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CHAPTER 15

Putting the hardest to reach at the heart of the Sustainable Development Goals

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Abstract

Universal access to improved sanitation by 2030 with an emphasis on the rights of all excluded groups is one of the Sustainable Development Goals (SDGs). This chapter argues that Community-Led Total Sanitation (CLTS) can support the achievement of this goal. However open defecation free (ODF) status can be put at risk by just one person. It will be unachievable and unsustainable unless people who are marginalized and vulnerable are actively and meaningfully included, consulted, and considered in all aspects of CLTS programming. Without this, there is a risk of inappropriate design or location of facilities, overlooking the needs of people who are marginalized, which can limit or deny their access to sanitation. This chapter outlines the dimensions of equality and non-discrimination and barriers to access, and suggests practical entry points for inclusive and sustainable CLTS programming.

Keywords: Equity, Inclusion, Exclusion, Non-discrimination, Gender, Disability, Rights, Sustainable Development Goals (SDGs)

Introduction

The Sustainable Development Goals (SDGs) provide an opportunity to go beyond the ambitions of the Millennium Development Goals (MDGs) and ensure universal access to improved sanitation. Over the lifetime of the MDGs, 2.1 billion people gained access to improved sanitation between 1990 and 2015. However, 2.4 billion people still use unimproved sanitation facilities, of which 1 billion practise open defecation (OD). Nine out of 10 people defecating in the open live in rural areas (WHO/UNICEF, 2015). There are stark disparities across regions, between urban and rural areas, and between the rich and the poor or people who are marginalized. Progress among the poorest wealth quintiles has been the slowest. The 2015 Joint Monitoring Programme report predicts, 'At current rates of reduction, open defecation will not be eliminated among the poorest in rural areas by 2030' (WHO/UNICEF, 2015: 24). Recent data from Uganda and Zambia indicates that a person who is older, disabled, or chronically ill is more likely to defecate in the open (Wilbur and Danquah, 2015).[1]

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The post-2015 agenda aims to eradicate poverty in all its forms by 2030. The commitment to 'leave no one behind', together with the idea that 'no goal should be met unless it is met for everyone' is already well established in the rhetoric around the SDGs. This directly links to issues around equality and non-discrimination. Community-Led Total Sanitation (CLTS) can help ensure that the human rights to water[2] and sanitation expressed in the SDGs are realized, and this will require an inclusive approach for total sanitation. The *CLTS Handbook* promotes community self-help and cooperation, and social solidarity between the rich and poor to ensure consideration of the needs of marginalized people (Kar with Chambers, 2008). However, this cannot be relied upon in all communities; some form of external assistance for poor and marginalized people may be needed (see Robinson and Gnilo, 2016a and b, this book). The right to sanitation places an obligation on states to ensure access to sanitation is progressively available to all, without discrimination (González, 2013).

Open defecation free (ODF) status for all is the first step towards realizing the right to sanitation. However, ODF status will be unachievable and unsustainable unless the poorest and marginalized groups are included, consulted, and considered in aspects of CLTS programming. Lack of consultation and active, free, and meaningful participation can lead to inappropriate design or location of facilities, overlooking the needs of marginalized people, and limiting or denying their access to sanitation (Wilbur et al., 2013). Arguably, if these barriers are not addressed, the CLTS process may cause discrimination of people who already experience marginalization. Addressing these barriers is crucial throughout the processes of CLTS: while OD continues, all are affected. This may include regulating service delivery and potentially targeting support to people who are marginalized.

Discrimination on the grounds of race, colour, caste, sex, language, or religion is prohibited under the right to sanitation (de Alburqerque, 2014). It also recognizes that particular attention may need to be given to people who are often marginalized or excluded including older persons, people with disabilities, people with serious or chronic illnesses, children, and women (de Alburqerque, 2014). These are complex challenges which need to be tackled if the ambitious targets of the SDGs are to be met and sustained in the future. This chapter will highlight the dimensions of equality and non-discrimination at play in sanitation and will give examples of how CLTS has contributed, and can contribute, to universal access to sanitation.

SDGs and equality and non-discrimination ambitions for sanitation

SDG 6: *Ensure availability and sustainable management of water and sanitation for all* demands adequate and equitable access to sanitation and hygiene for all, and an end to OD. The target refers to water, sanitation, and hygiene (WASH) for all women and girls in vulnerable situations and to improving their participation. It also contributes towards other SDGs. For instance,

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investing in school WASH services with Menstrual Hygiene Management (MHM) contributes to SDG 4: *Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all*, as well as SDG 5: *Achieve gender equality and empower all women and girls*. Having access to safe WASH services is also directly linked to reducing chronic malnutrition or stunting under SDG 2: *Ending hunger and improved nutrition*; *Ending poverty in all its forms everywhere* (SDG 1); and *Reducing inequalities within and among countries* (SDG 10).

With inadequate access to clean water, safe sanitation, and handwashing facilities with soap, people's living standards are impacted in various different but mutually reinforcing parts of their lives: education; health; nutrition; reproductive health; privacy and dignity; economic opportunities; safety and security; as well as personal development (Alkire et al., 2013). Measuring mechanisms like the Multidimensional Poverty Index can support the monitoring of progress made. It complements traditional income-based poverty measures by capturing the severe deprivations that each person faces at the same time with respect to education, health, and living standards (OPHI, 2015). In order for the SDGs to really 'leave no one behind' and to create a sustainable impact for people from marginalized groups (WHO/UNICEF, 2015; see also Thomas, 2016, this book), issues related to inequality and discrimination need to be taken into account at all levels of interventions.

What is equality and non-discrimination?

Equality refers to the legally binding obligation to ensure that all can enjoy their rights equally. Human rights law requires equal access to water and sanitation services, but it does not assume identical treatment in all cases. It does not mean that everyone should have the same type of service, such as flush toilets. Equality does not imply treating what is unequal equally. People who are not equal may require different treatment in order to achieve substantive equality. States may need to adopt affirmative measures, giving preference to certain groups and individuals in order to redress past discrimination (de Albuquerque, 2014).

Non-discrimination is the legal principle that prohibits any distinction, exclusion, or restriction that results in individuals or groups not being able to enjoy, or recognize their human rights on an equal basis with others based on 'prohibited grounds'. These include race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, disability, age, health status, or economic and social situation (de Albuquerque, 2014).

Poverty and social exclusion is multidimensional, made up of several factors that constitute poor people's experience of deprivation (Alkire et al., 2013). The situation is often made worse by discrimination, stigma, and existing inequalities that occur at all levels (WHO/UNICEF, 2012), including:

- *Physical and geographical inequalities* such as those experienced by communities in remote and inaccessible rural areas, and slum-dwellers in urban and peri-urban areas.

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- *Group-related inequalities* that vary across countries such as those based on ethnicity, race, nationality, language, religion, and caste. Often, CLTS practitioners target communities that face such inequalities.
- *Individual-related inequalities* that are relevant in every country of the globe, such as those based on sex/gender, age, disability, and health conditions, which impose constraints on access to water and sanitation. For instance:
    - Globally, an estimated 1 billion people have an impairment (WHO and World Bank, 2011).
    - More than 700 million people are aged 60 and over (UN, 2011). Within ten years there will be over a billion older people worldwide (UN, 2011; HAI Global Age Watch, 2013).
    - An estimated 35 million people are living with HIV (UNAIDS, 2014).

There are limited studies that have looked at the conditions of individual household members, who are not using a household toilet, and why.

The dimensions of equality and non-discrimination in practice

CLTS is a participatory and community-driven approach to rural sanitation that can powerfully contribute towards reaching universal access to rural sanitation. However, equality and non-discrimination are not guaranteed in the process of striving for and achieving ODF and sustainable sanitation. CLTS can actually reinforce inequalities for people with disabilities, older people, children, and women and girls if facilitators do not have explicit objectives for inclusion (Adeyeye, 2011; Wilbur and Jones, 2014). This has a direct impact on sustainability. It is also a violation of human rights.

Some critics have argued that the focus on community rights comes at a loss to individual rights (Bartram et al., 2012). However, rights do not exist in isolation; individual behaviour has a community-wide impact, and conflict can arise between individual and community rights. For example, when a person refuses to build a toilet and/or chooses to continue practising OD they have exercised their right to choose whether and where to invest their labour, but this has a direct impact on the health and related rights of other community members (see House and Cavill, 2015; Musembi and Musyoki, 2016).

During triggering, strong emotions such as disgust, shame, and shock are often experienced (along with positive emotions such as pride, self-respect, and dignity). The perceived use of shame has attracted criticism from a human rights perspective (Engel and Susilo, 2014; Galvin, 2015); however in CLTS stigmatization of individuals is not the intention. Rather it is to make the practice of OD shameful, and embed a new social norm (House and Cavill, 2015; Musembi and Musyoki, 2016). Shame may be experienced,

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but the primary motivator for behaviour change, which comes from the realization that, 'we are eating each other's shit', is usually disgust (Bongartz, 2012). The use of sanctions has also been controversial, with anecdotal evidence of encouraging people to throw rocks at those practising OD near water sources, threats of fines, and threats to withhold government subsidies (Bartram et al., 2012; O'Reilly and Louis, 2014). Sanctions must never take the form of rights abuses. Throwing rocks would be a criminal offence and CLTS should not be used as an excuse to break the law. Such human rights abuses obviously must be challenged and condemned wherever they are found. Sanctions against the poorest or most marginalized people who are unable to build toilets without support from either within or outside the community must not happen (Myers, 2015a; Musembi and Musyoki, 2016). People should be encouraged and supported, not harassed and bullied into changing their behaviour. However, the use of sanctions *per se* should not be dismissed. Where sanctions are needed, they should target households who can change (e.g. have the means, both in terms of money and time) but are refusing.

Care must be taken when implementing CLTS to understand and analyse the context and culture in which CLTS is being implemented, and integrate practical ways to reduce or avoid the risk of abuses taking place into programming. This section documents and explores some experiences, with reference to key elements used for effective intervention, and suggests entry points for inclusive and sustainable CLTS programming.

Gender

Women and girls are disproportionally affected by a lack of access to adequate WASH (WHO/UNICEF, 2010: 13). Gender-related power dynamics and discrimination determine women and girls' ability to access these basic services, as well as the multiple impacts of living without them. WASH is core to dignity and wellbeing. It is important that existing gender issues and power dynamics within communities are consistently considered and addressed before and during implementation of CLTS activities (Adeyeye, 2011). Without this, problems will quickly arise that can threaten the sustainability of ODF status and, ultimately, sustainable sanitation achievements:

> CLTS recognizes the importance of women in creating sustainable sanitation and hygiene systems, but CLTS projects are often designed without gender considerations. CLTS facilitators do not often ensure gender balance while facilitating triggering sessions, thus compromising the equal participation of men and women and limiting the emergence of both female and male natural leaders. Hence, the entire process is gender unaware. By not explicitly focusing on gender relations, CLTS processes are more likely to overburden women, rather than making them agents of change. (Plan International, 2012: 8)

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WASH development staff need to be trained in gender relations to ensure they have the knowledge and capacity to address these issues. Care must also be taken not to reinforce patriarchal norms within societies when implementing CLTS or other WASH programmes, for example through toilet promotion campaigns that appeal to patriarchal notions of women's seclusion to the household, modest behaviour, and practice of veiling (Coffey et al., 2014; Srivastav and Gupta, 2015; Gupta et al., 2016, this book).

Research in Sierra Leone noted that Natural Leaders are not often trained in gender issues and that gender inequality can be heightened when the majority of Natural Leaders who 'emerge' are men, often due to existing power dynamics (Africa Ahead, 2013). Recent research in Zambia has found implementation of CLTS more successful when Natural Leaders are inspired community members from all sections of the community, including those from marginalized or stigmatized groups, not just the chiefs and headmen:

> The three villages with positive outcomes had more community volunteers, active and empowered women and support to vulnerable social groups such as widows and the elderly. They had, as one leader stated, 'the spirit of togetherness'. Again, this was well shown in Chaata where motivations to improve health were not driven by the headman – an unassuming who had 'owned the village' (as he stated) for two decades but himself had no latrine! Rather, a group of young men and women associated with the local school across the road … were the main catalysts (Bardosh, 2015: 61).

Encouraging and supporting women from marginalized groups to become leaders can also raise awareness of their rights to water and sanitation as seen by WaterAid in Nepal.

> Though I am *Dalit* and uneducated, the community people selected me as a Water and Sanitation User Committee member. In the training I learnt about the rights of both men and women in terms of labour and decision-making. Now I can help people with these issues regardless of their education or economic status, which I couldn't do before (female Water and Sanitation User Committee member, Mahattori) (WaterAid, 2009).

Plan International's research on the impact of gender on CLTS processes in Uganda aimed to establish the participation and inclusion of men and women, boys and girls, and disadvantaged groups, in decision-making processes and assesses the degree of collective action towards ODF (Plan International, 2012). One of the research findings was that, while most children were said to be active, adolescent girls were reported to be most active, as they often encouraged – and sometimes forced – their parents to install toilets in households. Both parents and girls acknowledged the importance of toilet use in protecting the dignity and integrity of women. The study also revealed that gender issues were not consciously and consistently addressed during the introduction and implementation of CLTS activities. Where gender was addressed, it was not by design (Plan International, 2012).

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Integrating gender strategies into WASH programmes and monitoring their progress towards change can be a challenge. To assist this process, Plan International piloted a Gender WASH and Monitoring Tool in Vietnam to enable practitioners to explore and monitor gender relations in WASH projects. It was found that the effectiveness and sustainability of WASH programmes is enhanced when there is an explicit focus on gender equality (Plan International, 2014).

In Timor-Leste, WaterAid and partners have developed a facilitator's manual to guide gender dialogue sessions with communities as part of CLTS activities. Using the manual, gender focal point persons/staff carry out practical activities which explore gender aspects during each stage of CLTS. The idea for the manual grew out of the challenge that WASH actors faced in talking about power relations and engaging women in decision-making processes during CLTS. The manual has been piloted and tested in Timor-Leste, and the process of developing it has been an action learning approach. The gender manual is now an annex to the Timorese Government's national CLTS Guidelines (Government of Timor-Leste, forthcoming).

In Malawi, dialogue circles were used to identify problems and barriers experienced by disabled, older, and sick people with an outcome of action planning (Jones, 2015a). The circles worked best with small groups of around 20 people, targeted to encourage active participation of the most vulnerable people. It was found that dialogue circles were very effective in creating practice action plans agreed by the village and follow-up meetings.

Violence against women and girls

Open defecation can be especially degrading and dangerous for girls and women. The evidence that a lack of WASH can increase vulnerability to violence against women and girls is growing. For example, research carried out in an urban township in Cape Town revealed 635 sexual assaults of women travelling to and from toilets were reported between 2003 and 2012 (Gonsalves et al., 2015). The study stated that providing sanitation close to homes in South Africa's townships could reduce vulnerability to sexual violence by up to 30 per cent. Reaching the nearest toilet may require a circuitous route through the alleyways of the township. The nearest toilet may be in disrepair, and individuals may visit a toilet as part of a longer trip to other destinations. Locations such as alcohol serving establishments and the home are important loci of risk for women in urban settlements. Other research shows the psychological impact of lack of sanitation on women who openly defecate (Steinmann et al., 2015). Coping mechanisms used by women and girls include reducing the consumption of food and drink to limit the need to relieve themselves in daylight. These have obvious health implications (House et al., 2014).

There are a number of practical ways to reduce vulnerabilities to WASH-related violence (House and Cavill, 2015). For example, privacy, safety, and dignity can be increased through toilet design.[3] CLTS mapping combined

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with Safety Mapping can be a tool for women and girls to map out their community/surroundings and show the areas where they feel safe or unsafe. The map shown in Figure 15.1 was developed by women from Bhalswa slum in Delhi, who identified places in their local environment where violence had occurred (Lennon, 2011). While the map was developed in a low-income urban context, the same principles apply to the rural context.

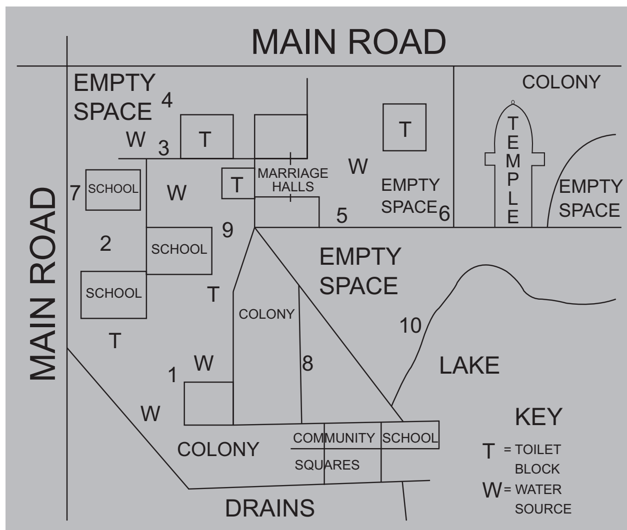

Figure 15.1 Map showing frequency and severity of violence against women in Bhalswa slum, Delhi)

Source: Based on original from Shirley Lennon/SHARE, 2011

Menstrual hygiene management

Menstruation is a natural process, but menstrual hygiene (how to manage menstruation safely and with dignity) has in the past been largely neglected by the WASH sector (Roose et al., 2015). This makes the menstrual hygiene challenges faced by women and girls even more difficult. Without menstrual hygiene services at school and in homes, girls may skip school or drop out altogether if there are no private toilets and hygiene supplies in their place of education. In Ethiopia, 50 per cent of girls in one school missed between one and four days of school per month due to menstruation (WaterAid, 2012). In India, inadequate menstrual hygiene services lead adolescent girls to miss five days of school a month (Nielsen and Plan India, 2010). Approximately 23 per cent of these girls drop out of school after they begin menstruating (Nielsen and Plan India, 2010). This limits their opportunity for education, income generation, and societal participation, all of which hamper self-worth and confidence. CLTS programmes can be expanded to address menstrual hygiene in schools and communities to alleviate these stresses on women and girls, as well as challenging the myths, silence, and negativity which often surround menstruation.

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- In Uganda, Plan International has used a range of approaches to engage school children as peer educators of menstrual hygiene, sharing poems and 'change' stories with other girls. Village Health Teams, and other community members, have performed drama sessions on the myths and taboos of menstruation, demonstrated effective use of pads, and included MHM in the hygiene awareness sessions held in CLTS post-triggering (Roose et al., 2015).
- WaterAid Zambia and partners have supported menstrual hygiene awareness-raising in schools through School Health and Nutrition Coordinators, School Health Clubs, Mother's Support Groups, Parent Teachers Associations, peer learning, and focus group discussions, to provide a supportive environment for girls and boys to learn about menstrual hygiene (Roose et al., 2015).
- In Mulanje, Malawi, Plan International has been encouraging school-based Mothers' Groups to engage village leaders to organize community-level discussions (involving men, women, boys, and girls) on menstrual hygiene to break down existing taboos and myths. Existing school Sanitation Clubs, strengthened through School-Led Total Sanitation (SLTS), have also proved receptive and motivated to engage with menstrual hygiene management (Roose et al., 2015).
- WaterAid Bangladesh established cultural groups for adolescent girls and boys in the schools and communities where they spoke about menstrual hygiene (or just menstruation). The outcomes have been impressive: negative myths, taboos, and restrictions during menstruation for girls and women have reduced. For instance, families no longer expected girls to bathe in secret or restrict food, and girls were able to wash sanitary cloths in the spring and hang them out in the sunlight to dry. Adolescent girls described no longer feeling ashamed of menstruation or trying to hide it. They described how this change in attitudes and improved hygienic practices had occurred slowly, over the course of several years. They saw themselves as change agents for both older and younger generations. Adolescent boys saw themselves as champions of menstrual hygiene among their peers and the broader community and had carried out advocacy activities with senior community members. Adolescent girls described how they felt listened to by their male peers and how boys came to them for help and listened to their opinions (Wilbur and Huggett, 2015).

Children and ageing

Almost half of all schools in low-income countries still lack water and sanitation facilities (UNICEF, 2015). Providing adequate WASH in schools significantly reduces preventable diseases. It can increase student attendance and learning achievement, and help promote dignity, inclusion, and equality. This establishes an important foundation for ongoing development and economic growth (UNICEF, 2012).

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Children can, and often do, play a key role in CLTS. They can be very enthusiastic in motivational activities and preventing people from practising OD. In Ethiopia, Plan International uses teachers as community facilitators in the promotion of hygiene and sanitation. Students play active roles by initiating families to go to triggering sites, to construct toilets, and to report on developments after communities have been triggered. After a village has decided to stop OD, a village 'shit eradication team' is created, which includes adults, boys, and girls (Plan International, 2011). Plan International also uses sanitation and hygiene games to empower children to influence their parents to improve their sanitation. The purpose is to imprint the concept of hygiene and sanitation in the minds of children, so that using the toilet and washing their hands with soap becomes their daily routine (Plan International, 2010).

In Tanzania, SNV are harmonizing school WASH and improving sanitation access for school children, including those with disabilities. SNV engaged with four government ministries, development partners, local authorities, village councils, and school committees, all of whom had key roles to play in improving the WASH situation in Tanzanian schools. The intervention involved: improved coordination; financial arrangements; operation and maintenance; development of School WASH Guidelines and toolkits; and a pilot of the toolkit. As a result of the interventions, school children, including those with disabilities, now have access to improved and gender-friendly WASH facilities in schools. The intervention will be up-scaled in order to help more schools improve their facilities (SNV, 2012).

Recent research in Uganda and Zambia revealed that older people consistently face difficulties accessing toilets, especially at night, as they may find it hard to find the toilet and maintain balance inside without any support structures (Danquah, 2014). Older people in these communities faced the most discrimination in the community and within the household, because of decreased mobility and ill health (Wilbur and Danquah, 2015).

People with disabilities

An estimated 15 per cent of the world's population have an impairment, and 80 per cent of those reside in developing countries (WHO and World Bank, 2011), where as many as one in five individuals living in the lowest wealth quintile are likely to be disabled (Jones and Reed, 2005). Poverty is both a cause and a consequence of disability. Disabled people are more likely to be poor and if you are poor you are more likely to be disabled (Jones and Reed, 2005: 6–7). The lowest wealth quintile are 5.5 times more likely to lack improved water access and 3.3 times more likely to lack adequate sanitation, compared with households in the highest wealth quintile in the same country (Moe and Reingans, 2006).

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People with disabilities in poor communities often lack WASH services because:

- Facilities are not inclusive, meaning that some physically disabled people have to crawl on the floor to use a toilet or defecate in the open (Wilbur and Jones, 2014).
- There is limited information on inclusive WASH options, so people with disabilities and their families are often unaware of the options available (Wilbur et al., 2013).
- A lack of information about the cause of disability leads to stigma and discrimination. In Uganda, 19 per cent of people with disabilities in a research sample were stopped from touching water points because they were considered 'dirty' (Wilbur and Danquah, 2015).
- They are rarely meaningfully consulted or involved in decisions about WASH policy and programmes.
- Policies and standards are often not enforced, or do not adequately include the needs of older people, people with disabilities, and children (WaterAid, 2011).

A WaterAid research project, 'Undoing Inequity – water, sanitation and hygiene services that deliver for all in Uganda and Zambia', aimed to understand the barriers to WASH services and opportunities faced by disabled, chronically sick, and older people; to develop and test an inclusive WASH approach that addresses the barriers; and to assess the impact that improved access to safe WASH has on the lives of people from excluded groups (Wilbur et al., 2013). The project has found ways in which CLTS can address many of the barriers that people with disabilities face and make each stage of CLTS more inclusive, accessible, and sustainable.

A study on social inclusion in Malawi, by Plan International and the Water, Engineering and Development Centre (WEDC) (Jones, 2015a) found that the use of accessibility and safety audits was especially useful. Some key findings included the importance of:

- Men, women, and people with disabilities being part of the audit team.
- Consulting with a range of different users, not just committee members or community leaders, in a range of different locations: for example, women working at the market had a different approach to managing menstrual rags from that of other women.
- Considering multiple issues at a time: for example, a person living with disability is also a woman who experiences menstruation and gender discrimination.

During implementation of a number of Plan's CLTS projects in Indonesia it was found that people with disabilities needed special attention to enable them to have full access to the toilets. Training sessions were held, based on WaterAid's and WEDC's awareness raising materials (WEDC, 2014), to increase awareness of disability inclusion and disability rights among field staff who were responsible for implementing the activities at the community level.

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Sub-district officials who participated in the training were 'triggered' to adopt a disability inclusive approach in their sub-district. Project staff members and government counterparts are working together with communities to achieve universal access to toilets at the village level, the scale at which ODF is declared. However, the most promising result has been the effort to link sanitation marketing and disability inclusion. Local entrepreneurs have been encouraged to focus on sanitation options for people with disabilities and include them in design processes to address their specific needs (Triwahyudi and Setiawan, 2014). Despite all these efforts, there is limited evidence of sanitation marketing being led by people with disabilities and the sector lacks evidence on how successful sanitation marketing is in meeting the needs of the poorest and excluded.

How can CLTS contribute to universal access to sanitation in the SDGs?

CLTS aims for ODF, but it does not automatically equate to adequate sanitation. ODF is an important, but intermediate step to sustainable sanitation.

The initial rung on the sanitation ladder (ODF) can be jeopardized by just one person. It is essential to ensure that everyone's needs are being considered and that accessible facilities are available (Wilbur and Jones, 2014). This can be made a reality if we move beyond the assumption that the basic CLTS tool is always inclusive and equitable, and if we actively build-in equality and non-discrimination considerations at every stage of the approach, to ensure ODF status is sustained as well as to move sustainably beyond ODF. Unless explicitly included, equality and non-discrimination risk being omitted by implementers in their rush to simply reach ODF.

Research is under way to discover how to do this in practice. The London School of Hygiene and Tropical Medicine (LSHTM), WEDC, Mzuzu University, and the Centre for Social Research at the University of Malawi are collaborating on a research study in northern Malawi. The purpose is to see whether it's possible for CLTS implementers to make small adaptations to the usual CLTS implementation process that would result in improved participation by vulnerable people in the process, and improved access to sanitation for vulnerable people in the community (Jones, 2015b). So far this research has indicated that integrating inclusive WASH training in CLTS has effectively increased awareness of communities about the needs of people with disabilities, older people, and those with chronic illnesses and has resulted in some structures being modified and adapted to help people move towards improved sanitation.

However, it is clear that more effort is needed to include the perspectives of all toilet users when designing and constructing toilets and handwashing facilities and evidence is still to be gathered (in the end line evaluation) on whether there has been a resulting increase in access to sanitation and hygiene for disabled people, older people, and those with chronic illness in Rumphi district in northern Malawi.

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The voices, views, and needs of those who have low status, minorities, those who are very poor, women, girls, and children are relevant in deciding technical options for toilets, their location, and accessibility. Their empowerment throughout CLTS and WASH processes can be enhanced by the following actions:

Training and capacity development for pre-triggering. Without adequate facilitator training, aspects of equality and non-discrimination may be omitted. Pre-triggering is the most important stage of CLTS to bring in components of equality and non-discrimination.

Triggering. The more inclusive attendance at triggering, the better. A target of 80 per cent of community members present is cited as a rule of thumb. The Plan International ODF sustainability study found that women's attendance at triggering was more important than men's (Tyndale-Biscoe et al., 2013). All community members, including people with disabilities, older people, and the marginalized, should be encouraged and supported to participate by a supportive facilitator (Wilbur and Jones, 2014).

Post-triggering, monitoring, and follow-up. Post-triggering, there may be some households that are unable to construct a toilet (either from lack of time or resources). Ideally, support will come from within the community (Kar with Chambers, 2008). However, we need to understand the extent to which this actually happens (Robinson and Gnilo, 2016a, this book; Musembi and Musyoki, 2016). In addition, it is possible that members of the community getting assistance may be provided with facilities they do not want or that do not meet their needs, and subsequently they will not use. This could leave them vulnerable to abuse or sanctions from other community members.

Post-ODF towards sustainable sanitation. Post-ODF follow-up is critical for sustainability (see Robinson and Gnilo, 2016a, this book; Regmi 2016, this book; Wamera, 2016, this book; Musyoki, 2016, this book). To ensure the new social norm is embedded and sustained, everyone has to be included and not revert to the existing practice of OD. Ideally, households will climb the sanitation ladder over time and improve their toilets; however, this does not always happen, particularly among poor and marginalized households. Reversion to OD is also a problem.

Practical steps to integrate inclusion

To avoid reinforcing inequalities, and to ensure behaviour change is sustained, there are a number of practical steps that can be taken within CLTS programmes. The suggestions outlined in Table 15.1 should help ensure meaningful participation of excluded groups, and integrate measures to support sustainability from the start of the process.

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Table 15.1 Practical steps to integrate inclusion into CLTS processes

Activity	Purpose	CLTS stage
Equality and inclusion integrated into training of facilitators	Equip facilitators with the mind-sets and skills to avoid shaming poor or marginalized people. Training should include the issue of stigma and mentor schemes, and groups could be set up to ensure facilitators receive adequate support and advice, and are able to discuss ways to address any problems (Musembi and Musyoki, 2016). Marginalized people, such as people living with disabilities, can also be trained as facilitators to improve participation of people from excluded groups and raise awareness of the experiences of marginalized people. It also demonstrates that people from excluded groups can take leadership positions.	• Training and capacity development for pre-triggering
Situational analysis, scoping studies, or wealth ranking	Understand power dynamics and resource (time and money) burdens faced by men, women, the poorest, marginalized individuals and groups, people with disabilities, older people, children, and youth, in CLTS programmes.	• Training and capacity development for pre-triggering
Analysis of key influencers	Identify people within the community who can become Natural Leaders and help drive the process (see Dooley et al., 2016, this book). Identify people who may be marginalized, bearing in mind that they may be 'hidden' in the household due to stigma and discrimination. Ensure inclusion of marginalized people. People who have faced social exclusion often feel disempowered, so appropriate support is vital in order that they can effectively deliver their roles and responsibilities. Guard against unintentionally putting additional economic and domestic burdens on marginalized people, otherwise the process will be extractive rather than mutually beneficial and empowering.	• Pre-triggering
Mapping of community groups	Identify those who have access to all sections of the community to carry out pre- and post-ODF activities (see Dooley et al., 2016, this book; and Wamera, 2016, this book). Involving excluded groups, such as transgender groups, can help to ensure they are not only participants, but also leaders in the process of change (Tiwari, 2015). Identification of people with disabilities can be helped by including disability organizations who are more aware of this issue.	• Pre-triggering
Accessibility and safety audits	Raise awareness of the barriers to access that different people face; highlight designs that are not accessible, and jointly propose solutions for greater access. Auditing teams should be made up of CLTS implementers, sanitation masons, women and men, older people, girls and boys, including disabled people with different impairments. The team should not be too large and there should be a strong coordination role. If the team attempts to use facilities and encounter challenges, they can discuss how to make them more accessible (WEDC and WaterAid, 2014; Jones, 2015a).	• Pre-triggering • Triggering • Post-triggering, monitoring, and follow-up

(*Continued*)

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Table 15.1 Practical steps to integrate inclusion into CLTS processes (*Continued*)

Activity	Purpose	CLTS stage
Timing of triggering	Ensure as many people as possible can attend the triggering sessions. This means considering the place, timing, and pace for triggering carefully (Wilbur and Jones, 2014). Consider the possibility of separate discussions with women and with children, and home visits for disabled or older persons who may not be very mobile.	• Pre-triggering
Separate meetings and dialogue circles for different groups	Hold separate meetings for people or groups who may feel unable to speak in community meetings, or those unable to leave their homes such as older people and disabled people. Discuss specific needs of people with disability and women/girls with regard to WASH. WEDC (2014) have developed tools and activities that can be incorporated into CLTS monitoring and follow up, to encourage a reflection on barriers to inclusion (WEDC, 2014). There is a revised guidance note on how to conduct effective dialogue circles developed by WEDC and Plan International (Jones, 2015a).	• Pre-triggering • Triggering • Post-triggering
Identification of those unable to build toilets	The CLTS process can facilitate the linkages between people, encouraging local actions and innovations to provide what is needed (Kar with Chambers, 2008; Chambers, 2012).	• Triggering • Post-triggering
Information on menstrual hygiene, disability, and communicable diseases	Reinforce the need to provide access to all, and challenge false beliefs that result in discrimination. Information should be available in local languages and accessible formats, with pictures for people who cannot read or hear, and audio for people who cannot see.	• Triggering
Information about accessible technology options for household toilets	Ensure materials to inform choice are available, as well as practical support on low-cost, low-tech inclusive designs (e.g. Jones and Wilbur, 2014).	• Post-triggering
Inclusive monitoring and evaluation indicators	Indicators should reflect targets for: facilities with a specified level of accessibility; reduced numbers of people who are marginalized lacking access to facilities; increased participation of marginalized community members, not only as users but also in active roles with responsibilities and payment where possible. Participation monitoring can be carried out to include a range of excluded groups. This can also be carried out using dialogue circles (Jones 2015a).	• Post-triggering
Data collection	Capture data on sanitation for people with additional access requirements. Population data should be disaggregated by sex, age, disability; questions about menstrual hygiene, safety, security, accessibility of facilities for disabled persons, and traditional attitudes about gender, disability, and age, in relation to WASH. Surveys collect views of women, children, older people, disabled people and their households, and any groups living in the area whose needs are likely to be neglected (low caste, pastoralists, migrant workers, displaced people, sex workers, prisoners).	• Post-triggering

(*Continue*)

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Table 15.1 Practical steps to integrate inclusion into CLTS processes (*Continued*)

Activity	Purpose	CLTS stage
Review of progress up the sanitation ladder	Identify households who are stuck on the bottom rung of the sanitation ladder. Consider options that encourage communities to gradually improve (Robinson and Gnilo, 2016b, this book).	• Post-ODF
Post-ODF follow-up	Maintain ODF status especially when, e.g. the pit is full or the infrastructure collapses during flooding. User committees have a role in post-ODF follow-up, alongside follow-up by programmes or government, and should be facilitated to ensure meaningful participation by marginalized groups. It is important that these groups receive adequate support and encouragement to ensure they are not overburdened (Wamera, 2016, this book).	• Post-ODF
Availability of financing options	Consider financing options such as vouchers, rebates, and rewards to ensure poor and marginalized people are able to retain ODF status and climb the sanitation ladder (Myers, 2015b; Robinson and Gnilo, 2016b, this book).	• Post-ODF
Toilets in public places	Public or institutional toilets (in markets, schools, health centres) should include separate facilities for males and females, with accessible cubicles, and water provided inside the women's cubicles for MHM.	• Post-triggering
Cross-sector collaboration	Establish links with relevant agencies (e.g. health, rehabilitation) to address issues or needs that are beyond the scope of the WASH sector.	• All phases

Institutional enabling environment

Realization of the human rights to water and sanitation is both the duty of the state and the responsibility of the individual. CLTS actively promotes community and individual responsibility. However, attention to government and institutional strengthening for inclusive rural sanitation is also critical. Successful approaches to ensure a supportive enabling environment include:

- Active involvement of national and district governments (including traditional leaders) in barrier analysis, accessibility, and safety audits, community meetings, training for implementing officers on inclusion, triggering, and follow-up.
- Creation of institutions that can support CLTS processes and integration into the broader systems that provide sanitation delivery options.
- Where there is high turnover of government and local partner staff, follow-up training and support for monitoring.
- Collection of baseline data on people who may face barriers to accessing sanitation during CLTS household registration, which is included in ODF criteria (Wilbur and Jones, 2014).
- Providing financial support where necessary, in terms of subsidies or other support for those households that cannot afford to construct an adequate toilet that complies with the standards set out in the human right to sanitation (see Robinson and Gnilo, 2016b, this book).

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Conclusion

The local approach and global reach of CLTS makes it an ideal methodology for promoting equality and non-discrimination in communities. CLTS can lay the ground for active community ownership of new behaviours and habits, and ensure that all community members are involved in the process of change, especially those who were previously ignored or excluded. This can support the achievement of the ambitious SDGs on sanitation and their emphasis on the rights of all excluded groups to achieve sustained access to sanitation and hygiene. It is important to recognize, however, that CLTS cannot solve existing social inequalities and structural problems by itself, and should not be expected to. Unless implemented with care and inclusion in mind, CLTS can actually reinforce or exacerbate existing problems. Currently, many programmes are run and financed with a focus on scale and speed, which are key to achieving universal access. However, there is also a critical need for ensuring quality CLTS programmes that lead to long-term sustainable change; incorporating concerns for equality and inclusion may mean that it will take longer to reach everyone and reach targets, but this approach might be the only way to achieve sustainability. Wide societal shifts in terms of awareness about, and establishment of, social norms will be needed. While the imperative for equality and non-discrimination is widely recognized in the WASH sector, we still have a lot to learn about how to turn these binding principles into reality through programme implementation.

About the authors

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Endnotes

1. However, this research did not investigate if every household member defecates in the open, or if it is just the person who is marginalized. Nor did it examine reasons for practising OD. More research is required to understand these specific conditions.
2. UN General Assembly resolution (2015) defines water and sanitation as two separate rights for the first time.
3. For example, facilities are well lit, or women and girls have access to torches or other forms of light; the facility has a solid door and a lock on the inside of the door. Toilets have roofs. Facilities are accessible for family members with limited mobility (House and Cavill, 2015).

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