THE UNIVERSITY OF ZAMBIA

SCHOOL OF PUBLIC HEALTH

DEPARTMENT OF HEALTH POLICY AND MANAGEMENT

FACTORS THAT SHAPE IMPLEMENTATION OF COMMUNITY LED TOTAL SANITATION IN SELECTED CHIEFDOMS IN MONZE DISTRICT, ZAMBIA

BY

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A Master's Dissertation Submitted to the University of Zambia, in Partial Fulfillment of the requirements for the Degree of Master of Public Health (Health Policy and Management)

UNZA

DECLARATION

I, HAZYONDO GIFT, declare that this dissertation submitted to the University of Zambia as a partial fulfillment to the award of the Degree of the Master of Public Health (Health Policy and Management) is my own work and has not been submitted either wholly or in part for another degree to the University or any other institute for higher education.

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DEDICATION

This dissertation is dedicated to my late mother Mrs. Ruth Nakasansa Hazyondo and late brother Vincent K. Hazyondo for their inspiration, vision and support throughout my life, to all my brothers, sisters, children and wife for their support and patience during the study period.

CERTIFICATE OF COMPLETION OF DISSERTATION

The undersigned certify that they have read the dissertation and are satisfied that it is the original work of the author under whose name it is being presented.

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ACKNOWLEDGEMENTS

To God is the Glory under whose guidance and blessings all things become possible.

Secondly, I would like to extend my gratitude to my Principal supervisor, Dr. Bornwell Sikateyo (Department of Medical Education and Development) and my Co-Supervisor Mr. Chris Mweemba (Department of Health Policy and Management, University of Zambia) for their guidance and support throughout this research process.

Thirdly, I would like to acknowledge the indispensable input and support/encouragement of Dr Peter Hangoma (Head of Department of Health policy and management) and all faculty members. In addition, would like to thank Mr. Gabriel Yali for support and his input in the analysis of the qualitative study.

Fourthly, my gratitude also goes to Monze District Health OfficeHO administration for giving me an opportunity to study, to Monze Town Council Secretary and traditional leaders for allowing me to conduct a research in their CLTS implementation areas and for support rendered to me during data collection process.

Lastly but not the least, to all my Lecturers and Course mates for support and encouragement up to completion of the study. To you all, I say thank you and am most sincerely indebted.

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ACRONYMS

BCC	Behaviour Change Communication
CLTS	Community-Led Total Sanitation
DAPP	Development Aid from People to people
DfID	Department for International Development
DHIS2	District Health Information System
D-WASHE	District Water, Sanitation and Hygiene Education
DWS	District Water and Sanitation
EHT	Environmental Health Technologist
IDS	Institute of Development Studies
INGOs	International Non-Governmental Organisations
MDC	Monze District Council
MDGs	Millennium Development Goals
NGOs	Non-Governmental Organisation
NLs	Natural Leaders
NRWSSP	National Rural Water Supply and Sanitation Program
OD	Open Defecation
ODF	Open Defecation Free
PHAST	Participatory Hygiene and Sanitation Transformation
PRA	Participatory Rural Analysis
RESA	Regional East and Southern Africa
SDGs	Sustainable Development Goals
SPSS	Statistical Package for the Social Sciences
SNNPR	Southern Nations, Nationalities & People's Regions
UHC	Universal Health Coverage
UN	United Nations
UNICEF	United Nations Children's Fund
UNZABREC	The University of Zambia Biomedical Research Ethics Committee
VERC	Village Education Resource Centre
VIP	Ventilated Improved Pit latrines
WHO	World Health Organization
ZDHS	Zambia Demographic and Health Survey

OPERATIONAL DEFINITIONS

CLTS: Entails the facilitation of the community's analysis of their sanitation profile, their practices of defecation and the consequences, enabling the community members to take collective action to become ODF

Latrine and Toilets: Typically, a direct pit and a toilet is typically an arrangement with a water seal

Natural Leaders: Activists and enthusiasts who emerge and take the lead during CLTS processes. Men, women and youth can all be natural leaders.

OD: Defecating in the open and leaving the Shit exposed.

ODF: A situation where no faeces are openly exposed to the air.

Verification: Refers to inspection to assess whether a community is ODF

Certification: Official confirmation and recognition of ODF status.

Sanitation Action Group (SAG): A committee established to sensitize subjects on issues of sanitation and hygiene at village level.

Community Champion: A community volunteer in CLTS selected by the community to sensitize communities to become ODF.

ABSTRACT

Globally, 2.4 billion people lack access to sanitation facilities and 946 million practice open defecation, with majority being in Africa. Zambia has one of the lowest accesses to sanitation and hygiene facilities on the continent. The open defecation free Zambia by 2020 strategy aims to move Zambia into an open defecation free nation through community led total sanitation (CLTS). Understanding factors that shape implementation of the CLTS is crucial to improving its acceptability among communities. However, they are limited studies in this regard. This study sought to identify barriers and enablers to implementation as well as explore community attitudes towards CLTS in Monze District. The study used a qualitative explorative study design and was conducted in two purposively selected chiefdoms with low sanitation coverage in Monze District. The sample size included 15 key informant interviews and two Focus Group Discussions conducted with the chiefdom sanitation action groups. The data was transcribed and indexed into various themes using Nvivo 11 Plus qualitative software.

Enablers to CLTS implementation included community sensitization, material support, punitive action, and eliciting a feeling of shame among community offenders. The barriers included poor soils, inadequate human resource, lack of financial motivation, inadequate support from local leaders, lack of building materials and transport shortage. Poor individual behaviour/attitude and lack of knowledge were some of the negative attitudes among selected community members. The community generally accepted CLTS, viewed it to have reduced water- borne diseases such as diarrhoea after its introduction. It was also perceived to have increased knowledge/awareness with a deeper understanding of CLTS through the triggering process.

The planning of CLTS intervention can utilize insights from the current study, which can serve as a framework for deciding which factors should be considered. Future research and programs should consider focusing on routinely collecting household level data on indicators of sanitation so that they can measure incremental progress in these communities.

Keywords: Barriers, community, enablers, sanitation, Monze, Zambia

CHAPTER ONE: INTRODUCTION

1.1 Background

Inadequate hygiene and sanitation remain leading global contributors to morbidity and mortality in children and adults. According to the World Health Organization (WHO) Global Health Observatory, improvements in drinking water, sanitation, hygiene, and water resource management could reduce the total burden of disease worldwide by nearly 10%.(WHO,2012)

One strategy for improving access to sanitation is community-led total sanitation (CLTS). It is an approach and a process of empowering local communities to stop open defecation (OD), and to build and use latrines without the support of any external hardware subsidy. It therefore, moves a community from OD to a status of open defecation free (ODF) using their own initiative. It focuses on the behavioural change, shifting the focus from toilet construction to the creation of "*open defecation-free*" villages.

CLTS triggers (stimulating a collective sense of shame among community members) the community's desire for change, propels them into action and encourages innovation, mutual support and appropriate local solutions, thus leading to greater ownership and sustainability. It also assists the community in identifying its problem and optimising its potential to improve sanitation (Kar, 2008).

CLTS was first developed and pioneered by a development consultant from India Kamar Kar in 1999 in Bangladesh after evaluating the water and sanitation program of Water Aid Bangladesh under their local partner organization, Village Education Resource Centre (VERC) locally funded by Water Aid (Kar et al., 2008). CLTS has since spread to over 60 countries in Asia and Africa, many of which now include it in national policy (IDS, 2016). CLTS has a role to play in addressing the SDGs, as it is participatory, generally includes capacity building, and has shown promise in addressing Open Defecation (Kar & Chambers, 2008).

Globally, 2.4 billion people lack improved sanitation, and 946 million people practice open defecation (UNICEF, 2016). The 2030 Agenda for sustainable development adopted by all united Nations (UN) member states in 2015 provided a shared blue print for peace and prosperity for the people and planets now and in the future. The United Nations reaffirmed the importance

of sanitation by including it in the Sustainable Development Goals (SDGs) especially SDG No 6, which ensures availability and sustainable management of water and sanitation calling for ending open defecation and have universal access to adequate and equitable sanitation to all by 2030. The SDGs also set out the means of implementation to strengthening the participation of local communities and capacity building support for developing countries (UN, 2015a).

Achieving Universal Health Coverage (UHC) is also one of the targets the nations of the world set when adopting SDGs in 2015.UHC enables everyone to access the services that address the most significant causes of disease and death and ensures that the quality of the services that are good enough to improve the health of the people. The countries that progress towards UHC will also make progress towards other health related targets and goals (UN, 2015).

In 2002, 300 million Africans were without access to basic sanitation and hygiene, and unfortunately, the figures have increased even more since then (WHO & UNICEF, 2008a). Notably, sub-Saharan Africa has the lowest sanitation coverage, according to a report on the global of sanitation and hygiene prepared annually by the World Health Organization (WHO) and UNICEF Joint Monitoring Programme (WHO & UNICEF, 2008a). Only 60 per cent of the African population has access to improved sanitation services, and the continent needed to increase coverage to more than 221 million underserved people to meet the 2015 MDG target date. Despite significant efforts by governments, progress on sanitation targets has been slow and uneven, with only five countries in Africa expected to meet the sanitation MDG. Innovative approaches, urgent action and political good will were therefore; needed to accelerate achievement of the MDG targets for sanitation and to achieve sanitation uptake, coverage and improvement at scale (WHO & UNICEF, 2008b).

Additionally, like in many developing nations, the determinants of health such as access to clean water, sanitation and good hygiene are still in a critical state in Zambia. Limited access to water and sanitation facilities, and poor hygiene has been associated with skin disease, Acute Respiratory Infections (ARIs) and diarrhea diseases, the leading preventable diseases, which are among the leading causes of child deaths in Zambia (ZDHS, 2014).Zambia has approximately 5-6 million people lacking access to improved sanitation and only 36% of rural inhabitants and 44% overall have access to improved sanitation facilities (WHO/UNICEF, 2015).

According to the Zambia Demographic and Health Survey (2014), only 25% of households have access to improved toilets, 20% have access to shared toilet facilities and 55% have access to non-improved facilities while 16% still use bush for defecation. Over several past years, different approaches were applied to improve sanitation profiles of communities without much progress at all. Some of the approaches used included; use of sanctions, provision of construction materials and incentives to attract households and assigning households with some form of subsidies (NRWSSP, 2009).

The ZDHS, 2018 results showed that 33% of the population had basic sanitation services (defined as use of improved facilities that are not shared with other households), 41% in urban and 28% in rural areas. 54% of households in Zambia have access to improved sanitation facility (defined as a facility that hygienically separates human excreta from human contact), with the most commonly used facility being a pit latrine with a slab (37%).

Zambia has one of the lowest accesses to sanitation and hygiene on the continent, an estimated 8.4 million lack access to improved sanitation where 2.1 million practice open defecation (OD).The ODF Zambia by 2020 Strategy aims to turn Zambia into an open defecation free (ODF) nation by 2020, both in rural and urban areas. The latest available data reports that only 40% of population in Zambia lives in an ODF community while 60% of the population is an Open Defecation (OD) community (MLGH, 2016).

In Zambia, UNICEF together with the Government of the Republic of Zambia (GRZ) decided to first introduce the CLTS approach in Choma District in Southern Province in July, 2007. It was then piloted in Macha Chiefdom where the sanitation coverage was at 40%. Twelve communities were triggered by trained CLTS facilitators. Within the period of two months, sanitation coverage increased from 23% to 88% within a population of 4,536 and 75% of the villages were verified as Open Defecation Free (Mbulo et al., 2017). Since then, CLTS has so far spread to other provinces such as Luapula, Western and Central Provinces where it showed an increase in ODF. The harmonized programme is active in 73 districts of the 92 rural districts in Zambia. The Ministry of Local Government developed national guidelines for CLTS to be used for verification and certification of ODF. The programme target was to reach 3 million people with improved sanitation by 2015 (SNV, 2012). So far, over 2.5 million people have been reached.

The Ministry of Water Development, Sanitation and Environmental Protection (MWDSEP) embarked on the 2018-21strategy to improve access to water and sanitation services and improve good hygiene practices among all segments of the population. The target of these efforts is to provide basic sanitation to 70% of urban population and 55% of the rural population by December, 2021(MWDSEP, 2018)

The involvement of traditional leaders continues to be a strong component of CLTS coverage. Traditional leaders make community visits and ensure that their subjects attain and maintain ODF. One of the key principles of the Sanitation Programme is community self-financing which has provided scope for private sector participation. Provision of market-based latrine options enables consumers to progress on the sanitation ladder. Integration of private sector actors also ensures sustainability (e.g. designing of latrines that suit local conditions).

Due to high incidence of diseases of poor sanitation such as Diarrhea and also low sanitation coverage at 31%, Monze District adopted the CLTS as a preferred approach to improve the sanitation profile in the District which was in line with National Rural Water Supply and Sanitation Programme (NRWSSP) of increasing access to proper sanitation to 66 % of the rural population by 2015 (NRWSSP, 2009). According to the District Water and Sanitation (DWS) report, the CLTS Program was introduced in Monze District in 2011 in 22 Wards. This Program covered all the 6 Chiefdoms in the District which includes Chona, Mwanza, Ufwenuka, Monze, Choongo and Hamusonde. The biggest Chiefdom is Monze with 9 wards covering even the Township, Chief Choongo with 4 Wards whose palace is 15km from Town, Chief Hamusonde with 3 wards about 50 km from town while Chiefs Ufwenuka, Chona and Mwanza have 2 Wards each and are all located about 30km from town (DWS, 2017).

To strengthen and enhance community ownership of the CLTS Program, each Ward has community leadership structures such as Traditional Leaders, Civic Leaders and Chiefdom Sanitation Action Groups (SAGs). These community structures were trained at both District and sub-District levels to easy the implementation of CLTS (DWS, 2017). Since 2011, all the six Chiefdoms in the District adopted CLTS to improve sanitation coverage in their respective communities. It is from this background that two out of the 6 Chiefdoms (Chief Chona in November, 2013 and Mwanza in November, 2017) managed to attain an ODF status respectively

while the other 4 Chiefdoms have lagged behind with an average District sanitation coverage at 31%. The lowest in terms of sanitation coverage in the district are Chiefs Choongo and Hamusonde respectively (MDC, 2016).

1.2 Statement of the Problem

According to the District Water and Sanitation (DWS) Report (2017), there has been little progress in terms of sanitation coverage in Monze district. In an ideal situation, all the six Chiefdoms were supposed to be ODF for the district to be declared ODF as well. Only two Chiefdoms namely Chona and Mwanza had improved sanitation coverage and were declared ODF areas in November, 2013 and November 2017 respectively out of the 6 Chiefdoms with an estimated low district average coverage below 65% (DWS, 2017). However, despite the improved sanitation coverage in the two Chiefdoms, the remaining four (4) chiefdoms which include Ufwenuka, Monze, Choongo and Hamusonde have lower sanitation coverage at 65%, 55%, 45% and 40% respectively. These four Chiefdoms have continued to lag behind in terms of sanitation coverage and compliance by the communities as compared to the other two chiefdoms despite having similar resources, cultural and demographic backgrounds (DWS,2017).

Since the inception of CLTS, different approaches have been applied to improve sanitation profiles of communities in all the Chiefdoms of Monze District. Some of the approaches used included; use of sanctions, community sensitization, provision of incentives to attract households and assigning households with some form of subsidies (NRWSSP, 2009). However, in this study, the researcher focused on Choongo and Hamusonde chiefdoms as they had the lowest sanitation coverage below 50% at 45% and 40% respectively. The gap is the unknown reasons why the two chiefdoms failed to have improved sanitation coverage to become ODF. In addition, the enablers and barriers which affect the CLTS coverage in these two Chiefdoms were still not known too. It is against this knowledge gap that this study aimed at exploring the enablers, barriers and community attitude towards CLTS coverage that could have facilitated and hindered the achievement of ODF in the two selected Chiefdoms in Monze District.

1.3 Justification of the study

The study will generate information or increase body of knowledge on the failure of the selected chiefdoms to improve sanitation coverage and become ODF. The project implementers, donors, policy makers and other stakeholders would use the findings to make evidence-based decisions

on how barriers would be addressed in order to improve CLTS coverage to achieve ODF status in the respective Chiefdoms and Monze District in general.

By bringing the enablers to CLTS coverage, it will help the project implementers to replicate the enablers to enhance successful CLTS coverage to become ODF and ensure sustainability in the chiefdoms. Unearthing the barriers will help the project implementers, donors and other stakeholders to develop the mitigation measures to enhance the CLTS coverage.

Zambian citizens and organisations who may be interested in the same area of study could also benefit from the study findings for further investigations. Additionally, it will also provide a basis for further academic research especially to other researchers who might want to undertake an evaluation of the same CLTS Program.

1.4 Conceptual Framework

The Concept was modified from the conceptual framework of environmental sanitation by UNICEF (1991). The idea of CLTS implementation begins with the manifestation of poor hygiene and sanitation in the environment. This culminates into disease burden and other ecological and environmental challenges. There is need to formulate policies and political will to drive programmes through resource mobilization, human resource development and organizational skills.

The underlying causes should be taken care of as they are deep rooted into society way of life. These include community cultural beliefs and values, their attitude towards an intervention and community social structures through which traditional leaders can influence their subjects. The underlying factors may determine the success or failure of a programme as they play the integration role of communities and make it either possible or difficult to coordinate and mobilize resources.

Once the underlying factors are taken care of, it becomes easy for the community to respond positively to sensitization and community engagement. There is behavioural change and easily adhere to the improved health standards and services. They begin to value and appreciate the environment and begin to use latrines. There is a feeling of shame and begin to demand to become and stay ODF. Ultimately, the majority of the households would build and use toilets and attain Open Defecation Free (ODF) status.

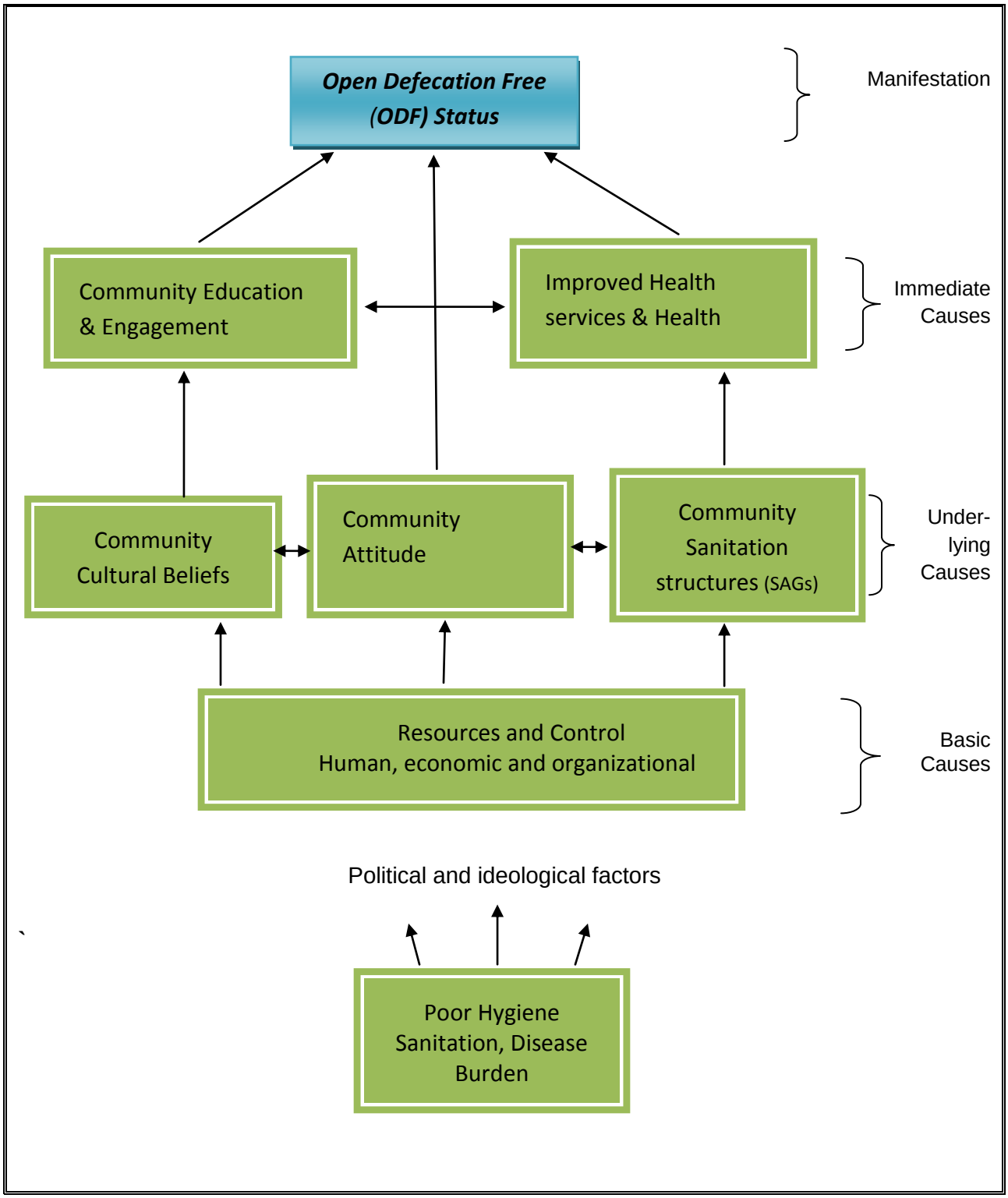

Fig: 1: Conceptual Framework showing relationship among variables: Modified from CFES (Unicef; 1991)

CHAPTER TWO : LITERATURE REVIEW

2.1 Introduction

The literature review focused on reviewing relevant literature to identify what has been done by other researchers in Zambia and other countries in relation to Community Led Total Sanitation (CLTS).

2.2 Enablers to CLTS Implementation

In a study by Lawrence et al., (2013), done in six districts namely Lundazi, Chadiza and Chipata (Eastern), Choma and Kalomo (Southern) and Lufwanyama (Copperbelt), he qualitatively explored community members' and stakeholders' sanitation, knowledge, perceptions, and behaviors during early CLTS implementation in Zambia. It was found that inadequate hygiene and sanitation remained leading global contributors to morbidity and mortality in children and adults and that Community-led total sanitation (CLTS) was one strategy for improving sanitation access in which participants were guided into self-realization of the importance of sanitation through activities called "triggering."

He also found that Triggering activities elicited strong emotions, including shame, disgust, and peer pressure, which persuaded individuals and families to build and use latrines and hand washing stations. Further, traditional leaders such as chiefs and headmen were seen to have important cultural and legal influences in communities to play a major role in changing sanitation behaviours to become ODF.

In an impact evaluation of sanitation and hygiene program in Zambia investigated by Yeboah-Antwi et al., 2017, in spite of the various measures taken, Zambia, with improved sanitation coverage of 44%, was not able to reach the MDG 7c for water and sanitation which is halving the proportion of people without sustainable access to safe drinking water and basic sanitation by 2015 and Sustainable Development Goals (SDGs) or Global Goals, were complemented to improve upon the goals initially outlined under the MDGs.

The SDG 6, which builds upon MDG 7, has as one of the targets to achieve access to adequate and equitable sanitation and hygiene for all and end open defecation (ODF), paying special attention to the needs of women and girls and those in vulnerable situations by 2030.

It was found out that, to address the high burden of sanitation and hygiene related morbidity and mortality, especially in rural areas of the country, the Zambian government through the Ministry of Local Government and Housing (MoLGH), in partnership with UNICEF, the Department for International Development (DFID), and other cooperating partners, implemented the Zambia Sanitation and Hygiene Program (ZSHP) to contribute to the achievement of the MDG 7c (and SDG 6) targets in Zambia, with an additional 3 million people consistently using improved sanitation facilities and adopting related hygiene practices (such as hand washing with soap or ash).

In addition, ZSHP featured community led total sanitation (CLTS) as core activity comprising a package of activities including supporting enabling environments, sanitation marketing, school-led total sanitation (SLTS), and national behavior change communication to increase the use of improved sanitation facilities from an estimated 46% to 75% and contribute to the reduction of diarrheal diseases amongst children from an estimated 15% to 12%.

Finally, ZHSP demonstrated many improvements in sanitation and hygiene measures as well as associated improvements in important child health outcomes such as the prevalence of stunting and wasting, building a foundation for sustainability and expansion.

In Nigeria, a qualitative study by Francis et al., 2017 on barriers and enablers to becoming and staying ODF in remote Timor-Leste, location was found to be one of some enabling factors as it was perceived that people who lived close to the road (main road) could easily build toilets because they understood on how to build toilets and it is difficult to use bush to answer the call of nature and Chambers, 2009 had similar findings.

It was also found that households with children attending school near regional Centers were likely to have more toilets due to pressure put on parents by children to have same standards as the town or city. In addition, the perceived incentive of new water supply system became an enabler at the start of the program because some community members believed that it was dependent upon households building their toilets.

Similarly, a study by Ashley, 2010, in Sierra-leone, government has been providing incentives and rewards once the village becomes ODF. Once a village has been successfully ‘triggered’,

changes are said to be taking place in a matter of weeks or months, and can have a dramatic effect on individual and collective wellbeing. For example, a study by Ashley, 2010 from Sierra Leone, stated that; 'in three weeks, CLTS managed to do what millions of dollars, hundreds of construction projects, and dozens of NGOs failed to do over decades. CLTS inspired communities to take responsibility for cleaning up their villages, and has motivated them to do so.

2.3 Barriers to CLTS Implementation

In Zambia, in the same study by Lawrence et al., (2013), despite reported high latrine usage after CLTS triggering, several inhibiting factors were also discussed. These included socio cultural traditions and taboos regarding sharing a toilet facility and embarrassment using a latrine, because others may see someone enter and know that he or she is defecating. However, particularly influential is the long-standing taboo that people should never use the same toilets as their in-laws, members of the opposite sex, or different generations within a family. This belief has produced a formidable barrier to toilet use in many communities. About half of the Lundazi IDI participants, one-third of the Choma IDI participants, and one-fifth of those in Lufwanyama reported that people still refused to share toilets with their in-laws.

In Kenya, a similar study by Musyoki, (2007), cultural beliefs and traditions were cited to be key challenges. For instance, Maasai communities in some parts of Tanzania where social convention upholds the myth that men do not defecate at all, making public discussion of defecation virtually impossible. This was a barrier for any approach that sought to engage communities in mapping and publicly discussing defecation. Musyoki, (2007) noted that in other communities it is not traditionally allowed to share toilets among some members of the family. For example, among the Luo in Kenya, Uganda and Tanzania, it is taboo for in-laws to share a toilet or bathroom. It is assumed you will be cursed if you undress in the same space as your in-laws. It is believed that pregnant women may lose their fertility if they use pit latrines. A nother study in Uganda,by Mehta, 2009, found out that in some parts of Uganda, it is believed that if children's waste is disposed in a pit latrine they won't grow up to be healthy.

As earlier noted, Tefera, 2008 also found out that in Uganda and elsewhere, young children were afraid of using the toilets. Very small children were also allowed to continue to go in the

open. Similarly, whilst shame and dignity were important motivators for women, the taboo and shame around being seen whilst defecating also extended to latrine use. Women and girls did not want to be seen going to the toilets, so they often continued to go for defecation before sunrise or after dark even though they were now using toilets. In some areas, for example Alaba, women also do not use the same toilets as their in-laws, so separate toilets need to be built. It was found that even though health (45 per cent) and previous toilets filling up (43.8 per cent) were given as motivating factors for building toilets, most people dug the pits they never intended to use because they were told to do it.

In Ethiopian context, Tabuchi, 2002 noted that there are several constraints to behaviour change. Like in other parts of Africa, women do not appear to want to use toilets used by their fathers-in-law. They seem to want to use separate toilets. Many women complained about the lack and inadequacy of superstructures which meant that users of toilets were sometimes still visible which deterred some from using them. Some women, thus, seemed to prefer open defecation in the bush to using a toilet.

In a study by Cockerham, 2005 ,socio-cultural constraints and behaviour change has been a challenge to successfully improve CLTS coverage in many countries Old habits die hard and it is believed that often behaviour change for something as fundamental as health and wellbeing can only be achieved through structural forces and coercion. However, forcing people to use toilets cannot work due to strong cultural values held by the people in the communities.

Therefore, there is a need to understand cultural practices and beliefs in the communities in order to implement responsive strategies to facilitate behavior change. Furthermore, such behaviour change will also be influenced by factors such as rural-urban divides, migration, destitution and declining real income.

In Nigeria, the study by Francis et al., 2017 in remote communities in Manufahi District revealed many factors which affect the communities becoming and staying ODF. The most commonly raised factor by household representatives was the financial cost of constructing a toilet. Those who could afford bought the cement needed for a ‘permanent’ toilet which was the style of toilet preferred by most participants. Some said they had the funds, and even the cement, for building a ‘permanent’ toilet but needed to finish building their house or other projects first.

A study by Ashley, 2010 found out that the amount of time or effort required to construct a toilet was found to be a barrier. Those who had too much other work to do did not have time to build a toilet or they would stop after digging the pit because it was too much effort to gather the bamboo and sand needed for the toilet and superstructure. It was also noted that lack of prioritization of time or effort towards building a toilet as laziness, although this comment was only ever made about others.

According to a study by Chamber, 2009, the findings also revealed location as being a barrier to becoming ODF because people who lived far from the main road had difficulties to build toilets due to inadequate understanding on how to build toilets and they prefer using bush to answer the call of nature to using toilet (Ibid, 2009). Some participants referred to being instructed what to do as a factor in whether households became and stayed ODF. Some had mistaken implementing organisations, for instance, Water Aid to be representing a government agency and therefore built toilets to act in accordance with the law. However, even some of those who knew that Water Aid was not a government agency explained that if people trusted and liked the implementing staff, then they would follow their instructions.

A study by Sah, 2009, durability and lifetime of the toilets were found as factors for sustaining ODF status. Whilst many people built toilets initially, as the toilets broke down or filled up some would become frustrated at having to construct another toilet and revert to open-defecation. It was also found out that those unwilling to have merely a 'traditional' toilet might be deterred by the discomfort of such toilets due to the flies and smell; therefore, preferring to defecate in the open.

According to a study by Francis et al., 2017, the perceived incentive of the new water supply system may have been an enabler for some households at the start of the program after some community members believed that this was dependent on households building their own toilets, it became a barrier later because once the water system was operational the (perceived) incentive to maintain toilets were gone.

The vulnerable households would generally face specific challenges in becoming and staying ODF compared to non-vulnerable households. It was thought that households with people with disabilities or age related impairments were likely to find it difficult to build toilets for

themselves and believed that it was the responsibility of the relatives of vulnerable households to assist them.

Tefera (2008) argued that even though 'behaviour change' is the aim of sanitation programmes, this is difficult to sustain because many poor women and men face constraints in terms of resources, time and capacity with respect to their daily hygiene and sanitation practices (Tabuchi, 2002). In villages without much social cohesion and where special efforts have not been made to address interests of the poor, behaviour change of the whole population may not be achieved. There is also a tendency to lose sight of the role of water in the context of both livelihood strategies and in acting as a constraint towards toilet construction and use.

A research by Ripple, 2008 found that the most common problems with latrine construction and sustainability were floods, for example, in highland areas in Mirab Abaya. In some instances termites have been destroying the toilets which had been constructed from wood, for example in Alaba. However, the termite problem was being solved by using stone constructions instead. Similarly, according to a study by Mehta, 2009, sometimes the flooding of pits was said to have occurred whilst waiting for slabs. It was not clear whether having a slab subsequently solved the problem of flooding. If a latrine collapsed due to flooding, people may wait to reconstruct toilets till after the heavy rains and revert to open defecation in the meanwhile. Other reasons cited for not having toilets were lack of money, lack of awareness and lack of construction materials such as san plats which were considered as better toilets and looked clean for use, hence people wanted to receive handouts of san plats.

For some,(Mehta, 2009), additional factors preventing latrine construction included insufficient access to necessary materials (such as "strong logs") for building permanent toilet structures and poor soil conditions (either rocky soil that inhibits pit digging or sandy soil that predisposes latrines to collapse)

Study Objectives

2.4 Main Objective

The main objective of the study was to establish the enablers and barriers towards Community Led Total Sanitation coverage in selected chiefdoms in Monze District.

2.4.1 Specific Objectives

i. To identify the enablers to CLTS implementation in selected Chiefdoms of Monze District
ii. To explore the barriers to CLTS implementation in selected Chiefdoms of Monze District.
iii. To explore community attitude towards CLTS in selected Chiefdoms of Monze District

2.4.2 Research Questions

i. What are the barriers to CLTS implementation in selected Chiefdoms of Monze District?
ii. What are the enablers to CLTS implementation in selected Chiefdoms of Monze District?
iii. What are the community attitudes towards CLTS implementation in selected Chiefdoms in Monze District?

CHAPTER THREE: METHODOLOGY

3.1 Study Setting

The location of the study area was Monze District in Southern Province of Zambia. Monze District is in the Southern Province of Zambia, situated about 200 Kilometres South of Lusaka and 300 Kilometres North of Livingstone Town. The District covers an area of 6,687$Km^{2.}$ It shares boundaries with Mazabuka District to the North, Pemba District to the South, Gwembe District to the East and Namwala District to the West. The District has a projected population of 270,439 people (CSO 2017, Report).

The District has two major rivers namely Magoye and Kafue Rivers and several seasonal streams, which only have water during the rainy season. There is a dry spell from about April to October and the major sources of water during this period are dams constructed and ground water. The weather pattern consists of the wet season from November to March, the cold season from April to July and the hot season from August to October.

The main road passing through Monze links Lusaka to Livingstone. There is a fairly well-developed road network road linking the peri-urban part of Monze to the rural areas. Currently most township roads got a face lift by being upgraded to bituminous standard. The main road between Monze and Namwala is also being upgraded and tarred.

Monze District is home to a largely rural population and the main economic activity is agriculture. A small fishing community with an estimated population of 4,000 people lives in the Kafue Flats situated on the North-Western Part of the District.

These Islands can only be accessed by water transport. Communication between the District Health Office and the Health Centres is facilitated by the use of communication radios, land phones and Mobile Cell Phones.

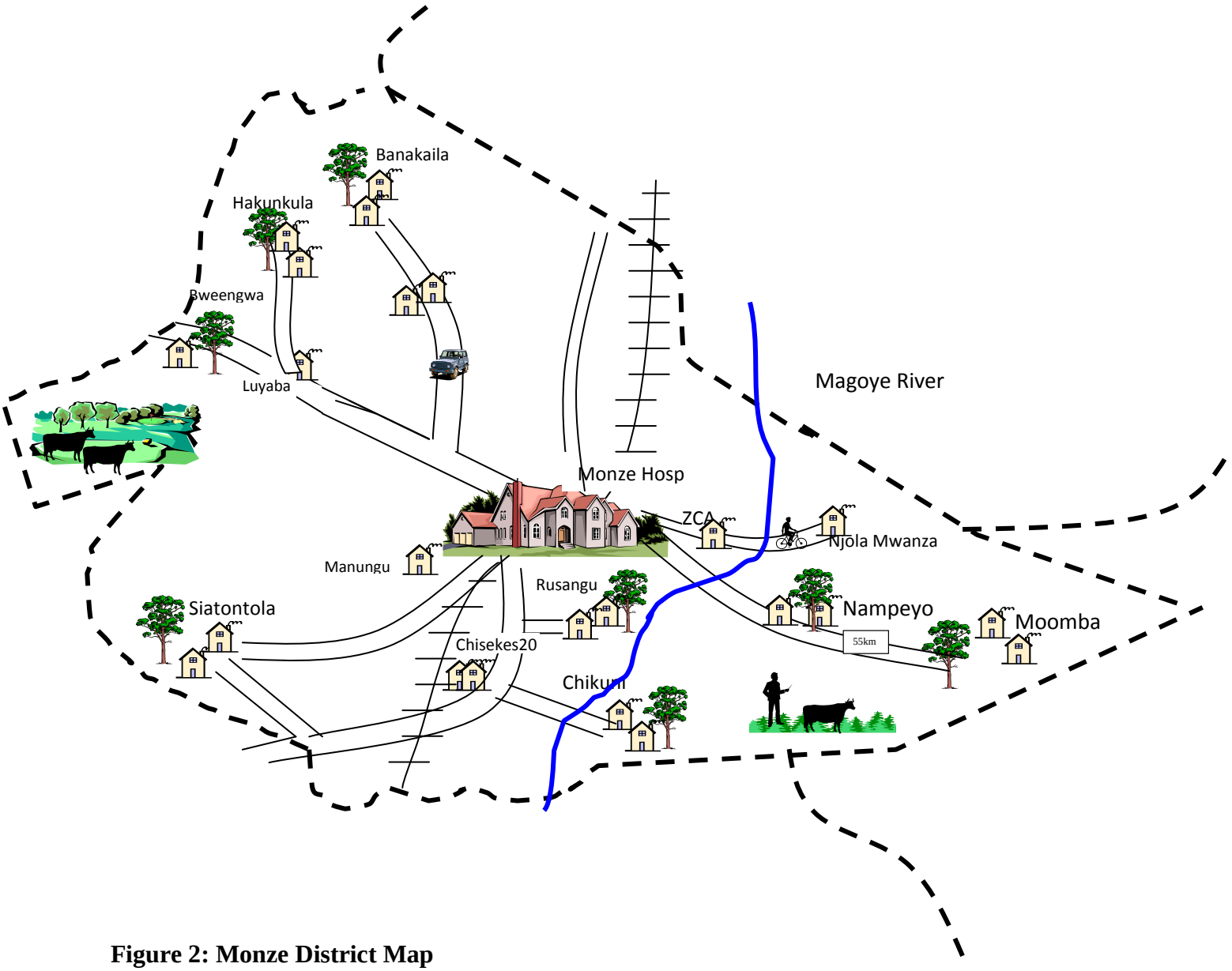

Figure 2: Monze District Map

3.2 Research Design

To get in-depth and detailed information on CLTS coverage in Monze District, the study used a qualitative explorative study design to establish the enablers and barriers towards CLTS coverage in Monze district. The study preferred to use the explorative study design to avail useful information on enablers, barriers and attitudes of the community towards the CLTS coverage. It is also carried out when little is known about the situation with an aim to gain an insight into a problem or situation through investigating people's views on the situation. Explorative study design provided more realistic responses directly from the respondents, and it was used when collecting information about the coverage of the programs, opinion or any social issues (Creswell, 2007). Furthermore, explorative study design was appropriate for this study because it involved interviewing and discussing with Key informants, supervisors and implementers of the project on the CLTS coverage and thereby collected data to show the actual situation on the ground.

3.3 Data Collection methods

Data included information that was gathered directly from the respondents such as traditional leaders, Community Champions, Environmental Health Technologists (EHTs), Ward Counsellors and other government officials in Monze district. The data was gathered using in depth interviews. Open ended questions allowed the respondents to give their own views.

The study assumed focus group and in-depth discussions as data collection methods used in qualitative research. Therefore, verbatim was used in presentation of opinions expressed by respondents. FGDs and in-depth interviews were conducted using interview guides; this allowed respondents to have freedom of expression to state how they understood the implementation process of CLTS. Key Informants included WASHE Coordinator-Town Council, WASHE Coordinator-District Health Office, Ward Councilors, EHTs, Community Champions, and Traditional Leaders. Focus Group Discussions were used to collect data from Chiefdom Sanitation Action Groups.

3.4 Data Collection Instruments

Interview guides for Key Informants and Focus Group Discussions were developed for use during this study.

3.5 Target Population

The target population for this study consisted of all those involved in the CLTS program in the selected chiefdoms which included 15 key informants (CLTS implementers and supervisors) in Monze District and two FGDs (One per Chiefdom). The key informants included; the Water Sanitation and Hygiene Education (WASHE) Coordinator-Town Council, the WASHE Coordinator-District Health Office (DHO), One CLTS district trainer, four Ward Councilors, four Environmental Health Technologists (EHTs), four Community Champions, two Senior traditional leaders and two Chiefdom Sanitation Action Groups (CSAGs)

3.6 Sample Size

Lavrakas (2008) described a sample in a research context as a subset of elements drawn from a large population. Sample size was a collection of units chosen from the universe to represent it (Kothari, 2004). The total sample size for this research study included 15 Key Informants and 2 Focus Group Discussions using Chiefdom Sanitation Action Groups with each chiefdom consisting of one Chiefdom SAG. The 15 Key Informants included; 1 WASHE Coordinator from Monze Town Council, 1 WASHE Coordinator from the District Health Office,1 District Trainer in charge of the two selected Chiefdoms, 2 Ward Councilors (one from each chiefdom trained in the program), 4 Environmental Health Technologists (two from each chiefdom trained in the program), 4 Community Champions (two from each chiefdom), 2 Senior traditional leaders also called the Ngambelas (one per Chiefdom). In addition, the researcher conducted two Focus Group Discussions with one per Chiefdom. Each Chiefdom Sanitation Action Group consisted of (8 to 10 members with both males and females for gender balance and selected because of their involvement and influence they had on CLTS program.

3.7 Sampling Techniques

The study used purposive non-probability sampling techniques to select the two Chiefdoms (Choongo and Hamusonde) as they had the lowest CLTS coverage. Furthermore, Key Informants such as Ward Councilors, WASHE Coordinator-Town Council, WASHE Coordinator-District Health Office, District Trainer, Environmental Health Technologists, Community Champions, Traditional leaders, and Chiefdom Sanitation Action Groups were also sampled using purposive sampling because of the key roles they played in CLTS coverage.

3.8 Data Analysis

Kothari (2004) defined coding as a process of reviewing notes and discovering common "themes." Therefore, after the data was collected, the responses were coded into main themes and sub-themes. In simple terms, thematic analysis involved integrating themes and responses into the text of the report by using Nvivo 11 Plus which illuminated the main themes for discussion that emerged from the research findings. This process allowed the researcher to interpret findings more easily. When all the data was analysed, data interpretation and synthesis was also done that led to the writing of the report.

3.9 Ethical Considerations

Research ethics were strictly observed when conducting this research to reduce psychological and emotional harm on the respondents. Ethical issues anticipated in this study included disclosing the use of toilets at households especially during FGDs which was considered as taboo in communities which had strong traditional practices. Disclosing personal information (private information) on barriers of CLTS implementation was another ethical issue which participants could be uncomfortable to give. To mitigate on these ethical issues, the researcher assured the participants that the information was to be used for academic purposes and were also assured of the confidentiality of the information given ie the personal identifiable information of the participants would be kept confidential. The data collected from respondents was kept in a secure and private place. Informed consent and voluntarism were required to ensure that participants join the study out of their own free will. Participants were also informed that they were at liberty not to answer any question which made them feel uncomfortable and were even free to drop out of the study without any implication to them or their family members.

Ethical approval for the study was also sought from University of Zambia Biomedical Research Ethics Committee (UNZABREC) and permission from the Zambia National Health Research Authority (ZNHRA).

Furthermore, the permission letter to conduct this study was sought from Monze Town Council and traditional leaders.

CHAPTER FOUR: RESULTS

4.1 Introduction

The results are presented according to the emergent themes that were identified during the data analysis. Firstly, we provide description of the enablers and barrier to implementation of CLTS. Secondly, we then present community perspectives on user attitudes towards the CLTS interventions in Monze District.

Table 1: Summary of key thematic areas

Major Themes	**Emergent Themes**
Enablers to CLTS implementation	• Community sensitization • Material support • Punitive action • Feeling of shame
Barriers to CLTS implementation	• Environmental barriers • Inadequate human resource • Lack of financial motivation • Inadequate support from local leaders • Lack of support with building materials • Lack of transport • Poor individual behaviours/attitude
Community attitudes/perspectives towards CLTS	• Reduced water-borne diseases • Increased awareness and Knowledge • Acceptable among community members

4.2 Enablers to CLTS implementation

A number of factors enabling implementation of the CLTS interventions were identified. Among them included the wide community sensitization conducted prior to implementation, material support for toilet construction provided by programme implementers, punitive action by the traditional leaders as well as involving a feeling of shame among community members who behaved in the contrary to community efforts to achieve the open defecation free status.

4.2.1 Community sensitization

Participants reported that a lot of sensitization aimed at increasing awareness had been done by the government through the Environmental Health Technologists, with the help of Non-governmental organizations such as Development Aid from People to People (DAPP). The participants added that they were very committed to disseminating information to the community members during the implementation of CLTS activities. Thus, this prompted the community members to continue constructing latrines in an effort to attain ODF status.

> "*with massive sensitization and campaign by the Ministry of Health and DAPP, at least a lot of the villagers now know the importance of using a latrine to defecate as opposed to running to the bush. This has made many households to build pit latrines than before."* [IDI 4, M 13.02.19]

4.2.2 Material support

Most of the respondents stated that some Non-governmental Organizations such as DAPP, were supplying or giving free building materials such as roofing sheets and cement to households for the construction of pit latrines. This helped in increasing coverage of CLTS program in the chiefdoms to where it is currently being implemented.

> *"we had DAPP and other stakeholders who used to give us free cement and roofing sheets, when the program (CLTS) started somewhere around 2015. At least with this support, a number of villagers were encouraged to construct pit latrines before this support was stopped…"* [FGD, 7 M 15.02.19]

4.2.3 Feeling of shame

The Behaviour change techniques promoted under the CLTS were meant to ignite "a sense of disgust and shame" in the community about open defecation practices. Feeling of shame and disgust arose as an important influence of behavioral change as respondents reported that shame was particularly powerful in relation to the exercise where flies are observed moving between feces and food at a given a household.

> *"we were touched and felt embarrassed during demonstration on how we eat contaminated foods because of defecating openly. We realized that we have been eating shit and drinking contaminated water and thus, realized the importance of having a toilet.*" [FGD, 6 M 15.02.19]

4.2.4 Punitive action by traditional leadership

Leadership social structures and leadership styles practiced in the selected chiefdoms contributed significantly to either the success or failure of CLTS implementation in Monze District. Community leaders including most villagers stated that a policy aimed at punishing households without toilets was being enforced across most CLTS chiefdom. They further said that households without an erected toilet get charged and pay either a k300, or a cow.

> "*if we find or realize for the first time that a household lacks a toilet, we would charge the household head a k300 which would then be channeled to constructing toilets for the aged. And then if we visit that household for the second time and still find that they don't have a toilet, we would then make them pay a cow".* [IDI 9, M 14.02.19]

4.3 Barriers to implementation of CLTS

The respondents revealed a number of barriers which were a hindrance to the successful implementation of CLTS programmes especially in the two selected chiefdoms Hamusonde and Choongo where sanitation coverage was relatively low. The identified barriers included environmental related, lack of resources, inadequate finances and lack of human resources.

4.3.1 Environmental barriers

The participants narrated that they faced a challenge of building toilets owing to the poor soil in the CLTS chiefdom areas. They added that the type of soil in their areas was sandy and that during rainy season the rainy water would wash away their toilets no matter how good they were. This restricted the number of toilets that can be built in a given area. Even when toilets were built, they could not stand the test of time.

> *"here in the district, some areas have bad soil which is sandy. Imagine, you can build a toilet quite okay which can even be strong enough but when it is rainy season, the water from the rain will wash away the toilet because the soil type does not strongly support the toilet structure".* [*FGD*, 5 M 15.02.19]

4.3.2 Inadequate human resource

The participants expressed dissatisfaction with regards the number of people who were willing to participate in the implementation process of the CLTS program. They said that the numbers of those on the ground who are trained on how to construct good quality latrines were few compared to the area they needed to cover. This they stated that affected their productivity in terms of how many toilets construction activities they can oversee or be involved in.

> *"I feel like the number of trained SAGs who are supposed to help in the construction of pit latrines are very few, we need to increase that number because the area that we need to cover is very big. In fact, some people are not even willing to be part of us as implementers of this program due to lack of motivation."* [IDI 8, M 14.02.19]

4.3.3 Lack of transportation

About two-thirds of the study participants reported challenges with transport to and from the chiefdom for construction activities, and a lack of resources, such as talk-time for communication. Most key personnel involved in CLTS implementation, such as Community Champions, Headmen, and SAGs reported that one of their major challenge was the lack transport to move around the chiefdom, and inspect other projects. This made it difficult for them

to cover large distances between chiefdoms and spread critical messages about sanitation and hygiene.

> *"we are very much willing to work, but you see, we do not receive any support in terms of transport and also talk time for our phones. Like for me, I just use my own bicycle and buy talk time using my own money. This affects our work in the field very much."* [FGD, 10 F 15.02.19]

4.3.4 Lack of financial motivation

Almost all different categories of participants, with an exception of Environmental Health Technologists (EHTs) complained about a lack of financial support/appreciation to fully execute their CLTS duties. They said that lack of emoluments demotivated them from doing their jobs effectively. It also affected the sustainability of the CLTS, because some community members who started well could not sustain ODF if not continually supervised.

> *"you know, we are very much willing to move this program forward, but unfortunately we do not get paid for anything. We do this work for free and just for passion. We have families that we need to take care of, but with the current situation, we are demoralized to even work effectively as we are supposed to."* [IDI 3, M 13.02.19 Champion]

4.3.5 Inadequate support from local leaders

Some of the participants felt that their traditional leaders were not supporting the CLTS program fully as they never used to implement some of the policies aimed at enforcing every household to own a toilet due to lack of support and motivation to traditional leaders. The lack of support by the traditional leadership in certain instances meant that some residents of certain chiefdoms did not feel obliged to own a toilet. It also meant that sanitation was not prioritized under the local leadership structures in such chiefdom.

> *"it is not that easy to achieve the status of ODF because the traditional leadership is not sufficiently enforcing some of the policies such as fining households found*

not to have a toilet with a k300. I feel they need to change how they are implementing some of these policies." [IDI 10, M 14.02.19 Councilor]

4.3.6 Poor individual behavior/attitude

Despite adequate sensitization on the importance of using a toilet some local leaders in the Chiefdom stated that, villagers still opted to defecate openly in the bush. They added that, despite the majority of the villagers knowing the importance of using a toilet, there were still some who had the old habit. These kinds of people were said to behave in an irresponsible manner. The chiefs stated that even if such people could be punished, they could only go as far as the law could allow with the hope that one day such subjects can learn from the negative outcomes of poor sanitation and behave appropriately.

"there are some people in our village who actually still run to the bush to defecate. They would leave behind, a pit latrine toilet and opt to go to the bush to answer the call of nature because they are used to doing so and don't see themselves changing their behavior and attitude anytime soon" [IDI 1, M 13.02.19 Headman]

4.3.7 Lack of support with building materials

Initially, when the program of CLTS started, community members were supported with roofing sheets and bags of cement in efforts to achieve ODF. This support however, never continued according to most respondents who said that this lack of support contributed to the slowing down or stagnation of the coverage rate of CLTS across the chiefdoms in Monze. In contrast, some community members who were asked about building latrines reported that cost was not a limiting factor as local and traditional building materials could easily be sourced within the community at a minimal cost.

"we need the support of the NGOs and the government to continue. At least in the past, they used to supply us with pockets of cement and roofing sheets which I think helped in building pit latrines. But ever since they stopped supporting us, most of the villagers are now reluctant to build toilets as they feel neglected. This

I feel has contributed to the failure of our chiefdoms to reach ODF status." [FGD, 2 F 15.02.19]

However, another participant had a slightly different view;

> *"The government and some organizations used to help us with cement, but they stopped doing that as the villagers used to sell the cement for monetary gains. This made the NGOs to stop sponsoring us with cement. Nevertheless, even if they stopped the support, we can still use what we have like grass to thatch our toilets and also make mad bricks, which are in fact free to source."* [IDI 2, M 13.02.19 Councilor]

According to the senior headmen from Chief Hamusonde and Choongo respectively, the other factor which affected either the success or failure of CLTS is the cultural and traditional values within Monze District. The other two chiefdoms lagging behind in sanitation coverage, Chiefs Choongo (45 percent) and Hamusonde (40 percent) predominantly practice pastoral agriculture which is done on semi-nomadic arrangement (transhumance). These have temporal homesteads, one in the flood plains where they migrate to graze their animals during the dry season and the upper lands used at times when the lower plains are flooded. Such transhumance arrangements make it practically impossible to construct permanent latrines and people resort to Open Defecation as opposed to Open Defecation Free.

4.4 Community Attitudes

In establishing the attitude of the community towards Community Led Total Sanitation (CLTS), it was very cardinal to establish if the respondents understood the concept of CLTS adequately.

The program was extensively and adequately campaigned throughout the district and most respondents indicated that they were aware and understood the programme and its purpose.

4.4.1 Reduced water-borne diseases

Many respondents reported a perceived reduction in diarrhoea-related diseasesever since CLTS program was initiated. This was said to be the case by both in the community CLTS members

and Environmental Health Technologists (EHTs) based at health facilities. Overall, perceptions of CLTS were highly positive.

> "*In the past years before CLTS program was initiated, we used to experience a lot of cases of diarrhea, but after the program was initiated, at least we have seen a decrease in the number of these cases."* [IDI 13, 14.02.19 EHT]

4.4.2 Increased awareness and knowledge

Almost all participants reported increased knowledge of the CLTS program, and they described the positive effect it had on their chiefdoms, including more knowledge regarding latrine construction and usage, disposal of waste, and water usage. They also attributed this increase in knowledge and awareness to significant increases in household latrine construction than before.

> *"A number of us in our village are very much knowledgeable with regard to the importance of using a toilet to answer the call of nature as opposed to the bush. This current number of pit latrines that you are seeing I as a result of community members being more aware of the dangers of not having a toilet."* [IDI 11, F 14.02.19 Champion]

4.4.3 Program acceptance

During interviews, most respondents said that the process of triggering resulted in a deep understanding by the community accompanied by a feeling of shame. This in turn, has resulted in the acceptance of the idea of constructing pit latrines through Community-led Total Sanitation (CLTS) program by the majority of the community members.

> "*triggering and regular meetings have made most of us as community members to realize how dirty we have been living in the past. This has actually made most of the villagers welcome and embrace the idea of CLTS. It's actually a very good program for us".* [FGD, 8 M 15.02.19]

CHAPTER FIVE: DISCUSSION OF FINDINGS

5.1 Introduction

Community-led total sanitation (CLTS) is an approach used mainly in developing countries to improve sanitation and hygiene practices in a community. It focuses on spontaneous and long-lasting behavioral change of an entire community, of which the goal of CLTS is to end open defecation (OD). The current study has highlighted factors that have both enabled and hindered the progress by the community towards achieving ODF. In addition, it has also brought out the views regarding the CLTS program in general by community members and other stakeholders involved in the implementation process.

5.2 Enabling

The current study showed that one of the factors that have helped facilitate the construction of latrines was the triggering process which brought out the feeling of shame by community members. This is also in line with the other study done by Lawrence et al., (2013), that found out that triggering also elicited strong emotions and shame which led to families constructing and using latrines.

The current study findings also indicate that frequent sensitization and awareness campaigns that were done by champions, SAG members, EHTs and traditional leaders (headmen and women) as cited by most of the participants acted as motivator for latrine construction in the chiefdoms.

The participants added that they were very committed to disseminating information to the community members during the implementation of CLTS activities. Thus, this prompted the community members to continue constructing latrines in an effort to attain ODF status. This was supported in a study by Jenny et al., (2014), where community members were more willing to construct latrines after massive campaigns that led to villagers being made more aware of the importance of achieving ODF. Behaviour change techniques used in CLTS are meant to ignite “a sense of disgust and shame” in the community about open defecation practices. The underlying assumption is that once people are convinced about the need for sanitation, they construct their own toilets according to the resources that are available (financial, land and so on).

In addition, before the program of CLTS was initiated in 2011, households would receive materials for their toilet constructions which included roofing sheets and cement. This was seen by most members of the community as a positive move that motivated and advanced the progress of attaining ODF status through latrine construction in the two chiefdoms where the current study was conducted. However, according to Galvin (2015), the original concept of CLTS did not include subsidies for toilets,and that CLTS proponents at that time believed that provoking behavior change in the people alone would be sufficient to lead them to take ownership of their own sanitation situation, including paying for and constructing their own toilets.

It should also be noted that the strength of any CLTS program mainly lies in a community-based approach in which community members reach their own conclusions about the importance of having good sanitation and thereby develop their own strategies for implementing changes based The traditional leaders such as chiefs and headmen were seen to have important cultural and legal influences in communities and play a major role in changing sanitation behaviours. The Zambian Government and UNICEF also established a chief to chief advocacy strategy by using seven chiefs with verified ODF chiefdoms (MOH & UNICEF, 2014)

On material support, Most of the respondents stated that some Non-governmental Organizations such as DAPP, were supplying or giving free building materials such as roofing sheets, san plats and cement to households for the construction of pit latrines. This helped in the increase of coverage of CLTS program in the chiefdoms to where it is currently.

However, in some cases where the programme was not successful, the recipients of sanitation materials diverted the materials and used them for the purpose they were not intended. This was common in chief Hamusonde and Choongo where DAPP had come up with the programme to improve sanitation through provision of basic materials needed for construction of latrines. Materials were abused and used for the personalized interests other than the sanitation Progammes intended for and CLTS could not take off as planned.

Leadership social structures and leadership styles practiced in the selected chiefdoms contributed significantly to either the success or failure of CLTS in Monze District

Community leaders including most villagers stated that a policy aimed at punishing households without toilets have been laid out. They further said that households without an erected toilet get charged and pay either a k300, or a cow.

5.3 Barriers

A number of challenges hinder the successful implementation of CLTS program in most rural areas. In the current study, community members of Choongo and Hamusonde chiefdoms face different challenges ranging from environmental, human resource, financial resources, inadequate support from local leaders, building materials to lack of transport and poor individual behavior/attitude.

Poor soil condition was stated by participants as one of the challenges being faced in latrine construction as the soil is mainly sandy. It is reported that several areas of Zambia's Southern and Eastern provinces face challenges in latrine construction which include soil conditions and insufficient natural resources to build latrines. In Zambia, many such barriers have been overcome through community-led innovations in latrine construction (Cole, 2013). In CLTS triggering, specific designs of latrines are not presented. Instead, basic principles of sanitation are conveyed and communities are left to adapt their own designs and methods for building toilets (Kar et al., 2008).

The current study indicated that lack of material support for toilet construction was also seen to be one of the barriers to achieving ODF. A study conducted in Timor-Leste (Francis et al., 2007) found similar results, in that the community was disappointed with CLTS program that was being implemented by Water Aid for not providing material subsidies and therefore did not bother to build their toilets. However, according to Kar et al., (2008), it is important that CLTS involves no individual household material support for latrine construction and does not prescribe latrine models to enable community members build latrines according to their capacity and available resources and materials. In fact, almost all households are encouraged to build latrines with locally available materials; however, the resulting latrines are sometimes unable to withstand tough environmental conditions, such as floods, poor soil conditions, or termites. However, even with the above recommendations by Karl and Colleagues (2008), Tyndale Biscoe (2013) reported that studies on ODF sustainability in Ethiopia, Kenya, Uganda, and other

countries found that financial constraints, lack of support, maintenance and repairs, and quality of initial construction were all barriers to maintaining ODF status.

Another challenge in the uptake and the sustainability of CLTS coverage successes may be the human and financial resources needed to build latrines, particularly given the lack of subsidies in this approach. Although communities are not told specifically how to build a latrine, reducing costs and allowing for innovation and adaptation to locally available materials and construction techniques, some communities still may find building latrines to be a burden, particularly in areas where natural resources are scarce. A study by Jenny et al., (2004) in India found that "the people have a mindset that the government and partners should provide the financial assistance; then only, they will construct the toilets. But they are ready to contribute in terms of labor and money, if the government will provide some financial assistance for toilet construction".

In addition, transport was cited as one of the main challenges faced by the different groups (e.g Community Champions, EHTs, SAGS, Councilors e.t.c) tasked in the CLTS program to continue with their responsibility of supervising and monitoring households in the villages within their Chiefdoms. This has led to monitoring and supervision being reduced as some villages are located in very remote areas making it difficult to access them. The consequence of these findings is that it affects the attitude and behavior towards the achievement of ODF status as people develop the tendency of becoming reluctant when no consistentt follow-up is made. These findings are similar with the ones by the Water and Sanitation Program (WSP, 2011) conducted in East Java which revealed that lack of follow-ups was a barrier to collective behavior change to stop open defecation. In addition, Kar et al.,(2008) and Tyndale-Bicsoe et al., (2013) also stated that the success of the CLTS coverage process mainly depended on follow-ups that need to be well planned. Furthermore, in the current study, it came to light that some community members still were in a habit of defecating openly despite having a toilet nearby. A study by WHO/UNICEF Joint Monitoring Program of 2013 findings in the study conducted in East Java are similar in that, it was reported that some household members were defecating in the open despite owning latrines. Another study by Jenny et al., (2004) conducted in Odisha, India, also found that some of the family members in that community were going for open defecation, as they are habituated with open defecation practice.Thus, they opted to go for open defecation instead of using toilets.

5.4 Community Attitude

During the "triggering" process of CLTS program in the chiefdoms, community members were shown how infection transmission happens. Triggering is based on stimulating a collective sense of disgust and shame among community members as they confront the crude facts about mass open defecation (OD) and its negative impacts on the entire community (Kar and Chambers, 2008). The basic assumption is that no human being can stay unmoved once they have learnt that they are ingesting human waste.

Participants had a strong perception that diarrheal disease burden decreased greatly after the introduction of CLTS program in the chiefdoms. However, it should be noted that there was no documented evidence of a reduced disease burden as the study was purely based on interviews. Therefore, these perceptions may stem from assumptions about the potential impact of CLTS. In addition, the results may actually suggest more about positive reception and acceptance of CLTS and the triggering process, than an actual reduction in diarrheal diseases. A study by Joseph Lawrence and others (2016) conducted in Choma district of Zambia found similar findings as the community members reported noticing a significant reduction in diarrheal cases as more villagers built latrines.

This study highlighted new behaviors by community members, including increased latrine construction and usage which were widely reported in the two chiefdoms by the participants. This was as a result of acceptance of the program (CLTS) and increased awareness and knowledge about the importance of achieving ODF status through latrine construction. However, a systematic review done by Phiri and Mkanda (2010) showed limited success in long-term impact. In addition, a study conducted in India by Barnard S and colleagues (2013) found that the majority of community members were still defecating openly, despite a major CLTS campaign which was followed by dramatic uptake in latrine coverage.

CHAPTER SIX: CONCLUSION, RECOMMENDATIONS AND LIMITATIONS

6.1 Conclusion

With the findings that have been highlighted, planning an improved CLTS intervention can utilize the current study which can serve as a framework for deciding which factors should be taken into account. Behavioural techniques used during the triggering process (which primarily were shaming and inciting disgust to trigger change) were described by participants as effective means to motivate community members to end open defecation. However, this was viewed as not necessarily a way of sustaining behaviour change.

Achievement of ODF status is believed to serve as a powerful motivational tool for communities to change their sanitation practices.Nevertheless, the CLTS program implementation has continued to face a number of challenges that act as barriers to the achieving of ODF status in most rural settings in developing countries. In the current study, it has been shown that there are more challenges to CLTS implementation than enablers. It is these challenges that need to be eliminated that the chiefdoms under study including other similar settings can see rapid improvements towards ODF status. With the findings of the current study, it can be stated that the effectiveness of CLTS as a behaviour change strategy for promoting adoption of improved sanitation behaviours in Zambia is supported. Nevertheless, more improved monitoring of activities need to be done as this will help generate enough evidence on the potential, the effectiveness, and the limits of CLTS

6.2 Recommendations

Given that the majority of the participants cited reduction in diarrheal-related diseases, frequent supervision by different community leaders and punishment by the Chiefs were seen as respectful practice by most of the participants, it is thus recommended that these reasons be emphasized during designing of messages and when holding community sensitization meetings.

The traditional leaders and Sanitation Action Group members must continue with frequent supervision and monitoring of CLTS activities in their respective villages if ODF status is to be sustained.

In as much as results of the current study indicate somehow an increase in the reported usage of latrines, further research should be conducted to determine actual usage.Future research and programs should consider focusing on routinely collecting data (including baseline measurements) on household- level indicators of sanitation so that they can measure and recognize incremental progress in these communities.

6.3 Study limitations

The selection was limited to only two Chiefdoms in the district and may not be generalised as a representative sample for all chiefdoms in the district and or province.

Interviews could intimidate the respondents if the interviewer lacked interviewing skills, hence experienced Research Assistants with good interviewing skills were used to collect data from the respondents.

Since this study only collected data from community leaders such as champions, Civic leaders and SAGs, we were only able to collect data on reported latrine usage. However, as with most socially desirable behaviours, there is a discrepancy between reported usage and actual usage as shame and disgust play an important role in behaviour change in most CLTS programs. The guilt that community members felt as a result of the CLTS process might have caused them to be unwilling to openly admit that they still had open defecation in their villages.

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APPENDICES

INFORMATION SHEET

This information sheet is meant for Civic & Traditional Leaders, Environmental Health Staff and Community Champions that have been invited to take part in a study "An assessment of CLTS implementation in selected Chiefdoms in Monze district".

Dear participant(s),

My names are Hazyondo Gift. I am a student at the University of Zambia doing a Master's Degree program in Public Health. My research team and I are doing a study in your area on investigation of barriers and Enablers to CLTS implementation in Monze. We invite you to take part in this study because we feel that you can help us with the information that we require. If there is anything you do not understand please feel free to ask as we go through this information form and we will explain to you.

Purpose of the study

- The main aim of this study is to assess the CLTS implementation in selected Chiefdoms in Monze District.

The study will also:

- To explore the barriers to implementation of CLTS in selected Chiefdoms in Monze District;
- To identify the enablers to implementation of CLTS in selected Chiefdoms in Monze District;
- To document community perceptions in respect to implementation of CLTS in selected Chiefdoms in Monze District

Type of Research Intervention

- The study will ask you to take part in key informant interviews that will take about 45 minutes to an hour only.

Participant Selection rational

You are being asked to take part in the study because we feel that what you know as a Civic & Traditional leader, Environmental health Staff and community Champion will help us to understand the issue of barriers and enablers to CLTS implementation in your area.

Voluntary Participation

Your participation in this study is absolutely voluntary. Therefore, you are free to take part or not.

Duration

The interview will only be done once and will take about 45 minutes to an hour.

Risks

There are no risks anticipated in this study. However, in case you feel that some information is personal or confidential, feel free to tell us. Your taking part in this study will not affect your work in any way.

Benefits

Although the findings of this study may not benefit you now, it will help Government and its stakeholders in coming up with strategies to improve CLTS implementation in your area and the District in general.

Confidentiality

Anything you tell us will be kept as secrete and nothing you say to us will be personally applied to you in any reports that result from this interview. All of our reports will be written in such a way that no individual comment can be applied to a particular person. We have thought of including you in this study because we believe you know something about the implementation of CLTS in this area.

Sharing of results

The results from the information collected will be submitted to the University of Zambia and shared with appropriate stakeholders.

Right to refuse or withdraw

You have the right to refuse to take part or to withdraw from the study at any time.

Whom to contact

If you have any questions, you may ask me now or later. If you wish to ask questions later, you may contact me on the following address:

GIFT HAZYONDO
UNZA School of Public Health
Department of Health Policy and Management
P.O Box 50110, Lusaka.

Cell 0977704198/0972662412/0955804198
Email: gifthazyondo25@gmail.com
The Chairperson: The University of Zambia Biomedical Research Ethics Committee (UNZABREC)

CONSENT FORM

I have read the foregoing information and I understand completely what the research is about, or it has been read and explained to me. I have had the opportunity to ask questions about it and any questions that I have asked have been answered to my satisfaction. I consent voluntarily to participate as a participant in this study.

I ……..……..(Names) agree to take part in this study.

Signature or Thumb print …… Date…… (Participant)

Witness…..…… (Names);

Signature or thumb print ……Date……

Persons to contact for problems and queries:

GIFT HAZYONDO
UNZA School of Public Health
Department of Health Policy and Management
P.O Box 50110
Lusaka.
Cell- 0977704198/0972662412/0955804198
Email: gifthazyondo25@gmail.com

The Chairperson: The University of Zambia Biomedical Research Ethics Committee
(UNZABREC)

UNIVERSITY OF ZAMBIA

INTERVIEW GUIDE FOR KEY INFORMANTS

Dear Respondent,

I am **Hazyondo Gift,** a student at the University of Zambia pursuing Master of Public Health Degree in Health Policy and Management. I am carrying out research on "An **assessment of the Community Led Total Sanitation (CLTS) implementation in selected Chiefdoms in Monze District"**. You have been purposively selected to help in providing information on this study because you are a person who is expected to have information on this topic. This study is purely for academic purposes and your participation is completely voluntary. Your responses will be treated with utmost confidentiality and therefore there is no cause for fear. The success of this survey depends on your co-operation and the correctness of the information you provide in the spaces provided.

Consent for the Participants

Are you willing to participate in this research study?

1. **Yes [ ] (Proceed with the Interview)**
2. **No [ ] (Do not proceed with the Interview**)

Signature/Thumb of Participant/ Interviewee:……..

Date……/……./……

Duration:……

Place:……

Interviewer:……

SECTION A: BACKGROUND CHARACTERISTICS

1. Please tell me about yourself. Probe more on these-:

a. Chiefdom…..……..

b. Ward…….

c. Position……

d. Number of Years in the Service/position……..

e. Main Duties:

……..……..……
……
……..……..

SECTION B: PROJECT STRUCTURES IN THE CLTS IMPLEMENTATION

2. In your own words, how would you explain CLTS to someone who has never heard of it?
3. According to you, what is the difference between CLTS and other approaches to sanitation?
4. Who are the implementers/actors of CLTS Program implementation here? Probe more on these:-

a. Government departments involved in CLTS implementation?

b. Chiefdom Sanitation Action Groups and Community Champions?

c. Community Leaders (Chiefs and Head person)?

d. What about community members themselves?

5. When you say "Open Defecation Free (ODF)", what do you mean by that? Probe more on these:-
6. Are there any rewards offered to communities for achieving ODF?
7. How often to you monitor/evaluate the coverage progression in these communities?
8. Training provision to stakeholders under CLTS Programme.

   Probe regarding training:

a. What type of trainings does CLTS provide to stakeholders such as your selves?

b. Who are usually trainees? (Traditional leaders, NGOs, Community Champions)

c. What support do Chiefdom Sanitation Action Groups and Community Champions provide in CLTS implementation?

d. Are the people trained provided with support?
e. Are the trainings adequate? (Probe whether the trainees are using knowledge acquired from trainings in the CLTS implementation)
f. Are the project stakeholders trained in the roles to play in the CLTS implementation?

SECTION C: ENABLERS TO IMPLEMENTATION OF CLTS IN CHIEFDOMS

9. What are the enablers to implementation of CLTS in Monze District?
    a. How do Government Departments support CLTS implementation?
    b. How do NGOs support CLTS implementation?
    c. How do chiefdom SAGS support CLTS implementation?
    d. How do Community leaders support CLTS implementation?
    e. Are there incentives provided to stakeholders who participate in CLTS implementation? Probe the type of incentives being provided and whether such incentives motivate them to participate actively?
    f. In your opinion, what other factors apart from the ones you have stated have also contributed to the successful implementation of CLTS in the Chiefdom?

SECTION D: BARRIERS TO IMPLEMENTATION OF CLTS IN CHIEFDOMS

10. What are the barriers to implementation of CLTS in Monze District? Probe more on these:-

a. What cultural practices and values hinder the implementation of CLTS in the Chiefdom? (Probe more on cultural practices)

b. What is the most difficult part of CLTS program implementation according to you? Why?

11. What other barriers hinder the successful implementation of CLTS in the Chiefdom?

SECTION E: PERCEPTIONS OF THE COMMUNITIES TOWARDS THE CLTS PROGRAMME

12. What perceptions do communities have towards the CLTS in Monze District? Probe more on:-

a. Explain how the communities have accepted/embraced the implementation of CLTS in the Chiefdom?
b. According to your opinion, do you think communities understand the importance of CLTS?
c. Before CLTS Program came to this Chiefdom/community to talk about sanitation, what was the overall sanitation situation like here?
d. In terms of health, what were the main health concerns of people in these communities? What about now?

13. What measures need to be put in place to improve the implementation of the CLTS Program in this Chiefdom?

THE UNIVERSITY OF ZAMBIA

GUIDE FOR FOCUS GROUP DISCUSSION

Dear Respondent,

I am **Hazyondo Gift,** a student at the University of Zambia pursuing Master of Public Health---Health Policy and Management. I am carrying out research on "An **assessment of the Community Led Total Sanitation (CLTS) implementation in selected Chiefdoms in Monze District"**. You have been purposively selected to help in providing information on this study. This study is purely for academic purposes and your participation is completely voluntary. Your responses will be treated with utmost confidentiality and therefore there is no cause for fear. The success of this survey depends on your co-operation and the correctness of the information you provide in the spaces provided.

Consent for the Participants

Are you willing to participate in this research study?

1. **Yes [ ] (Proceed with Focus Group Discussion)**
2. **No [ ] (Do not proceed with the Discussion**)

Signature/Thumb of Participant/ Interviewee:……..

Date……/……./……

Duration:……

Place/Wards/Chiefdom:……

Interviewer:……

Number of participants ……. Male…..……. Female……..

SECTION A: PROJECT STRUCTURES IN THE CLTS IMPLEMENTATION

1. In your own words, how would you explain CLTS to someone who has never heard of it?
2. According to you, what is the difference between CLTS and other approaches to sanitation?
3. Who are the implementers/actors of CLTS Program implementation here? Probe more on these:-

a. Government departments involved in CLTS implementation?
b. Chiefdom Sanitation Action Groups and Community Champions?
c. Community Leaders (Chiefs and Head person)?

d. What are your roles you play as community members? How do you come in ?

4. When you say "Open Defecation Free (ODF)", what do you mean by that? Probe more on these:-
5. Are there any rewards offered to communities or organizations for achieving ODF?
6. What type trainings does CLTS Program provide to the stakeholders? Probes regarding training:

- What of the type trainings were provided?
- Who were trained? (Traditional leaders, Community Champions)?
- Were the people being trained (trainees) provided with the support (fuel, food)?
- Were the trainings adequate (Probe whether the trainees are using the knowledge acquired from the trainings in the CLTS implementation).
- Were the project stakeholders trained in the roles to play in the CLTS implementation?

SECTION B: ENABLERS TO IMPLEMENTATION OF CLTS IN CHIEFDOMS

7. What are the enablers to implementation of CLTS in Monze District?

a. What support do government departments provide in CLTS implementation?
b. What support do NGOs provide in CLTS implementation?
c. What support do Chiefdom Sanitation Action Groups and Community Champions provide in CLTS implementation?

8. What support do Community Leaders (Chiefs and Head person) provide in CLTS implementation?
9. Are there incentives provided to stakeholders who participate in CLTS implementation? Probe the type of incentives being provided and whether such incentives motivate them to participate actively?
10. What kind of changes, have you noticed if any, in the communities since you started the implementation of CLTS here? This does not only have to be related to open defecation.
    Probes on:-
    - Why did these changes happen according to you?
    - Any changes not related to sanitation?
    - Is there anything else you would like to change that has not yet changed?

11. What other factors have contributed to the successful implementation of CLTS in the Chiefdom?

SECTION C: BARRIERS TO IMPLEMENTATION OF CLTS IN CHIEFDOMS

12. What are the barriers to implementation of CLTS in Monze District? Probe more on these:-
    a. What cultural practices and values hinder the implementation of CLTS in the Chiefdom? Probe more on cultural practices.
    b. What is the most difficult part of CLTS program implementation according to you? Why?
13. What other barriers hinder the successful implementation of CLTS in the Chiefdom?

SECTION D: PERCEPTIONS OF THE COMMUNITIES TOWARDS THE CLTS PROGRAMME

14. What perceptions do communities have towards the CLTS in Monze District? Probe more on:-
    a. Explain how the communities have accepted/embraced the implementation of CLTS in the Chiefdom?

b. According to your opinion, do you think communities understand the importance of CLTS?
c. Before CLTS Program came to this Chiefdom/community to talk about sanitation, what was the overall sanitation situation like here?
d. In terms of health, what would you say were the main health concerns of people in these communities? What about now?

15. What measures need to be put in place to improve the implementation of the CLTS Program in this Chiefdom?

LETTER FOR PROPOSAL RE-SUBMISSION (UNZABREC)

Monze District Health Office,
Ministry of Health,
P.O. Box 660144,
MONZE.

19th November, 2018.

The Chairperson,
University of Zambia Biomedical Research Ethics Committee (UNZABREC),
P.O. Box 50110
LUSAKA

Dear Sir/Madam,

RE: RE-SUBMISSION OF RESEARCH PROPOSAL FOR REVIEW

The above subject matter refers.

I am a Master of Public Health student in Health Policy and Management stream in the School of Public Health at the University of Zambia.

I am re-submitting this research proposal for review by the University of Zambia Biomedical Research Ethics Committee (UNZABREC) entitled:" **An Assessment of Community Led Total Sanitation (CLTS) implementation in selected Chiefdoms in Monze District".**

This research proposal is also being re-submitted to the University of Zambia as a partial fulfillment for the award of the Degree of Masters of Public Health in Health Policy and Management.

Your consideration for approval of this research proposal will be highly appreciated..

Yours faithfully,

HAZYONDO GIFT (0977-704198)

Email:gifthazyondo25@gmail.com

MPH -STUDENT

UNZA BREC PROPOSAL APPROVAL LETTER

THE UNIVERSITY OF ZAMBIA

BIOMEDICAL RESEARCH ETHICS COMMITTEE

Telephone: 260-1-256067
Telegram: UNZA, LUSAKA
Telex: UNZALU ZA 44330
Fax: + 260-1-250753
E-mail: unzarec@unza.zm
Assurance No. FWA00000338
IRB00001131 of IORG0000774

Ridgeway Campus
P.O. Box 50110
Lusaka, Zambia

7th December, 2018.

REF. No. 035-08-18

Mr. Gift Hazyondo,
University of Zambia,
School of Public Health,
P.O Box 50110,
Lusaka.

Dear Mr. Hazyondo,

RE: "AN ASSESSMENT OF COMMUNITY LED TOTAL SANITATION (CLTS) IMPLEMENTATION IN SELECTED CHIEFDOMS IN MONZE DISTRICT" (REF. NO. 035-08-18)

The above-mentioned research proposal was presented to the Biomedical Research Ethics Committee (UNZABREC) on 29th November, 2018. The proposal is approved. The approval is based on the following documents that were submitted for review:

a) **Study proposal**
b) **Questionnaires**
c) **Participant Consent Form**

APPROVAL NUMBER : REF. 035-08-18

This number should be used on all correspondence, consent forms and documents as appropriate.

- **APPROVAL DATE : 7th December, 2018**
- **TYPE OF APPROVAL : Standard**
- **EXPIRATION DATE OF APPROVAL: 6th December, 2019**
  After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the UNZABREC Offices should be submitted one month before the expiration date for continuing review.
- **SERIOUS ADVERSE EVENT REPORTING**: All SAEs and any other serious challenges/problems having to do with participant welfare, participant safety and study integrity must be reported to UNZABREC within 3 working days using standard forms obtainable from UNZABREC.
- **MODIFICATIONS**: Prior UNZABREC approval using standard forms obtainable from the UNZABREC Offices is required before implementing any changes in the Protocol (including changes in the consent documents).
- **TERMINATION OF STUDY**: On termination of a study, a report has to be submitted to the UNZABREC using standard forms obtainable from the UNZABREC Offices.
- **NHRA**: Where appropriate, apply in writing to the National Health Research Authority for permission before you embark on the study.
- **QUESTIONS**: Please contact the UNZABREC on Telephone No.256067 or by e-mail on unzarec@unza.zm.

Other

- Please be reminded to send in copies of your research findings/results for our records. You're also required to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study.

Yours sincerely,

Dr. S. H. Nzala
VICE-CHAIRPERSON

LETTER FOR NHRA AUTHORITY

Monze District Health Office
Ministry of Health
P.O. Box 660144
MONZE

12th December, 2018

The Director,
National Health Research Authority (NHRA)
Paediatric Centre of Excellence Block-UTH
P.O. Box 30075
LUSAKA

Dear Sir/Madam,

RE: REQUEST FOR PERMISSION TO CONDUCT RESEARCH

The above subject matter refers.

I am a Master of Public Health student in Health Policy and Management stream in the School of Public Health at the University of Zambia.

I am submitting this letter to the National Health Research Authority (NHRA) for permission to conduct research entitled:" **An Assessment of Community Led Total Sanitation (CLTS) implementation in selected Chiefdoms in Monze District".**

Attached herewith is a research proposal and an approval letter from the University of Zambia Biomedical Research Ethics Committee (UNZABREC).

Your consideration for permission to conduct research will be highly appreciated.

Yours faithfully,

HAZYONDO GIFT

Cell No: 0977-704198

Email:gifthazyondo25@gmail.com

MPH -STUDENT

NHRA APPROVAL LETTER

THE NATIONAL HEALTH RESEARCH AUTHORITY
Paediatric Centre of Excellence
University Teaching Hospital
P.O. Box 30205
LUSAKA
Telephone: +260 211 250309 | **Mobile:** +260 95 5632726
Email: znhrasec@gmail.com | **Website:** www.nhra.org.zm

15th January, 2019.

The Principal Investigator
Mr. Gift Hazyondo
Ministry of Health
Monze District Health Office
P.O Box 30205
MONZE.

Dear Mr. Hazyondo

Re: Request for Authority to Conduct Research

The National Health Research Authority is in receipt of your request for authority to conduct research titled **"An Assessment of Community Led Total Sanitation (CLTS) Implementation in Selected Chiefdoms in Monze District".**

I wish to inform you that following submission of your request to the Authority, our review of the same and in view of the ethical clearance, this study has been **approved** on condition that:

1. The relevant Provincial and District Health Director(s) where the study is being conducted are fully appraised;
2. Progress updates are provided to NHRA quarterly from the date of commencement of the study;
3. The final study report is cleared by the NHRA before any publication or dissemination within or outside the country;
4. After clearance for publication or dissemination by the NHRA, the final study report is shared with all relevant Provincial and District Health Director(s) of where the study was being conducted, University leadership, and all key respondents.

Yours sincerely,

Dr. Godfrey Biemba
Director/CEO
National Health Research Authority

All correspondences should be addressed to the Director/CEO National Health Research Authority

LETTER FOR TOWN COUNCIL PERMISSION

Monze District Health Office
Ministry of Health
P.O. Box 660144
MONZE

5th February, 2019

The Council Secretary
Monze Town Council
P.O. Box 660149
MONZE

Dear Sir/Madam,

RE: REQUEST FOR AUTHORITY TO CONDUCT RESEARCH

The above subject matter refers.

I am a Master of Public Health student in Health Policy and Management stream in the School of Public Health at the University of Zambia.

The authority to conduct research entitled:" **An Assessment of Community Led Total Sanitation (CLTS) implementation in selected Chiefdoms in Monze District"** has been granted by the National Health Research Authority (NHRA) as per attached copy for your reference.

Therefore, this letter serves to notify and also get authority to conduct the same research in liaison with the Rural Water Supply and Sanitation (RWSS) unit responsible for CLTS under your office.

Your usual supportive response will be highly appreciated.

Yours faithfully,

HAZYONDO GIFT

Cell No: 0977-704198

Email:gifthazyondo25@gmail.com

MPH -STUDENT

TOWN COUNCIL APPROVAL LETTER

MONZE TOWN COUNCIL

Plot No. 100
Independence Avenue
Tel/Fax: + 260-32-50201

All correspondence to be addressed to the Council Secretary

Office of the Council Secretary
P.O. Box 660149
MONZE

22nd February, 2019

Hazyodo Gift
Monze District Health Office
Ministry of Health
P.O Box 660144
MONZE.

Dear Sir/Madam,

RE: APPLICATION TO CONDUCT RESEARCH

Refer to the above subject matter

I write to acknowledge receipt of your application dated 5th February, 2019, wherein you applied to undertake a research Project on assessment of Community Led Total Sanitation (CLTS) under Rural Water Supply and Sanitation (RWSS) Unit.

Kindly note that Council has no objection to your application, however be informed that the research does not attract any monetary gain and all academic requirements will be met by yourself during the period for research.

Yours faithfully,
Monze Town Council

Justin Chombo
CHIEF HUMAN RESOURCE OFFICER
FOR/COUNCIL SECRETARY

Cc. Administrative Officer
File Copy