Community led total sanitation (CLTS): Addressing the challenges of scale and sustainability in rural Africa

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Abstract

Despite all efforts and significant investment in the sanitation sector; sub-Saharan Africa is far behind its Millennium Development Goal (MDG) target. Community led total sanitation (CLTS) is a concept that revisits all the past approaches, particularly the promotion of household sanitation within the context of basic human dignity. CLTS emphasises community facilitation to assess their sanitation situation and promotes natural leaders. CLTS supports community action plans developed under their leadership. The main yardstick of CLTS achievement is totally open defecation free (ODF) villages and not numbers of toilets. This paper reviews Plan’s experiences of promoting CLTS in Eastern and Southern African Countries. The potential of CLTS addressing the issue of scale and long term sustainability within the national planning framework is recognised and lessons learnt from ongoing programs in Ethiopia and Tanzania are shared. The challenges and some limitations of CLTS are critically assessed by this paper and issues needing more research and studies are presented.

Keywords: Sanitation; Participation; Cost; Africa; Challenges; Sustainability

1. Introduction

It is estimated that 2.6 billion people, more than 40% of the world population, do not use a toilet, but defecate in the open or in unsanitary places [1]. Sub-Saharan Africa remains the area of greatest concern (37% coverage). It is a region of the world where, over the period 1990–2004, the number of people without sanitation increased by over 30% [2]. An OECD study in 2005 worked out the average costs for various water supply systems and latrine types. The basis for the cost information was official documents and project reports from different...
countries worldwide to arriving to an “international” cost level for down or up-scaling to local price level [3]. Table 1 shows average costs for latrine types commonly used in rural areas.

Taking the cheapest option of a simple pit latrine and taking into consideration the growth in population, the cost for providing improved sanitation to the world’s population will be over $300 billion US by 2015. These calculations do not address collection systems, wastewater treatment facilities; re-use options or re-allocation to the environment. Achieving the sanitation goal – to simply halve the number of people without access to a toilet by 2015, is put at $38 billion per year according to another estimate [4]. However, past investment in sanitation has been far below what was expected. Approximately $15.7 billion US was invested annually in the global water supply and sanitation sector between 1990 and 2000. Only one-fifth of the total investment was directed to the sanitation sub-sector [5]. Sanitation was not normally considered a priority in development projects. It is clear that unless something is done immediately to improve the sanitation and hygiene situation in rural areas, we would be failing in achieving the Millennium Development Goal (MDG) related to sanitation.

Apart from the cost of technology, some of the past approaches to sanitation and hygiene awareness had certain limitations:

- They were top-down interventions or based on superficially participatory models.
- Emphasis was on sanitation coverage rather than on improving hygiene behaviour change.
- They were donor/supply-driven rather than demand-driven.
- They were largely externally funded, designed and implemented and developed dependency amongst people rather than empowering them to take action on their own.
- They resulted in a weak sense of ownership amongst communities.

2. Community led total sanitation (CLTS)

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

2.1. Process of CLTS

The following steps have been identified in the CLTS process [6]:

1. Pre-triggering: Includes selecting a community and building rapport with community members and opinion leaders. Certain types of communities, e.g. small communities that are remote and have a homogenous population are more favourable for CLTS and challenges are more in large communities that have a diverse population and are located near urban areas and major roads.

2. Triggering: This entails building a sanitation profile of the community utilising participatory approaches and the moment of ‘ignition’ when the community members internalise a need for behaviour change. It is this moment of collective realisation and emerging of natural leaders that due to open defecation all are ingesting each others’ faeces and as the result their children are dying of diarrhoea and related diseases.

3. ost-triggering: This step involves action planning by the community, design and construction of latrines and follow up.

4. Scaling up and going beyond CLTS for sanitation ladder: CLTS efforts can be scaled up through building a resource base of trainers, campaigns, advocating for policy changes, etc.

The shifts in attitudes, behaviours, policies and practices required by CLTS can be summarised as [7]:

- From teaching and educating to facilitating communities’ own analysis
- From ‘we must subsidise the poor’ to ‘communities can do it’
- From ‘we persuade and motivate’ to ‘it’s up to you, you decide’
- From top-down standardisation to bottom-up diversity (‘they design’)

Fig. 1. Sanitation profile includes community mapping utilising a participatory approach.
• From bigger budgets and disbursement targets to lower budgets to allow more to be achieved
• From spending on hardware to spending on supporting people (facilitators) and processes

3. Plan International and CLTS

Plan commenced its CLTS projects in its Region of Eastern and Southern Africa (RESA) in early 2007 by organising two CLTS Regional Trainings in Tanzania and Ethiopia for 10 Country WATSAN Advisors and Program Frontline staff. This initiative draws upon Plan’s experience in Bangladesh and the actual implementation of CLTS at scale focuses on four Plan countries: Ethiopia, Tanzania, Kenya and Zambia. Following this, Plan International started focusing on West Africa starting with a training of trainers for CLTS in Sierra Leone. CLTS is now actively promoted by Islamic Relief, WaterAid, UNICEF, Plan and the World Bank in different countries and has proven to be an extremely effective, sustainable and empowering solution to the growing sanitation problems in Africa. As well as addressing fundamental sanitation issues, the work process of CLTS unites communities (irrespective of individual community members’ social status) for a common purpose and empowers them.

4. Plan’s experiences in Africa

4.1. Start up in Ethiopia

Plan understood that there was some preparatory work required before it could implement CLTS in Eastern and Southern Africa. There was an acute lack of good CLTS trainers coupled with a lack of awareness on the concept of CLTS itself. Government policies have not recognised CLTS as a methodology for achieving sanitation goals and there were few successful models of CLTS implemented in Africa.

• To create the ‘buy in’ and create a resource base of trainers, one of the Plan’s Regional CLTS Training, organised in Ethiopia, was a hands-on training in eight villages namely Midre Genet, Leku town, Remeda, Taremessa, Fura and Moranco Kebeles (Lowest Local Administration). This was a completely new and first time experience for communities that have never experienced CLTS before and this is also the first CLTS initiative in the country.
• Communities’ natural leaders emerged during the process including children and youth who participated actively throughout the process.
• This was followed by a half day national level workshop where action plans for CLTS implementation in Plan programme areas were prepared.
• In Feb 2007, a Shebedino District CLTS Taskforce was established with the District Administrator as the Chairperson and the District Health Officer officiating as the Secretary. Members included representatives from government and non government organisations including Plan Ethiopia.
• The District Taskforce is responsible for follow up on CLTS activities in the communities and in March 2007, a District level stakeholder analysis and training of frontline staff was organised and CLTS implementation was started in March 2007.
• In the Plan office in Lalibela in North Western Ethiopia, a one day advocacy workshop was organised targeting District officials and another 1 day awareness workshop involved Kebele chair persons. This resulted in a decision to introduce CLTS in 28 villages by December 2007.

4.2. Results from CLTS implementation in Ethiopia and Tanzania

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

4.2.1. Case 1: The story of Weizero Belayinesh Worku’s brave acts

“After the CLTS approach was introduced, each household in our village dug a latrine of its own. For passers-by, we constructed seven communal latrines along the main road to the market place. After all these efforts, I found four men at different times defecating in open fields in our village. I ordered them to shovel it with their hands and take it into the nearby toilet. As I caught them with their trousers down, they didn’t resist; they only begged me to allow them to handle their shit with leaves. I allowed them and they shoveled it with leaves into the toilet”.

Fura Kebele in Ethiopia has 1265 households and achieved an ODF environment by building 465 household pit latrines and eight communal latrines for passers-by and visitors. Communities penalise offenders in various ways including making them scoop it with their hands!

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

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

4.2.2. Case 2: The transformation of Sangabuye village in Tanzania

Sangabuye is a ward in Mwanza region, Illemela district of Tanzania. The People in Sangabuye are Sukuma (ethnic group) and most of them are very poor. The area is rocky surrounded by some hills and few trees. The great part of Sangabuye is surrounded by Lake Victoria. When Plan Tanzania initiated CLTS in Sangabuye in 2007, the community members did not have many household or public latrines. The prevalent myth was that when family members shared the same place for defecation they would bring misfortune to the family. As a result of the CLTS initiative, a remarkable change was seen in Sangabuye:

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

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

UNICEF has started promoting CLTS at the regional level and the World Bank has provided training on CLTS with the help of Plan Ethiopia trainers.

As the approach empowers communities, it has been found to be useful in all areas of community development especially as an entry point for community facilitators.

5. Challenges in scaling up and sustainability

1. Communities where subsidy has been provided in the past are less receptive to implementing CLTS and triggering is much more challenging. Future subsidies by other NGOs or the government may have negative effects on what the CLTS process achieves.
2. Differences exist in efficiency and commitment amongst natural leaders, commitment among stakeholders and understanding and following CLTS approach and steps.
3. There is a severe lack of skilled staff that can facilitate the CLTS process effectively and efficiently. Insufficient personnel numbers has meant that continuous follow up and monitoring is hampered and this leads to loss of interest.
4. Community Facilitators need to find means to trigger action without shaming and disgusting the communities. One response in Tanzania from a community leader was: “Sikufurahia kuambiwa tunakula kinyesi, sio utanzania kuongea hivyo” (I am not happy to be told that we eat each other’s shit. It is not the Tanzanian way to speak like that).
5. Government policies have to be changed through advocacy so that CLTS is recognised as a successful methodology to create ODF communities that live with dignity.

6. Conclusions

The experience of implementing CLTS in Africa has shown that there are various benefits in comparison with the traditional subsidy led approach. There is actual visual improvement in the community and a cleaner environment when the community is declared ODF. The process leads to identification of natural leaders who then support the design and construction of subsidy free latrines. Community members are also more aware of water borne disease transmission and reduction due to the participatory approach utilised during the CLTS process.

During the AfricaSan Conference (Durban, South Africa, February 2008), Robert Chambers and Kamal Kar (Institute of Development Studies, University of Sussex) presented an open letter to all the leaders and participants from more than 35 African Countries and international delegates from all over the world on how CLTS should be taken forward by them as the most viable option to achieve sanitation goals. This letter urged “donors, lenders and governments to avoid programmes driven by big budgets, targets and pressures to disburse, and instead to go to scale in a steady manner, focusing on good training and building up and supporting a cadre of dedicated and committed staff and local-level natural leaders. Much damage has been done by pushing too much money too fast at NGOs”. This is extremely important to scale up and achieve sustainability.

Success in CLTS is measured by the number of communities that are ODF and hence much
more hygienic rather than the number of latrines built and the amount of money invested. Thus CLTS appears to be a quick and simple solution to reducing disease burden using a methodology that promotes behaviour change and awareness of health and hygiene aspects through a process of internalisation amongst a cross section of society that includes women and children. The low cost related to the process of CLTS and the immediate return in terms of internalising hygiene messages means that CLTS has great potential for scaling up, especially in an environment where funds for large scale sanitation projects are simply unavailable.

However, key issues that have to be considered in scaling up include a lack of awareness amongst national governments as a result of which their national sanitation policies do not recognise CLTS as a successful model for achieving sanitation targets. For the same reason, there are not enough resources from multilateral and bilateral agencies to support governments and civil society to undertake CLTS initiatives.

Further research and studies are also required to assess the direct link of disease incidence with ODF communities (epidemiological studies) as well as social impact of CLTS on rural communities (e.g. changes in behaviour, impact on the daily lives of women, etc.). Such studies will link CLTS to the achievement of the MDGs.

During the CLTS process it is important to consider existing social customs and cultural sensitivities so that the facilitators do not offend community members during the CLTS process. Investigation and research is also required on introducing improved latrine options based on the sanitation ladder amongst the communities using the social marketing approach after the demand is created by the CLTS triggering process.

CLTS as a technique to improve sanitation in rural areas is gaining ground with international NGOs and aid agencies. However, advocacy efforts are required with governments in various countries so that CLTS is a part of the National Sanitation Plans in resource poor developing countries, especially in sub-Saharan Africa, which is the worst off in terms of sanitation coverage. This process of advocacy could be supported by research studies that correlate...
disease reduction in ODF communities with the CLTS process.

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References


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