparing activities and claimed outputs to enable rapid results to be disseminated with a view to applying lessons learnt through follow-up pilots as soon as possible for the benefit of the WASH Sector.

### 2.2. Specific Objectives and Activities of this Assignment

The specific objectives and activities of the Rapid Rural Appraisal are as follows:

1. **To assess current strategies such as CLTS, PHAST, Social and Sanitation Marketing to identify areas of possible coordination and integration.**

**Activity:** A one day Consultative Workshop with 65 participants was convened by MoHS and Africa AHEAD to consult the WASH Sector and get a quick overview of health promotion activities in the country. The MoHS selected six NGOs (out of 13) to present their programmes within a framework which could enable the team to make comparative assessment of different strategies. These NGOs (see Part 1 below) were also visited in the field and their programmes assessed by RRA. In addition 13 NGOs completed a survey, the results of which are compiled below (refer Part 2).

2. **To raise awareness of the Community Health Club (CHC) methodology among sector actors by explaining the CHC methodology to Government, NGOs and stakeholders, as well as an introductory presentation on the approach.**

**Activity:** An introduction to the CHC Approach was provided in a one-day Debriefing Workshop which involved 44 participants from across the country including NGO programme managers and District Health Management Teams (DHMTs). Presentations on the CHC methodology were given, as well as findings and recommendations from the RRA. Two key staff members from MoHS were part of the RRA and travelled with the consultants for 10 days of continuous analysis as to how the CHC approach could be adapted to Sierra Leone. Two meetings were also held at the highest level with MoHS and UNICEF, as well as formal debriefings to DFID and Adam Smith International.

3. **To identify if any NGOs are already using the CHC type methodology, and whether there is a need for further piloting of CHC approaches with opportunities to expand the CLTS package.**

**Activity:** The Consultative Workshop was part of the research into current practice and the NGOs provided information on their existing methodologies. It was ascertained that the CHC approach (under a different name) is already being used by some NGOs in the country, particularly by CARE International, but the training is not consistent with the original design of the approach and much has been lost over the years. There is little institutional memory in government of the CHC training that was done in 2001 by Africa AHEAD, except that there are a few of the original trained individuals who are continuing CHC training outside the mainstream, particularly in Bo District which had not been included in the CLTS programme.



## 2.3. The Key Indicators of Best Practice : SISI

The information from the desk study and first-hand observations from the field informed the scoping study in order to identify gaps and opportunities for adapting and evolving the CLTS package. The key aspects of scaling up will focus on how to achieve the following:

- **Sustainability:** Improving the long-term sustainability of 'total sanitation' through community structures that can sustain hygiene behaviour change.
- **Integration:** Increasing the scope of the CLTS 'package' to include other methodologies so as to broaden **water and sanitation** programmes to include food hygiene, nutrition, child care and infant weaning, income generation, food security and community based saving schemes.
- **Self-Supply:** Community based capacity for construction, operation and maintenance of water supply and sanitation as well as access to hygiene products through sanitation marketing.
- **Institutionalisation:** Scaling up of health promotion through institutionalisation within MoHS and other key sector ministries (Water, Education and Local Government) to decentralise and create a structure at village level to maintain water-supplies, hygiene and sanitation with increased capacity for community management, monitoring and disease surveillance.

Specific areas of focus within the above broad areas include an examination of CLTS as follows:

- **Hygiene Behaviour Change:** the capacity and capability of the CLTS methodology in Sierra Leone to deliver hygiene behaviour change including highlighting issues which should be addressed in order to ensure higher levels of hygiene behaviour change and sustainable sanitation with health outcomes (i.e. Total Sanitation).
- **Empowerment of women:** improving systems and processes used by CLTS programmes to ensure full participation of the whole community, particularly women.
- **Cultural appropriateness** the social-psychology of behaviour change with particular focus on ethical standards of service provision which are consistent with local norms, values and culture.
- **Implementing Partner achievements:** in terms of levels of community hygiene improvement.
- **Recommendations:** how CLTS could be evolved to include other methodologies including conditions for combining the CHC approach with CLTS

## **PART 2: REVIEW OF EXISTING HEALTH PROMOTION STRATEGIES**

Although the main implementation approach in Sierra Leone is Community Led Total Sanitation (CLTS) there are variations of this methodology which may provide added insight as to how to achieve sustainable hygiene behaviour change. Therefore a review of the implementation strategies as currently being practised was carried out in order to better understand the variables that may have impact on sustainability. The survey analysed the extent to which IPs are implementing 'Classic CLTS'. N.B. '**Classic**' **CLTS** in this report is taken to mean the original CLTS Model as articulated by Kamal Kar during the first training in 2008 in Sierra Leone, and as also reflected in the CLTS Handbook (Kar, 2008) as well as the abbreviated version as developed by MoHS/UNICEF that is also being implemented.

The second question is to track how Classic CLTS has been modified by different NGOs to what is known as '**CLTS+**' or '**CATS**'; as well as using this in a combination of other strategies such as Health Belief Model, Social Planning, Social Marketing, Sanitation Marketing, PHAST and the Community Health Club Approach. Please see Glossary for a short explanation of these different methodologies. An overview of existing activities should provide a pointer to possible ways of sustaining ODF using practical strategies that are already being used in the field, building on local adaptations of CLTS, and the considerable local experience by IPs and DHMT for what works best in Sierra Leone.

### **2.1. CONSULTATIVE WORKSHOP WITH IMPLEMENTING PARTNERS**

#### **2.1.1. Methods:**

Ministry of Health and Sanitation (MoHS) and Africa AHEAD (AA) convened a consultative workshop (30<sup>th</sup> Jan 2013) attended by UNICEF and most Implementing Partners (IPs) in the WASH Sector. With a good attendance of 65 participants, the full range of activities and methodologies that were being implemented in the WASH Sector was presented within one day. Six NGOs were pre-selected by MoHS to present their programmes using a standard format provided by AA to allow comparisons on best practice.

All 13 NGOs completed a short survey of 10 key indicators as outlined below (See Fig.2. below). These 10 indicators have been pre-tested and refined over time based on literature reviews and have been used and approved in other workshops to analyse best practice for sustainable development (UNC, 2012). Variables are provided on 10 standard questions and the combination of the answers should enable a rough assessment of the thoroughness of the health promotion strategies currently being used in Sierra Leone. In addition six NGOs were selected to provide a 20 minute presentation using the same format but with more in-depth explanation of their programme, as well as highlighting achievements, challenges, and to also give recommendations about their own future plans. These same 6 NGOs were then visited in the field for spot observation of their projects to help verify their claims. However, it should be remembered that this was a Rapid Rural Appraisal and the short field visits cannot be considered statistically significantly, although randomly sampled. The spot observations aimed only to provide a snap shot of field strategies with a view to more in-depth analysis to enable a deeper understanding in the future. This is the start of a process of analysis which should be taken to greater depth academically, with an update of the achievements of IPs in other indicators, not only ODF (See Recommendation 9: Evaluation).

*Fig. 2. Key questions for Implementing NGOs*

<b>1.Method</b>	Which Methods are used to reach audience?
<b>2.Scope</b>	Which diseases / conditions are addressed?
<b>3. Length</b>	Period of contact with beneficiaries.
<b>4. Integration</b>	Type of development activities undertaken.
<b>5. Coverage</b>	How many people targeted at the same time?
<b>6. Cost</b>	'Cost per beneficiary'
<b>7. Effectiveness</b>	Number of observable hygiene indicators.
<b>8. Sustainability</b>	How long new practices have been maintained?
<b>9. Scalability</b>	Has the Model been used effectively at scale?
<b>10. Ethics</b>	Which human values does the Model encourage?

## 2.1.2. Analysis of NGO Best Practice

### i) Methodologies:

Of the 13 NGO's, all except one were using a mix of 3 - 6 different methodologies. Of the nine NGOs doing some form of CLTS: CADA is combining CLTS with PHAST and School Health Clubs, GOAL was doing only Classic CLTS, but about to start to use Sanitation Marketing to encourage better quality of unsubsidized latrines. PACE is using Social Planning, Health Belief Model and an adapted form of CLTS. PLAN is using adapted CLTS and also Community Health Clubs. Water Aid appears to be doing CLTS++ which includes elements of Social Planning, Health Belief, PHAST and adapted CLTS. Silpa is using CLTS+ and sanitation marketing. Only two NGOs (ACF and CORD-SL) are doing 'Classic CLTS' without any 'add-ons'. Four NGOs, (Development Initiative, CARE, Save the Children and Red Cross) are not doing any form of CLTS, three of them focus on either School Health Clubs or PHAST through Mothers Clubs whilst SCF is still pursuing the Health Belief Model and Social Planning. There is tension between some NGOs over the undermining of the 'non-subsidy approach' of CLTs which is at odds with the more 'community development' approaches. This dynamic needs to be coordinated by government, and there needs to be more in-depth understanding of the non-CLTS NGOs to understand their resistance to this relatively new approach (Recommendation 2: Institutionalisation).

**Fig 3: Methodologies used by NGOs doing health promotion in Sierra Leone, 2013**

Organisation	Social Planning	Health Belief	PHAST	Community Health Clubs	Classic CLTS	CLTS + Adapted	Sanitation Marketing	Sanitation Marketing	TS-SM	School Health Clubs
ACF										
CADA-SL										
CARE International										
CORD-SL										
Develop Initiative										
GOAL										
PACE										
PLAN										
Red Cross										
Save the Children										
SILPA										
WaterAid										
Welthungerhilfe										
<b>TOTAL</b>	5	5	5	3	6	5	1	4	0	2

### ii) Channel of Communication

Although all the NGOs indicated they used 'village gatherings', most of them also used a wide range of communication channels. Eight maintained they used a Community Health Club, and four used a 'designated group' of some sort. Nine used 'participatory activities' and nine also used 'radio'. 'Posters and pamphlets' were used by 8 NGOs and three also used 'billboards'. None of these channels are used in the Classic CLTS approach, which only uses 'village gathering'. Only Plan used 'village gathering' exclusively without any add-ons. Therefore, once again, we can see that CLTS as practiced by IPs in Sierra Leone is not the 'classic' variety and is in fact veering towards the more holistic CHC approach. The very fact that NGOs have opted to use additional channels may indicate that NGOs realise that the one-day triggering, on its own, is not enough to galvanise a community (Recommendations 5-7).

### iii) Number of face-to-face interactions with the 'beneficiaries'

We see from the survey that six of the NGOs in Sierra Leone (CADA, Goal, PACE, PLAN, SCF and Water Aid) usually provide beneficiaries with 3-4 sessions / meetings ( i.e. the norm with 'classic' CLTS:- a pre-triggering, a triggering plus a couple of follow-ups). Another four NGOs (ACF, CORD, WHF, and DI) deliver 5 -12 interactions, and this indicates an 'expanded' CLTS+ on a par with the PHAST approach.

**Fig 4: Channels of communication used by NGOs in Sierra Leone for health promotion, 2013**

Organisations	village meeting	designated group	community health club	clinic /	schools	participatory activities	house to house	Television / Radio	Posters / pamphlet	Billboards
ACF										
CADA-SL										
CARE International										
CORD-SL										
Develop Initiative										
GOAL										
PACE										
PLAN										
Red Cross										
Save the Children										
SILPA										
WaterAid										
Welthungerhilfe										
<b>TOTAL</b>	13	4	7	3	9	9	10	9	8	3

**Fig 5: Number of face to face interactions used by NGOs in Sierra Leone doing health promotion**

Organisations	1-2 times	3-4 times	5-8 times	9-12 times	13-16	17-20	21-24	25-30	>1 yr	>2 yrs
ACF										
CADA-SL										
CARE International										
CORD-SL										
DI										
GOAL										
PACE										
PLAN										
Red Cross										
SCF										
SILPA										
WaterAid										
WHH										
<b>TOTAL</b>	1	6	6	2	3	2	2	5	1	1

**However the most thorough interventions are achieved by CADA, CARE, PACE, Red Cross, and SILPA claimed to be doing 25-30 sessions, which is more typical of the expanded Community Health Club training which requires over 20 training sessions.**

#### iv) Coverage: Number of beneficiaries at each gathering / session

Whilst most NGOs that practice CLTS or PHAST estimated their gatherings are usually between 11-20 people, those using the Community Health Club methodology reckoned on 21-50 people. In fact, if scale is to be achieved, NGOs should aim to include the whole village, as it is important that a critical mass of people is involved if the balance towards good practice is to swing in a positive direction. If common communicable diseases are to be prevented then at least 80% of a village should have safe hygiene practices. (Recommendations 5-7)

#### V) Cross-Sectorial / Integrated programmes

Of the thirteen NGOs, eleven were addressing water, sanitation and health promotion within their programmes. It was encouraging to see that at least the three arms of the WASH Sector – water, sanitation **and** hygiene - are now being done by all the partners except one, which is only doing sanitation. Furthermore it was positive that all of the NGOs were involved in other issues, five doing income generation, five doing savings schemes, three doing nutrition and HIV/AIDs, four having child care projects whilst seven were attending to human rights. However it is startling that in a country with around 36% adult literacy, there are so few adult literacy programmes to empower the community.

**Fig 6: Integration of CLTS programmes**

Organisations	health education promotion	water supply	sanitation	Village Savings & Loans	Income Generating projects	Nutrition and Agriculture	Home based Care & First Aid	Adult Literacy programmes	Child Care & Reproductive Health	Human Rights
ACF										
CADA-SL										
CARE International										
CORD-SL										
Develop Initiative										
GOAL										
PACE										
PLAN										
Red Cross										
Save the Children										
SILPA										
WaterAid										
Welthungerhilfe										
TOTAL	11	11	13	5	5	3	3	0	5	7

#### vi) Holistic Health

Only three NGOs focus exclusively on diarrhoeal diseases. Four NGOs are also mainstreaming HIV/AIDS, and five are addressing reproductive health. Eight NGOs claim to be addressing skin disease, five are targeting eye disease, ten are addressing worms, and ten also focus on malaria. Five also focus on ARIs, which is the top killer of under 5's, four claim to be addressing bilharzia, two are addressing Nutrition and two are looking at TB. So if this self-reporting is correct then, contrary to expectations, there already exists a **holistic development pattern within the WASH Sector**, which is a good indication that there is more than just diarrhoea being targeted. (Recommendation 5)



Fig 7: Holistic Health promotion within the WASH Sector in Sierra Leone

Organisations	Diarrhea dysentery cholera	Skin disease	Eye disease	Worms	ARI	Malaria	Bilharzia	HIV	TB	Reproductive Health	Nutrition	TOTAL
ACF												1
CADA-SL												6
CARE International												6
CORD-SL												4
Develop Initiative												1
GOAL												11
PACE												5
PLAN												4
Red Cross												9
Save the Children												6
SILPA												1
WaterAid												7
Welthungerhilfe												7
TOTAL	13	8	5	10	5	10	4	4	2	5	2	

Fig 8: Wide focus of hygiene promotion targeting many indicators

Organisations	ODF / ZOD	Pour to waste method	Hand wash facility used	Use of soap	Disposal child faeces	Clean water /treatment	Clean water storage	Clean kitchen /eating area	Personal hygiene /	pot rack/ clean storage	Solid waste management	Swept yard
ACF												
CADA-SL												
CARE International												
CORD-SL												
Develop Initiative												
GOAL												
PACE												
PLAN												
Red Cross												
Save the Children												
SILPA												
WaterAid												
Welthungerhilfe												
TOTAL	9	10	12	10	11	7	9	7	9	10	6	5

### 2.1.3. Discussion: Cost-Effectiveness of Health Promotion

Cost-effectiveness means comparing quantity and quality of outputs with the cost of inputs. How much can an IP achieve for a given input and how sustainable is the result? It is obvious that a programme that targets **water supply and sanitation** while also addressing the prevention of many diseases, or provides many different benefits is likely to be far more cost-effective than one that has a narrow or single focus. **Therefore, the more holistic the programme, the more cost-effective it is likely to be.**

The **type** of methodology which is used for health promotion will obviously govern the effectiveness of the level of hygiene behaviour change. The success in achieving hygiene behaviour is dependent on a number of factors which affect the **thoroughness** of health promotion. Thoroughness, according to our perspective means: the **amount** of health promotion that is provided, with the assumption that the **more** face-to-face interactions, the more this **knowledge will be reinforced** and therefore the more likely it is to be **sustained**. The lower the level of education, the more reinforcement is needed, therefore the **number of sessions** is often critically important. In Sierra Leone, the UNICEF ODF evaluation (2011) showed that 50% of the **heads** of households had never been to school, (and the other 50% are barely functionally literate in that they have only a few years of schooling). For the WASH sector, intent on behaviour change, this means that the beneficiaries need more time to shift understanding from traditional perceptions. As the literature has long demonstrated, one of the most effective means of child survival is education of the mother, and yet little is being done by NGOs in the WASH sector to address one of the key determinants of poor health:- a mother's lack of understanding. **There should be far more focus on education of mothers so that they are empowered to manage the health of their family as far as it can be controlled through good hygiene** (Observation 4). As indicated to some extent during the field trip, local knowledge and information on germ theory is altogether missing.

CLTS has only one 2-3 hour session of triggering which is unlikely to provide sufficient time to push more than the one message: '*don't eat each other's kaka!*'. Although ultimately CLTS aims to achieve Total Sanitation, this has hardly been factored into the programme design as with an average of just 1-3 contacts with the community, there are simply too few face-to-face interactions with the local households to achieve the numerous aspects involved in achieving 'total sanitation' as it has been defined by Kar in the glossary. None of the NGOs doing WASH programmes appear to have made the linkage to **health literacy** and the **CLTS methodology largely ignores the role of women in the process of identifying and selecting so-called 'Natural Leaders'** (NLs) who tend to be men because of their ability to dig deep pits and construct latrines (see 4.2.2). The MoHS needs to work in conjunction with the MEST to address education not only for children but also for adults so that health/hygiene knowledge is equitable across the generations and gender (Recommendation 7).

In the 1990s, the methodology of choice tended to be PHAST that was designed to have **seven** community sessions to complete the programme, from 'needs identification' to 'project planning' for water supply. PHAST failed to achieve significant rates of behaviour change and as such was abandoned by mainstream health promoters (WSP, 2002). How can CLTS succeed as it basically consists of just **ONE** training session? The WASH sector then turned expectantly to CLTS despite providing NO training to the community. It is not surprising that understanding around hygiene issues is minimal as CLTS makes little effort to impart knowledge. This leaves the community having to figure sanitation out for themselves and, lacking information on very-low-cost latrine technology options and practical hygiene requirements, their efforts tend to fail after a relatively short period of time (on average 2 to 3 years).

The **number of people** that are gathered at each session is an aspect of community development that has largely been ignored. However CLTS does use clever 'reverse-psychology' in the group dynamics that are manipulated by the facilitator during the triggering. Public health has to target communities, not individuals, and it has been discovered that it is the critical mass which is most important in achieving behaviour change. Whilst some people will change because they have been converted by the facts or figures, others will change merely to be in-line with majority opinion. Therefore it is important to sway the opinion of the majority rather than concentrate on the few enlightened individuals and wait for a 'trickle down' effect to begin. Initially CLTS uses the group dynamic very well but it does not capitalise on this momentum by forming a dedicated group.

Instead it reverts back to the NL and to top-down reinforcement by traditional leadership to enforce change (ODF status).

***As a general rule the more well ‘formatted’ the group, the stronger will be the response by the group members.*** Thus, loose village gatherings such as are assembled for triggering events, are unlikely to be as effective as a dedicated membership such as a Community Health Club, because there is often little common understanding and a common sense of purpose. Genuine ‘common unity’ (community) takes time to develop.

The ‘**channel of communication**’ governs the scale of the projects, as, obviously, the number of recipients of a health message is contingent upon how the message is spread. This ‘channel of communication’ varies from accessing the community through a tight knit group such as a health club, or an anti natal class with a common objective, to the more open ‘village gathering’ where the physical audience are assembled in one area, to a ‘wide open audience’ which cannot be easily quantified, such as those listening to radio or TV or looking at a billboard. The effectiveness of the messaging will also be influenced by the intensity of the interaction, whether it is one-to-one as in a home visit, or 20-40 people in a classroom or in a village group using participatory activities under a tree. To scale up rapidly it is better to launch an appeal widely and catch as many people as possible, so that at least 80% of the population are included in the health club.

It stands to reason that the narrower the focus of the training and the fewer messages there are, the less effective will be the training in prevention of diarrhoea. There are many hygiene practices that need to be in place in order to block the transmission of diarrhoea. It should be noted that although CLTS has effectively managed to galvanise communities into building latrines, the design of the 2 hour triggering leaves little time for anything else. Because of the over-emphasis on latrine construction which is presented as a fix-all, CLTS triggering does little to address faecal contamination of water or food. Ordinary people do not usually compartmentalise their needs. After years of this type of ‘silo development’, the needs of the people for a more ‘integrated approach’ are at last being heard as their very survival depends on a range of factors, and health is dependent on many aspects, not least of which is the need for more income. Once the **need** for safe drinking water, improved sanitation and hygiene have been developed the ability of the household to actually maintain their water facility and to build a durable latrine depends to some extent on their income. Therefore programmes that provide Village Savings & Loans (VSL) or skills training for income generation will have the most chance of sustaining WASH facilities. This was demonstrated in the Zimbabwe study (Whaley & Webster, 2010) where disposable income was positively correlated with latrine construction. In the last few years the main theme at most international conferences in the WASH Sector has been to focus on greater levels of ‘**integration**’ (see 4.3; p.29).

In our survey we were encouraged to find that 10 out of 13 NGOs claimed they are engaged in promoting a range of non-risk behaviours. The projects that focused only on sanitation were the same ones that identified just four messages on which they concentrate. Whilst this is a start, it is not going to prevent diarrhoea. More importantly, it may not justify the cost of the programme, whose main aim (it is presumed) is not just to build toilets but to reduce sanitation-related diseases.

Cost-effectiveness means that objectives are not only met but achieved with minimal cost, so not only must the project deliver on its targets, but it should not be unnecessarily extravagant. A rather simplistic measure of cost-effectiveness is ‘**cost per beneficiary**’ - simply dividing the running costs of the programme by the number who benefit. As a bench-mark, the field costs of running a Community Health Club Programme are usually under US\$2 per beneficiary, depending on scale (Cairncross & Waterkeyn, 2005). Although no accurate information was available from the NGOs who were unprepared to answer this question, most NGOs estimated their programs cost at least US\$25, which is on the high side if there is only health promotion provided. There are two ways to achieve cost-effectiveness. Firstly, using the ‘economy of scale’, by having a large number of beneficiaries for a programme, and secondly by targeting multiple health topics within a community thereby maximising the return on cost of inputs: return on investments.

Although it was not possible to verify the claims made by the NGO’s own self-assessment, the general pattern indicates that although all of the 13 NGOs are using CLTS, most of them have broadened the scope of CLTS to include a number of other approaches and inputs. The fact that most NGOs have decided to implement a combination of approaches indicates that Classic CLTS, on its own, is simply not effective. Development Practitioners appear to have a more holistic approach to development than CLTS offers and it is encouraging to see that most NGOs in Sierra Leone are not just focusing on ODF and diarrhoeal disease but are attempting to address the many causes of child morbidity and mortality.

Although not presented during either of the two Workshops (as it was outside the WASH Sector), one of the most inspiring developments within Sierra Leone are the 406 ***Mother's Clubs***, and 1,494 Red Cross '***Mother to Mother***' (***M2M***) ***Clubs*** each comprising of 20 executive members who ensure all girls and boys go to and stay in school, with active community participation and support for education and the management of village schools. These groups now form part of the ***WiPikin strategy*** within MEST and activities include sharing information about reproductive health, HIV/AIDS, immunization, exclusive breast-feeding, malaria prevention and nutrition in preventing malnutrition and child mortality through improving the practices around early and exclusive breastfeeding and introduction of nutritious complimentary foods (Langer, 2011).

## 2.2. NGO'S PERCEPTIONS

### 2.2.1 Highlights and Achievements

NGOs generally are pleased with their achievements according to the workshop presentations from six of the key IPs in Sierra Leone. In particular they cited improved behaviour change and a reduction in water and sanitation related diseases. GOAL is particularly successful in achieving a high rate of latrine construction with 8,679 latrines built and 7,513 hand-washing facilities with soap that are claimed to be in place within 711 communities triggered of which 65% (465) declared ODF. PLAN has an even higher percentage of success with 93% (670) out of 723 said to be ODF. Muwoda, a local NGO, has completed triggering in 200 communities with 100% coverage in two chiefdoms. CARE, using a variation of the CHC approach, cited more qualitative achievements such as the empowerment of communities and the creation of social cohesion, with improved participation of women in health and development activities. WaterAid using a range of methodologies also mentioned the promotion of self-esteem, social solidarity and cooperation.

### 2.2.2. Challenges with CLTS

NGOs should be able to pinpoint the challenges to successful health promotion more precisely than short-term consultants. Attention should thus be given to the direction in which such NGOs are moving, based on their own direct recent experience. NGO strategies sometimes clash particularly with issues over levels of subsidy. Whilst the CLTS lobby believe firmly in 'no subsidy', justified by the need to wean community from donor dependency, other NGOs maintain that sustainability is unlikely unless latrines are properly constructed and this requires some input from donors as the communities are impoverished. Goal has flagged the issue of communities falling back into OD and a general theme is the lack of monitoring, which in fact is synonymous with 'policing' communities with an old style sanitary inspector able to impose fines. PLAN highlights the difficulty of keeping 'natural leaders' as continuous volunteers, and the need for a more institutional solution to facilitation and grass-roots monitoring. Then there are the technical constraints of difficult terrain for digging pits, the lack of sound roofing material, and the need for provision of safe water sources. Some of the social challenges include the difficulty in triggering a large community that lacks homogeneity and in urban settlements where there is little social cohesion or continuous settlement, making mobilisation and sustainability very difficult. NGOs are calling on GoSL to provide greater leadership, coordination and appropriate policies to enable a national strategy to be put in place. NGOs appear to want to harmonise their efforts with government objectives and have a closer engagement with DHMTs.

### 2.2.3. Future Plans

WaterAid intends to continue spreading CLTS to more communities, whilst PLAN is concentrating on increasing water facilities and sanitation to meet the needs of 50% of 'their' existing ODF communities; also to link this with the innovative Village Savings and Loans (VSL) scheme to increase sustainability. GOAL has completed all of the triggering that it had originally intended and is now focusing on Sanitation Marketing in all communities to promote more sustainable construction of latrines. CARE meanwhile will continue to scale up CHCs with a particular focus on maternal and child health. The Urban Wash Consortium plans to diversify its approaches. Thus each NGO has a strategy to improve on past performance and fill in the gaps according to their own various perspectives.

### 2.2.4. NGO Recommendations

It is most important that the future direction of health promotion in Sierra Leone builds on the fruitful efforts of IPs who have sustained the sector over the past decade during which significant progress has been made. Although some of the recommendations reflect a 'pro' or 'anti' CLTS tussle, the following key recommendations were representative of most NGOs:-

- ▶ Provide support for active research to gain a deeper understanding of community-led processes that are necessary for policy changes (share any learning evidence widely);
- ▶ Revive the role and powers of Sanitary Officers to support Natural Leaders in the monitoring process
- ▶ Develop a VS&L association strategy
- ▶ Strengthen the DMHT and GoSL institutions to implement the Public Health Ordinances.



## PART 3: RAPID RURAL APPRAISAL

### 3.1. SELECTION OF SITES FOR FIELD VISIT

With minimal time to cover the whole country, random sampling was necessary. It was decided that the sites for the field trip would be purposefully sampled to include two districts of 'high up-take' (Kenema and Tonkolili), two districts of median up-take (Port Loko and Moyamba), and two districts where there had apparently been too few ODF villages to warrant selection in the sample (Bo and Koinadugu) (See Fig 9). The selection of sites within the three categories was done pragmatically, based on the availability of projects on a route which could be done within 10 days. With more time available, more ground could have been covered, as there were information gaps due to lack of first hand observation of Pujehin, Kono, Bonthe, Kailahun and Western.

Ranking	Districts	ODF	Non ODF	improved
1	Kenema	84%	16%	67%
2.	Bombali	52%	48%	5%
3.	Tonkolili	47%	53%	-6%
4.	Port Loko	30%	70%	-41%
5.	Moyamba	29%	71%	-41%
	Pujehin	29%	71%	-43%
	Kono	25%	75%	-50%
6	Bo	0%	100%	0
7	Koinadugu	0%	100%	0
	Bonthe	0%	100%	0
	Kailahun	0%	100%	0
	Western	0%	100%	0
	TOTAL	42%	58%	-16%



Fig 9: Selection of Districts for field visit, and location on a Map of Sierra Leone

### 3.2. METHODS OF ASSESSMENT

#### 3.2.1. Protocol Observed

In each district the local authority was contacted, usually upon arrival and a meeting convened, as a matter of protocol. No resistance to our assessment was evident and the District Health Management Team, the NGO staff and the members of communities could not have been more helpful or informative.

In total, seven districts were visited and, depending on the relevance of each situation, certain standard tools were used to collect information as follows:

#### 3.2.2. Focus Group Discussion

Arrangements were made with the DHMT to have a Focus Group Discussion on the sustainability, integration self-supply, and institutionalisation of CLTS programme. Once permission had been given to visit the field, the Implementing Partner (IP) was then met as prearranged,

### 3.2.3. Selection of field sites:

This was followed by a visit to villages that were randomly selected by the consultants on arrival to prevent any preparations for the visit. In every case, a list of villages was requested and those triggered before 2010 were identified. We then randomly picked a number and chose the village so there could be no pre-selection in any way by the IP. This alleviated any bias due to the NGO preparing villages in advance. Of the ten villages visited, the only pre-arranged visit was to the Community Health Club in Koinadugu which had to be called in advance in order to assemble the members to demonstrate the session.

### 3.2.4. Village Meeting :

The team would arrive unannounced in the selected village and the Chief would appear and call the villagers for an ad hoc meeting. Villagers gathered quickly out of curiosity and there was no refusal by any village when our objectives were outlined. On average a village survey would take 2-3 hours each, consisting of a transect walk and a few household visits.

### 3.2.5. Transect Walk:

Usually we were accompanied on the transect walk through the village by a group of 10 - 20 people. There was no hesitation and they had no issue with us observing their sanitation facilities. In total there were 10 transect walks, each taking 40 minutes or more. Numerous facilities were inspected and exactly 100 latrines were actually photographed for the purpose of analysis.

### 3.2.6. Household Spot Observations:

14 households were inspected in depth and interviews of household heads were done taking 30-40 minutes each with observation of standard hygiene indicators. Bearing in mind that the UNICEF Evaluation found women unable to express themselves freely in the presence of men, a strategy was put in place to enable interviews at household level with women on their own. The men were drawn off by our two male team members to continue the transect walk, leaving the two women in the team to conduct household spot observations. This enabled the village women to speak freely without having to defer to their menfolk. A semi structured interview was conducted with these women whilst conducting informal spot observations inside their homes.

### 3.2.7. Demonstration of Training Methodology

In two sites we were given a demonstration:

- **CLTS** triggering of both sanitation and HIV/AIDs testing by MUWODA
- **Community Health Club** session on Nutrition by CARE (an additional report is available).
- **PHAST:** In two villages we held an impromptu PHAST session to test out the School Health Club visual aid toolkit (developed by MoHS, UNICEF, 2012) with the village children.

*Fig 10. Outline of Itinerary and tools used in each district*

2013	NGO	District	DHMT FGD	Village Meeting	Transect Walk	Spot Observe	Demo
1 <sup>st</sup> Feb	OXFAM	Freetown					
2 <sup>nd</sup> Feb	PLAN	Port Loko			2	2	PHAST
3 <sup>rd</sup> - 4 <sup>th</sup> Feb	MUWODA	Bombali			1		CLTS
5 <sup>th</sup> - 6 <sup>th</sup> Feb	CARE	Koinadugu			1	4	CHC
7 <sup>th</sup> Feb	WaterAid	Kenema			2	2	
8 <sup>th</sup> Feb	Goal	Kenema			2	2	
7 <sup>th</sup> & 9 <sup>th</sup> Feb		Bo			1	2	
	Red Cross	Moyamba			1	2	
	8	8	6	6	10	14	3

### 3.3. DISCUSSION

#### 3.3.1. Trying to count the true rate of ODF

There is no doubt that CLTS has been responsible for thousands of latrines being constructed by communities throughout Sierra Leone in the past five years, with an estimated 5,000 communities having been triggered by a range of Implementing Partners (IPs). Of this roughly 60% (3,000) have apparently been recorded as achieving ODF status (UNICEF, p. 6). However, what is not generally factored into the debate on CLTS, is the regressive rate: in this case of these 3,000 communities, at least 50% have returned to non ODF status in the past few years, leaving an **overall success rate of around 30%**.

However 30% does not include all the non-triggered communities. So although the 'Improved Sanitation' (see glossary for definitions) coverage of rural Sierra Leone is thought to be 39% (WHO. 2009) that figure is most likely to in fact be 'Unimproved Sanitation' with 'un-hygienic latrines'. The issue highlighted repeatedly by MoHS, UNICEF and IPs is that the quality and the durability of latrines constructed with local materials is a real challenge. It was clearly observed that when latrines collapse during the rains, they are seldom repaired or rebuilt. This indicates that whilst the communities have initially responded to the 'letter' of CLTS, they have not under stood the 'spirit' of the directive. They have not developed a 'culture of cleanliness' which informs their hygiene behaviour. They may have a latrine but do not have hygiene. This clearly undermines the objective for achieving 'Total Sanitation'.

#### 3.3.2. Classifying Districts as having achieved ODF status

Whilst the term ODF indicates 100% faecal free environment, in the UNICERF Evaluation (2011) from which we draw our data, Districts were classified as ODF if only 80% ODF, and in one unexplained anomaly, Pujehin was classified as ODF with only **38% ODF status?** Therefore one of the immediate issues that needs clarifying is the criteria and strict definition of the term 'ODF'.

Again, a closer look at the data reveals that Kono, for example, achieved 100% (which sounds impressive) but in fact the data was drawn from only 10 households! It is clear that the term ODF has been used far too liberally and in effect has become somewhat meaningless, as it is now a loose term to cover a multitude of weak statistics.

On top of this anomaly, the statistics using the CLTS system only account for those villages **within the programme that were triggered**. This implies, by way of example, that in a district of, say, 100 villages, 50 may have had the treatment of triggering. Of these 50 villages perhaps half (i.e. 25) become successful at achieving ODF. This means that the % coverage of ODF is actually 25% and not 50%, as is currently being counted when accessing the achievements of CLTS.

For example the graph on page 6 shows that 5,000 communities have been triggered, and only 3,000 are considered ODF. This is a 60% success rate. However when the non-triggered communities are factored in, then the sanitation coverage would be considerably lower. However these 'non-triggered' communities are simply not being accounted for. To accurately measure ODF we should have the % coverage of the whole district in terms of **number of households** and not just those triggered communities that may or may not have responded.

This difference between districts and areas within the districts, raises the obvious question of what happens to the other communities, less amenable to CLTS, the so-called 'damp matchboxes' that did not ignite, in CLTS-speak? In reality these 'damp matchboxes' may be the more needy communities, (given their tendency to be larger in size, and less homogenous), which would tend to increase amount and impact of open defecation. The weakness of the claims made by CLTS is that it counts villages / communities as the basic unit, and not houses / households in the more precise measurement of % coverage by household. This approach may be simple and many IPs have welcomed this short cut, but from the perspective of 'real development' this does not accurately account for the true picture on the ground.

## PART 4: ANALYSIS OF FINDINGS & WAY FORWARD

### 4.1. OVERVIEW

The above Rapid Rural Appraisal (RRA) provided a basis to analyse the CLTS programme that has been implemented over the past five years in Sierra Leone under four broad headings:

- (i) Sustainability
- (ii) Integration
- (iii) Self-Supply
- (iv) Institutionalisation

Under each of these four headings a SWOT (Strengths, Weaknesses, Opportunities and Threats) analysis helps to summarise the main findings and this in turn is used for a more detailed discussion concerning the main issues. However, a few very distinct patterns quickly became apparent across the entire spectrum of communities and districts that we 'spot checked' as follows:-

- (i) CLTS has been widely accepted by the GoSL and many Development Partners and is already included in relevant MoHS policy documents. Strong Political Will is evident and this has raised Hygiene & Sanitation high onto the national 'development agenda';
- (ii) CLTS triggering was found to have taken place in most of the villages that we assessed and there was clear evidence of considerable effort having been made by most households to construct deep pit latrines (often double for male and female) soon after the initial CLTS "triggering" had taken place;
- (iii) In every village we inspected there was anecdotal evidence many, often over 50% of pit latrines were out of use or the superstructure had collapsed. This is not unexpected considering the predominant technology choice of latrine in use (i.e. unlined deep pits using locally available building materials to construct floor slab, drop-hole and superstructure);
- (iv) There was little, if any, evidence that the collapsed household latrines were being replaced and as such there was either a heavy dependence on sharing with households or, as was clearly happening, some people were simply returning to open defecation nearby.
- (v) Few, if any, hand-washing facilities were evident in over one hundred households we saw over the ten days of random spot observation;
- (vi) Few if any fly-proof lids were evident on any of the latrines. The CLTS Handbook clearly states: "*A pit latrine with **no lid** is a form of **OD** or **Fixed-Point Open Defecation (FPOD)**. A pit-latrine with a fly-proof lid qualifies as **ODF***";
- (vii) Based on these empirical observations it would appear that the CLTS programme has succeeded in building latrines the quality is poor, and the approach has so far failed to block the faecal-oral disease transmission routes as obviously intended under the overarching goal of achieving Total Sanitation (See Fig.11 below);

SUSTAINABILITY of CLTS	
<b>STRENGTHS</b> <ol style="list-style-type: none"> <li>1. Strong Political Will in support of CLTS</li> <li>2. CLTS already in Health &amp; Sanitation Policy</li> <li>3. NGOs know how to implement CLTS</li> <li>4. There is a CLTS Handbook and strong methodology</li> <li>5. CLTS has been spreading over past 5 years</li> </ol>	<b>WEAKNESSES</b> <ol style="list-style-type: none"> <li>1. <b>Follow-up:</b> lack of reliable monitoring and/or policing mechanisms</li> <li>2. <b>Frustration:</b> DHMTs not fully engaged and feel undermined</li> <li>3. <b>Flies:</b> Faecal-oral disease transmission routes not being adequately blocked</li> <li>4. <b>Females:</b> Women tend to be screened out during CLTS 'triggering';</li> <li>5. <b>Function:</b> Inappropriate latrine designs in use that lead to fly breeding, collapse and engender a sense of <b>Fear</b> and a reluctance to re-build;</li> <li>6. <b>Focus:</b> CLTS is too narrow (i.e. mainly latrine construction) rather than wide and holistic WASH &amp; hygiene behaviour change</li> <li>7. <b>Unsustainable:</b> Minimal evidence of Communities moving <u>up</u> the Sanitation Ladder</li> <li>8. <b>Ethical &amp; cultural concerns</b> : insensitivity to norms of politeness of communities</li> <li>9. <b>Poor training:</b> not enough sessions</li> <li>10. <b>Male NLS</b> who tend to seek other work</li> </ol>
<b>OPPORTUNITIES</b> <ol style="list-style-type: none"> <li>1. Water, Health and Education sectors could collaborate at village level to achieve Best Practice in HS soft-ware and hardware;</li> <li>2. Engage Assistant Trainee Teachers to facilitate WASH in School catchment Communities</li> <li>3. Expand 'Wipikin' and <b>Mothers Club</b> movement to include more aspects of CHCs</li> <li>4. Expand use of existing WASH participatory training materials for School Health Clubs to be used by CHCs</li> <li>5. CLTS triggering could be adjusted to mobilise whole communities (especially the women ) to establish CHC in their villages;</li> <li>6. Use a <b>CHC Membership Card</b> to enable community to self-monitor with back-up from School Health Teacher;</li> <li>7. Use a <b>CHC Household Inventory</b> for village monitoring through Wash Coms and schools</li> <li>8. Redefine role of Natural Leaders and seek gender balance through CHCs in all villages.</li> </ol>	<b>THREATS</b> <ol style="list-style-type: none"> <li>1. Villages that 'fail' to sustain their ODF status may feel reluctant to re-engage in any new WASH approaches or campaigns.</li> <li>2. Capacity of DHMT has not been built.  No capacity in terms of vehicle or fuel for DHMT to monitor OD villages</li> <li>3. IPs tend to view Unicef as line management rather than DHMT</li> </ol>

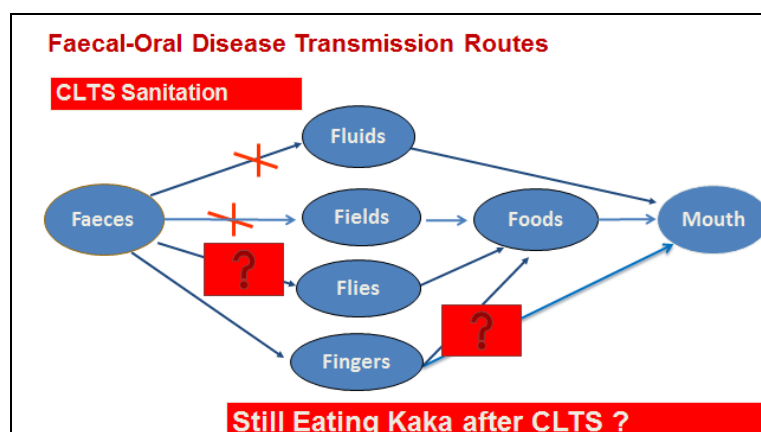
## 4.2. SUSTAINABILITY AND SELF SUPPLY

The main objective of a national Hygiene and Sanitation programme 'at-scale' is to improve the nation's Public Health. Ultimately such a programme should achieve a significant reduction in the national disease burden of which 87% are estimated to be preventable (WHO, 2009). A sustained improvement in Hygiene Behaviour should also achieve poverty reduction outcomes. This is especially important in a country like Sierra Leone where under 5 mortality rate is 269/1,000 live births, one of the highest in the world, and where child stunting through poor nutrition is 47% (WHO, 2009). Sierra Leone is a country well-endowed with water resources, high rainfall, fertile soils and huge agricultural potential but it is the 8<sup>th</sup> lowest country in the world on the on the UN Human Development Index at 0.336. With an estimated 35% (46,000 deaths per year) preventable by improved water, sanitation and hygiene there is an opportunity to substantially reduce this death toll, through an expanded public health policy that includes all diseases and works through a well formatted community structure in every village. However the 64% illiteracy compounds the difficulties being faced by the WASH sector and MoHS to spread key health promotion messages. The F-diagram (Fig.11 below) highlights the concerns that vital disease transmission routes are not being blocked



and as such **Total Sanitation is simply NOT being** achieved. In turn this means that overall health impact from CLTS will be marginal at best.

**Fig 11: Gaps in Blocking the Faecal Oral Transmission Routes with CLTS**



The RRA has confirmed a number of suspected weaknesses within the on-going CLTS programme highlighted by UNICEF (2011) and various IPs as key informants. Of particular concern is the apparent failure to achieve the implied objective under CLTS, that of **Sustained Total Sanitation**.

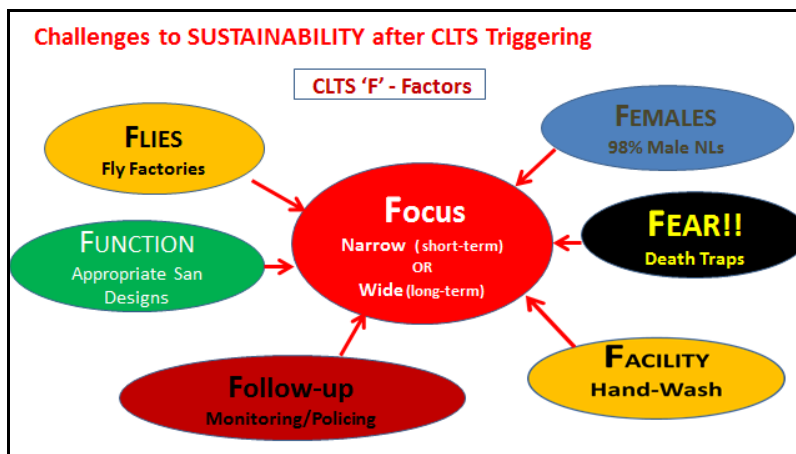
The following 'F- Factors' (refer Fig 12, page 32) have been identified that are here considered to be impeding the overall impact and sustainability of the CLTS programme as it is currently being implemented in Sierra Leone. By highlighting these limitations with constructive suggestions, it is hoped that the debate will be opened up to discuss how other methods can be used effectively to improve, strengthen and add value to the CLTS programme.

During the past 5 years CLTS has raised the profile of sanitation and gained much political will. This has been demonstrated practically by the Honourable President who has increased the Sanitation budget to 1% of GDP. MoHS is championing preventative health and sanitation through an expanded CLTS programme and the District Health Management teams in every district stand ready to take on more responsibility and coordinate the programme more effectively.

SELF-SUPPLY of CLTS	
<b>STRENGTHS</b> <ol style="list-style-type: none"> <li>1. Triggering is successful in mobilising communities to construct temporary latrines</li> <li>2. Rapid uptake of sanitation (3-10 months)</li> <li>3. Latrines are inexpensive, both for donor and household</li> <li>4. Minimal resources &amp; time required of IP</li> </ol>	<b>WEAKNESSES</b> <ol style="list-style-type: none"> <li>1. Latrines tend to be unhygienic and temporary</li> <li>2. Latrines built with local materials are not durable</li> <li>3. Virtually none of the latrines are fitted with fly-proof covers and do not block the faecal-oral transmission route by flies</li> <li>4. Latrines are rarely rebuilt if they collapse</li> <li>5. Inappropriate and very limited sanitation technology options being promoted</li> <li>6. Older people find it difficult to squat and prefer OD in bush where they can stand up to defecate!</li> <li>7. Children are afraid of latrines because they are dark and may have spiders and snakes</li> <li>8. Abandoned pits are 'death traps' for children and animals</li> </ol>
<b>OPPORTUNITIES</b> <ol style="list-style-type: none"> <li>1. Could use Sanitation Marketing to improve local designs and make inputs more readily available</li> <li>2. Ensure demonstration of far more appropriate latrine technology choices are disseminated eg double composting with shallow pits.</li> </ol>	<b>THREATS</b> <ol style="list-style-type: none"> <li>1. Communities have been disillusioned by unfulfilled IP promises</li> <li>2. Communities may not want another try at sanitation activities</li> <li>3. ODF notice boards have created perception of completed job- no need of more further effort!</li> </ol>

#### 4.2.2. CLTS 'F- Factors'

**Fig 12: Challenges to Sustainability after CLTS Triggering**



*'This programme is not a healthy baby!' (DMO)*

##### i) Flies:

- Weaknesses:** Communities are successfully 'triggered' or 'ignited' (to use usual CLTS language) when they realise that their uncovered faeces allows flies to transfer fresh faeces to food that they are eating or drinking. In other words it is the **fear of what flies do to our food** that triggers such an immediate response by the community to go off and dig pit latrines. Latrines work well for a year or so until the pit begins to fill up, the sludge liquefies and the latrine turns into a cess pit (this usually takes 2-3 years). Although there are attempts to cover the pits, this is seldom effective using local materials and every one of the latrines that were randomly checked (as part of the RRA) were found to be allowing the passage of flies. So in effect the latrines become an ideal breeding site for flies; they in effect turn into '**fly factories**'! The very same fear of flies that triggered communities to act in the first place now actually gets worse! The rational response of the family is to abandon the pit latrine and go back to OD in the bush. Here at least the sun will quickly dry the fresh faeces and meanwhile the flies and stench are kept a lot further from where the families are actually living and eating.
- Opportunities:** More emphasis should be placed on the vital importance of at least getting onto the very first rung of the Sanitation Ladder. Most rural communities spend all day farming away from their homes (and latrines) and should understand the benefit of burying faeces or 'cat sanitation'. Cat sanitation when combined with hand-washing does in fact block ALL the faecal-oral disease transmission routes as per the F-diagram. Anything extra, may just add aspects of comfort, convenience and status, but little more in terms of health impact.

In many villages there are capable carpenters and they should make carefully fitting covers for the latrines in order to effectively seal off the flies and stench. (Note needs to be taken of the fact that frequently the handles on covers can become a point of contamination).

Adopt shallow compost latrines that minimise fly breeding and are easy and cheap to construct and turn faeces into safe and useful fertiliser. In Asia (where CLTS originated) water is almost universally used for anal cleansing and the pour-flush latrine is the preferred norm as it blocks both flies and smells and as such, is far more likely to be sustained and upgraded. This technology choice (i.e. **pour-flush latrine**) should be promoted in Sierra Leone where key informants from MoHS suggest that over 30% of people already use water for anal cleansing.

##### ii) Females:

- Weaknesses:** During the 'triggering' the CLTS Facilitator asks the community what they are going to do about the problem the community has now identified - that they are all, in effect,

“eating each other’s kaka”? Usually it is the young men who stand up and declare that they are going to dig latrines... after all, this is man’s work! These young men are now singled out with little mandate from the community to be so-called ‘Natural Leaders’. Not only is this approach undemocratic and echoes the past top-down/ social planning programmes, it has the very obvious effect of **screening out women**, the very people who should be most engaged and even in control of any hygiene programme that impacts on the health of the family and the community! The observation that women are systematically de-selected from being the Natural Leaders right from the moment of CLTS ‘triggering’ is confirmed by the fact that 98% of the NLs are indeed men (UNICEF, 2011). Meanwhile, as noted by many key informants, the men, by their very nature, cannot afford to volunteer indefinitely and very often leave their villages to seek work on the mines or go into the towns, thereby abandoning their ‘leadership’ role in spearheading latrine construction for ODF.

- **Opportunities:** How different would the programme be if was led by a chair-woman of a Community Health Club, supported by a group of active and informed women who are permanently in the village and ensure hygiene standards are maintained? Gender inequity is at the heart of the current weakness in the programme to-date, and something that CLTS doesn’t attempt to address.

### iii) Function:

- **Weaknesses:** By ‘Function’ is meant the design of the latrine. If the use of local unsubsidised materials (poles, grass and mud) is all that is available for the rural householder to construct a toilet then latrines can only be temporary. However there are designs for temporary latrines that are appropriate within this context compared to the deep unlined pit latrine and these should be promoted by training village builders and by hands-on demonstrations. However the CLTS Handbook explicitly decries any form of outside guidance in the choice of latrine. So, unlike traditional community capacity building, there is no attempt to enlighten communities as to the wide range of very appropriate and low-cost sanitation technologies that do indeed exist.
- **Opportunities:** More systematic dissemination of information is needed for a population that has little comprehension of the various appropriate latrine designs that already exist. Communities should avoid digging deep pits that will inevitably collapse unless properly lined and fitted with concrete / waterproof slabs. The programme should consider piloting a range of shallow alternating compost-making latrines; pour-flush latrines and pit latrines that are fly-traps. To start with, develop a **WASH Technical Manual** that would greatly assist local householders and communities to construct affordable water and sanitation facilities as well as other household improvements (e.g. tippy-taps, upgraded family wells, bath shelters, fuel efficient stoves, compost latrines, pour-flush latrines etc.)

### iv) Fear:

- **Weaknesses:** When a very deep pit is covered with wood that will rot or be eaten by termites after a couple of years and give way, then it follows that fear will be associated with using the pit after a while - especially after similar pits have been observed to cave in. When the latrine floor does eventually collapse, as it surely must, then the disused latrines will continue to present a risk in that the deep pits are unlikely to be filled in. They will remain dangerous for small children and animals (and drunken adults) to fall into. One DMO correctly called them ‘Death Traps’.
- **Opportunities:** Slabs have to be more durable, either made with cement or from moulded poly plastic, but this needs to be linked to a supply chain, as is being designed by GOAL in Kenema. However this may not provide a solution unless capital is available for the community to buy these slabs. VL & S schemes need to be rolled out or more income generating projects within a CHC context need to be encouraged so that people prioritise sanitation needs with their disposable income. Alternatively adopt latrine designs that do not

require deep and dangerous pits in the first place such as the shallow alternating compost latrines.

#### v) Facility:

- **Weaknesses:** This refers to Hand-Washing Facility (HWF). There were few, if any, HWFs observed in or outside any of the >100 latrines we photographed, although owners said they used a kettle of water kept inside the house. This reported practice was not convincing based on standards of hygiene generally in the homes, and lack of concern for personal hygiene. Thus it can be assumed that hand-washing, with soap, which is estimated to block 47% of diarrhoea transmission (Cave & Cairncross) has been omitted. Therefore by the CLTS definition, Total Sanitation (see Glossary) is simply NOT being achieved.
- **Opportunities:** The literature shows that CHCs develop a 'Culture of Cleanliness' that is able to raise the level of hand-washing with soap, through positive peer pressure of all the families in a village (Whaley and Webster, 2011).

#### vi) Follow-Up:

- **Weaknesses:** Challenges to adequately 'monitor' whether 'ODF Communities' were retrogressing was highlighted by every DHMT and key informants interviewed in the field. The reason given repeatedly as to why communities were reverting to OD, was because there was lack of 'monitoring' which seems to be a polite word for 'policing' of communities. Many favoured the instigation of the 'Ordinance' which would reinstate the old role of sanitary inspectors. This all indicates that the CLTS programme is becoming 'Top Down'. It cannot be called 'Community Led' if the community is having to be 'policed' by authorities to ensure ODF is guaranteed and being sustained.
- **Opportunities :** Community monitoring is needed and can be arranged as has been done repeatedly in the standard Community Health Club Model: a CHC Membership Card (see Fig. 13) itemises the health promotion sessions as well as listing key recommendations (i.e. homework), which are checked quarterly by the Chairperson. This is a community-based household inventory, through which they can monitor their own achievements and report through the schools or Health Centres. The use of cell phone monitoring should also be explored as a country-wide self-reporting system can be achieved with a central data-base, on a website.

#### vii) Focus:

- **Weaknesses:** The CLTS methodology has a **narrow focus** to achieve speedy latrine construction and the attainment of ODF status; a 'sticking plaster' approach that does not tackle the determinants & causes of poor sanitation and hygiene practices.
- **Opportunity:** Take this opportunity to evolve CLTS to **broaden the focus** by using lessons learnt from the CHC Model which develops a steady rate of development that is primarily concerned about achieving much more than just the construction of latrines. A "Culture of Health" is established over a six-month period of weekly meetings and addresses the whole WASH process as it affects the 'as lived' reality of families who want to protect their children from as many preventable diseases as they can, not just sanitation. As such, CHCs also reinforce and sustain any new water facility that is installed by providing the necessary community-based management and maintenance for the water facility as part of the CHC Executive's responsibilities.

No.	TOPIC	DATE	SIGNATURE	PRACTICAL HOME WORK	DATE	SIGNATURE
1	Mapping of Village			Cotton Banner of Village Map		
2	Disease Identification			Disease Monitoring in Club		
3	Balanced Diet			Health Songs		
4	Weaning Foods			Weaning Recipes		
5	Baby care : weaning			Baby Feeding Spoon		
6	Child care : feeding			Own Cups for Family Members		
7	Child immunisation			Children Immunised		
8	Mother care: Nutrition			Balanced Meal Recipes		
9	Nutrition Plans			Nutrition Garden		
10	Diarrhoea			Fruit Trees		
11	Salt Sugar Solution			Salt Sugar Solution		
12	Home Hygiene			Clean Yard : Garbage Pits / Fence		
13	Water Sources			Protected Water Source		
14	Drinking Water			Ladle/Jug for Taking Water		
15	Water Storage			Covered Drinking Water		
16	Storage of Pots/plates			Basket/Shelves for Pots/plates		
17	Hand Washing			Hand Washing Facility		
18	Skin and Eye Diseases			Soap Making		
19	Worms			Stand for Hoe : Cat Sanitation		
20	Sanitation Ladder			Dig Pits for New Latrine		
21	Sanitation Story : Plans			Make House for Latrine		
22	Malaria			Make Blocks & Slab for Latrine		
23	Respiratory Diseases			Clean Bedrooms and Bedding		
24	Tuberculosis			Own Plates for Family Members		
25	AIDs and STDs			Health Dramas		

**Fig. 13: The Community Health Club Membership Card developed for Sierra Leone in 2001**

**NB:** *Integrating CLTS into CHC Training: In Session 1: a mapping exercise is done and in Session 20 the usual Transect Walk and 'water demonstration' is done. By this time there will be full understanding of the benefits of safe water supply, improved sanitation and good hygiene practices and no shaming is required to reinforce the seriousness of open defecation.*

## 4.3 INTEGRATION

There are four aspects of integration;

1. Integration of Implementation and Mobilisation Strategies:
2. Holistic Community Development
3. Integrated Preventative Health (i.e. holistic disease prevention)
4. Inter-Ministerial / Inter-Sectoral, Cross-cutting Integration

### 4.3.1. Integration of different Implementation Approaches / Strategies

It was clearly shown during the presentations by the 6 select NGOs and the reports from all 13 of them that there is in fact little in the way of 'classic' CLTS being practised in Sierra Leone right now. This tendency to broaden the programme is in fact a response to the needs of the community which do not see their lives as being divided into separate compartments. Increasingly IPs are seeking alternative strategies and low-cost approaches (like the CHC methodology) that can achieve more sustainable sanitation outcomes that also address a whole raft of hygiene practices that are so critical to improving health and preventing not only diarrhoea but as many other preventable diseases as possible.

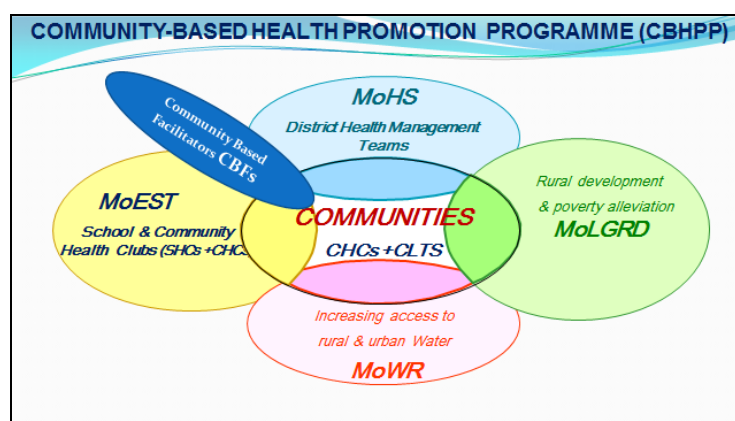
CLTS focuses on improved sanitation but this is but one small part of a much wider picture. There is need and opportunity in Sierra Leone right now to integrate a combination of approaches, using each for its strengths, whilst using others to fill the gaps. The objective is to provide a holistic and integrated programme which will succeed, not only in achieving sanitation but also sustaining it. Sanitation on its own is not enough;

it needs to be embedded in a wider more holistic and fully integrated programme as the diagram below attempts to depict.

For example, the need to Integrate Sanitation Marketing (SM) into CLTS could provide a solution to the challenges now being faced with in-appropriate sanitation technology (hardware) options currently being implemented (e.g. deep unlined pit latrines that collapse after a few years). SM aims to develop a chain of builders as well as the necessary supplies to enable a natural uptake of latrines without the need for subsidy.

<b>INTEGRATION of CLTS</b>	
<b>STRENGTHS</b> <ol style="list-style-type: none"> <li>1. UNICEF is providing full support to the CLTS programme</li> <li>2. CLTS has been included in GoSL policy</li> </ol>	<b>WEAKNESSES</b> <ol style="list-style-type: none"> <li>1. CLTS mainly focuses on attainment of ODF status</li> <li>2. There is limited success achieving 'total sanitation'</li> <li>3. CLTS focuses on diarrhoea</li> <li>4. ODF validation is seen as an end in itself by the community</li> <li>5. DHMTs complained that UNICEF and IPs are ignoring their own responsibility for CLTS</li> <li>6. Limited integration with the water component of WASH programs</li> <li>7. Negligible buy-in from medical practitioners</li> </ol>
<b>OPPORTUNITIES</b> <ol style="list-style-type: none"> <li>1. Integrate the WASH &amp; Education sectors through leadership and administration capacity found within local schools and PHUs</li> <li>2. Integrate CLTS with CHC approach to achieve more holistic and women-led outcomes</li> <li>3. Integrate with SSHE to strengthen School Health Clubs and CHCs</li> <li>4. Use training manual developed by CARE for Nutrition, and Mother &amp; Child Health Care programmes; also incorporating reproductive health modules</li> <li>5. Use training materials for schools recently developed by MoHS / MoEST / UNICEF for CHCs.</li> <li>6. Integrate Lassa Fever into HS approaches</li> </ol>	<b>THREATS</b> <ol style="list-style-type: none"> <li>1. DHMTs appear resistant to CLTS after becoming disappointed by outcomes: may not want to integrate approach into other health programs</li> <li>2. Defensiveness by proponents of CLTS to admit challenges arising after 5 years of implementation</li> </ol>

**Fig 14. The integration of different Ministries through an Integrated Health Promotion Programme**





### 4.3.2. Holistic Community Development

In Sierra Leone with 70% living below the national poverty line, and 57% earning less than US\$1 per day, rural householders are more often than not very impoverished. The Zimbabwean Study (Whaley & Webster, 2010) clearly indicated that latrine construction is heavily correlated with disposable income. Therefore, unless there is a means of earning more income or borrowing from Village Savings and Loan (VSL) schemes (as is currently being introduced by a number of IPs), then poor quality latrines made with perishable materials will continue to be built. This also points to the need for income generating activities and the necessary skills training.

As the level of literacy is so low, it makes sense to adopt a Health Promotion programme that takes the time and provides sufficient face-to-face interaction in order to generate understanding of a whole raft of preventive health topics (See Fig. 12, CHC Membership Card). Such promotion of health education can be conducted so that the whole community can become fully conversant, through participatory activities with visual aids, with the causes, transmission and prevention of all communicable diseases, and not just diarrhoea. This sort of capacity building will also increase trust, reciprocity and build Social Capital within a village and enable further development initiatives to succeed. The integration of Village Savings and Loans (VSL) schemes can also be factored into this more holistic approach to enable communities to manage their own health.

### 4.3.3 Holistic Disease Prevention

According to UNICEF (2011), diarrhoea is responsible for 17% of the child deaths worldwide and yet it is the principle disease that is being targeted by the WASH Sector. More and more practitioners in the WASH Sector are realizing that their approach to disease control has to be more holistic if it is truly to meet the needs of rural mothers, who want to know all the diseases that they can effectively prevent through their own efforts and good practices if their children are to survive and prosper. As the 'F' diagram (Fig. 11) clearly indicates, all transmission routes must be blocked, if diarrhoea is to be minimized. But there remains the rest of the burden of disease: 19% dying from ARIs, 4% dying of measles because their mothers do not know what should be done to prevent it by vaccine, 8% dying of malaria because mothers do not understand the urgency of treatment, and 37% dying from poor birthing practice.

Nutrition and child care are all factors that can be improved with learning and even totally illiterate mothers have shown a strong desire to become more informed. This love of knowledge was demonstrated in recent research on women's preferences and reasons for joining a CHC, as the most common response was to 'learn'. High risk weaning methods and a poor diet have resulted in widespread malnutrition and stunting of children and it is only by training mothers in a coordinated and holistic way that Sierra Leone will succeed to overcome such challenges. As Julius Nyerere, the first president of Tanzania famously said, *'Educate women and you educate the Nation'*. He also said *'In Africa we sit under a tree until we agree!'* Women who have not been to school need time to learn and understand the basics of good health, the germ theory and the most important hygiene practices that can protect their family and ensure child survival, and this takes time, and repetition. There are some that propose that knowledge is not important in health promotion, and advocate only a few basic messages for the illiterate (Loevinsohn, 1999). Our experience has shown that knowledge is a very necessary (although not sufficient) component of hygiene behaviour modification (Waterkeyn & Waterkeyn, 2013). Mothers need knowledge to enable them to make informed decision but they also need positive peer pressure from their community to give them the necessary strength and self-efficacy to change their ways. The Community Health Club builds this consensus and peer pressure while also providing group support for individuals. A woman on her own is often powerless, but a group of women can transform a village.

## 4.4. INSTITUTIONALISATION OF CLTS

Whilst Agencies such as Unicef and the non governmental sector can assist government, there is a tendency to take over and side line the efforts of the Ministry of Health in order to get the job done quickly. However this will in the long term slow development of the whole country as the outreach of these organisations is never large enough to reach the whole country. The Government is the responsible body and the surest way to scale up so that the maximum numbers are benefiting is to build the capacity and resources of the Ministry of Health, particularly the Environmental Health Department who have the ultimate responsibility for the welfare of their citizens. What is often lacking is a feasible Plan of Action.

INSTITUTIONALISATION OF CLTS	
<b>STRENGTHS</b> <ol style="list-style-type: none"> <li>1. CLTS can be scaled up with minimal inputs</li> <li>2. With no subsidy, costs of the programme are low</li> <li>3. No visual aids and minimal training is needed for facilitators</li> <li>4. Local materials are used which are readily available</li> <li>5. It is quick needing only 2-4 visits to reach community</li> <li>6. CLTS empowers local leadership (headmen)</li> <li>7. CLTS identifies local Natural Leaders</li> </ol>	<b>WEAKNESSES</b> <ol style="list-style-type: none"> <li>1. Monitoring is essential to keep villages ODF</li> <li>2. CLTS programme could be better integrated into DHMT</li> <li>3. ODF status is a questionable measure as it is inexact</li> <li>4. None of the ODF villages actually are ODF according to classic definition</li> <li>5. To remain ODF, villages have be monitored (i.e. policed)</li> <li>6. Weak self-monitoring aspect in the design of CLTS</li> <li>7. The need for 'top-down' monitoring implies no real community ownership.</li> </ol>
<b>OPPORTUNITIES</b> <ol style="list-style-type: none"> <li>1. MoHS capacity can be strengthened in monitoring ability through direct support to DHMT</li> <li>2. An integrated Road Map should be developed to enable proper planning between sectors for public health</li> <li>3. DHMT could have a definite coordinating role in national programme</li> <li>4. IPs could be properly regulated and coordinated by the mandated authority</li> <li>5. Donors could be given a clear direction from Government who should take back the lead</li> <li>6. Activities can be done with existing resources</li> <li>7. Government and MoHS / MoEST will benefit for improved efficiency and reporting</li> <li>8. Schools will benefit from improved linkages with parents</li> </ol>	<b>THREATS</b> <ol style="list-style-type: none"> <li>1. DHMTs are generally lacking capacity and resources (transport for monitoring ) and UNICEF has filled the vacuum.</li> <li>2. DHMT appears disempowered by lack of resources</li> <li>3. Some IPs in the CLTS programme appear to be undermining the role of DHMT and Council</li> <li>4. DHMT's role is being undermined by some IPs independent and uncoordinated activities</li> <li>5. Some Districts have resisted participation on CLTS</li> <li>6. CLTS is sometimes perceived to be an imported or foreign approach</li> </ol>

#### 4.4.1. A Roadmap for a Community-Based Environmental Health Programme

A Roadmap should be developed by MoHS that clearly sets out a practical 'Way Forward' to achieve a more integrated and holistic approach that is also practical and low-cost and can be rapidly taken to scale nationally. The diagrams below are intended to assist in highlighting the key elements of such a Roadmap that would seek to add value to CLTS implementation. The Roadmap is based on a similar approach that has successfully been developed in Rwanda and Zimbabwe and may well be appropriate for Sierra Leone to consider.

In terms of Value for Money (VfM), the more a national programme can facilitate change in multiple aspects, the more cost-effective the programme. It goes without saying that a project that narrowly targets only hand-washing and sanitation but neglects other aspects like drinking-water supply maintenance or kitchen and home hygiene and personal cleanliness is unlikely to be as cost-effective as one which can tick all the boxes for the same cost. The simple maths is appealing to Ministry of Finance who always want the best 'bang for their buck' for national development. If a programme to prevent diarrhoea can, for the same amount, also help to prevent skin disease, eye disease, bilharzia, malaria, worms, ARIs and HIV/AIDs and others then why not go for the much more holistic option and thereby reduce the massive costs associated with cure and treatment?

A programme that is cross-cutting and spans across several Line Ministries will not only have more capacity but will also be more cost-effective, if it can be properly organised. The diagram above (Fig. 14 above) captures the interface between different Ministries to show how Community Health Clubs, when combined with the CLTS programme, can provide the institutional structure at grass root level for a number of Ministries. As in other countries, the capacity of the Environmental Health Department within the Ministry of Health and Sanitation should be strengthened so as to support a chain of Community Based Facilitators, preferably one in each village, who can fill in for Village Health Workers if there are none in existence in the area, and provide a linkage between the community and the Primary Health Unit, or other government structures. They should be properly trained in basic hygiene and sanitation issues and related diseases. They should be equipped with visual aids 'tool kit' especially developed for Sierra Leone and an instruction manual so that they can conduct a session every week within a Community Health Club structure. This CHC can be attached to the school, as women will likely be the parents of the school children. A School Health Club can be started at each school, linked to the CHC so that cross learning between generations is possible, given that the children are often more literate than their parents.

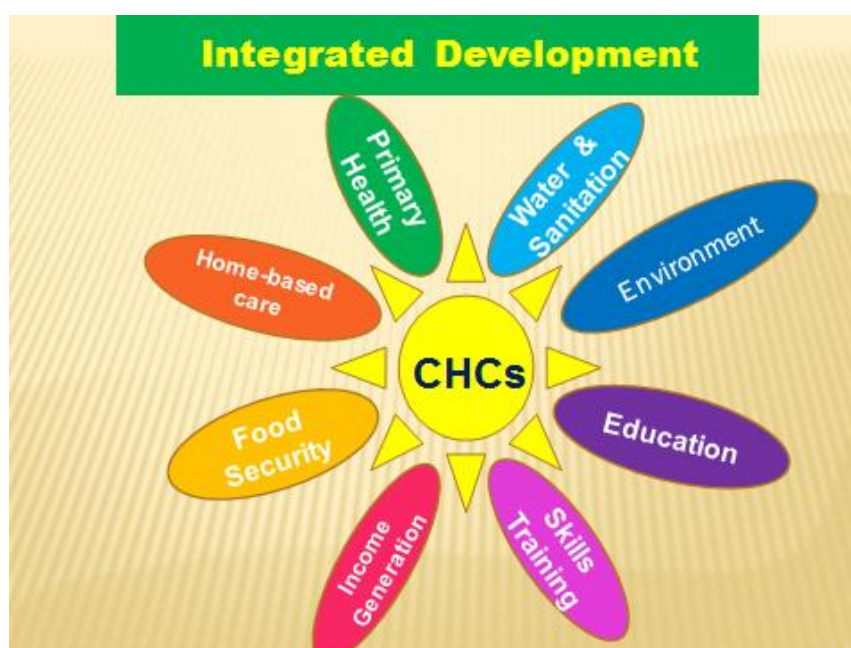
The school should be used for the parents 'health education' so that they can meet on Saturdays or whenever possible while the children are not at school, and complete the 24 sessions of primary health instruction (as per the CHC Membership Card), using participatory activities with visual aids. If there are assistant school teachers they should be encouraged to support this training and in return get credits towards their own qualification as teachers. In this way MoWR, MoEST and MoHS can all complement each other's activities. With a fairly good structure already in place to monitor teachers, the reports can go through the MoEST reporting channels and be shared with MoHS / DHMTs.

Similarly if there are water supply projects the MoWR will link into the CHCs through their representation at District level through the DHMT. Other Income Generating activities in the agricultural sector will link to MoLGRD and MoA, and the central planning can take place each month in the DHMT. Therefore this group has to be properly resourced and supported with adequate policies put in place to ensure full accountability and enable a cost-effective use of resources in each District.

Broadening CLTS by incorporating a more holistic and integrated model like the CHC Model all WASH topics can be integrated into one balanced health promotion strategy in support of all WASH objectives and outcomes. The CHC is merely a village structure mandated to monitor and influence all health and hygiene issues in the community. This also includes crucial issues around **sustaining a safe drinking water supply through Community-Based Management (CBM) of the water facilities**. Once basic hygiene training has been done, a second phase maybe the training of water committees within the context of a CHC, so that many people understand how to maintain their water facility.

If it is sufficiently incorporated within the MoHS system, CHCs can supply the vital outreach needed for Primary Health Units to reach mothers, for monitoring growth of babies, for ensuring the prevention of cholera, for controlling the local environment so that there is no open defecation and for managing water and sanitation projects and income generating and saving schemes. Such integration of the CHC approach would strengthen the existing CLTS programme and help to ensure that the benefits of sanitation are translated into a wider context of general safe hygiene both at a personal level and in the home as indicated in the diagram below:

*Fig 15: Using Community Health Clubs to integrate development*



## 5. CONCLUSION

CLTS has provided a 'kick start' to the improvement of sanitation coverage levels in Sierra Leone, but it needs to be reinforced in order to sustain the many benefits of ODF. It is clear from this survey that MoHS, UNICEF, and IPs have already started to diversify activities within the CLTS programme and most need no encouragement to 'evolve CLTS' to become more holistic and integrated with other methodologies, as they have already identified some of the weaknesses of a programme that is to many development practitioners too narrowly focused on latrine construction.

Whilst there are many constraints to scaling up, the political will in Sierra Leone is supportive of 'Best Practice' and with sufficient leadership within the WASH sector, there are many ways in which the sector can continue to 'evolve' and 'add value' to the CLTS programme. The willingness of communities to construct thousands of latrines, indicates they are primed to continue up the sanitation ladder, provided there is sufficient support from the mandated authorities in a way which is respectful of local culture. To sustain CLTS and increase hygiene gains, the MoHS must get back into the 'driving seat' and position itself to drive the process of scaling up.

If MoHS is willing to develop a Roadmap to adopt some of the many suggestions within this study where appropriate it should be possible to achieve much broader and more ambitious outcomes. By integrating the CHC methodology and training package into a WiPikin programme linking community and schools, hygiene is likely to be substantially improved in the rural areas of Sierra Leone.

As this study shows, the CHC Model would be an appropriate strategy for health promotion in Sierra Leone, and by combining the CHC Model with CLTS, the capacity of community-based facilitators to better organise communities to manage their own health will be increased. **Empowerment of women** and the building of consensus, trust and reciprocity should be factored into any evolution of the CLTS approach, as well as the added value of reducing not only diarrhoea but also malnutrition, malaria, bilharzia worms and skin disease, all of which can be prevented through more thorough hygiene training. A CHC-CLTS combination will provide Sierra Leone with the possibility of not only meeting their MDG targets for sanitation but more importantly reducing one of the highest infant mortality rates in Africa.

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