ADDRESSING SOUTHERN AFRICA’S SANITATION CHALLENGES THROUGH COMMUNITY-LED TOTAL SANITATION (CLTS)
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Oxfam’s Community Facilitator teaches a hygiene training session using the CLTS (Community Led Total Sanitation) tool. This involves getting the entire village together for basic sanitation education. Villagers are shown laminated pictures of good hygiene and bad hygiene. It is a participatory exercise. They arrange the pictures into “good” and “bad” piles, and talk about why some of their practices are dangerous. Donsiro village, Central Bougainville, Papua Guinea.

PHOTO © Tom Greenwood | OxfamNZ
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<td>CLTS</td>
<td>Community-Led Total Sanitation</td>
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<tr>
<td>ODF</td>
<td>Open Defecation Free</td>
</tr>
<tr>
<td>PHAST</td>
<td>Participatory Hygiene and Sanitation Transformation</td>
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<td>AACES</td>
<td>Australia Africa Community Engagement Scheme</td>
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<td>WASH</td>
<td>Water, Sanitation and Hygiene</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>VERC</td>
<td>Village Education Resource Centre</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>APDO</td>
<td>Afram Plains Development Organisation</td>
</tr>
<tr>
<td>CREPA</td>
<td>Centre régional pour l’eau potable et l’assainissement</td>
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<tr>
<td>IWSD</td>
<td>Institute of Water and Sanitation Development</td>
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<tr>
<td>NETWAS</td>
<td>Network for Water and Sanitation</td>
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<tr>
<td>TREND</td>
<td>Training, Research and Networking for Development</td>
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<td>JMPT</td>
<td>Joint Monitoring Programme Team</td>
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<td>CATS</td>
<td>Community Approaches to Total Sanitation</td>
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<td>SLTS</td>
<td>School-Led Total Sanitation</td>
</tr>
<tr>
<td>SANTOLIC</td>
<td>Saneamento Total Liderado Pelas Comunidades</td>
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<td>WSP</td>
<td>Water and Sanitation Program</td>
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<tr>
<td>DFID</td>
<td>Department for International Development</td>
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<tr>
<td>TSC</td>
<td>Total Sanitation Campaign</td>
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<tr>
<td>PRA</td>
<td>Participatory Rural Appraisal</td>
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<tr>
<td>VIP</td>
<td>Ventilated Improved Pit</td>
</tr>
<tr>
<td>WRC</td>
<td>Water Research Commission</td>
</tr>
<tr>
<td>OD</td>
<td>Open Defecation</td>
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<tr>
<td>CSO</td>
<td>Civil Society Organisation</td>
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<tr>
<td>SARAR</td>
<td>Self-esteem, Associative strength, Resourcefulness, Action planning and Responsibility</td>
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EXECUTIVE SUMMARY

Non Government Organisations (NGOs), donors, and governments have enthusiastically introduced Community-Led Total Sanitation (CLTS) measures over the last decade in over 26 African countries to address the continent’s seemingly impenetrable sanitation challenges.

“CLTS” refers to the facilitation of the community’s own analysis of their sanitation profile, practices of defecation and its consequences. This leads to collective action to become “Open Defecation Free” (ODF). It does not support subsidies or technical/hardware solutions but uses participation to trigger communities’ commitment to address their own lack of sanitation.

In contrast to literature that is primarily produced by legal practitioners and advocates, this report explores challenges and gaps in CLTS through constructive critical engagement, based on a review of available literature on CLTS and indicative interviews with practitioners in five African countries. Its objectives include exploring how CLTS is implemented in Southern Africa and identifying challenges and gaps within CLTS and other participatory approaches.

Some of the issues considered under the physical, economic, social and cultural aspects of CLTS include:

PHYSICAL

- Significance of context: need for social cohesion; constraints faced by the poor in terms of resources, time and capacity; and ineffectiveness where subsidised sanitation approaches have been utilised.
- Lack of technical planning: latrines’ robustness and longevity, possibility of contaminating water supplies and environmental risks, role of water in toilet construction and use, and passing over of ecosan or other optimal sanitation options.
- Sanitation ladder: concern that people may not move past basic CLTS sanitation if they stop seeing sanitation as a problem and/or the areas fall off the radar of government and donors.
- Facilitation: depends on strong facilitation and thus needs rigorous training programme and African training capacity in appropriate languages.
- Monitoring and follow-up of behaviour change: Natural leaders may emerge but some find roles too onerous in the long term. NGOs are needed for sustained support.
- No established linkage or direct causality between toilet construction and health since there are many intervening factors.
- Specific conditions are needed for CLTS to work in urban areas, and significant technical matters need to be overcome.

ECONOMIC

- Zero subsidy does not mean zero cost: there are costs related to sensitisation of community leaders, training of facilitators, triggering1 of communities and monitoring, review and evaluation activities. Nevertheless, CLTS can cost only $14 per household.
- National and local government still need to support work that promotes sanitation and strengthens the supply chain.
- Some public or external investment will remain part of most sanitation programmes, even if household subsidies are eliminated.
- Complexities: controversy exists over subsidies (who disperses funds is less disputed if built into an urban tariff structure).

1. Triggering, also referred to as an “igniting event”, is the method that is central to CLTS. As CLTS has developed, it has been “sharpened and enriched”. Kamal Kar’s “Practical Guide to Triggering Community-Led Total Sanitation” (2005) is about how to trigger or ignite CLTS. The CLTS handbook is “an attempt to bring together experience, diversified practice and local innovations from different countries and many sources” (Kar and Chambers 2008, p8).
• Reports reflect mixed experiences of the use of rewards for achieving ODF status; this requires more exploration in Africa.

SOCIAL

• Communities find their own solutions.
• Invisible inequalities and power relations need to be made more explicit: CLTS tends toward an idealised notion of community; however, conflict, patronage, and inequalities can make CLTS implementation tricky. The poor can experience huge pressure due to their inability to invest in a latrine and from being stigmatised or fined for open defecation (OD).
• Facilitators need to understand social customs and be wary of cultural assumptions.
• Community mechanisms of control (like sanctions and fines) are used more easily in smaller and more homogenous communities.
• CLTS is not just about triggering. More attention to training, implementation, and follow-up is needed.

CULTURAL

• Gendered nature of latrines.
• Shocking people as a means of triggering action versus causing offence.
• Need for sensitive, capable facilitation that can adapt to the context.
• The impact of “naming and shaming” on community social structures, especially the role of the youth.

SCALING UP AND “MIXED” APPROACHES

Scaling up requires a resource base of trainers, government recognition of CLTS and the commitment of stakeholders. In the process of scaling up, which entails government involvement and support, mixed approaches often emerge.

While mixed approaches are seen by CLTS “purists” as undermining its aims, such mixes are being implemented in Malawi, Zambia, and Tanzania, amongst other countries. This may be a pragmatic move to avoid a turn-around in approach on the ground or with government staff, or it may be a way around sensitive tugs of war between government departments or with donors. Most positively, it is also a case of practitioners finding what works on the ground: CLTS as entry-level sanitation and Participatory Hygiene and Sanitation Transformation (PHAST) for higher rungs in the ladder, or a “mix” of approaches such as the Mtumba approach being used in Tanzania.

There is no question that CLTS reinvigorated attention to sanitation in Africa, emphasising the central role of communities in formulating their own sustainable responses. However, CLTS should not be seen as “a convenient way for governments and support agencies to abrogate responsibility for sanitation or to reduce sanitation budgets”. [Harvey 2011, p5] There is still a need for financing at a national as well as a local government level both to promote sanitation and to strengthen the supply chain (Hutton 2012 personal correspondence).

NEXT STEPS

Given the powerful role that CLTS is playing in Africa, more independent and critical research is needed. Two possible areas for research include the establishment of a Pan-African monitoring system and an in-depth study of “successes” using CLTS and mixed approaches.
BACKGROUND TO THIS STUDY

Given the scope and scale of sanitation challenges in Africa, the introduction of Community Led Total Sanitation (CLTS) has been embraced by international and national NGOs, donors and governments as a promising way of responding to a problem by turning it upside down. Robert Chambers from the Institute for Development Studies at Sussex University is regarded by many as a “guru of participatory development” and has been actively involved in the development of CLTS. He describes CLTS as “an international movement, itself a community of like-minded people who are inspired by the vast potential of the CLTS approach”.

Given this global pool of information, it is not surprisingly that most resources on CLTS are produced by proponents of CLTS. For example, searching the CLTS website search shows three external evaluations, but two are done by the Water and Sanitation Programme and WaterAid – both supporters of CLTS. Only a 2007 study in Nepal was done by an external NGO. While we are fortunate that organisations are capturing their findings and reflecting on their application and meaning (CLTS values and encourages reflection), their naturally vested interests may raise questions about their objectivity.

Overall, there is a problem in moving from anecdotes to quality research, which Chambers himself notes: “With CLTS, we desperately need much more good research and feedback on field and implementation realities.” (Chambers 2011) In a CLTS blog, Ned Breslin wrote:

“The real issue with CLTS remains the fall back we see in the ground all the time, after initial adoption and enthusiasm wane. In general, CLTS has generated a buzz and enthusiasm in sanitation that has been absent for 30+ years. That should be applauded. That should be built upon. The tragedy is that CLTS remains fairly unmonitored, the reports on it pretty weak, and as such we battle over anecdotes. This article is full of them. Chambers’ is full of them. Some of the reports cited above are equally poor and methodologically weak. Pity – as good monitoring and a commitment to constant improvement would likely lead to better programming. We will get there, one day. But for now it is anecdote versus anecdote, BS versus BS, and poor people around the world would be better helped with more rigorous monitoring (not just platitudes about monitoring), openness and honesty.”

(Chatterjee blog response by Breslin 2011)

In short, analyses have explored CLTS’ success, but there is a need to explore challenges and gaps through constructively critical engagement. With this motivation, Oxfam commissioned this study as part of its Australia Africa Community Engagement Scheme (AACES) and Water, Sanitation and Hygiene (WASH) programme with the following objectives:
• To explore how CLTS is implemented in Southern Africa.
• To identify challenges and gaps in the approach and what other participatory approaches are being used in Southern Africa.
• To highlight governmental positions on CLTS in selected countries.

It was expected that this report would provide a basis for formulating a second phase of research based on interviews with a broader group of respondents and interfacing with key informants at the community level.

The author of this report researches responses to sanitation dilemmas and, although she is an advocate of participatory approaches, does not have any direct involvement with CLTS. She is committed to conducting robust research that explores the “development bandwagon” and the interests driving development.

Methods included:

1. A review of the available secondary literature on CLTS generally and with an African focus, with an eye to capturing the complexities and challenges that have arisen in CLTS implementation. The limitations of this literature are discussed above.
2. Interviews with representatives from organisations implementing CLTS in Southern African countries. On the whole, they repeated what is well captured in materials but were also frank in their critiques. As only one or two practitioners were interviewed per country, these interviews were purely “indicative” of country experiences and issues arising.

This report is structured in two parts: the first outlines the main contours of CLTS and the second explores key questions related to its implementation, drawing on some illustrative examples from African countries.
CLTS BACKGROUND

Kamal Kar, a development consultant from India working for the United Nations Children’s Fund (UNICEF), pioneered CLTS in Bangladesh with WaterAid and its local partner VERC (Village Education Resource Centre) during an evaluation of a subsidised sanitation programme in 1999:

"Kar, who had years of experience in participatory approaches in a range of development projects, succeeded in persuading the local NGO to stop top-down toilet construction through subsidy. He advocated change in institutional attitude and the need to draw on intense local mobilisation and facilitation to enable villagers to analyse their sanitation and waste situation and bring about collective decision-making to stop open defecation." (Mehta 2010, p.2)

CLTS took off in Bangladesh based on its remarkable results, which are well documented in Kars’ numerous publications. International NGOs enthusiastically adopted CLTS as a means of responding to the sanitation dilemma, supported by bilateral donors and multinationals. Kar was proactive in the spread of CLTS first within Bangladesh and then to wider Asia, followed by Africa, Latin America, the Middle East and the Pacific.

CLTS is also promoted by Plan International, UNICEF, the Water and Sanitation Programme of the World Bank, WaterAid, and Islamic Relief. It is now used in over 40 countries, with many implementing agencies and governments experimenting with "scaling up" this approach.

Taking CLTS to scale in Africa is promoted by many as a response to the 2010 assessment that only 4 of 44 sub-Saharan African countries appeared on track to meet Millennium Development Goal 7 (halving the proportion of the population without access to sanitation).

Why has the adoption of CLTS in Africa been so rapid? Kar explains that donors call the shots:

"Most African countries do not have access to the levels of internal funds available to some of the Asian countries such as India and China. This clearly puts many of them in a different relationship to donors and multilaterals than in those countries. Internal budgets in Africa do not generally allocate sufficient, or in some cases any, funds to develop and implement national strategies on sanitation, so most governments have not much choice but to take on board donors’ sanitation programmes."

(Kar and Milward 2011, p.38, emphasis added)

He goes on to explain the powerful influence of UNICEF:

"This is another key factor in the difference between how rapidly CLTS has spread in Africa and Asia. UNICEF in particular, a United Nations (UN) agency which supports national government partners with UN funding according to agreements, is not a straightforward donor organisation. Partly as a result of this role, they do not have the kind of influence in many parts of Asia that they have in Africa."
As of 2009, CLTS had been taken up (or was in the planning stages) in 26 countries in Africa. The following chart was compiled from a variety of sources (and may contain gaps):

<table>
<thead>
<tr>
<th>Country</th>
<th>Year of First Introduction</th>
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<tbody>
<tr>
<td>Uganda</td>
<td>2002</td>
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<tr>
<td>Zambia (Choma)</td>
<td>2003</td>
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<td>Nigeria</td>
<td>2004</td>
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<tr>
<td>Ethiopia</td>
<td>2006</td>
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<td>Kenya (Kilifi)</td>
<td>2007</td>
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<tr>
<td>Malawi</td>
<td>2007</td>
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<tr>
<td>Tanzania</td>
<td>2007</td>
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<tr>
<td>Burkina Faso</td>
<td>2008</td>
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<tr>
<td>Ghana</td>
<td>2008</td>
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<td>Mali</td>
<td>2008</td>
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<td>Mozambique</td>
<td>2008</td>
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<tr>
<td>Sierra Leone</td>
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<tr>
<td>Zimbabwe</td>
<td>2008</td>
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<tr>
<td>Benin</td>
<td>2009</td>
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<tr>
<td>Cameroon</td>
<td>2009</td>
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<tr>
<td>Chad</td>
<td>2009</td>
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<td>Congo Brazzaville</td>
<td>2009</td>
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<td>Cote d’Ivoire</td>
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<td>Gambia</td>
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<td>Guinea</td>
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<td>Liberia</td>
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<td>Mauritania</td>
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<td>Niger</td>
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<td>Senegal</td>
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<td>Togo</td>
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In 2010, Plan launched a CLTS project worth 8.5 million “euros” in eight African countries where CLTS has taken root: Sierra Leone, Kenya, Ethiopia, Zambia, Malawi, Uganda, Niger and Ghana. This five-year project, supported by the Dutch government, is entitled “Empowering self-help sanitation of rural and peri-urban communities and schools in Africa”. It was designed to promote and scale up a community-based and school-focused self-help sanitation approach in Africa, and introduces sanitation marketing to help communities climb the sanitation ladder. (IRC 2010-1011)

While the focus of CLTS was initially rural areas, it is being advocated for urban slums in Kenya and Nigeria as well as India and Mauritania.
MAIN FEATURES OF CLTS

In brief, CLTS refers to the facilitation of the community’s own analysis of their sanitation profile, their practices of defecation and the consequences, leading to collective action to become Open Defecation Free (ODF). One of the most succinct and powerful descriptions of CLTS was written by Sah and Negussie (2009, p667):

“It recognises an individual’s or a household’s right and responsibility of living in a totally sanitised environment. CLTS is participatory in nature and facilitates communities to take a decisive role in ensuring that each and every member internalises the implication of poor sanitation (e.g. open defecation). The CLTS methodology unites the community to commit to using sanitary latrines and hygienic behaviour and the community understands that the process is a shift towards a zero subsidy approach rather than providing them with money to construct latrines. Once ‘triggered’, adults and children become passionately involved in the management of their own sanitary well-being. CLTS uses communication for social change and in the process community members are able to declare their villages as ‘Open Defecation Free’ (ODF) as families gradually climb steps in the ladder of total sanitation. The process can also lead to a development entry point to communities by identifying natural leaders who have the potential to take a more active role in planning, monitoring and implementation of sustainable community livelihood projects. The process of planning for an open defecation community is jointly undertaken by all community members through their participation which is facilitated by CLTS implementers.”

The entire CLTS approach is based on principles that build on participatory approaches and include changes in attitudes, behaviours, policies and practices:

• From teaching, educating and telling people what to do, to facilitating, empowering and enabling people/communities to come to their own conclusions.
• From “we persuade and motivate” to “it’s up to you and you decide”.
• From “we must help/subsidise the poor” to “communities can do it”.
• From focus on individual behaviour change to social solidarity, co-operation and collective action.
• From top-down standardisation to bottom-up diversity (“they design”); from imposing solutions and standards from the outside to local solutions, diversity and context-appropriate innovations.
• From spending on hardware to spending on supporting people (facilitators) and processes; from counting latrines to counting ODF communities; from building latrines to building capacity.
• From bigger budgets and disbursement targets to lower budgets to allow more to be achieved.
• From sanitised words to crude ones.
• From being sensitive to cultural norms and taboos to letting communities deal with them.

(Bongartz et al 2010, p29; Sah and Negussie 2009, p668)

Traditional approaches to rural sanitation assume that people will change their behaviour when educated about sanitation and hygiene, and that they will use toilets if they are given subsidies/ support to build them. However, these assumptions often prove to be wrong.

So these principles are all constructed around a central idea: change is communal and is driven and supported by the community. This is an important corrective to a didactic, top-down approach focused on numbers and funding targets, and infuses the approach to sanitation with the best of community development lessons.
Many practitioners consider “triggering” to be the most powerful element of CLTS. It has been described as:

“The underlying assumption is that once people are convinced about the need for sanitation, they construct their own latrines according to the resources available (financial, land and so on). This approach does not require high subsidies from governments or external agencies. Instead, what’s key is an understanding of the individual or collective ‘triggers’. The principle here is a ‘sanitary mirror’ that will enable individuals to see the unsanitary conditions of their existing lifestyle. This leads to an ignition process that leads to collective behaviour change [See Kar 2005, Kar and Pasteur 2005, Kar and Bongartz 2006, Kar with Chambers 2008].

Through the use of participatory methods, community members analyse their own sanitation profile including the extent of open defecation and the spread of faecal-oral contamination that detrimentally affects every one of them. This is believed to cause an upsurge of various emotions in the community, including the feeling of embarrassment and disgust. The community members present are supposed to collectively realise the terrible impact of open defecation on their health. The realisation that they are quite literally ingesting one another’s ‘shit’ mobilises them into initiating collective local action to improve the sanitation situation in the community (see Kar 2005, Kar and Pasteur 2005, Kar and Bongartz 2006, Kar with Chambers 2008, Bongartz 2007, 2008).

The CLTS triggering process often starts with an informal talk with a few community members during a walk through the village (a ‘transect walk’). The aim is to motivate people to carry out a more substantial sanitation analysis involving the whole community. There are many different ways of initiating a discussion on open defecation and village sanitation, for example by visiting places where people defecate and raising questions like: ‘Whose shit is this?’, ‘Who defecated in the open this morning’ etc. Throughout the facilitation process, local and crude words for ‘shit’ and ‘shitting’ are used rather than the polite terms often used when discussing these taboo subjects. Other methods include a transect walk as well as calculation of the shit produced in the village every day. The facilitator is not supposed to preach or tell people what to do. The embarrassment experienced during the transect walk, sometimes referred to as a ‘walk of shame’, generally results in an immediate desire to stop open defecation. CLTS doesn’t tell people what they should do. It often tells them what they are doing and then a dialogue should ideally ensue between the facilitator and local people and between different categories of villagers (rich/poor, women/men, different castes and ethnic groups).” (Mehta 2010, p6-7)

Once we begin to discuss how CLTS is implemented, it becomes more interactive. Here are the key messages of the CLTS approach:

- CLTS is a low-cost, high-impact sustainable approach to sanitation.
- CLTS works. Communities are taking joint action to stop open defecation.
- CLTS is making an impact on the health and socio-economic development of communities.
- Key principles of CLTS:
  - Don’t build latrines; catalyse behaviour change so that communities take action themselves.
  - Don’t give subsidies to communities to build toilets.
  - Use ‘raw’ language to shock.
  - Challenge unhelpful cultural norms; harness those that support CLTS.
• For CLTS to work, high quality facilitation is essential.
• CLTS facilitators must have hands-on training in communities.
• Good facilitators challenge cultural norms where needed but also take advantage of them.
• CLTS requires changes in mindsets and behaviours at all levels: in communities and amongst practitioners, professionals and institutions.
• Good CLTS requires flexibility in timing and funding and is context-specific.
• There are both opportunities and challenges in scaling up CLTS through governments.
• CLTS is a new approach in Africa and there is still a need for further critical research and evidence, as well as challenges to address.
• CLTS can be an entry point for work on livelihoods and changing power relations.” (Milligan and Bongartz 2010, p206)

PURISTS OR PRAGMATISTS?

Two of the most debated issues around CLTS are most aptly summarised by the question of whether CLTS is implemented by purists or pragmatists.

First, some critiques are triggered by the underlying claims of CLTS as an ultra-democratic approach to community development. They argue that CLTS needs to be recognised as a pragmatic approach to a difficult problem: the end justifies the means rather than an idyllic means to an impressive end. In her blog, Liz Chatterjee, a DPhil candidate in international development at the University of Oxford, summarises her experience in visiting villages in India where CLTS was introduced:

“We concluded that humiliation and fear are strikingly effective tools. What’s the objection, given that the emotional coercion has been spearheaded by the local community itself? Improved sanitation is an undeniably great good, especially for women and children.

But we need to stop pretending that decentralised development is necessarily the ultra-democratic panacea it’s often made out to be. As we told UNICEF, the ultimate success of the project in Karnataka was founded on community-led coercion – not a utopian democratic upsurge. If we think the ends justify the means, we ought to be honest about it.” (Chatterjee 2011)

In response, pragmatist Rose George writes:

“There is no one perfect solution to the question of why there are 2.6 billion people without a toilet, and why some of those 2.6 billion see nothing wrong with that. Every solution has its downsides. Every single one. But they should all be tried, and worked on, and improved. I don’t really see the problem in relying on community-led emotional sanitation. If it cuts down on soaring diarrhoea rates that kill more children than HIV/AIDS, TB and malaria put together, what does it matter if it is considered a ‘utopian democratic upsurge’ or not?” (Chatterjee blog response by George 2011)

Second is the issue of how “pure” one needs to be in implementing CLTS. Kar highlights how mixing CLTS with other approaches waters it down and makes it less effective (or even ineffective). Yet African practitioners tend to explain that they are doing “what works” by combining CLTS with other approaches. This typically includes PHAST, sanitation marketing, rewards to the community for achieving ODF status, and/or some type of follow up programme to subsidise hardware (this “mixing” is discussed at more length in the second section of this report).
Oxfam’s Community Facilitator teaches a hygiene training session using the CLTS (Community Led Total Sanitation) tool. This involves getting the entire village together for basic sanitation education. Villagers are shown laminated pictures of good hygiene and bad hygiene. It is a participatory exercise. They arrange the pictures into “good” and “bad” piles, and talk about why some of their practices are dangerous. Donsiro village, Central Bougainville, Papua Guinea.
KEY IMPLEMENTATIONAL QUESTIONS

PHYSICAL ASPECTS

Impressive progress is being achieved with CLTS in a number of African countries, evidenced in the number of people gaining access to sanitation and the percentage of villages verified to be ODF. For example, in Zambia, CLTS’ success includes:

“517 villages were triggered during 2008. Over 14 500 toilets were constructed by households with zero hardware subsidy and approximately 90 000 people gained access to sanitation in less than a year. For the triggered area, overall sanitation coverage increased from 38% to 93% and a total of 402 villages were verified as ODF.” (Harvey 2011, 4)

One of the strongest characteristics of CLTS is that it is based on local participation. It is argued that CLTS addresses the pitfalls of previous sanitation programs: no sustained behaviour change. This is the cornerstone of sustainability:

“There is growing evidence that when intense community mobilisation allows local people to play a key role in project design and execution, sustainability is enhanced and there is an incentive to make the system more resilient. The rapid spread of CLTS is a good case in point. It has been documented that when there is a high level of ownership and mobilisation, local people continue to maintain the toilets even after floods and other shocks (Kar and Pasteur 2005).” (Mehta 2010, p17)

Yet some communities lack social cohesion and, without special efforts to address the interests of the poor, the resource, time and capacity constraints faced by the poor may block collective behavioural change. There are also indications that extreme poverty can hinder sustainability: after toilet structures collapse, households may not rebuild their toilets due to a lack of affordability. (Mehta 2010, p17) The ability of the community at large, and the poor in particular, to undertake CLTS successfully and change their behaviour is most effective where there is an easily accessible water source. (WaterAid 2007)

A WaterAid evaluation (2007) confirmed that context is highly significant: CLTS was much less successful in larger communities, urban communities, and those with past or ongoing latrine subsidies. Harvey (2011) found that “The only communities in which the CLTS approach had very little or no effect were those in which previous subsidised sanitation approaches had been implemented. It is interesting to note that none of these had 100% coverage and open defecation was still practised in the majority.” (p4) Of course these factors are inter-related, as larger and more urban communities are likely to have had latrine subsidy programmes.

The flexibility to engage sensitively with different community contexts is also important. This flexibility is affected by the funding requirements and targets that organisations must respond to, as well as by the qualifications of the trainer and his/her scope to engage intensively with communities. The current structure of most donor funding and targets is arguably “unconducive to CLTS methods”. In contrast smaller organisations with more fluid funding or larger projects with more flexible targets are able to engage with the specific requirements of communities. (Chatterjee blog response by Snoad 2011) The WaterAid evaluation (2007) also found that the CLTS approach was “most effective in communities where trained external facilitators guide communities through an intensive, participatory mobilisation process making use of the full set of CLTS tools (including transect walks, social mapping and faecal load calculations).” It is important to note that the flexibility of organisation and donor, and the focus of a skilled external facilitator to engage intensively with a community characterises early days of CLTS, before its widespread adoption and its being taken to scale.
TECHNICAL/PLANNING

CLTS triggers the community to take action to address open defecation and members construct their own toilets, usually pit latrines. This responds to previous approaches that have treated the construction of toilets as highly technical, which had the negative impact of a lack of community ownership and thus non-use. CLTS is built on the recognition that behaviour change is most likely when people contribute things themselves and thus value them more. So technical aspects are not a priority; instead community members can seek support from each other and devise their own solutions. They realise that they can improve their situation with existing materials: local knowledge and resources.

However, according to interviewees, the use of existing knowledge and resources was an issue. One Zambian interviewee said: “There is not enough technical support with construction and siting. Latrines are constructed in haste, are too shallow with a shoddy superstructure and are not properly sited. Some have been abandoned or buried because they create a stench and havoc.” Another explained that, after triggering, community members wanted to know who can help with construction - they need artisans who know how to construct toilets given soil, high water levels or other issues. What does that demand mean? Is this evidence that the community has a mentality of dependence on outsiders instead of a mentality of power to develop solutions without external assistance? Or are very poor rural areas in need of some external expertise even if they are the ones who manage and control it?

There are still a number of challenges and potential shortcomings that arise from a lack of technical planning:

- The robustness and longevity of latrines that are built,
- The challenge of mitigating contamination of water supplies when latrine construction is not planned and there are a large number of pit toilets,
- Potential environmental risks from physical circumstances, e.g. high water tables, sandy areas or flooding,
- Failure to recognise the role of water as a constraint towards toilet construction and use, and
- Ignoring optimal sanitation options like ecosan toilets. (Mehta 2010, p10)

CLTS processes do not require critical water and sanitation improvements. One author asserts that “CLTS processes can precede and lead on to, or occur simultaneously with, improvement of latrine design; the adoption and improvement of hygienic practices; solid waste management; waste water disposal; care, protection and maintenance of drinking water sources; and other environmental measures.” (Bongartz et al, 2010, p9)

In terms of scaling up, it is important to note that own-built latrines are not recognised or accepted by some national governments such as Zambia and Zimbabwe, since their quality is not considered up to standard. As a result they are not “counted” in the official statistics or Millennium Development Goal tallies.
SANITATION LADDER

In CLTS, people generally start with a pit latrine that they build themselves. People who already have pits are made aware of the need to cover them.

The idea is that people start at the bottom of the sanitation ladder, building a latrine to end open defecation in their community. Once they recognise the benefits and have achieved this behavioural change, they will be motivated to move up the sanitation ladder. This requires that they are able (in terms of knowledge and skill) to build something better and that they can afford the necessary materials.

One concern is whether people will actually move up the sanitation ladder. They may be hampered in two ways: First, do they feel that they have addressed the problem and no additional actions are needed? Second, once ODF status has been achieved, do these areas fall off the compass of donors and government’s sanitation support? The tendency is to suggest that artisans be used and that people build better quality facilities from the start that last much longer; however doing so would mean a return to subsidies, which CLTS does not support (see later section).

The Water and Sanitation Programme in Ethiopia engages with these issues by highlighting what needs to happen after ODF status is achieved:

“If a household digs an unimproved pit latrine that does not meet minimum standards, will they progressively move up to better practices, or stop at the first small doable action? The next steps are to assure the importance of minimum standards, operation and maintenance of latrines; support communities to have more permanent types of latrines than the present temporary ones; and to build a viable market for sanitation goods and services where consumers make choices and sellers respond to these demands, which results in moving households up the sanitation ladder.” (Faris and Rosenbaum 2011, p3)

The case of Tanzania serves as an example of how CLTS applies if people have already achieved a basic level of sanitation.

“A high proportion of households still have pit latrines as a result of the government campaign 40 years ago but many are not covered so that flies cannot enter or get out, or are not kept clean... or are not actually used. In 2009, the Water and Sanitation Program commissioned a survey by Price Waterhouse Coopers that covered 1 000 households in five districts in Tanzania. It found that almost 40 percent of households had visible faeces on the floor, only five percent had soap and about four-fifths lacked a latrine cover.” (Chatterjee blog response by Nataruk 2011)

Mtega argues that, although CLTS works well where open defecation is common, CLTS has not been effective in moving past the basic level of sanitation in Tanzania:

“Tanzania’s challenge is to persuade people to upgrade from very basic latrines, which are often very ineffective barriers against the spread of disease, to something more lasting and effective. Nobody has yet found a way to do this.

CLTS is very effective at getting people in other countries away from open defecation to where Tanzania already is. But it has proved unable to take people a step higher, to persuade people to construct latrines that will prevent the spread of disease...

So CLTS has not lived up to its reputation. It’s not being rejected on the basis of theoretical or analytical objections, but because it hasn’t proved effective in practice.” (Chatterjee blog response by Mtega 2011)
FACILITATION, MONITORING AND FOLLOW-UP

Without effective facilitation, monitoring and follow-up, the danger is that announcements of ODF achievements do not reflect what has really transpired in the community, and that there is a false sense of success. It is well recognised that these aspects of CLTS require greater attention:

FACILITATION

Since the quality of facilitation has been shown to be a key factor in the success of CLTS, there is a need for a “strong cadre of ‘convinced’ and capable facilitators”. A rigorous training programme is required which teaches the methodology as well as philosophical aspects of the approach (Bevan and Thomas 2009, p7). Most African countries rely on government extension workers as facilitators, which makes it particularly important to make sure they are “convinced” of the value of CLTS in order to facilitate CLTS fully. Facilitators need to embrace CLTS as an effective, desirable and implementable approach, which can be difficult to achieve when government health workers become facilitators.

The initial training in a number of African countries was done by Kar himself, but focused largely on government and donors since this is UNICEF’s focus. They then trained a wider NGO group.

CLTS’ first introduction to Africa proved to be a “powerful south-south knowledge transfer, with experienced Asian practitioners training a core body of English-speaking African facilitators. Training capacity in Anglophone countries continues to be supported and developed through a network of NGOs (including Trend and Afram Plains Development Organisation [APDO] in Ghana, and PLAN and WaterAid in Kenya and Nigeria).” (Bevan p3) Some steps have been taken to train non-English speaking trainers, but this still requires attention.

Furthermore, regional resource and training institute staff were trained with the aim of building capacity for long-term sustainability. This is also important for scaling up and helping to meet the quality facilitation gap given the rapid growth of CLTS. These include the Centre for Low Cost Water Supply and Sanitation (CREPA), Burkina Faso; Institute of Water and Sanitation Development (IWSD), Zimbabwe; Network for Water and Sanitation (NETWAS); and Training, Research and Networking for Development (TREND), Ghana. (Hickling and Bevan 2010, p52–53)

It is not clear whether going to scale has compromised the quality of facilitation and mobilisation and the use of participatory approaches. A fieldworker in Bangladesh reflected on changes with going to scale: he used to spend 2–4 hours mobilising in a village, but with present work and targets he now has only 30 minutes (Mehta 2010, p8).

MONITORING AND FOLLOW-UP

Ending open defecation is only a first step. Many prominent CLTS advocates have asserted that the follow up efforts after community mobilisation are key to behavioural change. However, it is difficult if not impossible to monitor or verify progress when CLTS is implemented in regions with hundreds of communities. Kar highlighted the problem posed with monitoring by outsiders:
“Setting up monitoring systems in which outsiders are in the lead roles can cause various problems. Where monitoring and follow-up is only or mainly in the hands of outsiders, the opportunity for creating and empowering natural leaders is lost or weakened. Rather, the ultimate responsibility for the sanitation situation is vested in the hands of outsiders. This may interfere with natural leaders’ sense of responsibility, making them less effective in pursuing the ODF process in the community. In addition, losing the opportunity for building a group of community leaders, even if no damage is done to the single village, can seriously hinder the scaling-up process – because a handful of outsiders cannot possibly cover the whole area or country.” (Kar and Milward 2011, p46)

CLTS relies on “natural leaders” from the community to monitor and support ODF progress. Natural leaders (or “spontaneous leaders”) are “activists and enthusiasts who emerge and take the lead during CLTS processes. Men, women, youths and children can all be natural leaders. Some natural leaders become community consultants, and trigger and provide encouragement and support to communities other than their own.” (Bongartz et al 2010, p10)

One interviewee explained that using local structures and leadership provides a clear channel to the community: people respect government and traditional structures, so implementation is easier and is not seen as coming from “outsiders”. But most interviews with practitioners working in a range of African countries report that “natural leaders” may emerge but typically find this role to be too onerous, particularly with no compensation.

Instead, areas with NGOs that can provide support, monitoring and follow-up for two years after a community achieves ODF status typically maintain their ODF status. Areas without this institutional support often do not. As one interviewee put it: “Where NGOs provided support for less than a year, few households constructed latrines after being triggered. The impact ‘just went away’.” So promoting follow-up communications and visits results in more sustainable outcomes in terms of behaviour change and maintenance and improvements in latrine technology.

Interviewees described the reality of trying to use traditional authorities and government in monitoring:

• “It was expected that local people would take on encouraging construction and monitoring. But there is so much reliance on external support (allowances, fuel) that this did not occur. The Joint Monitoring Programme Team (JMPT), comprised of traditional authorities and government, took on a monitoring role but the areas they cover are widespread. JMPT worked well but Council said it could not take this on as it was not budgeted for. So JMPT has not visited ODF villages and Oxfam is no longer there. UNICEF evaluation showed that latrines either no long existed or were unused. (Zambia)
• “Behaviour change is difficult. We need to monitor whether latrines can survive. They work for ‘formality’, so we can point that it is done, but the rainy season comes and they disappear.

Government wants to stop subsidies, but we need government extension officers who are trained and whose job it is to monitor. Government is committed but needs to make sure that monitoring is a priority. Who is doing monitoring on the ground? Other countries use natural leaders but this only works to a certain extent since people are volunteering and see they get nothing from this.” (Malawi)
• WaterAid and its partners have gradually involved environmental health assistants. Environmental health assistants typically “summon people if they do not use the correct behaviours”, which stands in contrast to CLTS’ dependence on people’s own conscience. So environmental health assistants generally need to relearn how to approach people. [Ghana]

TRADE-OFFS: HEALTH AS THE PRIORITY

Surprisingly authors assert that local people usually do not cite positive health impacts as the top benefits of sanitation.

“Instead, the benefits listed included privacy and comfort (largely for women), a clean environment, security for young girls, dignity and so on. Some people explicitly mention health benefits and freedom from diarrhoea but this is often on prompting by those who are very active in CLTS work and spread. This concurs with studies by Jenkins, Scott and other researchers (2007) who have argued that prestige, dignity and not health are listed as the key benefits from toilet use…. An evaluation of WaterAid’s CLTS Programme in Nigeria similarly found that communities wanted to be more ‘developed’ or ‘advanced’ like their neighbours. [WaterAid 2007]” (Mehta 2010, p12)

It is assumed that addressing open defecation leads to decreases in diarrhoea and improved health status. Yet this is not necessarily the case:

“Only villages declared to be open defecation-free, with 100 percent toilet usage, reported a significant drop in diarrhoea recall to seven percent. The lesson was that if the population continues to practice open defecation, the risk of bacteriological contamination and disease transmission may continue to be high. [Source: Formative research by WSP-Knowledge Links for IEC Manual in Himachal Pradesh, 2005].” (Mehta 2012, p13) So there is not a clear causality between toilets and improved health. This is probably due to other intervening variables that require further research. Mehta explains:

“In the rush to provide numbers misleading information and statistics can be circulated. It is safe to say that it is notoriously difficult to provide conclusive links between toilet construction and improved health outcomes. There are several intervening factors which include breastfeeding, maternal health, nutrition, groundwater quality, poverty, living conditions and so on which make causal linkages difficult. Concentrated toilet construction can also have second and third generation effects that we haven’t been able to study in tremendous depth. These include possible groundwater contamination, problematic waste disposal and the release of effluents in the environment which could also have knock-on effects on health.” (Mehta 2012, p13)

USE OF CLTS IN URBAN SETTINGS

So far CLTS has been implemented almost exclusively in rural areas. CLTS practitioners and others have assumed that CLTS could not apply in urban areas as sanitation in not as straightforward as building a simple latrine and other systems require some financing. So it was not clear how an urban area might comply with CLTS’ strict zero-subsidy approach.

Since 2008, CLTS has been introduced in three urban settings which, given their sizeable populations, are far more extensive than pilot studies. It was introduced in Kalyani in West Bengal, India in 2008 and now in Nanded City, with a population of 500 000, located in Maharashtra State. Its first urban application in Africa is in Mathare, village number 10 – an informal area of approximately 20 000 people in Nairobi.
Concerns about the use of CLTS in urban areas include technical matters and the need for subsidies, and the specific conditions needed for CLTS to work in this setting. There is a concern about the health risk of applying the model in high density settlements when there are no design regulations to prevent groundwater pollution (Smith 2012 personal correspondence). The aim is higher levels of sanitation hardware in response to settlement density, and this requires subsidised forms of sanitation. One account asserted that “there is no way people can manage their waste disposal and sewage systems without strong state action and funding”. (Mehta 2010, p15)

There are a range of specific conditions that various authors argue are necessary for CLTS to work in urban areas. The Water and Sanitation Program (WSP) evaluation of CLTS in urban Kalyani states that good governance, relatively sparse population and planning make the area “uniquely well-suited” for urban CLTS implementation. WaterAid’s case study in Nigeria (2007) concluded that a lack of community cohesion in larger communities or urban or semi-urban areas “hinders the use of CLTS tools and limits progress”. Finally, Bevan and Thomas (2009) note that strong municipal leadership and political will remain essential.

**ECONOMIC ASPECTS**

Typically, between 30 to 100 percent of the cost of household latrines is subsidised. This level of subsidy places severe limits on the necessary expansion of water and sanitation services, and increases dependency on external financial support. Harvey (2011) explains that CLTS involves zero hardware subsidies but significant investment is still required:

“It should be stressed that zero subsidy strategies do not imply zero cost. Sectoral investment is needed for the creation of an appropriate enabling environment, comprising training of facilitators and artisans, community and household sensitisation, development of micro-financing mechanisms (where appropriate), and development of appropriate national strategies and policies.” (p7)

The cost of CLTS in Choma district in Zambia was approximately $400 per ODF village, $14 per household using improved sanitation and $2.3 per capita. These costs include sensitisation of community leaders, training of facilitators, triggering of communities, and monitoring, review and evaluation activities. (Harvey 2011, p5) This compares very favourably with the cost of subsidised latrine building programmes, where the tendency to require standard “high technology” latrine models can raise the cost to as much as $800 per household (Hickling and Bevan 2010).

However, CLTS should not be seen as “a convenient way for governments and support agencies to abrogate responsibility for sanitation or to reduce sanitation budgets”. (Harvey 2011, p5) There is still a need for financing at a national as well as a local government level both to promote sanitation and to strengthen the supply chain (Hutton 2012 personal correspondence).

Drawing from a range of case studies, a team of economists and other social scientists undertook an extensive study of subsidies. Trémolet et al (2010) summarise:

“Some have taken a simplistic ‘no subsidy’ position, arguing from the correct observation that hardware subsidies can sometimes limit sustainability to the invalid conclusion that hardware subsidies are always unjustified and counterproductive.”
As these case studies show, a wide spectrum of finance arrangements has been used with varying degrees of success. Experience teaches that sanitation, like other goods with significant externalities, does not ‘take care of itself’, especially among the poor. The case studies make a strong argument for the benefits of appropriate public investment in sanitation. The challenge is to define appropriate approaches, shares, and mechanisms to finance sanitation for the poor that match the specific local context.” (p. xiii)

So the authors make two highly relevant points:

“The studies show that the most relevant question is not ‘Are subsidies good or bad?’ but rather ‘How best can we invest public funds?’” The case studies reveal a wide range of sanitation finance options and approaches. While there has been much written on the dangers of ‘sanitation subsidies’, it is hard to imagine a sanitation programme that does not involve some public or external investment, if only to share information or stimulate demand... The case studies reveal a wide spectrum of options: from a minimal investment in start-up of a revolving fund, to significant community mobilisation and demand stimulation, all the way to hardware subsidies of up to 75 percent of capital costs in addition to community mobilisation. The choice is thus not “Subsidy or no subsidy?” but rather: “What form and level of public funding makes sense in a specific context?” (Trémolet et al 2010, p.xi)

Subsidy targeting methods need to be tailored to country circumstances. Community-based targeting (in which the community itself manages the identification and support of its poorest members) and self-selection (in which only in-kind support for the most basic sanitation is offered, leading to self-selection among potential subsidy applicants) appear to be more effective than means-tested systems, which can be costly and generate perverse incentives. (Trémolet et al 2010, p.xii)

Other comments on subsidies, and the perceptions they feed, highlight their complexity. One interviewee from Malawi explained that “a few NGOs are still giving subsidies, which affects people’s thinking, and they ‘wait and see’ for the NGO to come and build a toilet rather than building their own”. This makes it very clear why CLTS is strict in its zero subsidy approach: introducing subsidies quickly gets us into very murky waters. Bevan and Thomas (2009) explain:

“The provision of subsidies quickly becomes complicated where a legacy of subsidies exists, no co-ordinated policy on subsidies exists and when the range of what are considered subsidies for community sanitation remains broad and largely undefined, thereby further confounding best practice. Similarly, the discussion on subsidies is often fraught with contradictions as the definitions of what are considered acceptable and not acceptable and what are in fact subsidies and what are not is still up for debate.” (p6)

Still there do seem to be some general principles that can be applied:

• “Subsidies are often considered uncontroversial depending on who disburses the funds, i.e. when they are part of a community level fund, allocated by the community to community members they are not perceived as problematic, a subsidy directly provided by external agents i.e. government, NGOs is often felt to be problematic.
• Rewards for achieving ODF are generally considered problematic, while an exchange of technical assistance or resources for other community priorities upon achievement of ODF status are not considered problematic.
• Subsidies in an urban context are less disputed when built into a tariff structure (it is more the level of subsidy that might present an issue) whereas the issue of subsidised support to rural community schemes is often problematic in and of itself.” (Bevan and Thomas 2009, p6-7)
But even with the seemingly clear general principle that “rewards for achieving ODF are generally considered problematic”, it becomes a complex consideration that is debatable and context-specific:

“Experience from India’s Total Sanitation Campaign (also a Community Approaches to Total Sanitation (CATS) approach) shows that financial awards used to motivate villages to reach ODF are not considered problematic as they motivate community behaviour change and unquestionably have resulted in a rapid scale up in villages obtaining ODF status. Within the programme, subsidies are available to the poorest households to enable them to reach ODF as part of the prize allocation. Meanwhile in Nepal’s implementation of CLTS, some communities were awarded assistance in other forms, under a more informal structure that included technical assistance for other community needs and infrastructure. In some communities in Nepal, the award was in fact monetary and set up by the community as a rotating fund for supporting community members in achieving ODF (Plan, 2007). In each of the above examples, it is clear that the use of subsidies and awards in both CLTS and the Total Sanitation Campaign are very much a reality and, importantly, are often not considered problematic under various circumstances. This commonality suggests that a greater understanding of these contexts and the type of financial arrangements that constitute subsidies (and those that don’t) might be very useful.” (Bevan and Thomas 2009, p6)

Reports reviewed on the introduction of CLTS in African countries did not specifically discuss the use of rewards for achieving ODF status, although some NGOs in Malawi give free latrine slabs when communities achieve this. The provision of rewards in Africa requires more exploration.

SOCIAL ASPECTS

CLTS has boosted the confidence of many communities to find their own solutions. Instead of prescribing sanitation structures, it changes mindsets and leaves communities to sort out their own power questions. In an overview of CLTS in Africa, Bongartz et al (2010) state:

“When communities realise that open defecation is a collective issue, the poorest people do not need outside assistance but are supported by those who are better off in their community. For example, in Got Kabok, Homa Bay, Kenya, where there is a large percentage of sick and elderly people due to the high prevalence of HIV/AIDS, social solidarity has been key to ensuring that vulnerable members of the community receive help in constructing latrines (Musyoki, pers. comm.).”[p30]

A principle of CLTS is that the “community” must assist the elderly, disabled and child-headed households to build latrines. Some question whether the lack of subsidies harms the poor and whether the rich really cross-subsidise the poor:

“CLTS discourses draw on a rather idealised notion of ‘community’ which in reality may be conflict-ridden, full or patron-client relations and inequalities... The community is rarely problematised as has been done in the literature, say, on community-based natural resource management and participatory development... This begs the question: Are the interests of the poor, women and female-headed households really taken on board in CLTS?” (Mehta 2010 p16)

One example from Bangladesh shows that the needs of the poor present:

“(a) variety of dilemmas ranging from marginalisation due to an inability to attend community mobilisation meetings, inability to invest in a latrine and the prospect of stigmatisation by
the community. In one community, severe penalties for open defecation range from fines to confiscation of personal belongings. While these harsher approaches have led to quicker uptake by the poorest, such punitive measures seem out of line with the CLTS spirit of self-help and dignity (Mahbub 2008)”. (Bevan and Thomas 2009, p7)

How CLTS takes root in communities depends largely on facilitators’ ability to utilise a participatory approach and engage in a provocative manner that sparks complex behaviour change at the individual and collective levels. Facilitators need to have a good understanding of social customs and local cultural assumptions so that they do not offend community members during the CLTS process. The facilitator needs to guide the process using CLTS tools that empower community members to make autonomous decisions and to take action to improve sanitation in their community. (Gebresilase 2010, p105)

It appears most likely that the community can assert mechanisms of control moderately in smaller and more homogenous villages selected by NGOs. Control is more difficult in heterogeneous communities. Mehta (2010) provides an example of how control may be asserted by ostracising groups:

“Non-adopters are not allowed to participate in Edir (a community organisation that is key for local well-being in Ethiopia), fines are imposed or children blow whistles and spy on those shitting in the open. But sanctions, control and monitoring do not last very long. Sanctions and fines are typically lifted after the area becomes ODF or after the momentum has subsided.”

At some level, it is a matter of interpretation. One of the most critical accounts of CLTS appears on a blog by an MA student who spent time visiting some communities that implemented CLTS in India:

“From our very first meeting, everyone from senior bureaucrats to local kindergarten teachers talked proudly of their innovative approach to ‘persuading’ the more reluctant members of the community to construct a toilet.

At its mildest, this meant squads of teachers and youths, who patrolled the fields and blew whistles when they spotted people defecating. Schoolchildren whose families did not have toilets were humiliated in the classroom. Men followed women - and vice versa - all day, denying people the opportunity even to urinate. These strategies are the norm, not the exception...

Equally common, though, were more questionable tactics. Squads threw stones at people defecating. Women were photographed and their pictures displayed publicly. The local government institution... threatened to cut off households’ water and electricity supplies until their owners had signed contracts promising to build latrines. A handful of very poor people reported that a toilet had been hastily constructed in their yards without their consent.

A local official proudly testified to the extremes of the coercion. He had personally locked up houses when people were out defecating, forcing them to come to his office and sign a contract to build a toilet before he would give them the keys. Another time, he had collected a woman’s faeces and dumped them on her kitchen table.

These tactics of public shaming bore little relationship to the ‘good’ shame and fear that Community-led Total Sanitation relies on in its participatory analysis of how ‘we are eating one another’s shit’. People praised toilets for their convenience and not their health benefits, about which many were sceptical - including some of the teachers charged with carrying the campaign forward in the community. Several described toilets as dirtier than the fields. The vast majority of facilities did not have soap for hand-washing, which meant the expected health gains were lost...
CLTS and the information campaign did work in convincing a large majority to use a toilet, even if not for health reasons (around 80-95% of people started using toilets fairly rapidly).

(But) let’s admit this plays on people’s baser emotions rather than being all about participation, equity, democracy and freedom!” [Chatterjee 2011]

The counter-position is advanced by CLTS advocates:

“There is significant debate about the ‘shame’ aspect of CLTS. 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. One critic wrote: “I feel really sickened by the paternalism of using shame to get people to comply with your wishes. They are not children, they’re just people who live in different circumstances.”

The way these commentators understand it, in CLTS outside facilitators ‘shame’ communities into taking action. However, 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.

In CLTS, the impulse for change comes from the shock of realising the implications of one’s actions: 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 emotions 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 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 judgments.” [Chatterjee blog response by Pebong 2011]

In conclusion, all authors seem to agree that:

• Much more attention needs to be paid to training, implementation and follow-up. People need to realise that there is no quick fix – CLTS is not just triggering and then leaving communities to it.
• The invisible inequalities and power relations within communities need to be made more explicit.
Oxfam’s Community Facilitator teaches a hygiene training session using laminated pictures from the CLTS (Community Led Total Sanitation) tools. After this kind of training session villagers are motivated to build toilets. Donsiro village, Central Bougainville.

PHOTO © Tom Greenwood | OxfamNZ
CULTURAL ASPECTS

Surprisingly, Kar found that the CLTS approach needed little modification in its transfer from Asia to Africa. Some of the factors that required consideration include:

- “Latrine-building is naturally very seasonal in this region, and the timing of CLTS interventions needs to reflect this. CLTS has been found to be more successful when triggering takes place in the dry season when people have more free time.
- CLTS has been implemented and ODF status achieved most rapidly where there has been strong and regular follow-up and/or an enthusiastic natural leader to support villagers and champion the process.
- Overcoming the historical dependency on subsidies in this sector has been a challenge.
- In some countries, there has been significant resistance to unsubsidised domestic latrine building at both government and community levels. In other regions, such as in Ghana, the two approaches appear to co-exist. (Magala 2009)
- If cultural preferences such as gender-specific latrines are catered for, this will ensure greater use and sustainability.
- Specific CLTS concepts have transferred well from countries in Asia to West Africa, eg School-led Total Sanitation (SLTS) transferred well from Nepal to Sierra Leone.” (Bevan and Thomas 2009, p4)

The gendered nature of latrines in many African countries was raised repeatedly in the literature as an example of the need to adjust CLTS to an African context. “In parts of Africa, women cannot use the same toilet that is used by their father-in-law. Therefore, they might need a separate women’s toilet in the compound.” (Mehta 2010, p11)

Perhaps the most difficult aspect of CLTS for people to accept is related to using the local word for “shit”. While some assert that this lacks cultural sensitivity, using this word is foundational to CLTS’ approach to encourage straight talk so that people can discuss these issues: “The use of the term ‘shit’ is initially shocking to many participants and it’s important that this is the case, as this shock factor is a key part of the triggering process.” (Harvey 2011, p1038) “CLTS encourages people to break the silence around shit by using crude, explicit language, and exposing the taboos around shit.” (Bongartz et al 2010, p19) Of course this may be a difficult session to facilitate, but the discomfort of participants is expected as it forces the first steps of a change in mindset.

In contrast, Sah and Negussie (2009) conclude that “during the CLTS process, it is important to consider existing social customs and cultural sensitivities so that the facilitators do not offend community members during the CLTS process... Community Facilitators need to find means to trigger action without shaming and disgusting the communities” (p670).

This was also raised with all practitioners interviewed for this report. Their responses include:

- A community leader said: “I am not happy to be told that we eat each other’s shit. It is not the Tanzanian way to speak like that.” (Sah and Negussie 2009)
- Aggressive language was a problem with traditional leaders - one facilitator was even asked to leave the village. (Zambia)
- Facilitators need to be direct and tell the truth. But don’t say the word directly, trust them. One facilitator said it directly with the village head, kids and in-laws present and it offended them. (Malawi)
• Men and women react differently to triggering and it can divide them. Men threaten women if they go on the Walk of Shame, stating that “facilitators have come to insult us”. Men deny the reality that women report and are less likely to find CLTS resonates with their everyday experience. (Zambia)
• The poor consider it to be an insult for men and women, or youth and elders, to be seen using the same toilet.

One observer asserted that CLTS facilitators in Tanzania were unable to adjust their approach so that it was based on the local context, with almost farcical affect:

“In most of Tanzania, the vast majority of households (typically over 95% in most areas) have their own pit latrine - the legacy of a very effective health promotion campaign 40 years ago. Where I saw CLTS mobilisers trying to provoke shame at open defecation in this setting, the only shame present was the community’s embarrassment at the mobilisers’ lack of understanding of the local context…

While I wasn’t able to observe the great Kamal Kar’s training in Tanzania, I did get to see those he trained when they carried out CLTS ignition later. It was honestly embarrassing to watch. If there was supposed to be some clever point about fixed point open defecation, it had gone missing entirely. People were pretty happy with the state of their latrines before and after the ignition process (despite the facilitators claiming great success) and showed no sign at all of shame.” (Chatterjee blog response by Mtega 2011)

Bongartz et al (2010) note the importance of facilitators being able to adapt to the context and contribute sharing experiences toward the further development of the method: “When ‘triggering’ this process in communities, flexibility and innovation is encouraged. Good practice requires CLTS facilitators to adapt to the particular cultural and religious context, and to innovate and share new tools amongst practitioners.” (p21) Similarly, in response to criticisms of the approach, Rose George replies: “If it is true that there has been stone-throwing and photographs of women then published, then I would like to see better citations and/or proof. If that’s happening, of course it’s bad. But CLTS is an organic movement. It has to be continually fixed and perfected.” (Chatterjee blog response by George 2011)

There are indications that youth and child involvement in CLTS may, in some circumstances, contribute to shifting relationships between adults and young people, providing a pathway to child and youth empowerment. But findings indicate challenging power relations is never without risk of harm.

In Ethiopia both religion and children were used as motivating agents for CLTS. In terms of religion, churches and mosques advocated CLTS by asserting 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).” (Sah and Negussie 2009, p669) Children have also campaigned in favour of ODF communities by “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 shit in the open.” (Sah and Negussie 2009, p670)

While these may be effective motivators in the immediate and short term, we cannot know the longer term impact on communities’ social structures. Crosweiler asks these questions pointedly:

“I have asked the question elsewhere what this kind of naming and shaming will do to the social structure of communities where young people name and shame older members. Will
the youngsters respect those older members when they become more challenging young men and/or women? The problem is: the answer will only be apparent in another ten years or so, by which time we will also know whether people rebuild their pit toilets when they fill up or return to fields and bushes. And do they upgrade to better quality toilets? Again, only time will tell, but do we have the right to take risks with people’s community in this way?” (Chatterjee blog response by D. Crosweiler 2011)

SCALING UP

At the 2008 AfricaSan Conference, Robert Chambers and Kamal Kar called on international delegates, including leaders from more than 35 African countries, to adopt CLTS as the “most viable option to achieve sanitation goals”. Their open letter urged governments and donors to “avoid programmes driven by big budgets, targets and pressures to disburse, and instead to go to scale in a steady manner, focusing on good training and building up and supporting a cadre of dedicated and committed staff and local-level natural leaders. Much damage has been done by pushing too much money too fast at NGOs”. (Sah and Negussie 2009, p671

Since then, more and more African countries have adopted CLTS as a national policy with ambitious targets. Their main challenge in taking CLTS to scale is ensuring quality. Chambers asks: Do “people at all levels – from policy-makers to local leaders and facilitators – have the vision, guts and commitment to make it happen widely and well?” (Chambers 2011)

The low cost of CLTS and the immediate return in outcomes make scaling up an attractive prospect, particularly in countries where funds for sanitation projects are not available. However, both governments and multilateral and bilateral agencies often do not recognise CLTS as a model for achieving sanitation targets, making political buy-in and the allocation of necessary resources difficult. This requires more campaigns and advocacy for policy changes, supported by further research and studies that assess the “direct link of disease incidence with ODF communities (epidemiological studies) as well as the social impact of CLTS on rural communities (e.g. changes in behaviour, impact on the daily lives of women, etc.)”. (Sah and Negussie 2009, p670)

Sah and Negussie (2009) note that scaling up requires a “resource base of trainers, campaigns, advocating for policy changes” and that other challenges include:

- If communities received subsidies in the past, triggering is challenging as they are less willing to implement CLTS. Further subsidies by NGOs or government may impact negatively on CLTS success.
- Natural leaders and among stakeholders differ in their commitment, understanding and adherence to the CLTS approach and process.
- Skilled staff who are able to facilitate the CLTS process effectively and efficiently are severely lacking. This has hampered continuous follow up and monitoring, often resulting in a loss of interest.
- Community resistance and anger about how facilitators use shame.
- Advocacy is needed to introduce government policies that recognise CLTS as a successful methodology to create ODF communities. (p670)

SCALING UP EXAMPLES IN AFRICA

Interviewees from organisations implementing CLTS in Africa provided examples of scaling up in their countries:

- Kenya is rolling out a big programme and has set itself the target of making all rural areas ODF by 2013.
• Malawi has gone “flat out” using the CLTS approach through involvement in the Global Sanitation Fund. After years of small organisations trying it out, CLTS received appreciation two years ago as a hugely effective approach to mobilise the rural population to stop OD. The Ministry is playing a leading role in introducing the approach through the “ODF Strategy”, a framework to make sure all players are using CLTS on the ground.

• Tanzania can scale up since there is a new National Sanitation Campaign to adopt the Mtumba approach. Donors (African Development Bank and the World Bank) come with a ready-made approach based on CLTS to be used across the board, but the environment where it is to be introduced matters. It is unfair to provide funds and be prescriptive.

• In Ghana, the Donor Partners (UNICEF and WaterAid) took CLTS and, working with the Coalition of NGOs in Water and Sanitation, started telling communities that government and Donor Partners would not provide subsidies but that the new approach depends on the strength of the community. With the exception of institutional and public latrines, all funds for sanitation go to CLTS. Now the government has taken up CLTS.

• In Mozambique, CLTS (called SANTOLIC - Saneamento Total Liderado pelas Comunidades) was introduced in 2008 as a pilot covering 18 districts in three provinces of central Mozambique - Tete, Manica and Sofala - as part of the “One Million Initiative” (implemented by Government of Mozambique in collaboration with UNICEF with funding from the Dutch government). On the basis of an assessment conducted by WSP in 2010, CLTS was adopted and expanded to the entire country under the National Water Supply and Rural Sanitation. In April 2012, the national WASH group (the National Directorate of Water, Ministry of Health, European Commission, Swiss Embassy, Department for International Development (DFID), UNICEF and several NGOs) identified lessons learned around CLTS. Clearly governments across Africa are adopting CLTS as their main, if not sole, approach to sanitation. It is important that practitioners and researchers grapple with complexities that arise during and after CLTS implementation. The reality is that many practitioners may use the CLTS “label” but are actually used a “mixed approach”.

DO “MIXES” WORK?

Whether mixes work goes back to the “purist or pragmatist” question. Kar is clear that most mixes contain elements that contradict one another and ultimately undermine CLTS and overall effectiveness in achieving ODF status. Kar and Milward (2011) explain that a number of scenarios involve:

“tagging CLTS onto an existing approach, other elements of which may contradict essential principles of CLTS. Alternatively, different approaches with elements in common are brought under an umbrella term for strategic reasons, or CLTS is overlayed on top of the mechanisms and structures of ‘older’ approaches. This fails to transform these latter completely, with the result that elements of them emerge during training, triggering and follow-up, which are all weakened in the process…. These ‘mixing’ initiatives can work against the potential of CLTS”. (p46, emphasis added)

They also link mixes to the continued role of outsiders, meaning that natural leaders from the community do not emerge to lead the process:

“A major drawback of these mixes in this case [Nigeria] is that potential natural leaders have not clearly emerged from the triggering process and have not found the opportunity to flourish and lead the process. Outsiders continued to educate, teach, offer solutions and monitor at the household level after triggering, all of which could have been facilitated by the natural leaders.” (p50)
A community member draws a basic map of the village, including all roads, paths, houses, schools, churches and landmarks. Then villagers mark with a red "X" where they go to the toilet. This "poo map" is an excellent tool for raising awareness about the dangers of open defecation.
Doniro village, Central Bougainville, Papua Guinea
Kar and Milward write that these mixed approaches have created “severe challenges” to the spread and scaling up of CLTS in Nigeria and Ghana.

However, practitioners from African countries who were interviewed state openly that they are implementing what they have found works best, and that these are “mixes”:

Malawi is a particularly interesting case of combining PHAST and CLTS. One interviewee explained:

“In Malawi we have been using PHAST for years. Now we combine this with CLTS. CLTS targets OD so that people reach the first step. People use local materials such as clay and straw, and line unstable pits with old barrels. But CLTS is just another approach with its shortfalls and weaknesses. It is wrong to think that CLTS is the answer to sustainable sanitation, there are still some gaps. So don’t throw away other approaches that have been in use - see what works well in what area, so develop an approach that is more encompassing.

CLTS triggers but doesn’t provide technology. So people dig a hole but don’t know the proper depth and put grass around it. It collapses in the rain. If there is a leader from another village he may share how to get it to last longer.

So we make action plans how to move up the sanitation ladder. Once households stop open defecation, we support them to improve sanitation. But there is a need for technicians/local artisans to help and for a sanitation market. PHAST is broader and is for higher steps in the ladder. So CLTS is not the end and subsidies are still appropriate to move up the ladder.

So WaterAid Malawi looked at how progress from CLTS can be sustained. It supports engaging with local government, trains artisans on marketing and construction (form sanitation centres for demos), trains facilitators, and provides motorcycles to support monitoring. Governments and donors should continue to be responsible for the lion’s share of sanitation improvement and sustainable government involvement. It can’t be left to the private sector via sanitation marketing or to communities.*

In Zambia, one interviewee explained that the Department of Health promotes PHAST (against disease) and the Department of Local Government promotes CLTS (number of toilets). UNICEF is facilitating a harmonisation process with the two government departments so there is a uniform approach in the country. (UNICEF is also supporting CLTS in 3-4 provinces through the Department of Local Government).

In Ethiopia, CLTS “activities were complemented by a novel approach: to interpersonal communication for behaviour change: individual and household behaviour negotiation was conducted by Health Extension Workers to assess current practices and negotiate” which sanitation and hygiene options or “small doable actions” were feasible and best suited to each family’s need. The behaviour change strategy focused on three behaviours: hygienic disposal of human faeces; handwashing with soap at critical moments and household water treatment and safe storage of drinking water, with an ultimate goal of total behaviour change in sanitation and hygiene in the region”. (Water and Sanitation Program 2011, p2)

India’s Total Sanitation Campaign (also a CATS approach) “shows that financial awards used to motivate villages to reach ODF are not considered problematic as they motivate community behaviour change and unquestionably have resulted in a rapid scale up in villages obtaining ODF status. Within the programme, subsidies are available to the poorest households to enable them to reach ODF as part of the prize allocation.” (Bevan and Thomas 2009, p7)
SANITATION MARKETING

While critical of “mixes”, Kar considers “sanitation marketing” to have the potential to fill important gaps after CLTS is implemented and behaviour change has been established. It can enable or facilitate people voluntarily moving up the sanitation ladder. (Kar and Milward 2011, p49) Sanitation marketing is part of the Water and Sanitation Program’s approach:

“With a focus on building a rigorous evidence base to support replication, WSP combines Community-Led Total Sanitation, behaviour change communication, and sanitation marketing to generate sanitation demand and strengthen the supply of sanitation products and services, leading to improved health for people in rural areas.” (Mukherjee 2012, p1)

Sanitation marketing “applies lessons from commercial advertising to the promotion of social goals, in this case to improved sanitation and hygiene. The underlying premise of sanitation marketing is that the construction and maintenance of latrines are services that can be met by the private sector. The latrine owner is a consumer of those services. Social marketing consists of four components, the four Ps; product, price, place and promotion.” (WSP 2004, p3-4, emphasis added)

It seems that CLTS and sanitation marketing can work consecutively as envisaged by Kars, first CLTS leading to behaviour change and then sanitation marketing providing options so that people can move up the ladder. Yet it can also end up part of a new “mix”. Bevan and Thomas (2009) reflect on developments in Ghana and Nigeria:

“Getting the mix and timing of the promotion of both self-build and sanitation marketing right is a challenge that needs to be experimented with – this is being tested for example in Ghana through the development of SaniMarts (Magala, 2009) and in Nigeria with the combining of CATS approaches with SaniCentre entrepreneurial artisans” (Agberemi and Onabolu 2009) (p5).

UMBRELLA APPROACHES: CATS AND THE MTUMBA APPROACH

While “mixes” may simply be piecing together elements of different approaches, eg PHAST and CLTS, some mixes have been developed as a new approach. Below are descriptions of Community Approaches to Total Sanitation (CATS) and the Mtumba approach.

Community Approaches to Total Sanitation (this section is fully comprised of excerpts from Bevan and Thomas 2009, p2-7)

Community Approaches to Total Sanitation or “CATS” are a set of principles that reflect and guide UNICEF’s sanitation programming strategy. CATS principles are a distillation of best practice from global community-based sanitation programming that include community leadership, behaviour change and eliminating open defecation as components of effective programming (see Box 1 for the full set of principles). Conceptually, CATS is an umbrella term under which fall a variety of community-based sanitation programming approaches subscribing to nine basic principles of community programming. Community-Led Total Sanitation (CLTS), the Total Sanitation Campaign (TSC) and School Led Total Sanitation (SLTS) are a few of the approaches that are considered CATS subscribers by UNICEF.

By moving away from methodology-based approaches, and using principles as the basis of programming approaches, UNICEF hopes to enable greater programming flexibility in adapting context-specific solutions as well as the opportunity to engage in meaningful discourse and exchange of experience across regions/countries.
Monitoring of CATS programming has so far been limited to post-implementation evaluations - the introduction of a participatory “sanitary” baseline into CLTS processes may be an effective way to develop baseline data as well as to build evidence to convince politicians of its effectiveness.

**BOX 1 – THE CATS PRINCIPLES**

The CATS principles reflect the minimum elements for better community-based sanitation programming.

1. The goal is “total sanitation”: achieving open-defecation free communities through the use of safe, affordable and user-friendly solutions/technologies. Emphasis is on sustainable use of sanitation facilities as opposed to the construction of infrastructure. Safe disposal of human excreta includes the management of infants and young children’s faeces.

2. The definition of “communities” includes households, schools, health centres and traditional leadership structures in addition to women and girls, children and men. Working with communities inclusively is an integral aspect.

3. Communities lead the change process and use their capacities to attain their envisioned objectives. They play a central role in planning with special consideration to the needs of vulnerable groups, women and girls and in respect of the community calendar.

4. Subsidies - in the form of funds, hardware, or otherwise - are not given directly to households. Community rewards, subsidies and incentives are acceptable only where they encourage collective action and total sanitation, and where used to attain sustainable use of sanitation facilities (as opposed to the construction of hardware).

5. Households will not have externally imposed standards for choice of sanitation infrastructure. Technologies developed by local artisans from locally available materials are encouraged. External agencies provide guidance as opposed to regulation. Where viable, involvement/instigation of a local market with its local entrepreneurs is encouraged.

6. Local capacity-building, including the training of community facilitators and local artisans, is an integral part of CATS.

7. Government participation and cross-fertilisation of experiences are essential for scaling up.

8. CATS integrate hygiene promotion effectively into programme design; the definition, scope and sequencing of hygiene components are contextual.

9. Sanitation is an entry point for greater social change and community mobilisation.

*Source: Proceedings of an internal UNICEF sanitation meeting, July 2008.*
MTUMBA APPROACH

The Mtumba approach, developed by WaterAid and partners in 2007, takes elements from CLTS, PHAST, sanitation marketing, Participatory Rural Appraisal (PRA) and other participatory approaches and modifies them for Tanzania. They are not using the “full package” of any single approach but merged aspects of these approaches. By drawing together a range of approaches, Mtumba responds to issues that CLTS was unable to address: service level, sustainability, and scaling up. It uses CLTS’ triggering and shame/disgust so communities are the driving force and there is behavioural change.

Since the Tanzanian population wants to move from pits to basic latrines, the Mtumba approach draws in local artisans and sanitation centres displaying options, and points to the possibilities of microfinance. It seeks to achieve the agreed upon, defined minimum standards of a household latrine:

a. A washable/impervious floor
b. Adequate privacy
c. Adequate safety for the users, including children
d. A stable pit that is not overflowing or full
e. Handwashing facilities (e.g. tippy-taps) with soap or ash’ (WaterAid in Tanzania 2012, p9)

The Mtumba approach includes five steps:

1. Contact with local authorities and participatory analysis of baseline
2. Community Action Planning
3. Implementation of action plan
4. Participatory monitoring
5. Evaluation of achievements

In conclusion, analyses will continue to grapple with the question of whether these mixes are “precisely the adaptations which have enabled CLTS to be carried forward so fast in Africa” or whether they “represent deviations that may seriously undermine the approach”. (Kar and Milward 2011, p52)

CONTEXT MATTERS: CLTS IN SOUTH AFRICA?

Strong arguments have been made that CLTS should not be introduced in South Africa because the context means it is inappropriate, ineffectual, confusing and a waste of money. One respondent describes the state of sanitation in South Africa and explains why CLTS will not work here:

“There are many global examples that show poor people can and do fund their own toilets and sanitation improvement. But South Africa is different than many poor African countries - it has more money, it has made the commitment to provide, and it now has a well-entrenched national programme to fund provision of toilets through government. Despite investing large amounts of funding, South Africa is not succeeding at improving sanitation. This is a largely due to chasing infrastructure targets, irrespective of the service outcome; top down, non-consultative approaches of municipalities; a technocratic approach lacking an appropriate skills base to make it work; and delivery of shoddily built toilets (whether Ventilated Improved Pit (VIP) or flush) at vast cost and with personal enrichment of party-aligned opportunists. And it has been turned into an issue of toilets rather than people’s hygiene practices.
Sanitation is not primarily about infrastructure – it’s about people and their behaviour. People need to understand person-to-person transmission of oral-faecal diseases and the importance of good hygiene. Sanitation also has to engage with wastewater and solid waste and a range of hygiene behaviours. But in South Africa it’s only about delivering toilets – and barely engages with what’s needed to keep them functional – whether flush or dry. In a context of widespread HIV and compromised immunity, this is tragically squandered opportunity to support basic health improvement and support wellness in vulnerable people.

The progress report of the Water Research Commission describes the context of its CLTS pilot study in the same vein:

“Many projects have failed for lack of proper use of the infrastructure provided, despite the associated ‘Health & Hygiene Awareness’ attached to delivery. Subsidised hygiene education is attached to toilet construction, both of which are outsourced to private sector contractors.” [p18]

“In addition to traditional leadership not being adequately involved, community members are often excluded from comprehensive discussion about the implications of the specific implementation of policy principles in their daily lives.” [p22]

“It is emphasised that in developing countries like South Africa, more attention should be paid to ‘soft issues’ such as community empowerment, sanitation promotion, health education, and financial assistance to the households (SA Sanitation Policy review, Version 3, 2011).” [p23]

The respondent continues that “without question we need to seek to bring people back to the centre of sanitation improvement. That’s one thing CLTS is good at - it foregrounds people not infrastructure. But if you want to focus on people, there are far better ways than CLTS to go about it.

CLTS is designed for places where there is no source of external funding to help households. South Africa is not in that situation, so the debate should end right there.”

Instead, the Water Research Commission solicited research for a pilot study entitled:

“Adapting and piloting the new concepts of Community-Led Total Sanitation (CLTS) into the South African municipal environment’. The stated aim of the project is ‘creating bridges between community responsibility and municipal provision with a programme of support that is shaped at the interface between communities and their municipalities’.” (p.iii)

The first progress report on the pilot study (Lagardien and Cousins 2012) explains that it was inserted into municipal plans under the health and hygiene education component. So two things were being tested: whether CLTS can work in the rural South African environment and how municipalities (and other institutions) might take up CLTS and integrate it into their work. It seems that the main focus of the project to date has been the former, particularly through the training of facilitators and piloting of CLTS in communities. The interface between communities and municipalities has not been a main focus, as municipal engagement seems to have been relatively minor once how the CLTS “fit” within health and hygiene education had been agreed upon.

One of the main interim findings of the pilot study is that, while waiting for the government to deliver, rural communities in South Africa may embrace CLTS and get on with dealing with their own sanitation. In other words they can create a hygienic environment at the lowest rung of the ladder above OD.
Pilot communities built toilets (although warnings of international experience regarding planting season were not heeded), taught people about the impacts of OD (only a few hours process needed), and some natural leaders became active. It is worth noting that these experiences emerged from communities that practiced open defecation with no sanitation subsidies introduced by government or other agencies to date as they are located in one of the poorest and most isolated rural areas of South Africa. This would clearly be one of the most likely places in the country for CLTS to work uninhibited by subsidies (it is not clear how many other communities in South Africa fit this profile).

Even in these remote areas, the very existence of government programmes that provide toilets threatens to undermine this approach. Even if there are no such programs in operation, rumours that government services are on their way affect people’s attitudes. The progress report recounts how outsiders, whether government and politicians or even facilitators of CLTS from Civil Society Organisation’s (CSOs), corrupt the CLTS process with their attitudes and expectations of the government’s role.

What appears to run through the progress report is a level of frustration with the subsidy environment. This is not surprising as the literature notes that CLTS effectiveness will be compromised – if not blocked - in such an environment. Yet the dominance of subsidies was not fully recognised by researchers who conclude:

“With hindsight, existing guidance and tools for the pre-triggering preparation stage were insufficiently investigated for rising to the challenge of institutional mindsets and associated attitudes in the Eastern Cape, and most likely in all of South Africa.” [p.v]

It is understandable why sanitation researchers are pursuing CLTS in South Africa. CLTS is being embraced and applied by the main sanitation roleplayers throughout Africa and globally, so using the CLTS “label” may assist South African sanitation roleplayers in gaining attention and funding to promote a shift in focus away from “entitlement”.

However CLTS is not applicable to the South African context: CLTS operates without subsidies or the concomitant attitudes, which are central to the South African context. The most that can be tested in this context is a mixed approach. Since those who developed CLTS question whether “mixes” can work at all, South Africa seems an ideal place to test this proposition. Unfortunately the pilot study has not focused explicitly on testing a mixed approach.

Instead it appears to be attempting to carving out space for CLTS in the local environment. The Water Research Commission’s (WRC’s) progress report argues that the research team has maintained the “spine of the approach” to “adapt the CLTS approach in conditions where subsidy expectations dominate.” Is it possible for the pilot study to avoid the fraught sanitation environment and create a bubble of CLTS purity in these rural areas?

What is actually being tested is how we can re-introduce community-driven development into sanitation using participatory methods. This is clearly a response to two problems in South Africa: the use of consultants and the absence of true community engagement. First, we need to replace, improve and reduce the cost of services provided by “didactic consultants”. The WRC progress report states:

“We need to look at reduction of costly and short-term external educational inputs that are of dubious value to sustaining behaviour change” [p.vi]

“Integrating CLTS into the demand side of basic sanitation provision creates various spaces to complement the South African model of the municipal sanitation function more effectively than does a didactic educational service.” (p.v)
The village chief (and a trained Village Health Volunteer) holds a community map, or “poo map”, of Pisinam village. This is an effective way of raising awareness about the prevalence and dangers of open defecation. Central Bougainville, Papua Guinea.
“The high cost of consultants and contractors, in managing both toilet construction and educational services, may be partially replaced by community contributions and resourcefulness.” (p2)

Perhaps the most surprising aspect of the progress report on the pilot study is its findings in regard to development practitioners. There has long been a complaint by communities (or more accurately: those who reflect their concerns) that development practitioners are not empowering them but empowering themselves by keeping the community weak. The progress report found that:

“For the past decade, social development practitioners in South Africa have focused on raising health hygiene awareness as their contribution to achieving sanitation, rather than directly mobilising collective action by communities. Activities drawn from PRA, PHAST and Self-esteem, Associative strength, Resourcefulness, Action planning and Responsibility (SARAR) have been increasingly shaped into educational approaches to fit contractual terms of reference. This is partly due to traditional NGO capacity becoming increasingly tuned to carrying out contractual obligations as service providers to the state, due to changing streams of funds.

Persistence of doubt about community capacity and resourcefulness to act on its own behalf has prompted unanticipated questions as to the efficacy of weighting practical CLTS Triggering as the main trunk of facilitator training. Experience in the case study indicates that training South African facilitators requires guided critical analysis of lessons from local and wider experience with more space for deeper reflection on the underlying theoretical assumptions of practitioners.” (p59-60)

Second, we need to rejuvenate the role of communities:

“Rejuvenating community decision-making and supporting community-driven actions to overcome resistance to long term community ownership of their sanitation (p.vi)

The case study has confirmed that community mobilisation for achieving total sanitation coverage raises collective consciousness that facilities can only be effective if all households in a neighbourhood practice hygienic behaviour.” (p2)

This is also referred to as rejuvenating the demand side of sanitation:

“The CLTS approach does therefore appear to offer a way to alter negative attitudes associated with entitlement to receiving municipal services and the supply of toilets by contractors. A crisis of disenchantment with services delivery may thus open a window of opportunity for communities to overcome their sense of dependency, which is synonymous with their sense of entitlement.” (p54)

What emerges from the progress report on the pilot study is that its managers were aware of the difficulty of implementing CLTS in the South African context, but that they are exploring a means of shifting the balance away from municipal subsidies and carving out a space for CLTS:
Where there are persistent sanitation backlogs, adapting the central CLTS premise of no household subsidy in conditions that are surrounded by expectations of municipal delivery calls for more flexibility in both approaches. (p53, emphasis added)

There are potential opportunities for un-serviced communities to take initiative, as an alternative to passively awaiting sanitation provision through government procedures, (p2)

Where budget shortfalls constrain roll out plans, Municipalities may be prompted to consider support for community-driven sanitation where there is none and where delivery of VIPs is unlikely within 2-3 years. (p.vi)

Mobilising collective sanitary behaviour and associated action is not reliant on subsidy allocations to Provincial departments, District or Local Municipalities for planned five-year roll- outs of provision. (p2)

This report of the case study experience has confirmed that the CLTS approach facilitates local sanitation actions that are based on community decisions. Costly expenditure on hardware delivery and educational inputs by external service providers may be better invested, at least partially, in providing support for more communities to take ownership of their sanitation. (p3)

In other countries, CLTS has been introduced in a few areas and then proponents have lobbied government to adopt the approach, remove subsidies and implement CLTS. While respondents may consider it implausible that the South African government would remove subsidies, perhaps select local municipalities in rural areas would make this shift. This could then influence wider shifts in the national approach to sanitation, which is presently under review, as it takes the pressure off the state to deliver while showing some evidence of change.

Is this desirable? Communities’ continuing reliance on municipal government, particularly in the face of clear non-delivery, may frustrate community development practitioners who can see that community members have agency to respond to their own problems. However any shift to pass responsibilities to communities would be rejected by many as abrogating or “passing off” responsibility for socio-economic rights and basic services which are protected in South Africa’s constitution.
CONCLUSION

CLTS is an approach with huge potential to address one of Africa’s most challenging problems: a lack of sanitation with devastating health impacts. However, CLTS is still in early stages of being introduced and there are questions about its sustainability and its efficacy in helping households to progress up the sanitation ladder. So it is important that we continue to pursue CLTS, implement knowledge and continue to research its impact. It is important that we do not allow governments and donors to “tick the box” that these households are served and move on.

Many of the issues that arise in the implementation of CLTS in Africa are about trade-offs:

• The relationship between the means and the end,
• The relationship of CLTS to other approaches,
• Immediate gains of becoming ODF and maintaining and improving this sanitation status, and
• Taking CLTS to scale but possibly compromising the quality of facilitation (upon which its success largely rests).

What is being attempted is CLTS’ introduction at scale across communities and experimentally in a few highly urbanised areas. Such blanket introduction means that it will be introduced in types of communities where it will not take root but will still contribute to our understanding. If CLTS simply does not take root, one can argue that its introduction is benign. Yet the danger is that introducing CLTS in some inappropriate contexts could result in conflict, confusion or technical problems, which are damaging at the local level.

In terms of developing a future research agenda, the following areas have arisen:

• Map of approaches used: characterise the mix explore their possible connection to the sanitation ladder and assess differences between applications in diverse community contexts
• Sustainability: follow up CLTS after x years. Questions might include: Was infrastructure maintained and/or improved over time? Was infrastructure used and hygiene practiced over time (where, how and why)?
• Impact: In places where approach was implemented and sustained, what was their impact on diarrhoeal occurrence/mortality/morbidity?

Of course there are implicit causal relationships between these three sets of indicators that need to be explored further. In other words: what is the relationship between a certain approach, sustainable change and health impacts?

While such relationships could be explored in many ways, two promising projects emerge:

1. A Pan-African monitoring framework: what has been done and where, what is still in place/practiced, what are the past (if possible) and present health indicators? It is likely that the past data will be anecdotal or weakly comparable due to differences in how/what data was gathered? This will entail establishing a framework, gathering baseline data and developing a process for regular data gathering. This would be an investment in measuring sanitation outcomes and, depending on its initial scale, could be an ambitious and long-term critical intervention. It could be spearheaded by a small team but would require adoption by key stakeholders.
2. Drawing on the experiences of implementing organisations in Africa, it would be possible to identify areas considered “successful” in terms of CLTS and mixed approaches over time. These areas could be the basis for exploring a monitoring framework, while also providing a basis for a qualitative study of success cases that seeks explanatory variables and possible indicators of success. Two stages of exploration may be useful:

- What approaches are being implemented in places where behaviour has changed (for example: use of toilets and hygiene practices)? What is responsible for their success? What role do the departments of local government and health play?
- In successful cases (where behaviour has changed), how has this impacted on health and hygiene?

There is a clear need for better data and understanding of new sanitation approaches being implemented, such as CLTS, and their impact. Only with such understanding can we move past anecdotes and the passion of those promoting specific approaches to assess the most effective ways of responding to the dire need for sanitation across Africa.
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**CLTS Interviewees: representatives from southern Africa organisations**

**Malawi:** Concern Universal WASH programme, WaterAid

**Zimbabwe:** AACES - SFP

**Tanzania:** WaterAid –East Africa

**Zambia:** Oxfam

**South Africa:** Documentation from Water Research Commission, eThekwini Water and Sanitation: Head, independent researcher

**Ghana:** WaterAid–West Africa

**Mozambique:** Comments submitted by Concern Universal