HEART
HEALTH & EDUCATION ADVICE & RESOURCE TEAM

Helpdesk Report: Community-led Total Sanitation in Africa

Date: 24th May 2013

Query: There are doubts that Community-led Total Sanitation (CLTS) works in Africa, as culturally the "Walk of Shame" is not acceptable and there is no evidence that targets set are realistic.

Please research the CLTS application in Africa to find evidence to support or reject this position.

Content

1. Overview

Evidence and comments suggest that CLTS has been successful in some case in Africa, however it is difficult to find strong data to support this.

Claims to have achieved Open Defecation Free (ODF) status have often been exaggerated and estimates of numbers of ODF communities inflated. Verification systems need to be improved. Another problem is that ODF is an absolute condition, important as a community objective but unlikely to be strictly achieved. This does not mean that significant progress has not been made. Most studies identified for this report were observational.

Some results include:

- UNICEF reports 69 of 308 project communities attained open defecation free (ODF) status in Ghana two years after project implementation. There was 4.21% increase in access to sanitation over two years.
- WaterAid evaluates a CLTS programme in Nigeria found to be effective in communities where it was used as the only approach to promoting hygiene and sanitation. And not effective in communities that had been influenced by the subsidy approach or those which were more urbanised. There was an 813% increase in latrines constructed and availability of 1-2 newly established or rehabilitated water points in every community. Diarrhoea and skin infections were also reduced, especially among children.
- Plan Nederland achieved 63% of target their target of 805 rural and 36 peri-urban communities in 8 African countries in 2011. They achieved 26% of their target for 742 schools to be ODF.

- A Water and Sanitation Program report describe CLTS activities in Mozambique. 173 communities were triggered and 34 awarded ODF status two months later.
- Follow-up is found to be crucial in sustaining ODF progress.
- Statistics for co-relation between CLTS implementation and Cholera outbreaks are reported from the Government of Mali National Directorate of Sanitation suggesting positive results.

There is debate around the use of the term 'shame'. Phillip Otieno (independent CLTS trainer) notes that whether good or bad shame is provoked, a good and sensitive facilitator is most important. Petra Bongartz (IDS) comments that the shame element is overemphasised and is not the key emotion that CLTS is meant to evoke. Robert Chamber (IDS) and Peter Hawkins (World Bank) suggest that it is disgust rather than shame which is the motivator.

2. Evidence of improved hygiene and sanitation

Going to Scale with Community-Led Total Sanitation: Reflections on Experience, Issues and Ways Forward
Chambers, R. 2009. IDS Practice Paper, Number 1.
http://www.communityledtotalsanitation.org/sites/communityledtotalsanitation.org/files/media/Chambers_Going%20to%20Scale%20with%20CLTS.pdf

Note on scale and statistics

The actual scale of CLTS is difficult to know and impossible to put sharp figures on. Two reasons stand out.

First, developments in many countries, organisations and places are rapid. There is no central point for collecting and verifying numbers, even within any country, let alone globally. The IDS website (http://www.communityledtotalsanitation.org) is a source of some data but it depends on contributions and updating which are inevitably partial and continuously in need of refreshing.

Second, claims to have achieved Open Defecation Free (ODF) status have often been exaggerated and estimates of numbers of ODF communities inflated. Lyla Mehta describes Open Defecation (OD) continuing transparently in communities in India and Indonesia that had been declared ODF. There are problems of verification, certification and counting. The history of estimates for numbers of communities that have become ODF does not inspire confidence. In Bangladesh, the high figures reported in the early days of CLTS were later scaled back. In India, the numbers of local government entities certified for the Nirmal Gram Puraskar (NGP) award has taken us into realms of fantasy. There, in Maharashtra, rewards for achieving ODF status were an ingenious way round the problem of having to spend big budgets for hardware subsidy, but gave incentives for false claims and certifications, reportedly rampant more widely with the NGP. The certification process was stringent at first but then become a farce with subcontracting by NGOs commissioned to carry out inspections, and then even those subcontractors at times subcontracting to individuals. This is not to say that campaigns had no effect. There may indeed have been improvements in sanitation in many communities, but without getting anywhere near the ODF status certified. In Maharashtra, target-driven competition between districts can hardly have failed to inflate the numbers. Elsewhere, as in Kenya and Ethiopia to date, with small-scale and careful verification, the numbers have been more credible. The larger the number of verifications, the harder it may be to know how reliable they are unless there is a substantial proportion of failures. In these circumstances, some claims and statistics lack credibility and may be set to become a source of embarrassment, if they are not already.

Third, ODF is in theory an absolute condition, with no faeces exposed anywhere. This is vital as a community objective but is unlikely in many cases to be fully, strictly, achieved. What are

counted are communities that have declared themselves, or have been declared, ODF. Conditions may be dramatically better than they were but problems have persisted, for example of passers-by, children's faeces, old people reluctant to change their ways, some who are mentally disturbed, and men who are obstinate, and sustainability has been an issue. ODF statistics must be taken for what they are – claims and certifications of progress. Only rarely are they likely to be statements of an absolute condition.

Country cases

In Ethiopia the pattern has been NGO and government collaboration. There is no programme of hardware subsidy. A government-led programme in the SNNPR (Southern Nations Nationalities and Peoples Region) achieved successes preceding CLTS. On the NGO side Plan Ethiopia has played a prominent role. The first training by Kamal Kar in October 2006 was followed by others. In September 2007, the first community, Fura, was declared ODF. Plan Ethiopia, UNICEF, Goal Ethiopia, and the Irish NGO Vita were all active and the government showed interest. Sanitation and hygiene activities using CLTS were piloted in four regions. In each of these there was in late 2008 an expanding nucleus of communities that had been triggered and declared ODF. Plan Ethiopia piloted a system of joint government-NGO action research teams and meetings with a national forum, a scaling-up strategy of learning workshops, and National and Regional Steering Committees. In 2008 there was much debate within government, donor agencies and NGOs about strategies for scaling up, with the government ambitious to achieve 5,000 kebeles (subdistricts) ODF by the end of 2009.

In Kenya, the process has been through partnership between NGOs and the Ministry of Public Health and Sanitation. Since May 2008, Plan Kenya has played a key role in equipping government and NGO staff, and children and youth, with CLTS facilitation skills and supporting them to implement it in their communities. There is a growing movement of NGOs and agencies such as Plan, UNICEF, Aga Khan, NETWAS, and government, together with natural leaders (including children) to advocate for and scale up CLTS in favourable districts in the three provinces of Nyanza, Coast and Eastern. Since CLTS was introduced in Kenya in March 2007, about 500 CLTS facilitators have been trained and about 200 villages triggered. As of World Toilet Day 2008 (19 November), 25 villages had attained ODF status, and about 50 more were at an advanced stage. There is demonstrated commitment by the lead ministry to scale up sanitation using the CLTS approach, which is in line with the government policy on environmental health and sanitation launched in 2007. There is a component of action learning to share and document experiences, challenges and lessons that are emerging from the implementation of CLTS. In Kenya CLTS is steadily becoming a movement.

From Burden to Communal Responsibility. A Sanitation Success Story from Southern Region in Ethiopia.

Bibby, S. & Knapp, A. (2007). World Bank WSP Field Note, Sanitation and Hygiene Series 38731

http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2007/03/02/000090341_20070302152253/Rendered/PDF/387310ET0Burde1ponsibility01PUBLIC1.pdf

This is a sanitation success story from the Southern Region of Ethiopia where 20 percent of the country's population reside in 10 percent of a geographic area known for its high population density and ethnic diversity. This field note describes the Southern Region's (Southern Nations, Nationalities and Peoples' Regional State) rise to the top of the domestic 'on-site' sanitation league table in the span of three years, and how several sanitation prejudices were overcome along the way.

In early 2003, access to 'on-site' sanitation in the region was estimated to be under 13 percent. In just two years, the region experienced a rapid improvement. The Southern

Regional Health Bureau has applied some of the key guiding principles of the highly acclaimed CLTS approach – that of 'zero subsidy' – but allowing the community to come up with its own innovative and affordable models.

Yearly statistics from the Southern Nation's Regional Health Bureau for on-site sanitation showing the increase of latrine construction in the region:

- 12.8%, 2002/3
- 51.7%, 2003/4
- 78.8%, 2004/5
- 88.8%, 2005/6 (projected)

The head of the Regional Health Bureau said that between 2002/3 and 2004/5 the "The number of latrines rose from around 100,000 to 2 million," People did this at their own expense. The activities which were funded did not cost more than 500,000 birr (around US$50,000).

Evaluation of Strategy for Scaling Up CLTS in Ghana
Mgala, J.M. & Robert, L. 2009. UNICEF
http://www.communityledtotalsanitation.org/sites/communityledtotalsanitation.org/files/media/Ghana_CLTS_Evaluation.doc

The Community Water and Sanitation Agency (CWSA), Plan, UNICEF and WaterAid have been piloting CLTS since 2007 in approximately 308 communities in Northern, Upper West, Eastern, Central and Greater Accra Regions with an attempt to scale up hygiene and sanitation improvements.

The Evaluation Team (ET) observed that the CLTS pilot projects significantly improved sanitation coverage and practices in the communities within the 18 months of implementation.

- 69 of the 308 project communities attained open defecation free (ODF) status.
- Number of household latrines went from 1857 to 3247 in the project communities
- There was 4.21% increase in access to sanitation over two years. This was 8 times more than the annual percentage increase witnessed from 1990 – 2006.
- Of the communities visited hand washing with soap was still very low at (21%). Yet this was one of the key behavioural practices known to reduce the incidence of diarrhoea diseases among the children.
- 6 out of 33 (18%) had covers installed on the latrines. The key target for the faecal oral route barriers is the fly which is responsible for transmission of germs; therefore the importance of covers on the traditional latrines may be underestimated.

The CLTS process focused on ODF status in the pilot projects. Sanitation practices mostly involved upgrading or repairing the existing communal latrines, which was the first priority for most communities. Provision was made for construction of separate communal latrines for men and women. Individual household latrine construction was observed at various stages with the majority having the traditional pit latrine using locally available materials. Some communities were supported with slabs for the latrines to move up on the Sanitation Ladder. Improved latrine construction greatly contributed to sustenance of ODF status and will contribute to the achievement of MDGs. Some community members ended OD and adopted the "dig and bury" practice as a means to eliminate contact with faecal matter.

Promotion of improved hygiene practices such as well maintained compounds, construction of refuse pits which were in use and, in a few communities, hand washing with soap was evident in some communities and Hand Washing Facilities (HWFs) were provided and placed next to the latrines. Awareness of the faecal-oral transmission routes was very high and

behavioural changes were very encouraging among the communities where CLTS has been promoted. CLTS has proven to be an effective approach to reducing the high rate of OD in Ghana. CLTS has empowered many extension staff to move from hygiene education to empowering community members to take charge of their sanitation situation through participatory assessment, community action plans and sustenance of behavioural practices.

Community Led Total Sanitation (CLTS) – An evaluation of the WaterAid's CLTS Programme in Nigeria
Buton, S. 2007. Wateraid.
http://www.wateraid.org/~/media/Publications/community-led-total-sanitation-nigeria.pdf

This is an evaluation study which assessed the second expanded phase of the CLTS pilot programme in four States – Benue, Enugu, Ekiti and Jigawa – in Nigeria. The study aimed to assess the efficiency, effectiveness and relevance of the CLTS programme, and to recommend ways of improving and scaling up the programme in Nigeria.
Relevant findings on outcomes measured include:

- Reduction in the extent of open defecation, with some communities declaring 'open defecation free' status.
- Reduction in skin infections especially among children
- Reduction in diarrhoea and vomiting amongst children
- Large numbers of latrines constructed. Approximately 813% increase in latrines constructed (from 116 to 1060 latrines)
- Availability of 1-2 newly established or rehabilitated water points in every community

There was also wide ranging evidence from the evaluation showing that CLTS was an effective approach to establishing hygiene and sanitation practice in Nigeria, though was largely dependent on certain conditions. CLTS was found to be effective in communities where it was used as the only approach to promoting hygiene and sanitation. However, not effective in communities that had been influenced by the subsidy approach or those which were more urbanised. It was also observed that there were other 'triggers' in addition to 'shame' and 'disgust' that led to change in hygiene and sanitation improvements such as participation. It was seen that the more participatory the process was, the more effective CLTS became.

Sustainability and equity aspects of total sanitation programmes. A study of recent WaterAid-supported programmes in Nigeria
Robinson, R. 2009. A Wateraid Report
http://www.communityledtotalsanitation.org/sites/communityledtotalsanitation.org/files/Nigeria_CLTS_synthesis_report.pdf

This report summarises research conducted in Nigeria as part of a study into the sustainability and equity of Total Sanitation programmes supported by WaterAid in Bangladesh, Nepal and Nigeria.

Sustainability of sanitation behaviour change
Prior to the CLTS interventions, less than 20 percent of households were using latrines in all of the research communities except one; and neither of the two study communities in Jigawa state contained a single latrine. Following the CLTS interventions, three of the communities declared themselves open defecation free (ODF), while the remaining five communities reported between 11% and 86% latrine coverage. The research found that only one of the three ODF communities had remained open defecation free. Heavy rains during the research period caused the collapse and abandonment of latrine pits in Efopu-Ekile, and the research in Duhuwa revealed that, while only one Hausa household had reverted to open defecation, very few of the semi-nomadic Fulani households had ever built or used latrines.

Equity of sanitation outcomes

The data confirmed relatively equitable outcomes in the three high-performing communities: there was no open defecation among disadvantaged households in either Igba or Efopu-Ekile; and the open defecation rate was only 9% higher among the disadvantaged households in Duhuwa. However, the disadvantaged households fare less well in the median and low performing cases, with open defecation rates 26% to 59% higher among disadvantaged households than in the rest of the community.

Given that the baseline (pre-intervention) latrine coverage in these communities was largely among rich and middle-income households, it seems likely that these differentials in open defecation rates reflect the starting conditions, with much higher open defecation among the poor and disadvantaged, thus that the successful sanitation interventions have had a significant impact on open defecation rates among these disadvantaged groups.

In the high-performing communities, the data also suggested that the disadvantaged households had generally built similar latrines to those built by the bottom 35% to 45% of the community, and had maintained them to a similar standard. While the latrines built in these communities were fairly basic, these observations suggest that the interventions provide similar opportunities to all income groups, and that low-income households are not prejudiced by their lack of resources.

Limited follow-up reducing sustainability

The current approach, with implementation financed by WaterAid but conducted almost entirely by local government, allows no follow-up after the first year of the intervention. The local government Water and Environmental Sanitation (WES) Units confirmed that they are reluctant to visit remote communities unless paid a travel allowance and, once the intervention finishes, no funds are available for allowances.

The WES Units are relatively new institutions, with little experience of sanitation improvement, and few incentives to do their jobs well. Moreover, the current institutional arrangements provide little regular support from the WaterAid programme staff, other than a couple of training courses every year. This arrangement allows little monitoring of either the process or the outcomes, and is an important factor in the large variation in the quality and commitment of the WES Units.

The cost-effectiveness of the interventions could be improved. Similar interventions in Asia cost approximately US$10 per household latrine, whereas the costs in Nigeria average about $77 per latrine, with another $20 contributed by the household. Efforts need to be made to improve the efficiency of the process: to prune the unsuccessful elements, to monitor the relative cost-effectiveness of the various activities, and to focus on the core business of achieving collective sanitation outcomes that have a real impact on the health and economy of the target communities.

The effectiveness and sustainability of two demand driven sanitation and hygiene approaches in Zimbabwe

Whaley, L. & Webster, J. 2011. Journal of Water, Sanitation and Hygiene for Development, 01.1.
http://www.iwaponline.com/washdev/001/0020/0010020.pdf

The study presented compared the effectiveness and sustainability of CLTS and Community Health Clubs. Ten communities from three districts were used where surveys, focus groups and in-depth interviews were conducted. Results of the CLTS survey showed that:

- 77% did not use open faecal disposal
- 57% shared their latrine with others

- 44% owned a latrine
- 71% of the latrines owned were maintained and 80% of latrines were still in use

Overall CLTS was observed to be effective in promoting latrine construction

Community led total sanitation (CLTS): Addressing the challenges of scale and sustainability in rural Africa
Sah, S. & Negussie, A. 2009. *Desalination, Volume 248, Issues 1-3*
http://www.communityledtotalsanitation.org/sites/communityledtotalsanitation.org/files/Addressing_the_challenges_of_scale_and_sustainability%20in%20Africa.pdf

This paper reviews Plan's experiences of promoting CLTS in Eastern and Southern African Countries. The potential of CLTS addressing the issue of scale and long term sustainability within the national planning framework is recognised and lessons learnt from ongoing programmes in Ethiopia and Tanzania are shared. The challenges and some limitations of CLTS are critically assessed by this paper and issues needing more research and studies are presented.

Results from CLTS implementation in Ethiopia and Tanzania include:
- Establishment of shit (chilo in Ethiopia) eradication school clubs that promote CLTS in Fura and Taremessa.
- Establishment of Chilo committees at district level in Fura and Taremessan that follow up on CLTS initiatives.
- The cost of implementing CLTS in Fura and Taremessan was only the cost of facilitation and the installation of the latrines was completely undertaken by the community through their own resources using material that was already available with them.
- Advocating CLTS in Churches and Mosques that propagated that good Christians and Muslims do not defecate in the open and those ''who defecate on open field will be penalised five birr'' (written on a sign post Taremesa).
- Children playing a key role in persuading their families to construct latrines in their houses.

Case 1: The story of Weizero Belayinesh Worku's brave acts
Fura Kebele in Ethiopia has 1265 households and achieved an ODF environment by building 465 household pit latrines and eight communal latrines for passers-by and visitors. Communities penalise offenders in various ways including making them scoop it with their hands.

In Ethiopia, an initial effort on CLTS led to a total of 2648 latrines being constructed within 8 months at an average cost of only one dollar per latrine and that one dollar was the cost of facilitation.

CLTS has helped to empower the people to identify their own problems, think of solutions, and take actions on their own initiative. Children have played a key role in this process by campaigning in favour of ODF communities, putting pressure on parents and neighbours to construct latrines and deterring people from defecating in the open through various means of shaming such people, e.g. whistling at them or embarrassing them by drawing other people's attention towards them when they sit in the open.

Case 2: The transformation of Sangabuye village in Tanzania
Sangabuye is a ward in Mwanza region, Ilemela district of Tanzania. The People in Sangabuye are Sukuma (an ethnic group) and most of them are very poor. The area is rocky surrounded by some hills and few trees. The great part of Sangabuye is surrounded by Lake

Victoria. When Plan Tanzania initiated CLTS in Sangabuye in 2007, the community members did not have many household or public latrines.

The prevalent myth was that when family members shared the same place for defecation they would bring misfortune to the family. As a result of the CLTS initiative, a remarkable change was seen in Sangabuye:

- Within three months, 93% households in 14 sub villages in Sangabuye ward had constructed latrines as compared to 43.9% who had latrines before the CLTS programme was initiated.
- As a result of these improvements, communities with latrines have regained a sense of pride and are very aggressive to those without latrines/still practising open defecation.
- There are expectations that 100% of all households in the remaining villages in Sangabuye ward will be ODF by April 2008.
- Preliminary reports indicate significant reduction in diarrhoeal incidences in general and almost no Acute Watery Diarrhoea (AWD) incidence in the kebeles in Ethiopia where CLTS was implemented.

In Tanzania, a village CLTS committee educates neighbouring villages to make improvement in sanitation and is popularly known as 'kamati ya kuzuia kula mavi' or ''a committee to stop eating each other's shit''.

UNICEF has started promoting CLTS at the regional level and the World Bank has provided training on CLTS with the help of Plan Ethiopia trainers. As the approach empowers communities, it has been found to be useful in all areas of community development especially as an entry point for community facilitators.

Annual Report 2011. The Pan African CLTS Programme Empowering self-help sanitation of rural and peri-urban communities and schools in Africa
Plan Nederland, 2012
http://www.communityledtotalsanitation.org/sites/communityledtotalsanitation.org/files/Annual_report_2011_PanAfrica.pdf

The programme is running in Sierra Leone, Ghana, Niger, Ethiopia, Uganda, Kenya, Zambia, and Malawi.

Accumulated progress on sanitation and hygiene in 2011

Indicators	Target	Ethiopia	Uganda	Kenya	Zambia	Malawi	Ghana	Sierra Leone	Niger	Total Progress	% overall target
No. ODF communities	805 rural and 36 peri-urban communities	46	50	199	71	53	20	48	23	510	63%
No. ODF schools	742	41	12	105	3	2	7	7	15	192	26%

This report also includes details of:

- communities empowered and by programme activities and how they have effectively developed their own sanitation and hygiene systems and maintain them
- development of country specific models to initiate national strategies on CLTS at scale
- local entrepreneurs to help households climb the sanitation ladder active in Uganda, Ethiopia and Kenya
- progress in each different country.

Mtumba sanitation and hygiene participatory approach in Tanzania. Outcome and Impact monitoring for scaling up Mtumba sanitation and hygiene participatory approach in Tanzania.
Malebo, H.M. et al. 2012. Wateraid.
http://www.shareresearch.org/LocalResources/Scaling_up_MTUMBA_report_August_2012.pdf
This is an evaluation study aimed to measure the outcome of MTUMBA approach in terms of behaviour change and sanitation demand creation. MTUMBA approach was amalgamated from Participatory Hygiene and Sanitation Transformation (PHAST), Community Led Total Sanitation (CLTS) and Participatory Rural Appraisal (PRA) tools. The study was carried out in Masieda, Mtoa and Mambali in Tanzania. MTUMBA evaluation activities included In-depth interviews, desk reviews, focus group discussions and household surveys. Overall findings highlighted:

- 90% of the population had pit latrines
- Behaviour change was acknowledged by 80% of the respondents – e.g. decline in open defecation
- Decreasing trend in diarrhoea under-5 was observed especially in Mambali
- Fluctuating trends in intestinal helminthes, skin infections, eye infections, typhoid fever and schistosomiasis was reported

Effects attributed to CLTS alone could not be disentangled

Impact evaluation of drinking water supply and sanitation interventions in rural Mozambique
Ministry of Foreign Affairs, Netherlands. 2011.
http://www.oecd.org/countries/mozambique/49295401.pdf

In 2008 the Government of Mozambique, UNICEF and the Government of the Netherlands agreed to an impact assessment at mid-term and at the end of the Netherlands supported UNICEF Water Supply, Sanitation and Hygiene programme - the One Million Initiative – in Mozambique. The impact evaluation is a joint responsibility of the Policy and Operations Evaluation Department (IOB) of the Netherlands Ministry of Foreign Affairs and the central Evaluation Department of UNICEF. One Million Initiative was being implemented in 18 districts of Manica, Sofala and Tete provinces. The programme is to run for seven years (September 2006 – December 2013). The total budget for the programme is EUR 32.64 million.

Findings and general comments from the report – only related to CLTS:

- On-going challenges regarding the maintenance of latrines – which should be facilitated by the widespread use of local construction and materials – and of CLTS-induced behaviour: there is reportedly little international evidence yet on the latter.
- It was decided to merge the sanitation and hygiene education components through a community led total sanitation (CLTS) approach, in conjunction with an awards scheme for recognition of ODF status – this combined approach was referred to as 'community approach for total sanitation'
- On the recommendation of a study commissioned by the programme, a more modest system of awards was instituted from 2009, when 619 communities were mobilised through the CLTS process and, despite the less generous prizes, 130 awarded ODF status.
- There is little conclusive evidence about the sustainability of practices introduced through CLTS, although reversion to previous practices has certainly been observed in Bangladesh: "…even though there is a shift in attitudes and a drive to change habits initially, the enthusiasm may eventually peter out once the facilitators have

withdrawn, and the community's members over time fall back into their old routines." Overall, however, "monitoring and evaluation of ODF status is very weak in CLTS"

Documentation of CLTS Experiences with ASNANI in Nampula Province
Godfrey, A. 2010, Water and Sanitation Program
http://www.communityledtotalsanitation.org/sites/communityledtotalsanitation.org/files/media/ASNANI_CLTS_report.pdf

CLTS was introduced in the ASNANI project in Nampula Province in May 2009 with a training of artisans in Mecuburi District. Prior to the introduction of CLTS, the artisans were trained to use PHAST tools for hygiene and sanitation promotion but it yielded minimal results. Within three months of the introduction of CLTS, the artisans in Mecuburi reported over 3,000 latrines constructed in communities where CLTS was triggered. This success is concentrated in two of the four Administrative Posts, which coincides with the areas where the trained artisans reside. This encouraging report led to the expansion of CLTS to a second District, Moma with the worst sanitation coverage in Nampula District.

A new group of artisans were trained on CLTS in Moma District but did not achieve the same success as their counterparts in Mecuburi District. Some of the factors that could have contributed to this lack of success include the skills and interests shown by the artisans, the proximity to beaches away from the immediate living environment of the coastal communities, unstable soil conditions, lack of strong leadership with interest in changes in sanitation practices, long standing tradition of defecating on the beach and lack of appropriate and affordable latrine technologies.

Although CLTS was not successful in Moma district, the result in Mecuburi has demonstrated that CLTS could potentially trigger changes and uptake of latrines at a scale that has not been seen previously. It also reinforces the need to include the approach in the national strategy for sanitation promotion in rural areas.

Findings from the field visits indicate that with more comprehensive planning, CLTS could achieve better results. The experience of the ASNANI project points to the need to have regular monitoring and support mechanisms if local resources such as the artisans are to be used for triggering. This will include clear system of verifying and reporting progress; without this clear system, it will be difficult to validate the latrine figures provided by the artisans. It also points to the need to look in-depth into how to make CLTS and/or other innovative approaches work in coastal communities and the need for appropriate low-cost technologies for these communities. The findings reinforce the important role of community leaders post triggering. A committed and progressive leader that supports CLTS process is more likely to push for change than one that has very little interest. The effect of a committed community leader on the success of CLTS is almost equal to that of a skilled facilitator.

Preliminary Documentation and Evaluation of the Sanitation Component of the "One Million Initiative" in Mozambique
Godfrey, A. 2009. Water and Sanitation program
http://www.communityledtotalsanitation.org/sites/communityledtotalsanitation.org/files/media/CLTS_Prelim_Documentation.pdf

The interventions of the program in the area of sanitation and hygiene promotion were designed to be implemented using the PHAST (Participatory Hygiene and Sanitation Transformation) methodology through NGOs contracted by the Districts. Due to slow progress in obtaining the desired results, it was decided to introduce a new strategy. The new strategy, known as CATS (Community Approach for Total Sanitation), combines the

CLTS approach with a system of awards/prizes.

The system of prizes aims to reward ODF communities; community leaders who distinguish themselves in sanitation promotion work; heads of the sub-districtsin which the winning communities are situated; and district governments that have the largest number of open defecation free villages and the largest number of latrines in each province. The prizes include the following; one water point for every ODF community; a hygiene kit (bucket, soap, mirror, water purification solution) for every family; bicycles for community leaders; mobile phones for the sub-district heads; and computers or photocopying machines for the Districts.

The CLTS approach has been successfully implemented in other countries and was introduced in Mozambique in August 2008 with the training of 74 persons, supported by UNICEF. CLTS was triggered in 173 communities during the months of October and November 2008. Of the 159 communities that applied in December 2008, 34 were awarded ODF status, with over 5,000 latrines built and in use. In total over 49,000 latrines were built as a result of triggering CLTS in 173 communities. The results of CLTS have been very impressive, considering that 34 communities became ODF in only two months. The 34 communities were awarded ODF certificates and the corresponding prizes in a public ceremony.

An evaluation conducted in April 2009 showed that the majority of ODF communities were able to recount the CLTS triggering process, particularly the demonstration of the fecal contamination of food. The latrines built in the ODF communities were still in use 4 months after they were awarded ODF status, and collapsed latrines had been rebuilt. This clearly indicates that the prizes were not necessarily the motivation for ODF, but rather a combination of CLTS triggering and persuasion by the community leaders.

National ODF certification and celebration in the North Bank Region of the Gambia
communityledtotalsanitation.org country paper, no author, no date
http://www.communityledtotalsanitation.org/resource/national-odf-certification-and-celebration-north-bank-region-gambia

CLTS was introduced and piloted in The Gambia in 20 communities in the the Upper River Region (URR) in 2009. Since adoption the country has witnessed a decline in open defecation rates nationally. The MICs survey in 2012 shows an open defecation rate of 2.8% as opposed to 4.4% in 2005. The country needs to focus on sanitation improvements through CLTS, because they have been found to significantly reduce diarrhea morbidity by 36%.

In the URR May 2012, 75 communities were assessed and those practicing open defection were triggered in May 2012. At the later part of December 2012, a follow up was conducted in the triggered communities and it was found out that 44 communities representing 59% have now attained ODF status.

In the Central River Region (CRR), the CLTS concept was introduced in 2010 and was piloted in 5 communities, scaled up to 20 communities in 2011. Significant progress was made in terms of coverage, as 100 communities were triggered in that year alone. In all a total of 125 communities were triggered and only 12 attained ODF status. More effort is needed to get more communities triggered for the attainment of ODF. It is worth mentioning that open defecation rates have been found to be high in some Local Government Areas (LGAs) such as Kuntaur (13.6%), Janjangbureh (9%) in the CRR. There is therefore the need to focus on these LGAs.

In the North Bank Region East, The CLTS approach was introduced in 2010 and piloted in 6 communities. This was later increased to 20 communities in 2012 and 44 communities were triggered in that year alone. A total of 70 communities were triggered and 20 (28.5%) were

able to attain ODF status. A total of 70 communities were assessed and triggered from 2010 to 2012 based on their OD status. Significant progress was made in 2012 in terms of coverage, as 44 communities were triggered in that year alone. A total of 20 communities attain open defecation free status (28.5%) of the total number of villages triggered.

Joint VHT Efforts turn around the health situation of 3 villages after ODF declaration
Atuhaire, B. Case Study, World Vision Uganda WASH project
http://www.communityledtotalsanitation.org/resource/joint-vht-efforts-turn-around-health-situation-3-villages-after-odf-declaration

The UWASH project intensified its operations through its CLTS approach in the month of June 2011. Subsequent intensive follow ups were made with support from the Village Health Teams (VHTs) from each of the villages.

After realisation of a significant improvement in the hygiene and sanitation situation, a team from the Uganda Ministry of Water and Environment Technical Support Unit for hygiene and sanitation situation, a team from the Uganda Ministry of Water and Environment Technical Support Unit for hygiene and sanitation, Hoima district public health department together with these VHTs conducted an ODF verification exercise and discovered that the villages were clean and exempt from any open defecation and non-sanitary practices. This exercise took place in October 2012, almost a year after the project intervention. “It has indeed been a long and tiring journey. But a walk through the village gives me gratitude and convinces me that it was worth it.” Reveals David Ndyabahika, a 48 year old senior VHT from Kigwangu village. The villages currently stand at latrine coverage of 92 % for Kibingo, 100 % Kigwangu and 98 % Mumiti.

Accelerating access to rural sanitation in Kenya
MoPHS/ UNICEF/ PLAN/ SNV. 2012. An Initiative of the Ministry of Public Health and Sanitation with support from UNICEF, SNV and PLAN
http://bit.ly/12xlgMT

CLTS was introduced in Kenya by PLAN Kenya in May 2007, following two training workshops in Tanzania and Ethiopia attended by 3 of their WATSAN staff. From one ODF village (Jaribuni in Kilifi District) in November 2007, they were able to achieve close to 50 ODF Villages. The interventions generated interest with Ministry of Public Health and Sanitation (MOPHS) and NGOs who thereafter participated in various hands-on CLTS training. In 2010, MOPHS in partnership with UNICEF and SNV embarked on a pilot in six districts in Nyanza and Western Kenya. Within a period of one year this initiative registered impressive results with over 1,000 villages (571,231 people) attaining open defecation free status. From lessons learned in this initiative, MOPHS was inspired to adopt CLTS as a key strategy for scaling up sanitation in Kenya.

CLTS in Eritrea
UNICEF, 2012
http://www.communityledtotalsanitation.org/sites/communityledtotalsanitation.org/files/CLTS_Eritrea_Brochure.pdf
By late 2007, the Government of Eritrea and UNICEF were determined to change the approach and management of the sanitation programme for Eritrea. It was recognised that the concept of CLTS had much to offer in that it recognised the role of village communities in promoting and managing sanitation and focused on behaviour change on excreta disposal.

In 2009, 436 villages had been triggered and 165 had been declared ODF. Other achievements include:

- Draft Rural Sanitation Policy and strategic direction has been published and distributed.
- Number of people who have access to a basic sanitation facility increased to 350,000 in the last three years as compared to 96,205 in an eight year period.
- The issue of sanitation is given priority attention in review and planning meetings in Ministry of Health and local administrators.
- Computation is developing among the villages.

Water, Sanitation and Hygiene Evidence paper
DFID & LSHTM, 2013. DFID.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/193656/WASH-evidence-paper-april2013.pdf

This is a recent review paper that presents available evidence on WASH interventions, impact of WASH interventions, delivery options, cost effectiveness and gaps. Evidence on the best delivery models for WASH appears to be limited. In particular, the evidence around hygiene behaviour change interventions such as CLTS, Community Health Clubs and Social Marketing. It is also noted by the authors that the evidence base design around these is relatively new and anecdotal.

SSHIT (Shared Sanitation, Hygiene, Information and Tales): CLTS Newsletter
Ministry of Public Health and Sanitation. March 2012.
http://www.communityledtotalsanitation.org/sites/communityledtotalsanitation.org/files/SSHIT_Kenya_Newsletter_Feb12.pdf

In 2007 CLTS was introduced in Kenya by PLAN, generating interest from the Ministry of Public Health and Sanitation and NGOs. In 2010, UNICEF and MOPHS piloted the intervention in Nyanza and Western Provinces. Since then, CLTS has achieved the following results in Kenya:

- 305 public health officers/PHTs have been trained
- 5402 villages triggered
- 976 villages declared ODF
- 86 ODF celebration
- 457,716 people reached
- 16 counties reached

SSHIT (Shared Sanitation, Hygiene, Information and Tales): CLTS Newsletter
Ministry of Public Health and Sanitation. (October – November 2011)
http://www.communityledtotalsanitation.org/sites/communityledtotalsanitation.org/files/SSHIT_kenya_newsletter_oct11.pdf

Latest ODF figures from Western Kenya
In October 2010 to November 2011 the number of ODF villages has been recorded in Busia, Siaya, Bondo, Kisumu West, Nyando and Rachnyo districts where CLTS has been introduced to show the progress of the initiative. So far a total of 976 claims of ODF villages have been recorded, with a total of 617 currently certified, covering a population of 457,716. The success of CLTS has varied in each region, ranging between 86.42% achievement of targeted populations attaining ODF certification in Nyando, to a low of 59.12% achievement in Bondo.

National latrines coverage - on track

During the period from July 2010 to June 2011, the environmental health department at the *Ministry of Public Health and Sanitation* aimed to improve national latrine coverage by 8%; from 63% to 71%. Data for the progress of 8 districts was recorded in the Annual Operations Report on sanitation. Overall, the national latrine coverage was increased from 63.00% to 74.24% during the period. This is an increase of 11% which is 3% above the target for the indicator.

CLTS Kenya The Shit News
Qone, A.M. (Chief editor), 2011. *The Shit News, Issue 1*
http://www.communityledtotalsanitation.org/sites/communityledtotalsanitation.org/files/SSHITS_Issue_1_Aug_2011.pdf

The main article in this news letter is by the Kenya National Coordinator of CLTS Adam Mohamed giving an entry point of CLTS in Kenya, and how far CLTS approach is hoping to achieve by 2013.

CLTS activities started in Kenya in 2007. Within four months after triggering over 745 villages, including 3 sub-locations became ODF and 14 active natural leaders emerged.

The six wash districts are both in Nyanza and Western Province. Busia is the only district in Western Province, while Nyando, Bondo, Rachuonyo, Kisumu West and Siaya are in Nyanza Province. CLTS trainings were done between August and October 2010 in all the six districts. 10 villages were targeted to an individual implementer (Public Health Officer or Public Health Technician) in every district.

Overall, 1288 villages were targeted in the pilot districts. 819 claimed to be ODF. 357 were verified by a district public health officer and 168 were certified by a third party. 837 villages are awaiting third party certification.

Data from the Health Management Information System shows reduction in the incidence of diarrhea and cholera between 2008 and 2011 in the Nyando district.

Winning the Battle Against Cholera: impact of community let total sanitation (CLTS) in Africa
Kar, K. 2012. 6th World Water Forum Conference Paper
http://www.cltsfoundation.org/images/wwf.pdf

Statistics for co-relation between CLTS implementation and Cholera outbreaks in Mali are reported from National Directorate of Sanitation in the Government of Mali:

- In the Segou region 3 out of 117 communes had cholera outbreaks. None of these outbreaks occurred in the 12 communes where CLTS is implemented.
- In the Mopti region 17 of 108 communes had cholera outbreaks. Outbreaks occurred in 2 of the 31 CLTS communes.
- In Kayes, 10 out of 129 communes had cholera outbreaks. None of these outbreaks occurred in the 12 communes where CLTS is implemented.

Statistics show dramatic decrease in cholera cases in Kenya. However, the source of these statistics is unclear.

3. Comments from experts

Peter Hawkins, Senior water supply and sanitation specialist, World Bank, Mozambique

I don't really buy the "walk of shame" argument, which I think is more by way of political correctness by certain people at our elite level. My understanding and observation of CLTS says that it is the natural disgust we have for shit that is the motivator, rather than shame. Shame may come in later with the late adopters and peer pressure. However, that follow-up depends on dynamic local leadership, which is not always available.

I also find the questions around rural water supply totally out of context - CLTS is a very powerful but one-dimensional tool for getting people to worry about sanitation. No more, no less.

The more relevant question is on the sustainability of ODF status, which is related to the follow-up and community monitoring which I mentioned above. There has been significant recidivism, and I attribute this mostly to the lack of sustainable community monitoring and follow-up. There are also questions over the lack of quality control of facilitators, which may also lead to poor results.

*But I am convinced that CLTS is a very valuable tool **if** properly integrated into a wider supporting programme.*

Robert Chambers, Research Fellow, IDS

In my view, it is unfortunate that the term 'walk of shame' was used in the first place. It has got lodged in some of the common vocabulary through repetition. For those who have never been present at a CLTS triggering it can conjure up the image of an outsider who is trying to shame people. This is neither the intention nor wht one experiences. One wonders how many of those who criticise triggering on this basis have actually been present at a triggering. Disgust and shock are the dominant emotions. There is also a good deal of laughter that goes along with the seriousness. Triggering is largely through disgust and recognising that 'we are eating one another's shit'.

There are well known and well recognised problems with CLTS statistics. There is a perfectly understandable tendency for Government numbers for ODF communities to be on the high side, particularly if there are campaigns with targets and field staff feel that they will be judged on their reported performance, or if there are rewards for becoming ODF. One programme in India – the Nirmal Gram Puruskar – where there were rewards, led to exceptional exaggeration which has now been largely corrected. All this is well known and a lot of work has gone into systems for verification, which are now numerous, and vary by country (you can find a number of national manuals or guides to verification on the website).. A good test of the quality of verification is if there is a fair proportion of communities which do not qualify as ODF on the first attempt. A great deal of this can be found on the website www.communityledtotalsanitation.org under Lukenya Notes and Lilongwe Briefings and elsewhere.

International organisations are in a difficult position because they feel obliged to accept Government statistics. The danger then is that they will repeat them authoritatively, and a misleading impression will result. I have periodically done an estimate of numbers of people living in communities that have with reasonable credibility been declared ODF as a result of CLTS. This entails discounting, more for some countries than others. I do not doubt that in some countries the spread of such communities is exponential. I would name, for instance, Mali, Zambia and East Timor. Over time, as more has come to be known, I have made larger discounts for some countries, for instance India. That said, my current estimate would be that

the number is well over 20 million people and rising fast. There will be many more who have benefitted in communities which are not yet ODF but with substantial numbers of new latrines/toilets, giving a total well over 30 million who have benefitted one way or another.

None of this is simple. There are many issues of sustainability, and of moving up the sanitation ladder. We are convening an international workshop on sustainability to share research, experiences and methods later this year. There have been a number of good research projects on sustanability, which are illuminating and by and large quite encouraging.

The international agencies that support the spread of CLTS – WSP, Unicef and WSSCC among others, and the INGOs (Plan International, WaterAid, World Vision, Oxfam, Tearfund and others) have done and continue to do a good job of dissemination, as do bilaterals like DFID. Many in those organisations have championed CLTS. We all recognise the challenges that CLTS presents but also the astonishing achievements, in many countries (at least 20 have CLTS as national policy) where NGOs have initiated CLTS and it has then been scaled up by the Government itself.

Some targets have initially been unrealistically high. However, there is long experience that to get the highest performance it is good to set targets which are a bit beyond reach. In African countries there is a greater degree of realism than there was, and my judgement would be that some countries, for instance Zambia, will astonish the world with what they achieve.

Sue Cavill, Research Manager, WaterAid
To note: The query seems to misunderstand the nature/purpose of CLTS

Contribution to reduction in WASH related diseases and womens workload, improvement of basic education outcomes and gender equality

- *There is no real evidence on these outcomes in relation to CLTS to date – but an evidence base is starting to be constructed*
- *One example (http://www.oecd.org/countries/mozambique/49295401.pdf) makes some assessment of health impact for the approach in Mozambique*
- *Amy Pickering is leading a study on the health impact in Mali. The research is being funded by the Bill and Melinda Gates Foundation and conducted as a research collaboration of the Center for Distributive, Labor and Social Studies (CEDLAS) of Argentina (Universidad Nacional de La Plata), UNICEF and the PEP Research Network*
- *I only know of one study on CLTS and gender: http://www.communityledtotalsanitation.org/sites/communityledtotalsanitation.org/files/Gender_and_CLTS_Abridged_Plan_Uganda.pdf*
- *Plan International USA has a Testing Modified CLTS for Scalability project aims to improve rural sanitation by researching and testing the cost-effectiveness, sustainability, and scalability of the CLTS approach: http://www.planusa.org/contentmgr/showdetails.php/id/2586090*

Increased equitable and sustainable use of safe water supply and improved sanitation and improved hygienic practices among the rural population:

- *CLTS doesn't traditionally deal with safe water supply – CLTS ++ might include safe water storage*
- *Until recently, the lack of attention to improved hygiene has been a criticism of CLTS. A link to a recent brief from Malawi on how CLTS can trigger improved handwashing http://www.communityledtotalsanitation.org/resource/triggering-handwashing-clts*
- *There have been a few studies of equity and CLTS –WEDC/WaterAid study from Bangladesh- http://www.wateraid.org/~/media/Publications/community-led-total-sanitation-people-vulnerable-bangladesh.pdf*

- *Regarding equity, this paper might be of interest: Jamie Bartram, Katrina Charles, Barbara Evans, Lucinda O'Hanlon and Steve Pedley. Commentary on community-led total sanitation and human rights: should the right to community-wide health be won at the cost of individual rights? Journal of Water and Health Vol 10 No 4 pp 499–503 © IWA Publishing 2012 doi:10.2166/wh.2012.205 http://www.ncbi.nlm.nih.gov/pubmed/23165706*
- *Sustainability and equity were key issues in a WaterAid study: http://www.communityledtotalsanitation.org/resource/sustainability-and-equity-aspects-total-sanitation-programmes-study-recent-wateraid*
- *Some anecdotal evidence that CLTS if done badly can increase stigma and discrimination within communities especially of older women (e.g. children blowing whistles when find their elders defecating in the open)*
- *It is not clear yet whether ODF status can be sustained without sanitation marketing or subsidies*
- *Some countries have national guidelines for verification and certification of ODF communities (good examples are Ethiopia, Nigeria, Sierra Leone, Ghana and Zambia)– slippage back to open defecation is a key issue, particularly in rainy season when pits are prone to collapse*
- *See the documents at this link for more on this issue: http://www.communityledtotalsanitation.org/resource/lilongwe-briefings-outputs-international-workshop-lilongwe*
- *Some countries use the CLTS++ approach that includes well constructed toilets that are properly designed and maintained, that hand washing with soap and water are practiced, and drinking water is safely handled in the home*

Community based public- private sector partnership model established for sustainable operation and maintenance of rural water supply for water points and rural piped water schemes and sanitation:

- *CLTS doesn't directly address rural water supply. Government policies often state that sanitation is the responsibility of the household with a no-subsidy approach, where government has the responsibility to create an enabling environment.*
- *The social capital built during the CLTS process could possibly increase the likelihood of community action to improve the sustainability of rural water supplies but there is little evidence of this – one paper on the parallels between self supply and CLTS might be useful http://rwsnforum.files.wordpress.com/2011/11/152-annis-madagascar-long-paper.pdf*
- *PPPs – there could be examples of PPPs (i.e. a PPP involves a contract between a public sector authority and a private party) for sanitation promotion activities (e.g. under PEC Zonal in Mozambique) where the private party has a results based contract to trigger communities to become open defecation free using the CLTS approach.*
- *There are examples where Sanitation Marketing has been used to complement CLTS by building the capacity of local masons to build latrines in triggered communities and to address supply chain issues. For instance WSP using Total Sanitation, Sanitation marketing (TSSM) in tanzania http://www.wsp.org/global-initiatives/publications-and-tools-0#behavoir*

Rural Water Supply and Sanitation Institutions, strengthened and capacitated to plan, manage, implement and monitor WSS

- *Rural Sanitation Institutions or actors might be Health Surveillance Assistants/Community Health Workers/Health Extension Workers and others like natural leaders are often trained (by NGOs for instance) to trigger and monitor CLTS in collaboration with the responsible Ministry but results are variable – CLTS is intended to trigger behaviour change in communities (i.e. essentially so people move onto the first rung of the sanitation ladder - fixed point open defecation) – the issues*

of institutional strengthening and capacitating havn't been fully worked through yet. This might be a useful document on capacity https://www.wsp.org/sites/wsp.org/files/WSP_BuildingCapacity_TSSM.pdf

Michael Musenga, CLTS National legal adviser, Zambia

Ending open defection in Zambia will not be easy. It requires strong political commitment, a focused policy framework and reliable supply chain both building and maintaining affordable latrines and general sanitation. Most important of all we need effective public education as well as the enforcement of the public heath laws for urban sanitation so that people understand the hazards of open defection and insanitary conditions and together can succeed on the drive to 2015.

In contribution to reduction in WASH related diseases and women workload, improve basic education, income and gender equality. Under the Ministry of local Government and Housing the sanitation and hygiene component of the national water supply and sanitation programme (2006-2015) focused on:

- *Village leaders and organizations e. g. women, village youths and children.*
- *School sanitations and hygiene promotions.*
- *The Ministry of Local Government and Housing is working with other ministries such as the Ministry of Health (MOH) Ministry of Education (MOE) Ministry of Community Development and Mother and Child as well as Ministry of Chiefs and Traditional Affairs (MOCTA).*

Increased equitable and sustainable use of safe water supply and improved hygiene practices among the rural population.

- *The government has established a new ministry of chiefs and traditional affairs. (MOCTA) and included a sanitation component to the ministry which is dealing with the chiefs. Under the chiefs Act as well as the village development Act there is also a component of sanitation. It is now law that the village headman has to report to the chief twice a year about the sanitation status of a village. All the ten (10) provinces I have visited here in Zambia, all the chiefs now have good support of sanitation component and ending of open defecation. We have also established the joint monitoring program teams in most districts that are chaired by traditional chiefs and religious leaders under the CLTS approaches.*

Communities declare open defecation free (ODF) and sustain their ODF status through community-driven sanitation and hygiene practices.

- *In Zambia we have two chiefdoms so far that are ODF although several Districts have extensively expanded their scoop, they still need verification.*

Nimeri Ali, Operations Manager, Plan International Sudan

- *Thanks for giving the opportunity to reflect about CLTS approach.*
- *In Sudan Plan International Sudan is leading this approach we were started applying CLTS 2.5 years ago.*
- *Before applying this approach we were worked with the communities through traditional way, providing subsides for the families to encourage them to construct the latrines, but we observed that some of them they didn't use these latrine for its purpose. Some of them they use it as stores and others they didn't use it at all, through rapid analysis we realized that if we wants to cover all the communities Plan's Sudan work with (192) we needs for more than 80 years???*
- *So we think to find ways to accelerate the process and achieve the objective.*
- *Then we were started this approach and the results is encouraging us to continue introducing CLTS approach as the best way to eliminate open defecation.*
- *So, I am attaching two files about the overview of our experience and one case study.* (Relevant abstract follows)

CLTS experience in Sudan

Ali, Nimeri. (2013). Operations Manager, Plan International Sudan
As a response to Plan Sudan invitation, Dr. Kamal Kar who was initiated and called for community led total sanitation (CLTS) approach visited Sudan in 2009 to train Plan Sudan staff and partners to apply this approach in Sudan for the first time. The workshop was conducted in Guli Program Unit. Seven villages were then chosen for the pilot that did not have any intervention and also lacked a sanitation system. Difficulties encountered included:

- previous experiments in neighboring villages
- Rumors that the organisation is going to support those who will start the drilling process
- Changing climate – heavy rains led to avalanche of latrines holes that had been drilled earlier, and were yet to be roofed
- Difficulty in getting roofing materials for the toilets which were expensive

Findings:

- Rate of toilet construction by some communities reached at least 80% and over within 2 months, with one community having all its occupants use toilets.
- After six months, all the pilot communities were declared open defecation free (ODF)

Elise Wach, Evaluation and Learning Adviser, IDS
I would be very surprised if the overall consensus was that CLTS doesn't work in Africa. In my limited experience of it, it doesn't seem to be a good fit for very widely disbursed populations (e.g. in Bolivia there were challenges in rural areas), but it seems to have been successful in some areas of Africa. However, of course it will always depend on how well it is implemented, the context (e.g. soil condition, community dynamics, etc.) and the follow up.

4. Comments on shame

The 'shame question' in CLTS
Otieno, P., an independent CLTS trainer and consultant
http://www.communityledtotalsanitation.org/blog/shame-question-clts

An extract from the full blog:

There has been an interesting debate going on about the elements of shame, fear and disgust used during CLTS triggering session. The debate has been between those who believe that the element of shame as applied during a CLTS trigger is unethical as it amounts to degrading and embarrassing the community, and those who believe that the element of shame is actually positive, and that it indeed awakens the community to the realities of open defecation.

The word shame is a controversial term as it is open to different interpretations depending on one's culture or background. For as long as the interpretations vary from individual to individual, and from culture to culture then we shall remain stuck in a quagmire. So the first thing is to try and develop some common understanding.

Defining shame
In an article titled, Shame may not be so bad after all, Dr. Joyce Brothers argues that there are two kinds of shame. The 'good shame' and the 'bad shame'. She says that good shame 'can lead to self discovery and growth' while the bad shame 'humiliates and makes you feel bad about the way you look or feel'.

The people who practice and believe in the efficacy of CLTS are mostly of the view that CLTS triggering evokes the good shame which enables the communities to have insights about their sanitation practices, and consequently make improvements about their sanitation

situation. On the other hand the people who are uncomfortable with the element of shame in CLTS triggering, believe that it eats away the self esteem of the community and attacks the community's dignity. As a result of this they may fear that CLTS is likely to evoke an angry response from the community. Due to this underlying fear, they criticise CLTS as ethically unviable and culturally unfriendly to the communities.

Shame and disgust in CLTS triggering
First I want to start by saying that a CLTS trigger can either evoke the good shame or the bad shame. What makes the difference is facilitation! A good facilitator will conduct a CLTS trigger in a way that allows the community to collectively and in a participatory manner analyze their sanitation situation.

The shame evoked during a CLTS trigger is very different from the one the opponents of CLTS have in mind. It is the good shame. It is not the bad shame that everyone abhors including proponents of CLTS. However, I do admit that sometimes ill prepared CLTS facilitators may create bad shame in the community, and perhaps this is the experience some of the opponents of CLTS have. An ill prepared facilitator conducts the process in a manner that puts down the community. The process is not a genuine participatory session in which the community collectively analyses its sanitation profile. Instead the facilitator pontificates and lectures the community on the hazards of poor sanitation.

Getting it wrong, getting it right
I also wish to mention a few examples in which ill prepared facilitators have inadvertently got it wrong. CLTS encourages the use of crude word of shit as it is in the local language. A poor facilitator may insensitively start using this term liberally without first seeking the endorsement of the community. This may elicit negative reaction from the community and may result in bad shame. A good facilitator on the other hand will conduct the process in a way that enables the community on its own to mention the crude name for shit in the local language. Of course most the time the rural community rarely mentions this crude word quickly. Therefore a good facilitator must embody the virtue of patience. Through patience and further probing a community eventually mentions the word 'shit' in the local language. When the crude name of 'shit' is imposed in a community meeting without going through a participatory process that 'legitimizes' it and gives it collective ownership in a meeting, it amounts to humiliating the community. As such a community may feel resentful that an outsider is imposing on them something that is contrary to their values. This ignites bad shame.

Another example that can cause humiliation to the community during CLTS trigger is when a facilitator is quick to tell the community that they 'eat their own shit'. When an outsider comes to a community and confronts them by telling them that they eat their own shit, this is likely to come across as an insult! It is this kind of an approach that creates bad shame. On the other hand, a skilled CLTS facilitator will conduct a process in which the community participates in analyzing its sanitation and hygiene profile and comes to a verdict that they are indeed eating their own shit! The facilitator therefore only takes up the cue that has already been provided by the community. So when he tells the community that they are eating their shit, he is only repeating what the community has said. Facilitation in this manner cannot be seen to be demeaning or humiliating to a community. It does not create bad shame. Instead it creates good shame that inspires the community to improve on their sanitation situation.

Blog comments

Submitted by Nipun Vinayak on 19 November 2012:
Much is being talked about the propriety of using the element of 'shame' for triggering community in CLTS. My limited experience suggests –

1. A lot depends on who's triggering, and more importantly whether he's perceived as an 'insider'/well wisher or an 'outsider'/didactic….the former gets acceptable, because it is appreciated nothing is done to put down anyone.

2. ‘shame’ has been found useful in generating collectiveness…lately, even in rural communities, there’s much individualism…the ‘sane’ counsel of elderly/wise is not much followed…‘shame’ is perceived as a common determinant.
3. Such qualified ‘shame’…and especially with a realisation that there’s no one tool to achieve results may work. The proof of pudding is in eating. Whether such village sustains ODF will prove whether shame was necessary in the instance…

Nipun Vinayak
Deputy Secretary to the Government of India,
Cabinet Secretariat

Submitted by Anonymous on 19 November 2012:
As soon as we learned about CLTS we trained our staff and began implementing the pure form of CLTS with no subsidies or designs. For once people seemed to take an action towards ODF. Prior to CLTS I was involved in projects in 100s of villages (over 25 years) where latrines were seldom a priority and if they were built they were not used. CLTS seemed to work. It requires excellent facilitation skills. When it is done poorly it looks like shame only. Experiential learning is the key not shame.

Is shame a bad thing
Musyoki, S. 2012. In: *Global Forum on Sanitation and Hygiene. Insights on leadership, action and change*. Water Supply & Sanitation Collaborative Council, Geneva, Switzerland
http://www.wsscc.org/sites/default/files/publications/mumbai_final_report_en_light.pdf

The question on whether it is ethical or right to use “shame” as a resource for facilitating change has been an emerging critique of Community-Led Total Sanitation (CLTS). This question could be misleading, as at no point does CLTS require facilitators to say “shame on you” to target audiences for defecating in the open or for eating each others’ shit. The question should then be whether we should embrace a methodology that evokes negative emotions irrespective of the change or transformation such approaches bring in the lives of those we engage with.

Power in stigmatizing open defecation
The CLTS process has proven to be effective in evoking valuable emotions which some regard as negative. Critics of the CLTS method repeatedly single out the “shame” aspect. There is power in socially stigmatizing bad practice [not people] such as OD, corruption, and gender-based violence among others. In Kenya, for example, it is not the facilitator who stigmatizes OD, rather it is the process itself that enables people to reach that realization. At no point have we been told by a community that they have been shamed or embarrassed by the facilitators. Feedback has indicated that they themselves feel ashamed.

In Cambodia, losing face is considered one of the worst experiences one could have. The CLTS facilitators working in the country are extremely cautious of people feeling hurt, rejected or experiencing a loss of confidence. The transect walk, where people walk through their villages and identify defecation spots and calculation of shit, are conducted to raise awareness of the magnitude of the problem.

In Pakistan, it is the conviction among CLTS practitioners that it is the sense of pride and dignity and not shame that has proven powerful in effecting changing. So significant was the impact of CLTS here that in fact this led to the PATS (Pakistan Approach to Total Sanitation) being launched – similar to CLTS but with less emphasis on the elements of ‘shame’.

Shame can act as a powerful trigger in behaviour change
It is important to note that the concept of shame is not entirely defunct in South-East Asia. When government officials feel ashamed of the sanitation situation in their areas, they take action. Paulus Tereng, head of Lerahingga Village in Indonesia, highlighted his feeling of

'risih' (unease and embarrassment) about open defecation practiced in his village, a shame which peaked during the CLTS intervention supported by Plan Indonesia that encouraged, or 'triggered', community members to stop open defecation in their villages and adopt better sanitation practices. This motivated him to campaign for ODF status in his village, as well as neighbouring villages. Paulus has since been widely recognized as a CLTS champion.

In conclusion, evoking negative emotions such as "shame" or embarrassment may not ultimately be so bad. Feeling ashamed has propelled people into action in some cultures, and on the other hand is seen as losing face in others. We need to learn how to manage such emotion as a resource to change the social norm. We should not avoid creating conflict within the inner-self, as that could be the key to change. In South-East Asia how should it be done then? Given that the CLTS approach calls for being direct in talking about shit? Well, perhaps it is ok to 'beat around the bush', as long as it is not ok to be shitting in the bush.

Emotional triggers: Shame? Or shock, disgust and dignity
Bongartz, P., Coordination, Communication and Networking Officer for CLTS at the Institute of Development Studies
http://www.communityledtotalsanitation.org/blog/emotional-triggers-shame-or-shock-disgust-and-dignity

CLTS strategically provokes strong emotions such as shock, disgust, embarrassment and shame and the concurrent (positive) emotions like pride, self-respect and dignity, to trigger community's collective action towards stopping open defecation.

Many critics of CLTS have latched onto the 'shame' element of CLTS in particular, arguing that this is unethical and a questionable way of creating change. The way these commentators understand it, in CLTS outside facilitators 'shame' communities into taking action. However, in my view, this is a misinterpretation and overemphasises the role of shame as it is by no means the key emotion that CLTS facilitation plays with. The rendering visible of shit through the transect walk and other triggering exercises primarily evokes disgust. And disgust, as viewed by anthropologists and psychologists alike is a very healthy life-protecting emotion. (*See for example* Rozin, P., Haidt, J., & McCauley, C.R. (1993). Disgust. In M. Lewis and J. Haviland (Eds.), Handbook of Emotions, pp. 575-594. New York: Guilford *or* Douglas, Mary (1970), Purity and Danger: An Analysis of Concepts of Pollution and Taboo and Natural Symbols.)

In CLTS, the impulse for change comes from the shock of realising the implications of one's actions, i.e. that open defecation equals eating shit. With that realisation and the powerful emotions prompted by it, the desire for change kicks in. What could be called 'negative' emotions such as shock, disgust, embarrassment and shame, are accompanied by the 'positive' emotions of self-respect, dignity and pride. The latter motivate people to take action. As Kamal Kar puts it, 'no human being wants to live in a dirty environment and eat shit'.

Thus, shock, disgust, embarrassment and shame are really the flipside of the positive emotions that act as an incentive for change. Moreover, the shame, if any, is not shame triggered by or necessarily felt in relation to outsiders (there may be embarrassment when showing visitors how the community deals with their shit), but rather an internal process and feeling that comes with the realisation of the implications of shitting in the open.

Humour is key to CLTS and the facilitator plays the role of a devil's advocate- this does not mean that he or she acts disrespectful towards the community. At the same time, there is no traipsing around on tiptoes or treating people with kid gloves either. Good CLTS facilitators do not judge or comment on the community's sanitation behaviours but reflect and repeat their own reactions back to them. From the start, it is clear that the facilitators are not there to

tell people what to do. What they are there to do, is to facilitate a process that empowers the community to come to their own conclusions and make their own informed judgements.

The fact that around 2.6 billion people do not have access to a toilet and that around 1.8 million a year (6,000 people a day), 90% of whom are children, die of fecally-transmitted diseases, really is shameful and justifies radical means! Business as usual will not do. Making the shit and its consequences visible and evoking strong emotional reactions are what produces change.

5. Strength of the evidence

The case studies identified on CLTS in Africa in this report were predominantly descriptive and/or observational studies employing qualitative techniques such as in-depth interviews and focus group discussions, which have their own limitations of rigor. The studies were presented as field notes (Bibby, et al 2007 & Sah, et al 2009), reports (Mgala et al, 2009; Burton, 2007; Atuhaire,B 2011; Nederland, P, 2012; UNICEF 2012; Nimeri, A, 2013; MoPHS et al, 2012; Ministry of Foreign Affairs, Netherlands 2011), newsletters (Qone et al, 2011; MoPHS, 2012; MoPHS, 2011), conference proceeding (Kar, 2012) and general reviews/evaluations (Whaley et al, 2011; Chambers 2009; Godfrey, A, 2010; Godfrey, A, 2009).

Decreases in diarrhoea, cholera and skin infections were the main health outcomes reported. However, methodological weaknesses, including the lack of clarity around the proportions of the population exposed before and after implementation of CLTS for these conditions, made it challenging to determine the quality of the evidence presented.

Evidence on impact of CLTS on non-health outcomes was also reported. Improvements in Open Defecation Free (ODF)/Open Defecation (OD) status, latrines constructed and access to sanitation were commonly reported. However, none of the studies that reported on these tested the increment/decrease for statistical significance.

There was some variation in the design and implementation of the CLTS intervention from one country or setting to another. For example one study in Tanzania, incorporated two other behavioural interventions that encouraged community participation (Malebo, 2012).
The above listed weaknesses in the evidence base on CLTS are not perhaps only restricted to water quality interventions. Other WASH interventions which involve behavioural change are also reported to have the similar pitfalls (DFID, SHARE, and LSTMH 2013).

6. Additional information

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