RiPPLE

Community-led total sanitation (CLTS) across the seas

Experiences from Africa with a special emphasis on Ethiopia

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Prepared with the assistance of Petra Bongartz

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Working Paper 12

Research-inspired Policy and Practice Learning in Ethiopia and the Nile region

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This paper was written in 2008 and does not capture or analyse the recent developments of CLTS which are provided in Appendix 1. It is still work-in-progress and the usual disclaimers apply.

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Acronyms

ADB	Asian Development Bank
AWD	acute watery diarrhoea
BoH	Bureau of Health
BPL	Below Poverty Level
CBTS	community based total sanitation
CHPs	Community Health Promoters
CLTS	Community-led Total Sanitation
DAM	Dhaka Ahsania Mission
DFID	UK's Department for International Development
GoM	Government of Maharashtra
HEWs	Health Extension Workers
IDS	Institute of Development Studies, University of Sussex, UK
IRSP	Integrated Rural Support Programme
MDG	Millennium Development Goals
MHSM	National Millennium Hygiene and Sanitation Movement
M&E	monitoring and evaluation
MoH	Ministry of Health
NGOs	non-governmental organisations
NGP	Nirmal Gram Puruskar
NLs	natural leaders
ODF	open defecation free
PAMSIMAS	Penyediaan Air Minum dan Sanitasi Berbasis Masyarakat (Community-based Development for Clean Sanitation and Drinking Water
PHAST	Participatory Hygiene and Sanitation Transformation
PRA	Participatory Rural Appraisal
RESA	Plan Regional East and Southern Africa
RSPs	Rural Support Programmes
SNNPR	Southern Nations, Nationalities and Peoples Region, Ethiopia
TSC	Government of India's Total Sanitation Campaign
TSSM	Total Sanitation and Sanitation Marketing
UNICEF	United Nations Children's Fund
VERC	Village Education Resource Centre
WASPOLA	Water & Sanitation Policy Formulation and Action Planning Project
WHO	World Health Organisation
WSLIC II	Water and Sanitation for Low Income Communities Phase 2
WSP	Water and Sanitation Programme

Executive Summary

2.5 billion people worldwide lack access to improved sanitation facilities and sanitation coverage is the lowest in sub-Saharan Africa and South Asia where two thirds of the population lack access to improved sanitation. In recent years, Community-led total Sanitation (CLTS) has attracted significant attention. Unlike earlier top-down approaches which focused on toilet construction with upfront hardware subsidies, CLTS refrains from advocating toilet construction for individual households. Instead, through processes of intensive facilitation and mobilisation and powerful emotions such as disgust and shame, the whole community is encouraged to analyse the problems associated with open defecation in order to build toilets and create 'open defecation free' (ODF) villages and communities. From its early beginnings in Bangladesh in 1999, CLTS has spread rapidly across Asia, Africa, the Middle East and Latin America and is now being implemented in over 20 countries with the makings of a development success story.

This paper tracks the origins of CLTS and highlights its key tenets. It discusses how it spread from Bangladesh to other countries in Asia and the African continent and asks whether initial success has led to the generation of myths about the extent to which the approach really generates ODF communities. It discusses challenges concerning monitoring and evaluation and going to scale and issues of social, technological and institutional sustainability. It also looks at what is happening to the poorest and to women who are supposed to benefit most from CLTS as well as cultural beliefs and taboos around sanitation (for example, in many countries it is not appropriate for women to use the same toilets as their fathers-in law). The paper then focuses in depth on Ethiopia.

CLTS was introduced in Ethiopia in 2006 through the efforts of NGOs such as Vita and Plan. Prior to that, the Health Bureau of the Southern Nations Nationalities and Peoples Region (SNNPR) launched a major health and sanitation campaign that was implemented in 2005. While it shared some elements of CLTS (e.g. no subsidies and aimed at 100% toilet coverage), it was government-driven rather than a community-led initiative and targeted individual households instead of the whole community. It led to significant success with coverage increasing from 17 % in the region to about 80%. By drawing on RiPPLE research and a field trip in 2007, the paper demonstrates that despite the successful increase in coverage, there are challenges to sustainable toilet use arising due to factors such as flooding, the lack of money and awareness, poor incentives and rewards as well as socio-cultural constraints that prevent behaviour change from sustaining.

The relevance of CLTS to Ethiopia is significant. In 2008, the Ministry of Health (MoH) put CLTS as a key approach in the National Millennium Hygiene and Sanitation Movement' ('MHSM') and there are now ambitious plans to scale up CLTS in urban and rural areas. While CLTS in Ethiopia has got off to a promising start with high standards, the paper concludes with several points of caution. These include avoiding the temptation of going to scale too quickly and top-down target driven programmes that compromise on quality which are widespread in India and Bangladesh, focussing on facilitation rather than top-down teaching and didactic methods as well as paying attention to socio-cultural issues and existing power relations that impede behaviour change from taking root. Finally, sanitation also needs to be viewed in conjunction with issues such as hygiene, access to health, water and nutrition. Thus, while Ethiopia has the potential to make significant progress in achieving universal coverage in sanitation, the path needs to be taken cautiously with clear monitoring of socio-political and health impacts and overall sustainability.

1 Introduction

2008 was the International Year of Sanitation and a recent poll of the British Medical Journal voted for sanitation as the greatest medical advance in the last 166 years. (BBC News[1], 18th January 2007). In recent years, new innovations such as Community-led Total Sanitation (CLTS) have attracted significant attention. CLTS has led to thousands of low-cost toilets springing up all around the rural areas of South, South East Asia, Africa and beyond. Usually built by villagers and barefoot innovators out of local materials such as bamboo, tin, jute, the resulting 'open defecation free' villages have led to a noticeable increased sense of pride about toilet possession, self confidence about newly gained dignity, health benefits and freedom from embarrassment which was caused due to the lack of privacy, especially for women.

CLTS[2] differs from earlier approaches to sanitation which prescribed high initial standards in order to reduce the costs of operation and maintenance. Earlier approaches also involved upfront hardware subsidies in order to induce people to use the latrines or toilets. However, instead of adoption, toilets were often not used or used for other purposes like storage. There were also problems of affordability. CLTS refrains from advocating toilet construction for individual households. Instead, the whole community is targeted with the aim of 'open defecation free' (ODF) villages and communities. The core assumption is that even partial sanitation does not lead to minimizing the adverse effects of ODF.[3]

CLTS has captured people's imagination for many reasons. One, CLTS is based on the principle that communities must undertake their own analysis of their defecation situation and resolve to stop it by building and using latrines without the support of major external hardware subsidies. When it works, it leads to intense local community action, cross subsidisation of the poor by the rich and clean and shit-free villages. Its rapid spread within countries, across regions and continents has the makings of a development success story. This is not least because as its proponents argue (Chambers, personal communication), CLTS has the potential to contribute towards meeting a host of Millennium Development Goals (MDG), such as the one on water and sanitation (goal 7) and indirectly through the knock-on impacts of improved sanitation on combating major diseases, particularly diarrhoea (goal 6), improving maternal health (goal 5) and reducing child mortality (goal 4). It must be noted that while this paper appreciates that improved sanitation alone does not always lead to reduced diarrhoea incidence and that there are multiple factors that cause diarrhoea (such as poverty, overcrowding, water quality, malnutrition, poor access to health services etc.), this paper does believe that improved sanitation significantly improves human wellbeing, even if health outcomes are difficult to prove. Not least the benefits for women such as an enhanced sense of privacy and dignity are very important outcomes (see Mehta 2009, for more analysis on this issue).

1 http://news.bbc.co.uk/1/hi/health/6275001.stm

2 It must be noted that CLTS largely deals with the disposal of human waste and is now increasingly accompanied by hygiene programmes too. It does not necessarily deal with the whole range of solid waste management though in some cases, CLTS may be accompanied by solid waste management.

3 The author is aware that this is a contested issue both on epidemiological and practical grounds. Epidemiologically seen, the links between improved sanitation and enhanced health outcomes while recognised, are difficult to prove. It is now acknowledge that there are multiple factors such as poverty reduction, access to water, good nutrition, handwashing etc. (along with improved sanitation) that lead to disease reduction. Practically, it is often impossible to define what constitutes an ODF community due to porous boundaries between communities and villages. It is however beyond the scope of this paper to handle these issues in detail. See Mehta (2009) for literature reviews on these issues.

This paper tracks the origins of CLTS and highlights key tenets. It discusses how CLTS spread from Bangladesh to other countries such as India, Indonesia and Pakistan and raise questions regarding the key challenges. It then discusses how and whether CLTS will work in the African context by drawing on examples from Tanzania, Kenya and Nigeria before examining CLTS in the Ethiopian context.

2 The origins of CLTS, approach and spread

CLTS was pioneered by Kamal Kar (a development consultant from India) together with Village Education Resource Centre (VERC), a partner of WaterAid Bangladesh, in 2000 in Mosmoil, a village in the Rajshahi district of Bangladesh whilst evaluating a traditionally subsidised sanitation programme. 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 upfront 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 history (for more details see example Kar 2005, Kar and Pasteur 2005, Kar and Bongartz 2006) CLTS spread fast within Bangladesh where informal institutions and NGOs are key.

At the heart of CLTS lies the recognition that in the past many sanitation projects were unsuccessful because they assumed that the provision of subsidised toilets would result in improved sanitation and hygiene. It is now well known that merely building toilets does not guarantee their use. Instead, it is also important to focus on the behavioural issues at stake as well as traditional cultural habits and practices. Earlier, more conventional approaches to sanitation prescribed high initial standards in order to reduce the costs of operation and maintenance later, and involved hardware subsidies as an incentive for adoption. However, this often led to uneven adoption, problems with long term sustainability, only partial use of facilities or their use for other purposes such as storage or as animal shelters. As a result, open defecation and with it the cycle of faecal-oral contamination continued with negative impacts on human wellbeing.

The underlying assumption is that once people are convinced about the need for sanitation, they construct their own toilets according to the resources available (financial, land and so on). This approach does not require high subsidies for toilet construction from governments or external agencies. However, financial and institutional support is required for facilitation, monitoring, evaluation and mobilisation. What is also crucial 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 should lead to collective behaviour change (See Kar 2005, Kar & Pasteur 2005, Kar & Bongartz 2006, Kar & 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 2007c, 2008a)

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 everyday. 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). In most cases, this triggering is conducted by an external facilitator, who of course, may be a powerful and articulate person when compared to the villagers.

Once the community and individuals within it have started to take positive action against open defecation, facilitators can aid the process by fuelling their enthusiasm, for example by telling them that if they achieved 100 per cent total sanitation and stopped open defecation, many people from outside and neighbouring villages would come and visit their village to see it.

In many countries, governments now provide incentives and rewards once the village becomes open defecation free (ODF), something covered later in this paper. Once a village has been successfully 'triggered', changes are said to be taking place in a matter of weeks or months, and can have a dramatic effect on individual and collective wellbeing. For example a report on CLTS from Sierra Leone states that; 'In three weeks, CLTS has managed to do what millions of dollars, hundreds of construction projects, and dozens of NGOs failed to do over decades. CLTS has inspired communities to take responsibility for cleaning up their villages, and has motivated them to do so' (Geist 2008: 2).

Initially, people usually install easily affordable low-cost toilets from locally available materials to instantly stop open defecation. However, over time, the idea is that they will move up the sanitation ladder from pit toilets to more sustainable and complex models (IDS/IMHP research in India, however, suggests that this may not be happening as quickly as may be desired by the implementing organisation).

3 Going to scale and the spread of CLTS

Since its emergence in early 2000, CLTS has spread in different countries and has now also moved to Africa and the Middle East. Its spread has been through both NGO and government processes and its champions have been dynamic grassroot activists, state bureaucrats and members from the NGO and donor community. Today there is a tremendous diversity in CLTS approaches and practices around the world. It must be noted though that CLTS has not really been used in urban areas, expect for a few scattered cases such as Kolyani in India. The Water and Sanitation Programme (WSP) of the World Bank played an important role in enabling spread to neighbouring India, Indonesia and parts of Africa.

UNICEF, arguably the largest player among relevant aid agencies, has also recently turned around its policies and practices to support CLTS and similar community-based approaches to sanitation.[4] NGOs such as Plan and WaterAid have also played a crucial role. Today CLTS is in more than 20 countries including at least six different countries in Asia (Bangladesh, India, Indonesia, Nepal, Pakistan, and Cambodia) and has now also moved to Africa (Ethiopia, Tanzania, Kenya, Nigeria, Uganda, Zambia, Sierra Leone) and Latin America (Bolivia) as well as Yemen in the Middle East (see table overleaf).

One of the main forms of sharing the approach and illustrating the way it works in practice, have been exposure visits between countries organised by the WSP and governments. These have served not only as learning opportunities but often also in order to convince governments, NGOs and others to try CLTS by providing the necessary evidence that CLTS can work. The different regional branches of the WSP have played a key role in communicating and supporting CLTS internationally, across countries and regions. For example, WSP played a key role in facilitating exchanges between Indian and Bangladeshi officials and their official programmes towards CLTS and sanitation evolved together and influenced each other. WSP Indonesia facilitated contact between Indonesian officials and their counterparts in South Asia. WSP Pakistan too has played a significant role in supporting local NGOs who have adopted and embraced CLTS. In Ethiopia, the WSP note (WSP 2007) drew attention to the achievements of the sanitation campaign in the Southern regions**.** Along with UNICEF, it has also played an important role in promoting sanitation in the country.

International NGOs have also played an important role in sharing experiences with CLTS between their different regional and country programmes. A good example of this is Plan RESA (Region of Eastern and Southern Africa) which, based on Plan's positive experiences with CLTS in Bangladesh, Cambodia and Nepal, decided to introduce CLTS in all Plan countries in East and Southern Africa and hosted two workshops in Ethiopia and Tanzania for regional staff in early 2007. Similarly, WaterAid, after having trialled CLTS in Nigeria, decided to roll it out to their other three West Africa programme areas, Ghana, Mali and Burkina Faso and facilitated exposure visits not only to Bangladesh but also between their West Africa country programmes.

4 In 2008, at a global meeting of UNICEF Sanitation Specialists in New York in 2008, a new terminology for UNICEF's approach to community based sanitation was developed that describes the various approaches and details the non-negotiable principles that form the basis of their methodology. CATS – Community Approaches for Total Sanitation encompasses various approaches to community based sanitation such as CLTS, TSA, TS and others. It was felt that in order to work effectively with governments and partners, some flexibility was needed to develop the most appropriate route for a given setting. CATS thus reflects the diversity between regions, countries and communities and acknowledges hygiene (handwashing more specifically) although allows for variable sequencing and integration of handwashing/hygiene into sanitation programmes. (See for more details: http://www.communityledtotalsanitation.org/resource/unicef-community-approaches-sanitation-cats)

Table 3.1: CLTS in-country and year of first introduction

	Country	Year of first introduction
Asia	Bangladesh	2000
	Cambodia	2004
	India	2003
	Indonesia	2004
	Pakistan	2004
	Nepal	2003
	East Timor	2007
Africa	Burkina Faso	2008
	Ethiopia	2006
	Ghana	2008
	Kenya	2007
	Malawi	2007
	Mali	2008
	Nigeria	2004
	Sierra Leone	2008
	Tanzania	2007
	Uganda	2002
	Zambia	2003
Latin Americ	Bolivia	2006
	Middle East	
	Yemen	2006

Source: Kamal Kar and IDS research

The CLTS website www.communityledtotalsanitation.org, which forms part of the DFID-funded IDS research project: *Going to Scale? The Potential of Community-Led Total Sanitation*, and the networking activities associated with it have also been instrumental in spreading information about CLTS and advocating for continuous learning from practice in different contexts and countries. The CLTS website aims to be the global hub for CLTS, connecting the network of practitioners, communities, NGOs, agencies, researchers, governments, donors and others involved or interested in CLTS. The site contains practical information about the approach, information on CLTS in different countries, research papers, relevant news and events and many other useful materials. It is intended to serve as an up-to-date virtual resource centre and is a space for sharing and learning on CLTS across organisations, countries and sectors. This paper will focus on a few Asian experiences of CLTS before moving to the African context.

3.1 Bangladesh – NGO driven

In Bangladesh, where CLTS originated (Kar 2003), going to scale began with NGOs, leading to NGO collaboration with local government. The Government of Bangladesh has declared its intention to free the country from open defecation by 2010 and to use CLTS as the approach to achieving this and total sanitation has become a national policy. After CLTS was initiated by the NGO VERC along with support from WaterAid, its early spread and adoption were by other NGOs – notably Care,

Dhaka Ahsania Mission (DAM), Plan Bangladesh and World Vision with WSP in a strong support and advocacy role. The Dishari Project, managed by DAM with funding from DAM, Plan, WaterAid and WSP, was created with staff dedicated full-time to CLTS. In some areas where Plan and WaterAid's partners were active, their staff together with Dishari worked closely with local government in CLTS campaigns, leading to declarations of ODF in some upazillas (subdistricts). The Dishari Project helped to establish a close bond between the local government and communities by building the capacity of local government, improving transparency and openness (see also Chambers 2009 and Ahmed 2009).

Government set itself a target of total sanitation by 2010 and promoted sanitation on a national scale through local government, in practice with a combination of targets, sanctions against those without toilets, and rewards for Unions declared 100 per cent latrinised. Neither the Government nor the very large national NGO, BRAC, adopted CLTS but continued with policies and practices of individual household hardware subsidy. National figures for reported percentages of rural families using sanitary toilets rose from 29 per cent in October 2003 to the inflated and exaggerated figure of 87 per cent in June 2008 (See Chambers 2009 and Ahmed 2009)[5]. Ahmed writes: 'with the many active promoters of sanitation in Bangladesh today, the CLTS approach is at risk of diluting its inviolable principles and spirit' (Ahmed 2008: 21)

Despite marked progress in getting local government on board, the interest of government departments other than those directly concerned with sanitation is still low. At local level, a lack of continuity can threaten sustainability of programmes and the sustainability of behaviour change beyond project phase out also poses a challenge. The involvement of a large number of NGOs with overlapping and different approaches has also meant that CLTS in Bangladesh is one approach among many.

3.2 India – state driven

From Bangladesh, the approach first spread to India. The pattern of spread to and in India has been promotion and spread of CLTS by champions within the state governments and WSP India, with very little involvement of NGOs. The India Country Team Leader of WSP–SA had visited Bangladesh and learned about CLTS and was impressed by the results. He then involved Kamal Kar in discussions with the Government of Maharashtra (GoM) and eventually the GoM was convinced to introduce CLTS with pilot projects in two districts, Ahmednagar and Nanded, in 2002. The success in the pilot districts led to the ODF approach being adopted by all the districts in the state. Subsequently, other states showed a keen interest in adopting the CLTS approach. However, until now, only Himachal Pradesh and Haryana have adopted the approach, largely due to the efforts of district administrators from the Indian Administrative Service who personally got very involved in spreading CLTS in their districts. Efforts to introduce CLTS have been made in states such as Madhya Pradesh, Rajasthan, Chattisgarh, Orissa, Gujarat, Karnataka and Andhra Pradesh, but so far scaling up of CLTS in other than the three states mentioned above is happening very slowly. This is because this is quite a lot of resistance to CLTS in India, not least because of its emphasis on avoiding upfront hardware subsidies in rural areas.

5 For discussion of reported achievements, see Ahmed 2008:17, and 19-20 who reports that government sources recognised that the figures were inflated and were seeking to introduce M and E systems that would be more accurate.

The context for CLTS in India is the Government of India's Total Sanitation Campaign (TSC) and the Nirmal Gram Puruskar (NGP) award which is given to rural local governments that achieve open defecation free status and also manage sanitation in public spaces, drainage and solid waste issues to ensure total sanitation in relation to their environment. However, the NGP awards can be seen as a 'perverse incentive' and counteracting CLTS efforts, as it led to another target/toilet-driven top-down initiative rather than community-led processes. Moreover, verification and monitoring of ODF status are patchy and overall sustainability is thus questionable. Whilst some villages have indeed gone through the whole CLTS process and received the award for being 100 per cent ODF, the scheme has also led to false declarations and the 'massaging' of numbers. This gives a false sense of both success and the sustainability (Mehta 2009).

Indeed, CLTS in India faces several challenges. There is a widespread resistance to the no-hardware subsidy stance since India has a long tradition of doling out subsidies through which political leaders and politicians get political mileage. There is a reluctance to embrace the term CLTS by the government – instead TSC is preferred. CLTS is also often considered to be 'anti-poor' by NGOs and many government officials because it is assumed that the rich will not be interested in cross-subsidising the poor and that the poor will invariably lose out (Interviews by author, various). Based on IDS research on CLTS in South Asia it can be safely said that while CLTS proponents are certainly not anti-poor, in some cases marginalised people have been left out of CLTS programmes. This is because poverty has often prevented them from both constructing new toilets and/or rebuilding them after they collapse (Haq & Bode 2009). However, IDS research confirms that where wide scale subsidies have been doled out, toilet use is poor and worse than in areas where people have constructed their own toilets (Dyalchand et al 2009; Khale & Dyalchand 2009).

Another challenge to CLTS in India is the frequent transfer of officials which threatens the continuity of CLTS even in areas where it has been successful. For example, CLTS often takes off dramatically when it is promoted by local champions. This could be at the district or village level (e.g. Amit Agarwal has been responsible for championing CLTS in Panipat district in Haryana). When civil servants are transferred or promoted the momentum of CLTS in their areas may be lost.

3.3 Indonesia – Government-driven

In Indonesia, the prime mover of CLTS has been the Government and CLTS has been project-based. In December 2004, in their search for alternatives to existing rural sanitation strategies, government officials visited Bangladesh and India. After being exposed to the CLTS experience and its successes there, they decided to pilot CLTS in six districts through the existing conventional programme of the WSLIC II (Water and Sanitation for Low Income Communities Phase 2) project in South Sumatra and West Java (funded by the World Bank and AusAid and implemented by the Indonesian Government).

Indonesia has 440 Districts. CLTS was introduced through the WSLIC II project in 36 districts. Later it was adopted by an Asian Development Bank (ADB) supported project in a further 20 districts. CLTS was pronounced national policy by the Minister of Health in August 2006. CLTS is part of the new Penyediaan Air Minum dan Sanitasi Berbasis Masyarakat (PAMSIMAS – Community based Development for Clean Sanitation and Drinking Water) programme in 115 districts and also of the Total Sanitation and Sanitation Marketing (TSSM) programme in East Java. Both of these combine CLTS with the sanitation marketing approach.

CLTS is promoted in Indonesia by the Ministry of Health, with some buy in from other departments (e.g. infrastructure, water resources, public health etc.). The working group, Water & Sanitation Policy Formulation and Action Planning Project (WASPOLA), coordinates the efforts of different departments' inputs into sanitation. Unlike in India, there is no reluctance to embrace the term 'CLTS' – it is incorporated in official government policy even though in recent months, the new term 'community based total sanitation' (CBTS) has emerged – perhaps as a way to chart a programme distinct from its South Asian counterparts. Although CLTS has grown fast in Indonesia, there are still several challenges. IDS research has highlighted some of the institutional challenges in Indonesia concerning the scaling up of CLTS (see Priyono 2009). Priyono and colleagues (ibid) have argued for the need for an enabling institutional environment, given the country's rapid decentralisation process. However, at times there is a gap between national and local priorities and local district heads have not always embraced CLTS and sought to implement it in their districts.

As in India and Bangladesh, sustainability is also an issue. Until now, there are no clear monitoring and evaluation systems in place to track progress and monitoring is based on self-declaration by villages. A country-specific challenge for CLTS in Indonesia is how to raise the political profile of sanitation beyond the Ministry of Health at national and local government levels and getting government to engage more broadly with other stakeholders to address sanitation challenge. Finally, there are questions regarding the overloading the programme with donor agendas. For example, WSP is now promoting TSSM which seeks to combine sanitation marketing with CLTS. Whether these two approaches are compatible and can be addressed together remains to be seen.

3.4 Pakistan – community champion driven

Pakistan stands alone in putting spontaneous leaders or community champions at the centre of the strategy for going to scale. CLTS was introduced by Kamal Kar at a large national workshop organised by WSP–South Asia in 2004. It was successfully piloted by UNICEF Pakistan through an NGO in Mardan, Integrated Rural Support Programme (IRSP). Subsequently with support and initiatives from WSP, the Rural Support Programme Network, and others, further trainings took place. Key events were the training of some 70 Natural Leaders (NLs) in December 2007. Pakistan has gone furthest in evolving a strategy based on training and developing a system to to transform NLs into barefoot consultants. The devolved set-up in Pakistan with tehsil municipal administrations presents a great advantage and has greatly benefited the social mobilisation and integrated rural development approach taken by the Rural Support Programmes (RSPs). By integrating CLTS into the RSP approach, it has been possible to scale up through 90,000 organised grassroots organisations, helped by community activists and barefoot consultants (Bongartz 2007b). According to Robert Chambers, the decentralised and self-managing approach in Pakistan means that CLTS can be seen as probably the closest to a self-spreading movement to be found in any country (personal communication).

However, as in other countries, CLTS in Pakistan has come up against the problem of how to establish programmes that do not use subsidies and have the challenge of changing both communities' and donors' mindsets. With many areas available for open defecation, it is often not easy to convince people of the benefits of toilets and putting an end to open defecation. Practical issues such as the sustainability of pit toilets and the lack of space for building toilets near homes are also posing challenges (Bongartz 2007a). As CLTS in Pakistan is still in its infancy, many questions regarding sustainability remain unanswered.

4 Key issues and questions based on several country experiences and IDS research

4.1 Myth and Reality

Now that CLTS has taken hold in so many countries and triggered not only communities but also the interests of sanitation stakeholders and passions of CLTS advocates, critical reflection of what has taken place and what is and is not happening on the ground is urgently required.

There are questions surrounding the reality and practice of CLTS on the ground, for example, whether successes have led to the generation of myths about the extent to which the approach really generates ODF communities. There are also challenges concerning monitoring and evaluation and going to scale, for example whether scaling up (within institutions) and scaling out (across wider geographical areas, and from country to country) can take place without losing the integrity of the initial successes as well as the role of local and national government.

4.2 Spread

CLTS has spread rapidly and differently around the world. It is most successful when champions (at the village or state level) are present; when local facilitation and mobilisation are of high quality and time-intensive (which is an indirect form of subsidisation since governments or NGOs need to invest in good facilitation and mobilisation). Usually CLTS is successful in smaller and more homogenous communities that are cohesive and when efforts are made to address the needs of the poor and marginalised (Mehta 2009). In the absence of these factors, CLTS may not take off. There are questions about how to best support champions and natural/spontaneous leaders and what role NGOs and governments can play in supporting the spread at local level, without imposing constraints, turning it into a top-down process or limited by the length of NGO projects or government programmes.

4.3 Institutional challenges

As the Indian and Indonesian cases highlight, institutional context is key. Taking CLTS to scale means that messages can be diluted and proper facilitation is compromised. To enable spread, government may introduce targets and a reward system which could lead to a false sense of achievement (as discussed in the India example). There is also often the pressure to disburse hardware subsidies which may not lead to individual ownership of toilets. IDS research reveals that when CLTS begins as something that is either donor or NGO driven, there is a challenge to transfer CLTS into a regular government programme. Donors or NGOs need to change their roles from being an implementing agency to a supporting agency. This means champions within state agencies and institutions are necessary to promote CLTS.

It is important for CLTS to be located in an appropriate government institution. Often it is the ministry of health (Indonesia, Ethiopia) but sanitation also needs buy in from other departments (e.g. finance, water resources, public works etc). In the absence of buy in, sanitation will not be taking seriously and mainstreamed into development policies and programmes. This buy in could be in the form of developing a cadre of facilitators, developing campaigns around sanitation and CLTS, inciting local government to adopt CLTS and so on.

4.4 The poorest, subsidies and basic rights to sanitation

Despite examples that attest that CLTS can help to trigger solidarity, mutual help and collective action, the question of what happens to the poorest households in a community cannot be resolved. Whilst it is hoped that the realisation that everyone is ingesting each other's shit leads to inclusive collective action, the reality may often look different. Sanctions and fines as well as peer pressure to comply with the community's decision to go total could adversely affect the poorest. There is also a question whether in some contexts, help, in the form of subsidy is justified for the poorest of the poor, perhaps at the end of the project, when everyone else has constructed a latrine.

CLTS principles may not necessarily contravene the basic right to sanitation in rural areas. CLTS interventions (when they work) are more effective than top-down government, target driven approaches. There is much room for government and donor action to ensure people's basic rights to sanitation via CLTS. These could include ensuring institutional sustainability, providing funding for dedicated staff and facilitators and health and extension workers, proper verification and monitoring systems and also hard money for toilets in schools, market places etc. etc. But of course, if the poor in a community are being excluded, there is a need for concerted action to take their interests on board.

What about the community level? Do the rich really cross-subsidize the poor? Are the interests of the poor, women and female-headed households really taken on board in CLTS? IDS research and observations in the field have been mixed. In many villages in Bangladesh, there have been observations that the rich have provided land, bamboos, labour etc. to poorer households, widows etc, in order to make the entire community ODF. However, other observations show that rich Muslim households in North West Bangladesh have refused to grant the poorer and destitute groups of the village any land to build toilets. They considered the poorer Hindus to be dirty and unworthy of help.

It could also be argued that indirect forms of subsidy take place in CLTS all the time. The collective reward to a village at the end of the intervention could be seen as a form of subsidy. It is largely the no upfront hardware subsidy that's advocated. However, this rule seems to be bent too. In many parts of India, CLTS inspired programmes provide subsidies to households below the poverty levels. This can take place before or after the toilets are constructed. NGOs in Bangladesh may also explicitly target the poorest of the poor who are left out once most of the village achieves ODF status. Mahbub 2009 and Haq & Bode 2009 also talk about exclusion of the poor and some women in CLTS areas, alongside lots of positive benefits for poor women and men.

4.5 Targets, incentives, behaviour change and ODF

Incentives, rewards and sanctions (both formal and informal) play a big role in galvanising communities to achieve ODF status. In the drive to achieve targets, massive reward systems such as huge cash prizes to ODF communities can inflate the indication of success and lead to capture by elites (as is often the case in India). It is also unclear whether and for how long behaviour change is sustained once the reward has been obtained.

100 per cent ODF is the aim of CLTS but emerging research seems to suggest that this is difficult to sustain. In many cases, 100 per cent ODF may never have been achieved. Largely, the monitoring and verification systems are weak in most countries. The results from our country teams seem to suggest that behaviour change is very difficult to sustain and there are usually some defaulters. Even if there are some defaulters in the villages, it is common to hear both men and women speak with

confidence about the changes in their lives and villages (e.g. a cleaner and smell-free environment; benefits for women such as privacy and pride in community mobilisation). They are also happy about the other positive spin offs that have arisen after CLTS has been implemented (e.g. a water scheme as a reward either from the government or NGO, a new road or electricity etc.). Thus, even in CLTS behaviour change is difficult to sustain. There are several reasons for this:

1. Poor facilitation, verification and monitoring could contribute to a false sense of success in the first place.
2. There are many constraints faced by poor women and men in terms of resources, time and capacity with respect to their daily hygiene and sanitation practices (see Tabuchi 2002). In villages without much social cohesion and where special efforts have not been made to address the interests of the poor, behaviour change of the whole population may not be achieved.
3. There is a tendency to lose sight of the role of water in the context of both livelihood strategies and in acting as a constraint towards toilet construction and use.
4. The sanctions and restrictions imposed on defaulters could intensify processes of social exclusion in local communities and further exclude poor people.

4.6 Latrine/ toilet counting

Despite its emphasis on behaviour change, CLTS implementation through government programmes and NGO projects means that success is often still counted in terms of number of toilets constructed. Messages about behaviour change and empowerment can sometimes get lost in the process and indicators for CLTS success frequently revert back to easily measurable quantities like toilets. Governments want and need to measure the progress that they have achieved. But effectively measuring and understanding behaviour change are both notoriously difficult (which is considered later in this paper).

4.7 Appropriate and safe technology

In some cases, could decentralised open defecation be better than concentrated fixed point defecation? A high concentration of pit latrines near groundwater sources could contaminate water sources leading to second generation problems. Another issue is runoff and the flooding of pit latrines during the rainy season and the contamination of surface and groundwater. Soil contamination could also take place, depending on soil quality. Indeed, IDS research in India suggests that groundwater contamination has been quite high in some CLTS villages (Khale, 2009) Furthermore, open latrines may also not be hygienic as RiPPLE research suggests (RiPPLE, 2008). Even though CLTS does not prescribe models, it may need to build in more technical advice on what constitutes a safe latrine, depending on local topography, soil and water conditions.

4.8 Monitoring and evaluation

Verification of success is usually arbitrary and good monitoring systems do not seem to be in place in most of the areas studied. There also seems to be some slippage on the 100 per cent ODF status. Better monitoring and follow up systems are required to ensure the sustainability of CLTS. This could take place through facilitators, local government or community leaders. It has been proposed that when the monitoring systems are participatory and involve the community, sustainability is higher.

4.9 Gender

There are also a number of questions about the role of women and the impact of CLTS in terms of gender relations that remain unanswered so far. While it is true that there are extraordinary benefits to be derived for women in terms of their dignity, privacy, safety, comfort and wellbeing, it is not always clear whether women also end up taking on additional burdens. Unequal traditional divisions of labour may also be reinforced, with women being seen as responsible for sanitation and for the maintenance and cleaning of toilets. With CLTS making claims for community empowerment, it is crucial that gender and power relations are also taken under scrutiny. Participation of women in CLTS processes and improved well being for women as a result of better sanitation do not equal empowerment (see Mehta 2009).

5 What does this mean for the African context?

5.1 Sanitation in Africa

An estimated 2.6 billion people worldwide are without proper sanitation and thereby lack protection against preventable diseases. At the time of the last AfricaSan conference in 2002, 300 million Africans were without access to basic sanitation and hygiene, and unfortunately, the figures have increased even more since then. Sub-Saharan Africa has the lowest sanitation coverage, according to a report on the global of sanitation and hygiene prepared annually by the World Health Organization (WHO) and UNICEF Joint Monitoring Programme (see WHO/UNICEF 2008a). Only 60 per cent of the African population has access to improved sanitation services, and the continent needs to increase coverage to more than 221 million unserved people to meet the 2015 MDG target date. Despite significant efforts by governments, progress on sanitation targets has been slow and uneven, with only five countries in Africa predicted to meet the sanitation MDG. Innovative approaches, urgent action and political good are therefore needed to accelerate achievement of the MDG targets for sanitation and achieve sanitation uptake, coverage and improvement at scale (WHO/UNICEF 2008b).

5.2 CLTS in Africa

Even though several African countries, e.g. Nigeria, Uganda and Zambia tried to introduce CLTS previously, it is only since 2006/7 that there has been an increased interest in and activities around applying the approach in several African countries. Two key events were the hands-on trainings for Plan Regional East and Southern Africa (RESA) staff in Ethiopia and Tanzania in February 2007 which marked the beginning of Plan RESA's piloting of CLTS across all of their East and Southern Africa country programmes (Kenya, Tanzania, Malawi, Ethiopia, Sudan, Egypt, Uganda, Zambia). There was a strong buy-in from participants from and action plans to implement CLTS in the respective programmes were drawn up. WaterAid Nigeria piloted CLTS in four states in 2004. After some success with CLTS there, the decision was taken to roll out CLTS to the other three West Africa country programmes, Ghana, Mali and Burkina Faso. Efforts in these countries are still in the early stages at the moment.

Ethiopia's state-run campaign on sanitation and hygiene initiated by the Bureau of Health in 2003 under the leadership of the then Head of the BoH, Dr Shiferaw, (supported by senior civil servants) has similar features to CLTS (as will be discussed shortly) even though it was initiated independently (Demiessie Bubamo, personal communication, September 2007). The next section highlights some challenges of implementing CLTS in a few African countries based the experiences of NGOs such as Plan and WaterAid, and draws on views expressed by participants at Africasan 2008.

5.3 Experiences of Plan RESA

Within Plan, one of the challenges identified was the issue of subsidy. Plan has been practising a form of subsidy i.e. supporting households with materials such as cement, iron sheets and reinforcement bars as well as the technical capacity to build toilets. In such communities, Plan is seen as a provider and people have often internalised the notion that they are poor and dependent on outside help (Musyoki 2007). Plan traditionally had a big budget for sanitation – hence the pressure to spend. CLTS is a 'low budget – high impact' strategy and staff were not sure how to spend budgets set aside for sanitation projects. Of course, money is required for facilitation, training, follow up and monitoring. But it is still less than sinking in thousands of toilets.

Cultural beliefs and taboos also constituted a key challenge. A good example is the Maasai communities in some parts of Tanzania where social convention upholds the myth that men do not defecate at all, making public discussion of defecation virtually impossible. This poses a huge barrier for any approach that seeks to engage communities in mapping and publicly discussing about defecation (ibid). In other communities it is a taboo to share toilets among some members of the family. For example among the Luo in Kenya, Uganda and Tanzania, it is taboo for in-laws to share a toilet or bathroom. It is assumed you will be cursed if you undress in the same space as your in-laws. It is believed that pregnant women may lose their fertility if they use pit latrines. In parts of Uganda, it is believed that if children's waste is disposed in a pit latrine they won't grow up to be healthy (ibid). These findings have also been echoed in RiPPLE research in Ethiopia. Therefore, there is a need to thoroughly understand and build on local cultural assumptions if behaviour change should be successful. Furthermore, such behaviour change will also be influenced by factors such as rural-urban divides, migration, destitution and declining real income.

Plan Kenya had been using the Participatory Hygiene and Sanitation Transformation (PHAST) methodology which went hand in hand with the popularization of VIP latrines promoted by the Ministry of Health. Through the PHAST initiative, Plan Kenya used to finance construction of pit latrines with the community contribution amounting to between 5–20 per cent. Although the investment by Plan was huge, the rate of latrine coverage in Plan supported areas was minimal only about 3 per cent. An evaluation of the adoption and scaling-up of the VIP latrines by the communities using own resources revealed that this was negligible due to the high cost and resistance to change (personal communication from Plan Kenya to Petra Bongartz).

CLTS as an approach was seen to compliment Plan's Rights-based programming and as presenting a possible solution for a new low cost high impact strategy in order to support progress towards the government's sanitation policy goals and the MDGs. After the CLTS training workshops in Tanzania and Ethiopia in February 2007 which staff from Plan Kenya attended, many new CLTS facilitators were trained and by January 2008, CLTS had been implemented in 36 villages in the development areas. According to Plan Kenya (personal communication to Petra Bongartz) in many villages, people have stopped open defecation and latrine coverage has increased from 50 per cent to 100 per cent within very short periods of up to three months. It has been interesting to see that even some of the communities who were thought to be too poor to put up decent latrines, were keen and able to build toilets which one could call expensive in the sense that they are made of cement, made of sand, made of bricks (Philip Otieno, interview at AfricaSan, Durban).

There is demonstrated commitment by the lead ministry to scale up sanitation using the CLTS approach which is in line with the government policy on environmental health and sanitation launched in 2007. There is a component of action learning to share and document experiences, challenges and lessons that are emerging from the implementation of CLTS. In Kenya, CLTS is steadily becoming a movement.

Plan Kenya has now decided to go to scale in rolling out CLTS in all the 8 Development Areas where it operates and success stories have already emerged from Kilifi, Homa Bay, Kisumu and Tharaka DAs. Some of the challenges for CLTS in Kenya have included working in urban areas, for example, in Nairobi's slums, where the problems of tenancy, land ownership and council by-laws have made it difficult for CLTS to take off. Topography has been a problem in some areas, for example, in Nyanza province where soil is highly collapsible, making it difficult to maintain the communities' motivation to re-build. The challenge is to find more sustainable models that suit the

soil conditions. Seasonality has had an effect on community participation in CLTS and is linked to the overall challenge of sustaining the momentum after triggering. Similar findings have been reported by RiPPLE researchers in Mirab Abaya Wereda in SNNPR, Ethiopia, see RiPPLE (forthcoming).

5.4 WaterAid in Nigeria

An evaluation of WaterAid Nigeria's pilot of CLTS found that CLTS is an effective approach to establishing hygiene and sanitation practice in Nigeria (WaterAid, 2007). Its study of 13 communities in the states of Benue and Jigawa showed a significant reduction in the practice of open defecation. Overall, access to toilets increased from 5 per cent to 46 per cent – with 6 out of the 13 communities having virtually 100 per cent sanitation (ibid).

Communities were asked about improvements they have seen since the introduction of CLTS. Members reported reduction in skin infections particularly amongst children. Community members attributed this to the increased availability of water that came with CLTS and hygienic practices such as more regular showering as a result of their increased awareness. They also listed reduction in diarrhoea and vomiting also most significant amongst children (WaterAid, 2007).

Each of the communities now have 1–2 rehabilitated or newly established water points maintained with funds generated from either community contributions or tax from the sani-centre income. Communities studied were observed by the enumerators to be very clean. Except three communities in Benue all communities had weekly cleaning days. They noted the significant reduction in the number of flies and observed that they could be further reduced with continued effort to eliminate stagnant ponds and properly cover latrines (ibid).

Other benefits reported by the communities were more dignity of women and girls and safety (e.g. no more snake bites). There was also evidence that the community felt great ownership of the programme. The evaluation flagged that effectiveness was best when CLTS was the only approach to sanitation and hygiene and when subsidies had not been present before. When prior latrine use was almost nil, and where open defecation was widespread and there were no history of subsidy the uptake was the highest. It was also found that CLTS worked less well in more urbanised communities because on the one hand, many buildings were landlord owned and occupied by tenants and people in these communities were more heterogeneous. Community size also played a key role (CLTS success was easier communities were small, i.e. below 3,000 people). This finding has also emerged in IDS research in Bangladesh and India.

Triggering processes also appeared to greatly influence effectiveness of CLTS, with success depending on the participatory nature of the approaches, the skills of the facilitator in guiding but not interfering with the community's analysis and his/her knowledge of Participatory Rural Analysis (PRA) tools. It was noted that in Nigeria, in contrast to Bangladesh, PRA tools may not be as widely known and that there is a need for facilitators to receive adequate training in using them. In communities where CLTS was most effective, initial messages and the timing of the start of the project were intense, with many activities taking place simultaneously and reinforcing the messages. Finally, in this project, water was used as an entry point and/or reward since water is high on the list of a community's priorities. However, this type of reward system may be problematic as it could reinforce the notion that water is the key issue and sanitation is a mere add-on.

5.5 Insights from AfricaSan 2008[6]

IDS and Plan organised a one day CLTS workshop prior to AfricaSan in Durban and a session on CLTS at the main conference (see Bongartz 2008b). At these sessions, participants discussed the key issues facing CLTS in the African context. They echoed many of the concerns, challenges and questions of their Asian counterparts. Although there were culturally and regionally specific issues that emerged, the key areas for debate seemed to be similar across both countries and regions. Looking to India, many CLTS practitioners in Africa also express doubts about reward systems as the government's large scale reward programme, the Nirmal Gram Puruskar (NGP) has been a double-edged sword and led to false declarations and has been counter-productive to sustainability.

When CLTS is being driven or supported by government, targets can be a problematic issue. Often, these revert back to latrine counting, despite CLTS's emphasis on latrine usage rather than mere construction and on the behavioural changes required for sustainable improved sanitation. The question, in Africa, as elsewhere, is how to measure the latter in a way that gets the emphasis right and also fulfils both government and donor requirements. As in Asia, working in an area where there is a history of subsidy-based programmes is emerging as a major challenge. The issue of exposure visits was also touched upon. Some participants felt that the exposure visits by African countries to Asia, in particular Bangladesh, might not necessarily be helpful, seeing that the country and continent contexts are very different and suggested that exposure visits within the same region, where possible, may be more appropriate. However, others explained that it was sometimes necessary to visit those countries where CLTS has been established and successful for a while, in order to take lessons and findings from these countries back to their own governments and convince them to pilot the approach. By providing evidence that CLTS can work, such exposure visits can strengthen the case for introducing CLTS in new countries (ibid).

Training was seen as one of the crucial factors in 'getting CLTS right'. All participants agreed that CLTS requires a series of hands-on training sessions and special kinds of trainers and facilitators. Good training is especially important with a view to scaling up. A central concern becomes how to scale up with reasonable speed without compromising on quality. Triggering and follow-up are also crucial to the success of CLTS.

From some of the country timelines that had been drawn up, it emerged that despite a large number of triggers, in some countries where CLTS has recently been started, there were no ODF villages as yet. Given that CLTS can produce results very quickly, if the triggering that forms part of the training does not produce ODF villages, it suggests that there is a problem. This suggests the importance of post-triggering follow up which should be built into the training (see Kar & Chambers 2008 and Bongartz 2008b).

6 This section draws on Bongartz 2008b. AfricaSan+5 – was held in Durban, South Africa from February 18 to 21, 2008. At the conference Ministers signed the eThekwini Declaration (PDF) and approved the AfricaSan Action Plan. IDS and Plan jointly hosted a one-day workshop on CLTS, prior to the main conference. This was the first ever opportunity for regional sharing of experience with CLTS across so many African countries and different organisations. African participants came from Burkina Faso, Ethiopia, Ghana, Kenya, Malawi, Mali, Nigeria, South Africa, Tanzania and Uganda and were joined by a small group of non-African nationals from India, the UK and the US. Participants came from a range of organisations, and included practitioners, NGO and INGO staff, government ministers, World Bank and UN representatives.

6 CLTS in Ethiopia

For many years, Ethiopia has been at the bottom of the international league table regarding access to 'on-site' sanitation, estimated at less than 18 per cent in 2002/03 (Plan, personal communication to Petra Bongartz). On the initiative of the Health Bureau of one of the regional states of Ethiopia, a campaign for universal sanitation was started in SNNPR in 2003. A programme was introduced which made it compulsory for each household to have a latrine. As no subsidy was given for this and the idea behind the programme was to achieve 100 per cent construction and use of toilets in all villages in the region, it can be seen as a precursor to CLTS. The critical difference at the time was that this was a government-driven rather than a community-led initiative. The approach was 'targeted at households', rather than whole communities. Implemented in the run up to a national election in 2005, it helped raise awareness of the need for improved sanitation and also had a lot of success.

In October 2006, Kamal Kar visited Arba Minch on the invitation of the Irish NGO Vita, and ran a six day training workshop on community-led livelihood improvement. CLTS was used as an entry-point strategy. This workshop was followed by a national level sharing workshop in Addis Ababa, which was attended by many bilateral, multi-lateral, international and national agencies and NGOs. PLAN staff also attended the Vita workshop in Addis Ababa and organised another workshop for water and sanitation advisors in Awassa, Ethiopia in the same month. Staff from WaterAid, and local NGOs, as well as government representatives also attended. After the workshop, a national workshop in Addis Ababa was organised where eight CLTS triggered communities were invited to make presentations of their action plans to workshop participants who included senior officers from the Ministry of Health, heads of INGOs and NGOs, representatives from Plan UK, the Netherlands and RESA.

Plan Ethiopia has introduced CLTS in 14 kebeles since March 2007. Communities in Taremessa, Midre Genet, and Morancho Negasha kebeles have been 'competitively constructing latrines' and have increased coverage from between 28 and 65 per cent to 'near 100%'. Progress has also been made in Hobolso, Remeda and Leku Town kebeles. A particular success story has been Fura kebele where Plan claims 100 per cent coverage has been achieved, with 465 out of 1,000 constructed toilets also including handwashing facilities and superstructures for the toilets. Plan claims that open defecation has gradually become a 'taboo' and a 'triple punishment' being doled out to offenders. For example, villagers come to see the offender in the nude, make him pick up his shit with bare hands and scoop it into a latrine and fine him up to US$1 (Plan 2007a). The social consequences of such a punishment, however, are not known to me and it may well have led to increased social pressure and ostracisation of marginalised groups and defaulters.

Plan attributes Fura's success to good training, strong commitment from spontaneous leaders as well as health extension workers, the district health office, village health communicators, religious leaders, Fura School committee and Plan staff. The establishment of 'shit eradication committees at kebele, village, mosque, church and school level which 'teach sanitation and hygiene using the CLTS method', 'trigger for action, coordinate, follow-up are also seen to be crucial.

Plan Ethiopia finds that compared to the cost of previous programmes, the costs of the CLTS initiative are negligible. Whereas in the past, Plan used to spend US$25 per latrine for sanplat provision alone, with CLTS, costs amount to the equivalent of less than US$1 per latrine as all labour and materials are being covered by the communities themselves. Plan only spent US$2,000 on

training community natural leaders, village health messengers, health extension workers and partner organisation staff in Fura and four other kebeles. Preliminary findings in Plan programme areas show significant reduction in diarrhoeal incidences including acute watery diarrhoea and a visibly cleaner environment (Plan 2007c).

Other perceived successes include encouraging people to identify their problems and come up with their own solutions and actions. In the future, collaboration amongst the different actors in the sector, e.g. UNICEF, WSP and Plan will be crucial. Plan Ethiopia intends to introduce CLTS in several regions and districts but is also planning advocacy at national level. At local level, community-to-community visits, the sharing information and the formation of committees and clubs will be encouraged and the aim is to find and train more dedicated natural leaders and skilled facilitators. Plan recognises that follow up on triggering and M&E are essential to success and to ensuring movement up the sanitation ladder. Through CLTS training, the taboo of using the 'shit' word has been broken. Otherwise saying 'shit' is very difficult in the Ethiopian context (Plan staff member, personal communication, September 2007). In 2007, discussions with the BoH revealed that even if 100 per cent ODF coverage was not achieved, there were still significant benefits : 'Even with 80% utilisation, the health and public health benefits will be very high' (Demissie Bubamo, personal communication to author).

6.1 Ethiopia Timeline

2003	Community action at scale for Health and Sanitation in Southern Ethiopia initiated by Regional Health Bureau: In 2003 the idea of household mobilisation around hygiene and sanitation was initiated in a package of basic health promotion. Volunteer community health promoters were recruited to communicate simple doable actions on five key basic health themes of which Sanitation was one. This had some elements of CLTS but was not CLTS as we know it today.
2005	Election year and Health Extension programme launched nationally and the first health extension workers deployed
	25,000 health extension workers, all females deployed
	Household-based approach
	National hygiene and on-site sanitation strategy developed
2006	April: CLTS introduced to Arba Minch area by VITA RTI (Irish-based NGO)
	Flagging system by WaterAid Ethiopia
	September: Amhara region committed to scale up hygiene and sanitation
	National hygiene and on-site sanitation protocol developed
	Multi-sectoral commitment (on paper) for hygiene and sanitation (ministries of health, water and education –memorandum of understanding)
2007	February: Plan Ethiopia adopted CLTS
	September: CLTS expanded to Achefer district by the Regional government and the World Bank
	Increased stakeholder participation and NGOs' alignment (Plan, RiPPLE, WaterAid, CRS etc)
	Millennium Sanitation and Hygiene movement planned to be rolled out 2008-12

Source: Country Timeline from One Day Sharing and Learning Workshop at AfricaSan, 17th February 2008

7 The Case of the Southern Nations, Nationalities and Peoples Region (SNNPR)

SNNPR, the most diverse region in Ethiopia, has been the home of a large and successful state-run campaign and programme on sanitation and hygiene. Dr Shiferaw, since 2008 Minister of Federal Affairs and then from the Bureau of Health and his colleagues such as Demissie Bubamo and others, pioneered the campaign in 2003 due to the very poor coverage of sanitation and the related problems of on health. In 2003, they found that sanitation coverage was increasing only by 1 per cent, sanitation-related health problems were severe, and local people were relying on UNICEF and other donors and NGOs to provide slabs with their distribution arbitrary and unequal. At the time of conducting research, in 2007, the coverage in the region increased from 17 per cent to 80 per cent – 90 per cent with a utilisation of about 50–60 per cent (Demissie Bubamo, Interview, September 2007; see also WSP 2007 and Tefera 2008), which, as discussed below describes a substantial increase in the number of household latrines, in a few years, in Alaba and Mirab Abaya Woredas in SNNPR.

Demissie Bubamo, head of regional Bureau of Health (BoH), asserts that this was a regional campaign that was developed by the BoH out of a series of discussions, consultations at the woreda level (interview, September 2007). It was first piloted in a few woredas and then scaled out to the entire district a year later. The contribution of UNICEF and USAID and others was 'limited to capacity building, not more' (Interview, September 2007). They also introduced the models of promotion like the community health promoters approach (USAID) and PHAST (UNICEF), which were embraced by the regional government and scaled up region-wide. According to him, the WSP provided technical support at a later stage and also evaluated the programme which resulted in their fieldnote (WSP 2007). He and others assert that the programme was developed without knowing about CLTS, even though the BoH later engaged with CLTS and drew on some of elements. Hence it is regionally-inspired, not donor driven.

All the *kebeles* and *gots* in SNNPR are implementing the programme. The drivers are Community Health Promoters (CHPs) who are volunteers from the community and Health Extension workers (HEWs). The latter are employed by the kebele and receive a year's training on sanitation and other health issues (e.g. malaria, HIV etc). Due to the severe resource constraints, the programme emphasises low cost technology and local materials. Many of the latrines are open pits (no slabs or superstructure) using local materials such as logs from acacia. RiPPLE research (Alemu & Thomas, 2009) has revealed that sanitation and hygiene are part of a basic community health package (Health Service Extension Programme), within the responsibility of the health authorities. The key elements as described by the BoH are: "*broad based*", "*household-centered*", "*low cost*" (that is hardware subsidy-free, promoting use of local materials) – for "*high impact*". RiPPLE has analysed how the BoH succeeded in developing a strategy that was politically attractive to the regional cabinet (resonating with the values and goals of the ruling party), as well as financially and administratively feasible. It could also be implemented as part of a 'movement' to bring improved services to rural communities, promoted at election time. It is thus a unique initiative combining political promotion and institutional mobilisation which has achieved a large measure of success in launching and 'rolling-out' the sanitation programme, resulting in good results. As we will shortly see, ingredients of this policy will be applied at federal as part of a national movement.

7.1 Spread, achievements, incentives and sanctions

This section now turns to some observations based on a field visit in September 2007 and RiPPLE research. The programme has clearly led to rapid improvements in such a short time. The leadership in SNNPR has been striking in mobilising around the sanitation issue. The spread of the programme relies on the work of the HEWs and CHPs rather than on 'natural or spontaneous leaders' as in CLTS. The HEWs receive a salary and have a target to 'graduate' 25 households in 3 months. It must also be stated that HEWs are usually supported by Kebele chairmen who are political appointees and could be perceived as powerful actors in the community due to the attention and priority given to sanitation and hygiene in regional and woreda cabinets and politicians at the higher level. CHPs are from the community and largely volunteers. They neither receive a salary nor reward. Their reward for success is usually a T Shirt or their name is mentioned in celebrations. RiPPLE research finds that reduction over time of rewards and recognition to CHPs is resulting in them dropping out as volunteers.

The incentive and reward structure thus seems far weaker than in India and Bangladesh. The HEWs are supposed to provide technical support to the community around the different toilet models. As in other state-driven programmes, the message of sanitation is imparted in a top down manner (e.g. Haryana, India). As one man in a village in Alaba woreda said: 'The government through the HEWs and CHPs tells us to build latrines'. They lecture, explain the problems of open defecation after which people are supposed to build latrines. Local mobilisation, self analysis, community facilitation (transect walk etc) are all absent. The sanctions are high (e.g. fines from Birr 10 – 50, approx. US$ 1–5) or exclusion from the edir (a local community group that is highly influential and is responsible for funerals, celebrations etc). Exclusion from the edir is probably very difficult for a villager. Several villagers said that they were building toilets because they were scared they'd be fined 10 – 50 birr. Once they build the latrine, they get the money back though. These issues suggest that the programme may rely more on sanctions and official fines than the bottom up focus of CLTS which emphasises self analysis, local mobilisation and 'empowerment'.

7.2 Sustainability and constraints

RiPPLE research in Alaba and Mirab Abaya Woredas in SNNPR shows a substantial increase in the number of household latrines, in a few years, from 16 per cent to 94 per cent coverage in Mirab Abaya and 10 per cent to 69 per cent in Alaba (RiPPLE 2008). Despite a certain percentage of latrine owners who dropped back off the 'sanitation ladder' (10 per cent in Alaba, which seems significant; 2 per cent in Mirab Abaya), there is, overall, evidence of high impact of the BoH approach in the study areas. In September 2007, the outbreak of 'acute watery diarrhoea' AWD (which could mean anything from diarrhoea to cholera) had given a new impetus to the programme. However, if the programme was really so effective why should AWD break out? Poor water supply was mentioned as one of the causes of AWD. The water schemes are often poor. In water scheme mapping exercises carried out by RiPPLE it was found that 42% of the schemes in Alaba and 32% in Merab Abaya were not functioning and not providing enough water for the whole community. These figures are much higher than officially reported ones. Therefore people get water from untreated ponds and rivers which may be contaminated with faecal material. For example, those who drank water from the river in Haqule village had more diarrhoea than those who went to the water source provide by Water Action. In a village in Hamat Kebele in Alaba woreda, the water standpoint did not have enough water. People used the pond which was also used by animals. They could not afford the

firewood to boil the water. Based on the above discussion, there are clear links with issues concerning water quality. Even though toilets in the region are dry and water is not required for washing (as in South Asia), if water sources are poor or contaminated, AWD will occur despite latrinisation. Due to AWD, we also saw many toilets under construction as well as more threats of fines. The lack of local mobilisation and the 'lecturing' mode of the HEWs raises questions regarding overall sustainability and radical behaviour change.

RiPPLE research found that the most common problems with latrine construction and sustainability were flooding, for example in highland areas in Mirab Abaya, and termites where toilets had been constructed from wood, e.g. in Alaba, even though the latter problem has often been solved by using stone constructions instead. Sometimes the flooding of pits was said to have occurred whilst waiting for slabs. However, it was not clear whether having a slab subsequently solved the problem of flooding. If a latrine collapses due to flooding, people may wait to reconstruct toilets till after the heavy rains and revert to open defecation in the meanwhile (ibid).

Reasons cited for not having toilets were lack of money, lack of awareness and lack of construction materials, such as sanplats. There seemed to be a major focus on sanplats, with toilets with sanplats being considered as better toilets, more comfortable to build and use. As a result, some people were still waiting for delivery of sanplats by the kebele as there had been a history of handouts of sanplats by the kebele in the area. In other areas, NGOs and agencies (eg World Vision, UNICEF) had also previously distributed sanplats and since communities were not aware of criteria for distribution, they had hope that they would also be getting sanplats. Those with traditional pit latrines were also keen to get sanplats to upgrade their pits for more comfort and cleanliness. Even though it is encouraging to see that people are keen on upgrading their latrines, the implication here was that people want sanplats as a gift/handout as they are either not willing or able to spend money on it. Many people wanted to start on the second rung of the ladder and were therefore waiting for handouts rather than starting on the first rung with simple pits. As most of the toilets in the areas studied were open pits, there were complaints about smell and flies, with attempts to counteract the smell by pouring ash into the pits.

7.3 What happens to the poorest

Some of the issues raised earlier in the Asian context concerning the inclusion of the poor also hold here. There does not seem to be explicit targeting. There is the assumption that community members (sometimes through the edir) will provide logs etc. for latrine construction. Since the toilets are very simple (much simpler than in India and Bangladesh) the costs are minimal. Somebody is required to dig the toilet and along with simple materials such as logs and a cover. We met an old childless and poor couple in a village. They were the only people in the village who hadn't built a latrine. Sanctions or a fine hadn't been imposed on them as yet and after the holiday of Mesqual community members had promised to help them. According to Demissie Bumamo, '*We have a no hardware subsidy policy. However, if an NGO provides a slab – especially to the poorest we won't discourage it. We know that many poor are left out, however, once we have adequate coverage we will address the poor. We want to encourage the village to support the poor.*' (Interview, September 2007). However, from IDS research in Asia, we know that the poor can often be left out and when this happens 100 per cent ODF will not be achieved. There is also clearly a problem of female headed households who need special attention.

7.4 Socio-cultural constraints and behaviour change

Old habits die hard and it is believed that often behaviour change for something as fundamental as health and wellbeing can only be achieved through structural forces and coercion. Cockerham (2005) argues that health education can act like Durkheim's social facts and constrain and direct behaviour. For example, decades of anti smoking campaigns in the UK were not as successful as an outright ban in 2007. However, forcing people to use toilets cannot work like an outright smoking ban which is enforced all over the country and has worked with success. In Uganda in 2006 men were arrested for breaking into school toilets because they have not built toilets in their own homes (Odeke 2006). In India, councillors have been barred from contesting elections unless they have a toilet. However, in both these two cases, there is no guarantee that outside coercion and state intervention will make people actually use the toilets that they have constructed.

RiPPLE research and observations in this paper highlight several constraints to behaviour change in the Ethiopian context. Like in other parts of Africa, women do not appear to want to use toilets used by their fathers-in-law. They seem to want their own toilets. Many women complained about the lack or inadequacy of superstructures which meant that users of toilets are sometimes still visible which may deter some from using them. Some women, thus, seemed to prefer open defecation in the bush to using a toilet. As discussed earlier in the paper, like in Uganda and elsewhere young children were afraid of using the toilets. Very small children were also allowed to continue to go in the open.

Similarly, whilst shame and dignity were important motivators for women, the taboo and shame around being seen whilst defecating also extended to latrine use: Women and girls did not want to be seen going to the toilets, so they often continued to go for defecation before sunrise or after dark even though they were now using toilets. In some areas, eg Alaba, as discussed above, women also do not use the same toilets as their in-laws, so separate toilets need to be built: 'I won't use the latrine again as I faced my father-in-law when he intends to use it while I am using it. Rather, I would construct a new latrine for my own' (Tefera 2008, p. 12). The research found that even though health (45 per cent) and previous toilets filling up (43.8 per cent) were given as motivating factors for building toilets, most people dug the pits they never intended to use because they were told to do it.

IDS research suggests that even though 'behaviour change' is the aim of sanitation programmes, this is difficult to sustain. There are several reasons for this.

1. There are many constraints faced by poor women and men in terms of resources, time and capacity with respect to their daily hygiene and sanitation practices (see Tabuchi, 2002). In villages without much social cohesion and where special efforts have not been made to address interests of the poor, behaviour change of the whole population may not be achieved.
2. Two, there is also a tendency to lose sight of the role of water in the context of both livelihood strategies and in acting as a constraint towards toilet construction and use.
3. Sociologists have also argued against causal links between change as the stimulus and collective behaviour as the response. According to Bruce (1983), this implies curious models of human motivation.
4. It is also not clear how far sanitation/CLTS facilitators and practitioners (on the ground) seek to engage with indigenous beliefs and practices. Zeitlyn and Rowshan (1997) and Burghart (1988)

have demonstrated how expert knowledge on the part of biomedical practitioners and health workers has been dismissive of indigenous beliefs and practices. Instead, they could hold the key to understanding why some people adopt and others do not. While several public health scholars and epidemiologists seek to understand local perceptions, say, of diarrhoea and toilet use, there may not be a truly meaningful consideration of local knowledge and considerations. Instead, the focus is on changing people's behaviour, rather than considering how professional knowledge is also fallible and how local knowledge needs to be treated on an equal standing (cf. Tabuchi).

5. Once local knowledges are understood, they may help to develop culturally appropriate strategies. In parts of South Asia, for example, imbalance of 'heat' and 'cold' either within the body or environment can be blamed for diarrhoea (Helman 2002). In other groups, bad breast milk, heavy foods can also or pollution can be blamed. Supernatural causes (e.g. evil eye, witchcraft, sorcery etc., having sex during pregnancy) are also provided as causes. As discussed, 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. Burghart (1988) has criticised the notion that the health planner is devoid of her or his own cultural biases and knowledge. Usually, the facilitator, health worker or trainer is seen as a purely rational administrator whose own cultural background does not impinge on professional decision making. Thus behaviour change is also required on the part of facilitators, administrator and donors, not just of the 'poor' and end users CLTS has been good to flag this. As Kamal Kar has remarked, 'the only poverty is that of the mind and mindsets'.

8 Looking to the future – CLTS in Ethiopia[7]

The relevance of CLTS to Ethiopia is significant. The 2008 'National Millennium Hygiene and Sanitation Movement' ('MHSM') launched in Oromia explicitly says that the MHSM is a practical step that is heading towards total sanitation which will be led by community (CLTS). It includes key elements of the approach effectively implemented in SNNPR with hygiene and sanitation as key components of basic community health embedded in the Health Service Extension Programme, with similar focus on processes/ software. In SNNPR, targets may be set for ODF communities which may apply to all regions.

According to Robert Chambers, this is a tipping point for Ethiopia. He says:

> "*Ethiopia has had the advantage of learning from the experiences of other countries and has got off to a promising start with high standards and the key recognition that 100 % latrinisation is an achievement but is not the same as achieving ODF status. However, based on experiences elsewhere and on what has happened in Ethiopia so far, there are several points of caution. One, after initial quick successes, there can be a temptation to go to scale too fast. This usually means that one of the key emphases of CLTS, facilitation rather than teaching, falls by the wayside, as cascade trainings, classroom based teaching and lecturing take over and hands-on triggering experience is neglected. Based on experience with other participatory approaches, cascade training for CLTS is most likely to end in disaster*"
>
> (Chambers 2008b and personal communication).

Chambers also emphasises the central role of training and facilitation of a different kind that is required for CLTS. Trainers and facilitators, rather than teach, are supposed to step back and allow communities to do their own analysis, and to then support them in appropriate ways (ibid). However, in reality many of these facilitators and trainers may be HEWs who are rooted in existing political structures and may not be able to step back from the didactic mode of operation that is embedded in existing power structures. Furthermore, as is the case in South Asia, many consultants can emerge who are not experienced in CLTS approach and practice.

He concludes: '*There is a tension and contradiction between top-down didactic teaching, and local facilitative empowerment. The MHSM is mainly in the former mode – it largely speaks of messages though it straddles a bit with "negotiation". On page 11 it has "break the didactic technique" but does not answer how. The MHSM also seems to look to India and Bangladesh as role models. Targets and results orientation carry all the usual dangers. One serious weakness is being misled by the statistics from India and Bangladesh*' (Chambers, email communication, June 2008).

Ethiopia, like India and Bangladesh, has a top down bureaucracy and has hierarchichal structures in both formal and informal realms (Vaughan and Tronvoll 2003). Thus, it is important to avoid the pitfalls that CLTS has encountered in the Asian context. These include top-down target driven programmes that compromise on quality; rewards to communities generating false declarations; HEWs in a teaching role without the ability to mobilise or facilitate in a participatory manner; and, competitions between weredas that inflate the figures and cascade training does not provide enough time in the community.

7 Some parts of this section draw on a note written by Robert Chambers

Finally, the socio-cultural lessons that have emerged from sanitation research in other contexts hold in Ethiopia too. Powerful emotions released from shaming and punitive measures in highly complex political environments can be counter-productive. Using rewards to trigger and sustain change can lend itself to the worst kind of political manipulation by outsiders and elites within communities. Also behaviour change rarely takes place overnight and requires both in depth understanding and engagement with local cultural assumption and practices as well as persistent follow up. Finally, sanitation needs to be seen in conjunction with other issues such as hygiene, access to health, water and nutrition in order to really contribute to disease reduction.

In sum, Ethiopia has an opportunity to do something very meaningful around CLTS and be ahead of India and Bangladesh in quality and scale, building on past positive and negative experiences. But in order to be ahead of the Asian experiences, the path needs to be taken cautiously and carefully with clear monitoring of socio-political and health impacts and overall sustainability.

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Appendix I: Current Developments of CLTS in Ethiopia

2008 and 2009

- Ministry of Health (MoH) puts CLTS as a key approach in the *National Millennium Hygiene and Sanitation Movement*' ('MHSM'). MoH visited CLTS s implementation areas by Plan in Shebedino woreda of Southern Region and Jima. A year ago the MoH was planning to implement CLTS in 5,000 Kebeles each year, to cover all the Kebeles in the country in 3 years time and achieve universal sanitation coverage in time for 2012 – Universal Access Plan goals. In the current year – 2009/2010, MoH annual plans include scaling up CLTS in urban and rural areas. A five year urban strategy plan is being developed and CLTS will be included as an approach for S&H implementation in urban areas. (Interview with Ethiopian WaSH movement coordinator – Michael Negash, August 2009)
- The first hands on training on CLTS took place in Tigray in 2008 – where Kamal Kar gave the training and other regions participated. Following regional government's request for similar training, trainings were given to health professionals, environmental health workers, health extension workers and supervisors and staff from water offices in all regions with the support of UNICEF. UNICEF is now supporting government to scale up CLTS in over 80 Kebeles in different regions of the country. In UNICEF supported areas, CLTS is being scaled up slowly and with quality. In the pre-triggering phase, political decision makers at region and woreda levels will be brought together and mobilized to support the program. Villages will be identified for implementation together with politicians. In the post triggering phase, follow up education, training and monitoring and supervision will be carried out by health extension workers working in the Kebeles. (Interview with UNICEF WaSH Program Specialist, Muchie Kidanu, August 2009)
- CLTS is being implemented by regional government health bureaus in some regions like Tigray and some communities have been declared ODF. In some regions like Amhara, CLTS is used for triggering, while in post trigger phase various approaches are implemented for continued training and behavioural change. (Interview with UNICEF WaSH Program Sapecialist, Muchie Kidanu, August 2009)
- UNICEF and Plan have signed a partnership agreement to scale up CLTS.
- In June 2009, a national task force on CLTS is formed, led by Ministry of Health and supported by UNICEF and WSP. Plan Ethiopia, the WaSH movement and other key actors are also members of this task force. In the initial workshop when the task force was formed, it was discussed that there are various community led approaches on sanitation and hygiene. One of them is an approach that is being trialled by WSP in Amhara region, which is very similar to the 2003 SNNPR approach. And others like UNCEF and Plan promote CLTS. The task force will try to harmonize different community led approaches to improve coordination and uniformity. The task force will prepare a standardized guideline for community led sanitation approaches – a manual that can be used by those trying to scale-up CLTS. So far among the manuals and guidelines being prepared are: a protocol for verification of ODF communities and a guideline on pre-triggering and post-triggering. (Interview with UNICEF WaSH Program Specialist , Muchie Kidanu, August 2009)

(Source: Bethel Terefe, RiPPLE, 2009)

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