LUND UNIVERSITY
Institute of Sociology

Empowerment through Sanitation

A qualitative study on public participation in Community-Led Total Sanitation

Bachelor's Thesis in Sociology
a Minor Field Study
Autumn 2012
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ABSTRACT

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Public participation has gradually gained a stronghold within development theory during the last three decades. Researchers, policy-makers and aid workers share the belief that inclusion of beneficiaries in the development process is a prerequisite for purposeful and sustainable development of rural communities. The purpose of this thesis is to examine if participatory development leads to empowerment of rural 'poor'. In order to study this, a field study on a Community-Led Total Sanitation project was conducted in Mutomo, Kenya. Through a qualitative research approach interviews were conducted with key informants to examine the participant perception of CLTS. The empirical material collected during the field study illustrates the beneficiaries' embodiment of CLTS which correlates with the foundational pillars of this approach. The analysis further shows that some aspects of empowerment could be identified in the beneficiaries of CLTS. Through accumulation of collective knowledge and establishment of new organisational structures and networks, rural communities can be seen as collectively empowered.

Keywords: participatory development, public participation, Community-Led Total Sanitation, empowerment

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ACRONYMS

CLTS   – Community-Led Total Sanitation

CHW   – Community Health Worker

GO   – Government Organisation

MDG   – Millennium Development Goals

MFS   – Minor Field Study

MGHC– Mutomo Government Health Clinic

MMH – Mutomo Mission Hospital

NGO   – Non-Governmental Organisation

OD   – Open Defecation

ODF   – Open Defecation Free

PHO   – Public Health Officer

PLA   – Participatory Learning and Action

PRA   – Participatory Rural Appraisal

UN   – United Nations

1. Introduction

Public participation has gradually gained a stronghold within development theory during the last three decades. Researchers, policy-makers and aid workers share the belief that inclusion of beneficiaries in the process is a prerequisite for purposeful and sustainable development of rural communities. (Fredholm 2008: 13f) While the idea that participation is deeply linked with contemporary development thinking seems relatively unchallenged, clarification is needed to actually grasp whom, how and why the public is included in the development process. (Cornwall 2000: 51f)

Since public participation started gaining a position within development thinking during the 1970s, several methodologies based on these ideas have been developed and refined. At its core is Participatory Rural Appraisal (PRA), also known as Participatory Learning and Action (PLA). These methods rely on a learning process that occurs through the participants' own self-evaluation of local context. PRA practitioners suggest that by beneficiaries being active in their own development, the marginalized poor will not only achieve sustainable results but also become 'empowered'. In Community-Led Total Sanitation, which has its roots in PRA theory, public participation is used during a learning process in which the participants are made aware of the dangers of open defecation (OD) and 'triggered' to improve their living standards by building latrines. The method claims not only to promote rapid behavioural change but also claims to lead to new development initiatives. (Kar and Chambers 2008: 4ff)

The idea of participatory development, originated from the critique towards top-down aid projects which neglected the voice of those whom it intended to help. Participatory development practice intends be flexible and adaptable to whatever context it wishes to be implemented in a aspect which has been strongly defended during the years, with arguments that each project undertaken is essentially unique. The aspect of flexibility in participatory developmental projects gives rise to the traditional question of whether or not theory actually correlates with practice. In this paper a focal aim is to examine if the participants in CLTS show signs of empowerment. To do this I will first examine how local participants interpret CLTS and what they see as important aspects for the project to be successful and how it affects their surroundings and overall life.

1.2 Aim of field study

The general aim of this thesis is to examine the effect of participatory development approaches on rural communities. This will be done through a case study of an ongoing CLTS project in Mutomo, Kenya. Through a PRA approach, CLTS aims to ignite a process of collective behaviour change and action. The concept of participation can be seen as both a way of ensuring sustainability and effective implementation, as well as an empowerment processes in which participants are strengthened in the processes towards achieving a specific goal. The specific aims in this thesis are therefore to examine how CLTS is transferred from 'handbook' to village level and if CLTS show signs of empowering rural individuals.

By examining how CLTS is perceived by its practitioners and how local conditions help shape the programme, I will firstly discuss how facilitators and beneficiaries embody the project and how they interpret the CLTS methodology according to their context. Secondly I will discuss indicators of beneficiary empowerment and the overall effect of CLTS. To examine this, the following research questions are set:

- How do stakeholders within the Mutomo community embody the CLTS approach?
- Does CLTS empower beneficiaries through the process of participation, and if so how?

1.3 Context: Mutomo

Mutomo is situated in the rural area of central Kenya, roughly 230 kilometres south-east of Nairobi. Administratively, Mutomo district is divided into three divisions; Mutomo, Ikutha and Mutha within Kitui South electoral constituency. This complex administrative system and coverage of an extensive area complicates the connection between civil society and government, which has taken a toll on the welfare system. (World Vision 2011a: 20) Mutomo district holds approximately 180,000 people spread over a large arid area with roughly 17,000 residing in the administrative centre, Mutomo. One of the major concerns within the district is access to clean water, which affects health condition, economics and overall living standard in the area. The majority of households rely on natural water sources such as rock catchment, ponds/dams, rivers and wells (World Vision 2011b: 37). This water is untreated and without proper treatment methods, constitutes one of the major health dangers in the area. To improve the sanitary condition top-down health and sanitation campaign was conducted in the Mutomo

district between 2008 and 2011, raising the number of households owning a latrine from 53% to 75%. Although a majority of the population now have access to latrines, the remaining percentage still pose a serious health threat through the potential contamination of shared water sources. Latrine coverage is generally lower in the surrounding villages where open defecation still pollutes water sources and causes illnesses such as dysentery, typhoid and diarrhoeal diseases.

Within Mutomo district an estimated 74% of the population are living below the poverty line ($1.25 per day) (UN 2011: 7), which puts Mutomo as the second poorest constituency in Kenya (World Vision 2011a: 33; World Vision 2011b: 14). Since only a small percentage of the population can afford the transport to well-equipped health facilities, or even the lowest health care fees at the government clinics, preventive health care, such as clean water, is a priority for local governance.

1.4 Introduction to community-led total sanitation

The concept of community-led total sanitation was introduced and pioneered by Kamal Kar in 1999. CLTS was developed from the theory of participatory rural appraisal and aims to provoke collective community action towards improving local sanitation through construction of latrines. The fundamental principle of CLTS is a strict 'no-subsidy' policy combined with a hands-off approach by the facilitator, encouraging local 'natural leaders' to mobilize, plan and take action to improve the local sanitary condition. (Bwire 2010: 95) With a limited need for resources combined with adaptability to different contexts, CLTS has been applied in communities all around the globe in both urban and rural settings; by non-governmental organisations (NGOs) as well as governments organisations (GO).

The method intends to be both provocative and fun, using practical pedagogic to visualise the hidden truth about the unsanitary conditions caused by OD. An external, trained facilitator facilitates the initial phase of CLTS. During this 'triggering' process, crude words such as 'shit' are used to evoke a sense of shame and disgust about the practise of OD. (Kar and Chambers 2008: 34f) Once triggered, the community will come to understand the need for change, the collective benefit of total sanitation and agree that each household should have a latrine to ensure this. This learning experience is thought to trigger local initiatives to plan, implement and monitor the process towards becoming 'open defecation free' (ODF). (Kar, 2003:5)

2. Theoretical framework

2.1. Participation

The concept of public participation has since its introduction within the field of development in the 1970s, become intimately linked with development strategies undertaken in third world countries. (Zafarullah and Huque 2012: 311) The spectrum of meanings associated with 'participation' has in the last three decades been vast and still remains a debated subject. With a stronghold within the field of modern development discourse, the discussion concerning participation has become more focused on the definition and the potential benefits (Cornwall 2000: 15-16).

In the debate concerning the meaning of participation and its application researchers also disagree on its purpose. While some argue that participation is to be seen as a 'means' to achieve development others claim 'genuine participation', meaning a productive process in which the beneficiaries are in control and empowered, should be considered the end goal of participation in itself. The second view is supported by Oakley and Marsden (1984) who conclude that if genuine participation is established, development will inevitably occur. (Burkey 1993: 58, 70)

2.1.1 Development of participation

Historically there has been a debate about the 'level' of required participation in development programmes. Today including beneficiaries in all phases of development is considered standard practice, but the element of participation has varied over time (Fredholm 2008: 64-65). Initially public participation meant including local individual as 'informants', a role that merely functioned as a way of spreading information to civil society within the project area. Participation has since then included 'consultation', whereby locals are used to gain a better understanding of context and norms, which is thought to increase efficiency and help implementation. Nowadays it is also thought important to include beneficiaries in the process of implementation, monitoring and evaluation, as this holistic approach of participation is thought to avoid external dependency, as well as gaining legitimacy for the intended development within the community (Burkey 1993: 56-57).

2.1.2 Critique on participatory development

Although there is a large acceptance and acknowledgement of participation, critics have

pointed out some issues with the term. One argument is that practitioners neglect to fully recognise rigid local structures often strongly defended by those in power. The romanticized picture of collective desire for change is often skewed in relation to reality, where local authority figures often oppose changes to maintain their position within the community (Burkey 1993: 166-167). These authority figures can be both government elected and village elders, who often gain from the unbalanced conditions that development programmes wishes to change.

A second debate brings up the question of who actually gets to participate in these programmes and how. Participatory development programmes have often focused on abstract groups such as 'the poor' and 'the weaker', treating large diverse communities as a homogeneous group. In recent discussions this topic has been prominent and efforts have been made to include neglected individuals, which often have been women and illiterate (Cornwall 2000: 52; Chambers 1997: 213). Participation in these development programmes have also excluded those unable to attend, both due to aspects such as distance, but also for such reasons as poverty, where time spent in development programmes without monetary incentives leaves participants without income (Cornwall 2000: 56).

Critics have also pointed out the inherent paradox in participatory development strategies which through a flexible approach and loose framework have varied between context and practitioners, making it difficult to document, measure and identify what 'good participatory praxis' consists of, and essentially concluding what participatory development means. Uncertainty concerning what the concept means and acceptance of "Using one's best judgement" in practice, has led to malpractice and arbitrary use of the term in programmes which cannot be called participatory. (ibid: 44)

2.2 Participatory methodology
2.2.1 Participatory Rural Appraisal

From the 1970s and onwards the malleable meaning of 'participation' has given rise to a number of diverse methodologies. Initially focusing on research and assessment tools, public participation is now thought as important in all phases of development strategies. PRA, also known as PLA, is one of the methods which embrace this approach to the fullest. The essence of PRA is 'change and reversals – of role, behaviour, relationship and learning' (Chambers 1997: 103; 117). Chambers explains PRA through the relationship between outsider 'experts'

and the beneficiaries. Traditionally the expert has been lecturers and brought in new technologies; however, PRA encourages the outsider to 'hand over the stick', meaning locals are encouraged to analyse and teach about their own surroundings (Chambers 1997: 131). Sharing and expressing inherent knowledge between locals and outsiders creates a horizontal relationship which highlights that all participants are essentially experts in this process (Chambers 2007: 19). The outside facilitator is merely the catalyst for change. For this approach to be successful, the local community must come to understand that they are the actors and the evaluators capable of improving their own, self-perceived, local health issues. (ibid, p.103)

The outcome and purpose of PRA has historically had different meanings and during the 1990s it rapidly evolved to incorporate more aspects, as new applications on rural development were seen in the field while using the method (Cornwall 2000: 44). Chambers suggests that PRA can be seen as *"a family of approaches and methods to enable rural people to share, enhance and analyse their knowledge of life and conditions, to plan and act"* (Chambers 1997: 104).

Because the inherent diversity of PRA, it is more easily described by its 'three foundational pillars'. The first pillar is the attitude and behaviour of external facilitators, which should be humble and encourage local initiatives instead of dominating the process. The second pillar of PRA uses open group discussion where visual pedagogic and comparison provides an accessible approach for 'the weaker', thus preventing exclusion of certain community segments. This approach is thought to create an atmosphere where sensitive subjects can be discussed freely. The third pillar is the horizontal partnership between beneficiary and facilitator, which is seen as vital aspect for mutual sharing and learning as well as further promoting cooperation (ibid: 105f).

The gain of using PRA is that of not creating projects based on inaccurate assessments of rural conditions and avoiding unbalanced dependency on external experts and organisations. Instead it seeks to empower local individuals and structures, both existing in the community and new ones, in coping with occurring issues within the local area. The approach encourages rural communities to be autonomous and self-reliant, so that a balanced relationship can be built with outside organisations and institutions. A key aspect of PRA is acknowledgement of the capability of 'the weaker' as well as their responsibility of becoming self-reliant and owners of their development (Chambers 2007: 19, 25). During the PRA

process both beneficiaries and facilitators are participating in a learning experience where local conditions are discussed and scrutinized to identify problems within the community and possible solution. Through this process locals are empowered to deal with their own perceived issues.

Misunderstandings of what PRA practise consists of has in some cases led to faulty and in some cases harmful usage of the term in development strategies (Chambers 1997: 211-213; Chambers 2007: 11). The core of PRA being flexible, yet wanting to encourage 'good practice' could also contribute to the complexity in adopting this method in practice. While some consider handbooks as a way of ensuring a cohesive PRA practice, others claim that this goes against the very core of PRA. Chambers argues that a rigid framework would interfere in the implementation of this approach and fail to recognise the uniqueness of each rural community and thus result in inefficient and faulty PRA practice (ibid: 114-116).

2.3 CLTS

Community-led total sanitation derives from the theory of PRA. The CLTS model directs attention to the locals, which are seen as the agents of change and beneficiaries of the intended development. CLTS methodology uses PRA exercises aimed to trigger discussions concerning local sanitary conditions. The triggering process consists of 'transect walks' and 'mapping', whereby participants physically examine the community and marks out areas where open defecation occurs (Kar and Chambers 2008: 26-29). To further visualize the hazards of open defecation, human faeces is collected and brought to the training facility and clearly displayed next to where further discussions and eating is carried out. (ibid: 21-37)

Triggering and training sessions, combined with open discussions led by the community members themselves is thought to increase awareness of the risks of open defecation and poor hygiene (Kar and Pasteur 2003: 97). A collective sense of shame and guilt is then expected to ignite a behaviour change process which empowers the community into collective action, whereby a strategy towards becoming open defecation free (ODF) is adopted and organizational structures are created to monitor the process. Being based on the theories of PRA, one of the focal aspects of CLTS is the attitude of the external facilitator, where it is vital that they do not overtake the process. Facilitators are there merely as a catalyst for change, which will occur through the collective learning experiences of the participants.

Acknowledging the capability of 'the poor' and instilling a sense of ownership and accountability in the community-based movement is another critical aspect of CLTS. CLTS aims to remodel unbalanced relations between donor and beneficiaries and invites rural communities not only to participate in development projects as 'work force' but also be the ones to define local issues and come up with solutions (Freeman and Lowdermilk 1985: 111).

To prevent donor dependency, a 'no-subsidy' policy is used. Through encouragement of using locally-available materials, as well as community human and socio-economic resources (Bwire 2010: 95), the poor become aware of their inherent collective strength and capability. Becoming ODF is a relatively obtainable goal, as a first step in the process of improving local health conditions. Once a village has achieved ODF status, scaling up the project by expanding to nearby villages and by moving up the 'sanitation ladder', meaning old pit-latrines are improved or replaced with better structures is encouraged either spontaneously by 'natural leaders' within the community or by the facilitators. These steps are used as indicators of sustainable development and that participants have been empowered by the learning process.

2.3.1 Documentation of CLTS

There have been extensive documentations of CLTS within different countries and contexts. (Kar and Chambers 2008: 59) The documentation is showing a high-level of success in achieving a swift behavioural change and creation of initial latrine structures to ensure ODF status. Once ODF, the communities are certified by the facilitator and further projects and development is left to the community. This high level of success rate has been a contributor in achieving the United Nations (UN) Millennium Development Goals (MDGs). (Kar and Pasteur 2005: 1) CLTS primarily contributes towards achieving Goal 7; 'Ensure environmental sustainability' (UN 2011: 48), by improving sanitary conditions and preventing contamination of water sources, environmental resources are better cared for through proper handling of human waste (ibid: 52ff). By an improvement of sanitary condition, CLTS is also believed to contribute indirectly to other MDGs goals by improving health conditions for vulnerable groups such as pregnant women and children; Goal 4 and Goal 5 (ibid: 25, 30). It has also help reduce the origin of treatable diseases such as dysentery, typhoid and diarrhoeal diseases, which amongst rural poor communities can become potentially lethal; Goal 6 (ibid: 36).

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2.3.2 CLTS in Mutomo

Despite previous sanitation campaigns undertaken in the Mutomo district in 2008-2011, lack of latrine usage still remains an issue, especially in the rural villages. Therefore a CLTS campaign were initiated in February 2012 and has currently targeted three sub-locations within three separate locations; Mutomo, Mutha and Ikutha. The fourth and final location is currently waiting further funding to facilitate community training. The NGO World Vision is the main funder of CLTS but cooperates closely with government officials at Mutomo Government Health Clinic (MGHC). Interaction and facilitation of CLTS training in the villages is mainly done by government public health officers (PHOs) to ensure long lasting relationships and accurate understanding of local context.

2.4 Empowerment aspects

The concept of 'empowerment' is closely linked with development thinking (Cornwall 2000: 32) and furthermore with the concept of 'participation' (Zafarullah and Huque 2012: 318). The arbitrary use of 'empowerment' in development strategies and difficulty in defining the concept has led to a number of interpretations. Cornwall discuss this faceted concept and refers to definitions such as 'decentralisation of governing power', 'participation in economy driven activities', 'accumulation of new knowledge', and simply 'participating in development projects' (Cornwall 2000: 32-33) While none of these should be discarded they fail to encompass all aspects of the concepts. Bailey (1957) states that defining empowerment without regard for whom and in what context one wishes to empower, is simply not suitable. (Zafarullah and Huque 2012: 319) Empowerment is often seen as a synonym to decentralisation and self-governing. The influence in local decision-making and influence over the welfare is seen as an empowerment of rural poor which traditionally have been marginalized from these processes. (Fredholm 2008: 59f) Central to this form of empowerment is the right to definition of local issues, priorities and potential solution. Page and Cuzba (1999: 3) proposes the following open definition of empowerment:

> *[...] empowerment is a multi-dimensional social process that helps people gain control over their own lives. It is a process that fosters power (that is, the capacity to implement) in people, for use in their own lives, their communities, and in their society, by acting on issues that they define as important.* (Zafarullah and Huque 2012: 319)

The above-mentioned definition comprises a multidimensional approach to 'empowerment' which emphasises the strengthening of individuals in relation to the community. The abstract use of 'power' and 'capacity' allows a context-fitted meaning of empowerment which does not contradict the essence of empowerment by offering a rigid prescription (Zafarullah and Huque 2012: 319). By focusing on 'gain of control' it also highlights the potential power of decentralisation and self-assessment.

2.4.1 Network between state and civil society

People in rural communities are undoubtedly bound to experience a higher level of isolation than those in urban settings; however, this level of seclusion should not be mistaken for complete autonomy. In todays interlinked global society, few communities, if any, operate without outsiders affecting in one way or the other. (Burkey 1993: 50-51) While participation has come to mean empowerment through decentralisation of power, it paradoxically also refers to empowerment through interlinked actors. In a number of CLTS projects, it has been evident that by not recognizing the importance of joint efforts, development initiatives will most likely be set back and not able to scale up. To operate on a large arena, efficient interdependent partnership between organisations and institutions is needed. (Musyoki, 2010 : 156). Collier (1996: 121-122) argues that short-term NGO projects, which intervene with public services such as healthcare and sanitation, can potentially harm the link between state and civil society. To create conditions in which 'the poor' can achieve sustainable development, relations between local actors are necessary. Collier further emphasizes the potential of external NGOs as intermediary between government and civil society. Creating a link between government and its people will not only deepen the understanding for rural conditions but also, according to Collier, hold governments accountable and empower local grass-root movements through access to essential resources for further development and sustainability. (ibid:122)

Uphoff (1985: 359-360) argues that there has been a tendency to considering participatory development projects as merely an empowerment process for 'the weak'. He further emphasizes that for participatory approaches to be successful the facilitator should be equally devoted to the process of change that occurs when new knowledge emerge.

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3. Method

3.1 Qualitative research

In order to answer the research questions stated in chapter one, a qualitative approach was adopted in this study. Qualitative research methods are appropriate when one seeks an in-depth understanding of the interviewees perception of their natural setting. (Cozby and Bates 2012: 114) The purpose of qualitative research is to research attitudes and perceptions of a limited number of participants. However this in-depth understanding does not aim to gather quantifiable data that can be generalized and applied on other settings (ibid: 114). The primary research method used during this case study was open-ended interviews with key informants. Mikkelsen (2005: 89) points out that key informants are individuals with specific insight into the research subject and are not limited to educated professionals, an expert within the field of development might as well be the beneficiary, depending in the research topic.

With limited information available before entering the field and uncertainty concerning the context due to the PAR-encouraged adaptation to the local rural context of Mutomo, a qualitative research approach was best suited for this field study (McCracken 1988: 16) One aim of this study was to understand how the civil society embodies the CLTS methodology and how they adapted the project to local context, and it was therefore crucial to stay open-minded while conducting the interviews, which further emphasizes the use of a qualitative methodology (ibid: 21).

3.1.1 Reflexive ethnographic study

Because there was limited information available before entering the field, a traditional linear research methodology could not be used. (Crang and Cook 2008: 20) Instead a modified grounded theory approach was used whereby a general understanding of the Mutomo area and its current health condition was studied beforehand. After entering the field a research question was adopted concerning an urgent issue, which corresponded with what locals saw as relevant within the community. The initial research on local health care and health issues revealed a need for preventative health care and the research field was further narrowed down to a preventative health care campaign i.e. CLTS. After conducting pilot interviews, the research questions was reviewed and modified, afterwards which the interview guide was adapted to operationalize the research questions. Kvale and Brinkmann (2010: 218) describes this approach as grounded theory and by using this approach my hope was to not neglect the

voice of locals, but to be attentive to issues and aspect that seemed vibrant in the community. (Crang and Cook 2008: 28)

Given the fact that the CLTS approach is built upon individual behavioural change through change of collective attitude (Bwire 2010: 94-95) it seemed suitable to use an ethnographic approach that focuses on how individuals, within the community, affect the social order instead of just responding to rigid social norms (Gubrium and Holstein 1997: 40). CLTS and thus this research is built on the belief that civil society behaviour can be altered through its members and by using an ethnographic approach this ever-changing reality would hopefully be visible in the making.

3.2 Delimitations

3.2.1 Selecting research subject

The main criteria when selecting a research subject for this thesis was that it would involve civil society in the periphery of rural communities. These communities have often been marginalized in development research (Burkey 1993: 11) and it seemed important to shed light on them. The CLTS project comprised both a sociologically interesting development methodology and its beneficiaries and practitioners were primarily operative in the margins of Mutomo. The CLTS project was suitable on several notes, firstly it had finished the initiation phase, which meant that the facilitators role would be limited and instead local governing structures would be in charge of the project, thus emphasizing the beneficiaries role in the project. Secondly, the methods used to change behavioural tendencies were through participatory learning process, which meant that it was a sociologically interesting subject. Thirdly the project was showing a high technical success rate, but little research had been done on the social aspects, which meant that documentation and potential results could be used in further implementation of the project in the region (Kvale and Brinkmann: 89f; Crang and Cook 1995: 19).

3.2.2 Selecting key informants

Exclusion of rural poor has historically been an issue both from public services, but also development research. Difficulties with access, language barriers and gaining acceptance in the communities, has left the rural poor without a voice in development theory. For this reason the first step was to identify individuals living in the rural villages and participating in CLTS.

Officials from Mutomo's government health clinic (GHC) were used as the main "gate keepers" (Crang and Cook 2008: 16f) to the community, however to prevent bias selection of informants, a non-governmental organization, Mutomo mission hospital (MMH) was used to identify additional interviewees for comparison. (Mikkelsen 2005: 89) The organisations were chosen because they were the two main health care providers in the area and provided a diverse insight into the communities and offered access to different communities. It should be mentioned that the two organisations cooperated and coordinated their activities in the villages to prevent duplicated interventions, education and aid being given unequally to the villages as to prevent societal tension.

To map out how CLTS was transferred from handbook to grass-root level, interviews were conducted with both beneficiaries and facilitators. Inclusion of facilitators was important since they are the link between written material and essentially the once who transfers and initiated the idea of becoming ODF in the community. With CLTS methodology putting great emphasize on the facilitators it seemed inevitable to include their voice in the study. Both categories obtained vital information and a specific knowledge of the subject, meaning all could be considered 'key informants' (Mikkelsen 2005: 172)

According to McCraken (1988: 17) selecting interviewees should not be done to enable a generalized theory. Identifying individuals who could help make sense of cultural and local assumptions that shape the way in which "one culture construes the world" (ibid:17), was therefore a crucial aspect in selecting interviewees.

3.3 Field study
3.3.1 The interview
The primary research tool in this research was semi-structured interview with key informants. An interview guide was created (See Appendix 3) to ensure that the interview followed a predetermined framework. The questions were open-ended, to encourage interviewees to elaborate on their answers and not discourage when answering in an unexpected manner. (Mikkelsen 2005: 89; Crang and Cook 2008: 44) The guide enabled the interview to be 'free' but still within the subject which was researched. (McCracken 1988: 25) Twelve key informants were interviewed (See Appendix 1) and the interviews varied between 25 and 70 minutes in length. The interviews were carried out in two segments, firstly participants were asked to outline the local structure and health condition, and secondly to describe the training

and process of CLTS and its effect on the community. All interviews were done in English to avoid misunderstanding caused by getting secondary information and translation issues. To enable accurate transcriptions of the interview and citation, a tape recorder was used to capture the interview.

A semi-structured interview is most efficient when the conversation is flowing and naturally leads from one question to the next. This technique requires a level of craftsmanship from the researcher. (Kvale 2010: 268) The interview guide consisted of topics instead of strict questions which were adapted during the interview to fit the natural conversation. The topics in the interview guide were developed to let the interviewee, in their own words, describe and reflect on their relation to CLTS and their experiences from the process. During the interview each question was elaborated on by the interviewer to create a setting were a statement would naturally be analysed and tested during the interview. By interpreting the interviewees' statement and asking them to confirm this interpretation, the interview intended to be 'self-correcting' (Kvale 2010: 211f).

Follow-up interviews were conducted to give the interviewee time to reflect, rephrase and explain in-depth aspects of CLTS which stood out during the initial interview. A total of twelve interviews were conducted. Six CHO's on village level were interview of which three were picked for a second follow-up interview. An additional three interviews were done with PHO's, representing the government facilitators. (See appendix 1.)

3.3.2 Participatory observation

Participatory observation was not used to examine the CLTS programme in-depth but to gain cultural and contextual understanding, which was essential, both in grasping the CLTS project and to adapt the research questions and methodology in this study. Observing and participating in the everyday work of CLTS and gaining an understanding for the local and divers context in which this project took place in, was also crucial to fully understand and not misinterpret interviewees when references and examples were drawn from the local surroundings. (Cozby and Bates 2012: 115) The participatory observations were carried out during follow-ups conducted by officers from the Government health clinic (GHC), and during these visits extensive notes were taken for further analysis and for interview reference.

Having visited and participated in follow-ups and meetings in all CLTS targeted areas and where the informants resided, the interviews became efficient, with few things needing

clarification, and creative, with the interviewee having the option of using examples and discussing without limitation. A general understanding for the culture and research field enable one to anticipate ethical boundaries and sensitive subjects which could be harmful to the interviewee and/or the research success. (Kvale and Brinkmann 2009: 91; 94).

3.4 Ethics

When conducting an interview ethical aspects must be taken into consideration. Especially considering that the interviewer is being given an deeper view into the life of the interviewee. This access should not be mistreated nor taken for granted. Three ethical aspect were taken into consideration during this field; 'informed consent', 'confidentiality' and 'purpose'.

3.4.1 Informed consent

Before the interviews a general understanding of the purpose of the research was given to the interviewee, as to ensure that his or her consent was based on an accurate assumption on why they were asked to participate. The way in which their statement would be handled was also disclosed before initiating the interview. (Kvale and Brinkmann 2009: 87) A standardised phrase revealing method of tape-recording, freedom of participation and anonymity was told before initiating each interview (See Appendix 2).

Assuring the interviewee of full disclosure of the purpose of this study was not unproblematic in practice, since the research question was not fixed at the beginning of the study and alterations were made during the course of the research. Kvale and Brinkmann (2009: 87-88) argue that full disclosure of the research purpose, when using a qualitative reflexive approach can be misleading and potentially harmful. Instead full disclosure of the 'fluid' approach was given.

3.4.2 Confidentiality

The informants' confidentiality was ensured by not attaching the name of any of the interviewees to their statements (Kvale and Brinkmann 2009: 88). Although this study did not examine a sensitive subject, the interviewees anonymity still served as a way of encouraging openness from the interviewee. The interviewees were afterwards categorised into two categories; 'Public health officers' (PHO) and 'Community health workers' (CHW), and given a number for keeping track. The categorization was necessary to illustrate on which level (i.e.

district or village) they were operative in. It could be argued that the interviewees identity could be jeopardized by this information.

3.4.3 Purpose

Kvale and Brinkmann (2009: 89-90) argues that for it to be legitimate to conduct a research one has to consider the purpose and benefits that affect those involved and the represented population. If the possible harm outweighs the benefits then it could be seen as unethical to initiate a research study at all (ibid: 90). By choosing to focus on a project which is on-going and currently looking for funding, the potential benefits could be both to enlighten donors about the benefits of the project and encourage further grants. Furthermore by focusing on the post-triggering phase of the project and beneficiaries perception and embodiment of the project, information that could help future implementation of CLTS was identified, which is requested by practitioners of CLTS. (Kar and Pasteur 2003: 8) By merely describing and analysing what was being said and experienced, this paper does not impose a threat to interviewees, beneficiaries or the field in which the study was conducted.

3.5 Analytical framework

Within grounded theory and semi-structured interviews a level of craftsmanship is needed both in collecting data as well as when analysing the material. Wright Mills (1959) calls this 'intellectual craftsmanship' (Mikkelsen 2005: 181), which is needed to create valid results. As the aim of the field study was gaining an understanding for local perception of CLTS, the collected interview data would have to be interpreted through a theoretical framework, during which cautiousness and recognition of one's subjectivity had to be taken into consideration. (ibid: 168) The approach used in this analysis was inductive, meaning empirical data was used as the basis for development of theory, and coding i.e. the aim of the study was not to answer a predetermined hypothesis. (ibid: 169)

To get an overview of the material collected during the field study all interviews were transcribed and given an identification number. The material was then divided into two categories according to interviewee occupation, 'Public health officers' and 'Community health workers' (See Appendix 1). Coding was then used to break down the collected interview data into manageable information which could be examined, compared, conceptualized and categorized (Kvale 2009: 218). Once manageable, the data was further

examined and coded into concepts and themes to get a general understanding of the interviewees' perceptions. After this phase when the core concept of the study was identified, selective coding (Mikkelsen 2005: 182) was used to further examine if participation in CLTS leads to empowerment. This meant that themes were selectively identified to illustrate indicators of empowerment and signs of contradiction. To analyse how the CLTS methodology was transferred from handbook to local beneficiaries, the description given from key informants would be matched with the intended outcome described in the handbook of CLTS (Kar and Chambers 2008) correlations and inconsistencies were noted.

3.6 Methodological problems

The main methodological issue during this field study was the language barrier. All interviews were carried out in English which was a secondary language to both interviewer and interviewee. Although both parties felt comfortable in expressing themselves in English it had some overall effect on the flow of the interview. Abstract terms such as 'empowerment' and 'participation' were difficult to use in the interview setting, as they occasionally needed clarification. Since including those in the rural margins was the main focus of this field study the interview guide therefore had to be adapted according to terms and concepts which seemed naturally used in the community.

4. Results and Analysis

4.1. The three pillars of CLTS

CLTS projects theoretically rest upon the three foundational pillars of PRA, 'catalyst facilitation', 'untraditional methods' and 'horizontal partnership'. The idea of context-adapted implementation of CLTS is thought to ensure efficiency and sustainability since the programme is carried out according to the local view on sanitary issues and potential solutions. The transfer from theory to practice thus allows a great deal of deviation from the handbook. To examine if the Mutomo community embody the fundamental aspects of CLTS I will look at statements that either confirms or discard the presence of these three pillars.

4.1.1. Catalyst facilitation

The attitude and behaviour of the external leader has been pointed out to be one of the key pillars of CLTS as to ensure local ownership. For this to be efficient both facilitator and

beneficiaries need to acknowledge and perceive this fact.

> *[...]it's not that we are leaders, we don't led them, we are a part of it, but we "chip in" when they require technical advice [...] So they don't perceive us as leaders and we don't present ourselves to them as leaders.*
> *Public health officer 1.*

This aspect was noted by the above mentioned public health officer, who emphasises that this understanding must be seen from both sides. While former development approaches have included the beneficiaries in learning programmes, CLTS ensures genuine participation and avoids exclusion of marginalised individuals by using visual pedagogic that makes learning practical and thus appealing to a larger population.

> *[...]it is the community which is directly involved in this practise, not the ... you know the other approaches like, in the past, although they were participatory, but it's like they were more theoretical than practical, but this one is great because the community, the people just down in the community, are the once who are doing it and they also feel that it is affecting them.*
> *Public health officer 3.*

The function of the facilitator is moved from lecturing towards participation in the process. Once the training is organized and facilitated, the PHO can become a participator and potential benefiter of the learning experience. More importantly than the self-perceived passive attitude of the facilitator is how they are actually perceived by the beneficiaries.

> *[…] we ourselves, we are the beneficiaries of this because we have got facilitators who promotes it and they have trained us to take care of ourselves.*
> *Community health worker 9*

Once the initial training session ends and the community become aware of local conditions a sense of inherent capability to cope with the challenges is vital. Those left with this challenge are so called 'community health workers' who are faced with carrying out the adopted plan and become representatives to become ODF.

> *If I tell my friend that "you can dig a latrine and you can understand that", you are telling me what? But if you [meaning an outsider] come here, you help us very much because they [civil society] know, if somebody can come all the way from Nairobi to here and he's talking about the same thing as you've been told by*

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your friend, it means that thing is very important.
Community health worker 8

The statement above points out the 'expert' association that outsiders accumulate from the CLTS training session. For CLTS to be effective, the same respect for local knowledge must be perceived by the community. By using building methods suitable for the area and materials locally available which villagers are familiar with, the expert role is quickly embodied by the community health worker who is present in the village and can lead to further grass-root movements.

4.1.2 Untraditional methods

PRA methods such as transect walk, mapping and open discussions concerning sensitive subjects are the foundation on which knowledge is obtained and further acted upon. CLTS make use of this theoretical approach to highlight the uncomfortable taboo subject of open defecation, which is seldom discussed collectively. To ignite a sense of need for change and challenge old habits, sometimes based on traditions and religion, CLTS uses visual methods that evoke a sense of shame and disgust attached to one's behaviour.

> *What is right now going to trigger them is when you do the "walk of shame". You go around the village and you see now, this is a household which has got no latrine, then definitely there is some place around their house where they go open defecation, you take them to that place, you collect the shit then you come back with it where you are training,*
> *Public health officer 2*

The methods used in CLTS often are met with an initial resistance in participation but once beneficiaries are faced with the realities of OD, they come to understand the benefits of changing behaviour.

> *[…]of course when we started we thought it was a dirty game, because we use to collect faeces from the bush and bring it in a central place. They thought it was a dirty game but later they came to understand that hey, it's a very good project and it will help them. Because you know, before when I opened my bowels in a open place, the hens would eat, that's the poultry that we would feed on!*
> *Community Health worker 5*

> *[…]we even took food that was cooked and put it here and faeces nearby and the*

flies touch the food and infect it and we tell them that the faeces, "we eat the faeces like them" [meaning the flies].
Community Health worker 8

By using simple pedagogic, beneficiaries and future implementers of CLTS are empowered with simple tools which can be used to change people's minds in the villages. With OD being a rather abstract cause of future health dangers, facilitators illustrate the cost of not building a latrine by calculating the potential hospital bill of a household.

So when you are training, you calculate the hospital bill, and it also give them that triggering. So that people don't think "small, small money". With some time, it becomes big money, in a year... you see. In this year I have spent [calculating] ... three thousand on medicine, and three thousand I didn't know it was coming up to three thousand because this week 50 bob [slang for RSH], some other time a hundred, accumulatively in a year I've been using three thousand on diarrhoea, or something that could be prevented, that is one person. Then if you are four it rounds up, that is big money.
Public health officer 3

By using methods that illustrates a way of potentially saving money by avoiding expensive hospital bills, constructing a latrine becomes a cheap insurance.

4.1.2 Horizontal partnership

Through the process of CLTS, horizontal relationships are built between individuals and organisations. This partnership is used as platform from which knowledge and resources can be shared. At the heart of this relationship are cooperation and a mutual desire to achieve the end goal. One of the CHW explains how CLTS have brought them closer:

In this way, this is the government and public health and this is the CHW, so when they have something they come to us and when we have something like an outbreak we inform them, so we are just the link between the people and the government.
Community Health worker 5

In the above quoted statement the CHW exemplifies the communication between society and state and how CHW come to play a role in transferring information as well as linking the two together. The topic of discussion in the statement is however not directly concerned with CLTS activities and can thus be seen as an empowerment of the civil society by creation of a

new beneficial network that goes outside the framework of CLTS.

4.2. Empowerment through participation

Participation in CLTS can be seen as a means to achieve ODF status and ensure its sustainability, but some argue that a more beneficial approach of participatory development is to consider 'participation' as a goal in itself. This second view emphasizes the empowerment process of the participants. The participatory element of CLTS can be seen as a starting point, from which new initiatives can grow once beneficiaries become aware of their own strength and capability. This awareness campaign relies heavily on a self-perceived sense of empowerment among the beneficiaries. Combined with giving participators a leadership role within the CLTS project and a sense of contribution to the community, CLTS become a breeding-ground for individual empowerment.

> *You are recognized and you feel "yeah! That's my job" you feel like you are somebody to them [meaning the local community].*
> *Community Health worker 6*

The statement above showcases the potential empowerment of CLTS. Those previously marginalised and without a voice in the community consider working with a development programme as something to be proud of. However, for CLTS to be considered as an empowerment process, from which participants are strengthened as individuals to undertake further projects, a sign of confidence and a sense of capability outside of the frames of CLTS is needed. While this was true in some interviews (See below), one interviewee expressed a less progressive attitude:

> *[…] what we did in the CLTS, is just for that training. They trained us, there is no other power. It's only that knowledge they give us and they trained us how we can live.*
> *Community Health worker 5*

4.2.1 Empowerment through knowledge

CLTS is essentially a learning experience where participant examine their own way of life and surroundings in which capacity for improvement is built. Through the process, new knowledge is obtained from the CLTS self-assessment exercises.

They didn't have the knowledge. They thought going to the forest is the better. So we went to them and training them the benefits of latrines and how it would benefit them.
Community Health worker 6

By gathering people and allowing an open discussion concerning topics previously taboo, a consensus about the dangers of OD is reached. Knowledge about OD health risks come both from within the community as well as from the outsider facilitator. Those elected from the community to represent this new consensus and spread the word are empowered with knowledge about dangers and solution. Within the community this empowerment gives the CLTS participators an image as knowledgeable:

They come to seek information from me. Now suppose I am at my home, you see somebody coming, they call us doctors because we have come to educate them, now somebody comes to my home and tell me and I don't know what he is suffering from, then I have to come all the way to a home and go and see that okay, he is sick, what has happen? What food has he been given? Then you try to question, you try to see if he or she is not approving [meaning medicine] you insist in go to the nearest dispensary so that he or she can be treated and given the necessary help as soon as possible. Yes, we are recognized.
Community Health worker 4

The participators in CLTS training are seen as people with knowledge about health issues and someone who can advise and organize help when issues arise in the village. With large-scale outbreaks and other extensive issues in the community, the success of CLTS is seen as a sign that locals can cope with problems without the assistance from outsiders. In the above-mentioned statement, the CHW is not only recognised as knowledgeable but also carries out the task of assisting those who seeks advice.

4.2.2 Empowerment through decentralisation

Those who become natural leaders from the process of CLTS take on the task of leading the behaviour change process. To solve potential conflicts and issues that might arise during the process of becoming ODF, local committees are created to operate autonomously and decentralises the power otherwise linked to government organisations. This empowerment of self-governing structures leads to efficient administration and is seen as legitimate in the eyes of the community since they have a collective mandate given during the CLTS training.

We have been told instead of using the administration or the health officers we use the elected committees in these areas, those people will make these people dig latrines. If they tell them to do that and they deny, they will be forced to go to another place, which is possible, everyone can dig and there are neighbours, sisters, fathers who are forcing them to do so. Then they have to dig.
Community Health worker 7

With both community support and also legal right backing up the committee's message, community-based structures can oversee the CLTS project and make the change towards becoming ODF swift. Once these structures are built, new projects coping with other issues can hopefully be undertaken.

4.2.3 Empowerment through local organisational structure

A powerful tool is creation of governing structures, these are seldom limited to the initial project and have the potential of tackling new problems that exist or arises within the community. Community-based organisations become powerful actors, allowing those formally considered 'weak' to cooperate with other authority figures in the area.

I can collaborate with the community elders, like the head of the village and just walk around. When we are doing this community-led total sanitation, we had some committees that we elected to do some follow-ups. You know there are some people with hard minds, they cannot hear when they are told freely, but they need their people, who are near them and have latrines to make them dig latrines. So it is all good.
Community Health worker 7

A joint effort supported from different actors in the community emphasises the importance of the project and created a network in which resources can be collected and distributed. This network and cooperation is used from both sides, with a direct link to the smaller communities and an efficient way of initiating new projects in the villages, governments use the CLTS organisations as a way of gathering people and information.

They call us, they explain the project, then we do it or if it is a matter of... maybe they want the community to solve something, they call us from different areas, they explain and then we go back to the community and explain and then they come!, later on they come and meet the community and deliver the message on their own. So we always interact with them to know the latest, to know if there is any problem. To know if there is something we need to do maybe they have a plan for a certain period.

Community Health worker 5

The organizational structures established during the CLTS process are needed for the project to be efficient but once ODF is achieved, they serve as effective tools of communication and cooperation. Attention to other health issues is dealt with by the network that was built up during CLTS. This is visible in the statement below, explaining the previous complexity of requiring help and how this has changed.

> *It is the only report to use and our office now is in Mutha. The other is in Mutomo, but we can't come there to Mutomo! So we go to the one in Mutha. We do that because when we have something, we can report direct! ...when we see that there is a person who is doing this and there is a person who is now affected by the cholera, we can report directly because there are community health workers and public health officers and that person, they take it very seriously, because a time ago it was a cholera outbreak in our area, and a headman, that headman to the chief then that assistant chief up to DO [District Office] or DC [District Counsel] and this person was wrong. So we do this because of this area, our area as Kimani, many people was killed by this cholera, because of that chairman, to chief to assistant chief to DO, but now we make it simple!*
> *Community Health worker 8*

Once a link between state and civil society is established, people hold their government accountable. The active communication, in which information about current health issues are revealed to the government officials and the closeness to the people allows requests for funding and technical help to be requested by the community.

> *[I think the government needs to be active, because people themselves there, they have no initiative to start such a thing.*
> *Community Health worker 5*
>
> *Why not?*
> *Interviewer*
>
> *Because of poverty, it needs funding, it need funding and the people in the villages they can't fund that, we have to inform the provincial administration, public health, so that they can look for funds from donors and then they come.*
> *Community Health worker 5]*

With a majority of population residing in Mutomo living in extreme poverty, funds are limited for development projects. This fact affects all aspects of the community and counteracts local

initiatives. The support and access to influential actors is essential to motivate participation in development projects and while this could potentially be interpreted as dependency on external institutions, some level of interdependency on outside resources is to be expected.

4.2.4. Scaling up – indicator of empowerment

Scaling up the CLTS project is seen as indicator of sustainability and empowerment, through spontaneous initiative and expansion to new areas, CHW come to own their development and build capacity in their own. Through cooperation and sharing, the development is naturally adapted to the context and is not limited to a ridged project framework.

> *[...] if we do have to report to anything, then it is to the government or to the public health. But sometimes we visit other CU's [community units], to see how they are doing and maybe we can get information from them, maybe they have a better idea that what we have.*
> *Community Health worker 5*

The community health worker explains how they cooperate with other areas to gain more knowledge and share their experiences. The spread of CLTS in the district thus becomes self-operative and truly community-led.

5. Discussion and Conclusions

The conclusion drawn from the empirical material presented above is that the CLTS project in Mutomo show some signs of empowering rural poor. However, it remains difficult to conclude the origin of this empowerment and if it exceeds the framework of the CLTS project. Beneficiaries of this approach see themselves as the main actor in becoming ODF and are therefore creating organizational structures that allow a structured and gradual change to occur. These structures can be seen as empowerment by accumulating local material and socio-economic resources available in the community.

   To answer the research question "How do stakeholders within the Mutomo community embody the CLTS approach?" a correlation between facilitator and beneficiaries' perception of CLTS was examined and compared with the foundational pillars of PRA. The conclusion drawn from this material is that the beneficiaries understanding of CLTS and training correlates with the attitude of the facilitators and further with the three pillars of the methodology meaning the intended outcome of this training is to be expected.

Through the interviews of beneficiaries a perceived behavioural change can be seen as on-going in the villages as a result of collective action. This indicates that the CLTS project in Mutomo is still in the initial phase of becoming ODF. The second research question; "Does CLTS empower beneficiaries through the process of participation, and if so how?" was therefore difficult to confirm. Statements concerning empowerment, such as creation of organizational structures, knowledge and new networks suggest a possible empowerment of beneficiaries through CLTS. The main element of empowerment was seen in the network created between state and civil society. The aspect of creating a link between these two institutions can be seen as a horizontal relationship, whereby information and resources could be shared between the two. Empowering both sides to work closer together is a vital aspect of rural development and can have great benefits in the future. This study conclude that the empowering of beneficiaries is likely sufficient in ensuring the initial goal of becoming ODF. However a long-term study overseeing future progress would be necessary to determine whether or not participation in CLTS genuinely empower rural poor beyond the frame of the initial project.

This field study examines a community-led project which is self-reliant and owned by the beneficiaries. The methodology transfer from handbook to community level showed little sign of adaptation, which can be seen as ensuring a successful implementation, at the same time this rigid approach can also be seen as a failure to recognise the uniqueness of the villages.

Since this study looked at beneficiary empowerment and did not focus on assessing the actual participation process it is uncertain to say if other background factors and potentially projects are the origin to the empowerment of the interviewed beneficiaries. Although this cannot be determined, statements referring to the CLTS as the reason for new networks and new knowledge do suggest that CLTS is a contributor to public empowerment.

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7. Appendix

7.1 Appendix 1: List of interviewees

Repondents number:	Occupation:	Level:
1.	Public Health Officer	District
2.	Public Health Officer	District
3.	Public Health Officer	District
4.	Community Health worker	Village
5.	Community Health worker	Village
6.	Community Health worker	Village
7.	Community Health worker	Village
8.	Community Health worker	Village
9.	Community Health worker	Village

7.2 Appendix 2: Information before the interview

"This is an anonymous interview, I will not attach you name (or other sensitive material) to any of your statements. The interview is voluntary, meaning you can choose to stop at any time, you also have the right to not answer a question or erase a statement afterwards. The interview will be tape-recorded and material from this interview will only be used in the before mentioned thesis."

7.3 Appendix 3: Interview guide

Outlining the project

Name and Village

Background

Can you tell me your role in the CLTS project?

Explain the CLTS training?

– Explain the process

– Explain different exercises and how they achieve the goals?

Describe the everyday work with CLTS?

– (CLTS follow-ups, meetings with community members)

How do you encourage local innovation and ownership?

How is CLTS adapted to your local context?

How do you identify "Natural leaders" within the communities?

How do you conduct follow-ups and monitoring?

Empowerment

Explain the effect of CLTS in Mutomo?

– Why do you think this is?

Have you seen any change in the overall attitude in the triggered villages?

What do you think makes CLTS successful?

What are your responsibilities?

How do you incorporate/involve individuals within the community?

Who has a leadership role in the community?

– What is your relationship to them?

– (How) Do you include them in the process?

What sort of relationship exists with external actors organisations?

What sort of relationship exists with internal actors and organisations?

Are these relationship important and why?

Can you see any other positive aspects that the CLTS has brought to your area?

Do you feel empowered because of the CLTS programme?

These were my questions, is there anything you would like to add and/or clarify before we end the interview?