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Currently, some 2.5 billion people lack adequate sanitation, including 1 billion who practice open defecation. Because inadequate sanitation is both a cause and effect of extreme poverty, it deserves inclusion on the international social work agenda. This article introduces community-led total sanitation (CLTS), a recent and highly effective innovation for mobilizing whole communities to address their sanitation problems.

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Calling it a “silent global crisis,” UNICEF (2008) asserted that inadequate sanitation “constitutes an affront to human dignity on a massive scale causing widespread damage to human health and child survival prospects; social misery especially for women, the elderly and sick; depressed economic productivity and human development; and pollution to the living environment and water resources. Lack of sanitation is one of the single biggest challenges facing the world today” (p. 1; italics added). Likewise, the World Health Organization (WHO, 2011) describes lack of sanitation as “a serious health risk and an affront to human dignity” and notes that it particularly affects the poor and disadvantaged (para. 1).

In 2008, an estimated 2.6 billion people—four of ten people in the world—did not have access to adequate sanitation (UNICEF, 2008). Nearly half of those people, especially those living in rural areas, practiced open defecation (i.e., defecation in fields, forests, bushes, plastic bags, streams, lakes, or other open spaces; Sanitation Drive 2015, 2013). The most recent data indicate that there are still 2.5 billion people in the world—one in three—who lack adequate sanitation, and the number of people practicing open defecation has decreased but remains above 1 billion (UNICEF, 2013). The problem is most widespread and severe in Southeast Asia and Sub-Saharan Africa (Sanitation Drive 2015, 2013).

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Associated with extreme poverty, inadequate sanitation affects the lives of individuals, families, and communities in various ways (UNICEF, 2008). Most tragically, inadequate sanitation is the major cause of preventable diarrheal and other diseases (e.g., cholera, dysentery, typhoid, hepatitis A, polio, cryptosporidiosis, ascariasis), which kill five thousand children and another one thousand adults per day (Sanitation Drive 2015, 2013; UNICEF, 2008; WHO, 2011). Worldwide, diarrheal diseases are the second leading cause of child death (Glaussz, 2002). Even when diarrheal diseases do not kill, they leave hundreds of millions more people seriously ill. Such diseases cause many children and adults to miss school and work. In addition, inadequate sanitation contributes to the spread of other diseases, increases malnutrition, and deters children (especially girls) from attending school at all. In these and other ways, the lack of sanitation both directly increases poverty and deters social development, and thus it poses a major challenge to human well-being.

Although recognized as a root cause of extreme poverty (United Nations, 1995), sanitation was not originally included in the UN Millennium Development Goals (MDGs; UN General Assembly, 2000). However, it was subsequently added to the MDGs, and 2008 was declared the International Year of Sanitation to rectify the omission and to supplement other MDGs (UN General Assembly, 2005; UNICEF, 2008). Indeed, Robert Chambers (2008) first argued that providing adequate sanitation will substantially contribute to achieving all the MDGs by eradicating extreme poverty and hunger, improving maternal health, reducing young child mortality, reducing major diseases, increasing primary education, increasing gender equality and female empowerment, and ensuring environmental sustainability.

Remarkably, the International Federation of Social Workers (2012) does not mention sanitation as part of the social work profession’s agenda for global poverty eradication, despite noting that the Copenhagen Declaration defined absolute poverty as “a condition characterized by severe deprivation of basic human needs, including food, safe drinking water, sanitation facilities, health, shelter, education and information” (United Nations, 1995, p. 41).

Nevertheless, there is growing public recognition of the magnitude and severity of the problems posed by inadequate sanitation (e.g., Black, 2008; George, 2008; Sanitation Drive 2015, 2013). Promoting sanitation may never have the appeal of promoting clean water, but there is growing recognition that the two are inextricably linked. Indeed, readers of British Medical Journal selected “clean water and sewage disposal” as the most important medical advance since that journal began publishing in 1840 (Ferriman, 2007).

Despite the consequences and prevalence of inadequate sanitation in impoverished communities, both government and nongovernment organization (NGO) leaders have tended to ignore it. When the problem could not be avoided, the conventional response was to build public latrines and then provide financial incentives to promote their use (Kar & Pasteur, 2005). Despite the commitment of significant resources and efforts, these approaches have not succeeded in many parts of the world (Chambers, 2008; Sanan & Moulik, 2007).
Community-Led Total Sanitation

This article introduces community-led total sanitation (CLTS), a recent and highly effective innovation for mobilizing whole communities to address sanitation problems (Kar, 2005, 2008; Kar & Pasteur, 2005). In sharp contrast to previous efforts to build and incentivize the use of public latrines, CLTS "triggers the community's desire for collective change, propels people into action and encourages innovation, mutual support and appropriate local solutions, thus leading to greater ownership and sustainability" (Institute of Development Studies, 2011, para. 3). Kamal Kar (2005), the originator of CLTS, explains that it is based on stimulating a collective sense of disgust and shame among community members as they confront the crude facts about mass open defecation and its negative impacts on the entire community. The basic assumption is that no human being can stay unmoved once they have learned that they are ingesting other people's faeces. (p. 3)

By evoking a collective sense of disgust, CLTS apparently taps into a universal and visceral emotion that is key for human survival (Glausiusz, 2002). Robert Chambers (2009), the esteemed development scholar and practitioner, considers CLTS "a revolutionary participatory approach to rural sanitation" (p. 9).

Several basic principles distinguish CLTS (Chambers, 2009; Kar, 2005; Saman & Moulik, 2007): community self-help action (i.e., grassroots, or bottom up rather than top down), hands-off triggering, facilitation through questions rather than instruction, no standard latrine design (i.e., letting people choose their own designs, and allowing private suppliers to meet local demand); promotion of community assistance to poorer and weaker community members, no provision of a household hardware subsidy (focusing instead on community-level outcomes). Of these, refusing to provide either overt instruction or financial subsidy represents the most significant departures from conventional practice in sanitation.

Chambers (2009) identified five benefits of CLTS over traditional approaches to sanitation: the unusual speed of success; the community-wide scope of its success; the resulting social solidarity, which may lead to other initiatives; the development of local leadership, confidence, and livelihoods; and its application in other contexts, such as schools and urban communities.

Recently, systematic research on CLTS outcomes has begun to confirm anecdotal reports of its effectiveness. For example, a large, multicountry study in West and Central Africa found important but fragile progress on sanitation goals across eighteen countries (UNICEF, 2011). A multimethod study in Cambodia compared CLTS and conventional subsidized sanitation approaches (Kunthy & Catala, 2009). In camps with CLTS, it found greater use of latrines, greater equity across income levels, better cost-effectiveness (both short and long term), and more attitudinal and behavioral change, but some problems with sustainability. Mukherjee (2011) found that communities that became open-defecation-free (ODF) most quickly were also most likely to sustain those gains and that sanitation behavior change was more difficult to initiate in riverbank and waterfront communities. Given adequate triggering, according to Mukherjee (2011): 

Open Defecation Free (ODF) achievement and sustainability are hastened by: (a) community's social capital and the involvement of leadership in the change process, (b) local availability and affordability of latrine attributes desired by poor and non-poor consumers, (c) absence of externally provided subsidies to a few households, and (d) post-triggering monitoring and follow-up by external agencies together with communities. (p. 1)

In summary, the emerging evidence demonstrates that CLTS is no panacea, but it may be significantly more effective than previous approaches. In many parts of the world, it has generated significant progress toward the MDGs.

CLTS Tools

The CLTS intervention consists of several tools for promoting community members' comprehensive analysis of sanitation in their community. Drawn from participatory rural appraisal (Bar-On & Prinsen, 1999; Chambers, 1994a, 1994b, 1994c), the tools are "simple, visual, and practical" (Kar, 2005, p. 5). The tools are accompanied throughout by Socratic questioning to promote community members' analysis and reflection. Unless indicated otherwise, the following descriptions are drawn from several key sources (Kar, 2005, 2008; Kar & Pasteur, 2005) and personal experience.

Getting Started

The first step is gaining entrance to a community and building rapport with community leaders and members (Kar, 2005). The approach to this varies from informal to more formal. In some situations, CLTS facilitators simply visit communities and begin asking people about sanitation issues while walking through the community. In others, they contact community officials in advance to request formal permission to conduct sanitation analysis. In either case, the goal is to recruit as many community members as possible for the intervention (e.g., ten to more than one hundred). At the outset, facilitators also determine the crude local word for feces (i.e., the equivalent of shit in English) and proceed to use that terminology throughout the intervention.

Transect Walk

The CLTS usually begins with a transect walk—a tour of the community with the assembled community members—to visit and discuss areas of open defecation and all types of latrines. At each location, facilitators pause to smell and
view the effects of open defecation and poor latrine maintenance. Although community members find it embarrassing to have visitors view these parts of their community, they often gain a fresh perspective on conditions to which they have grown accustomed. The sight of a large group visiting open-defecation sites often attracts additional participants. Facilitators take time to ask questions at each stop (e.g., Which families use this area? Do people come at night? Do women and children feel safe here? Do people come here when it’s raining? When they are sick? What are the flies doing here? Do these flies stay here or go to the camp? How long have people been using this area?). The transect walk and questions are intended to stimulate frank conversation and reflection about open defecation among community members and to provoke visceral disgust.

Community Mapping

In the next step, facilitators encourage participants to draw a map of their community on the ground at a central location. The mapping often begins by noting landmarks in the immediate vicinity. After participants have drawn their own homes and key sites on the map, facilitators offer flour, bonemeal, or a similar powdery substance for marking open-defecation areas on the map. Again, facilitators use questions to guide the exercise (e.g., Where are the open-defecation sites that we visited? Where else do people defecate in the open? Where is the rubbish site? Do people ever go there? Where is the dirtiest neighborhood? Who lives there? Why is it the dirtiest neighborhood? Do people from other neighborhoods go there?). Building on the transect walk, the community-mapping exercise helps people visualize the scope of the sanitation problem in their community and provokes reflection about its uneven distribution.

Goo Calculation

After the mapping exercise, facilitators ask participants to estimate the amount of feces an adult produces each day (about 0.5 pounds, or 0.25 kilograms). On the basis of this estimate, facilitators ask participants to calculate the total amount of feces an adult produces per week, per month, and per year. Subsequently, facilitators ask people to calculate the total amount of feces produced by a typical family per day, week, month, and year. Finally, they ask about the size of the entire local community and repeat the questions. In addition, facilitators seek to help participants visualize the total amounts by selecting a locally familiar container and asking participants to calculate the number of containers required for each amount. Sample questions may include the following: How many basins (buckets, bags) would that be? How many wheelbarrows (wagons, boats, trucks) would that fill? The goo calculation dramatizes the cumulative volume of feces generated by a community and raises further questions about its disposal.
Open defecation, and facilitators remind community leaders and members that they came only to ask question, not to provide subsidies or other assistance. This moment often stimulates the emergence of natural leaders eager to address the problem of open defecation, typically by volunteering to immediately build latrines for their own families.

Open-Defecation-Free Planning

Once community members and/or leaders have decided to address the problem themselves, facilitators may provide general guidance and encouragement for the development of a sanitation committee and an action plan. The goal is to establish and reinforce community ownership of the solution, and their initiative must be respected. Possible activities may include listing or mapping households and their current sanitation status, digging pits or makeshift latrines, making plans and acquiring resources to build permanent latrines, planning outreach to other members of the community, establishing penalties to enforce community-wide participation, and establishing ODF goals. In short, facilitators encourage natural leaders to plan for mobilizing their communities to take collective action.

Follow-Up

At the conclusion of the intervention, facilitators schedule return visits to observe the community’s progress toward ODF. It appears that early and repeated visits to the community (e.g., monthly) serve to stimulate and reinforce follow-through on action plans and increase the likelihood that communities will achieve ODF (Government of Uganda, Ministry of Health, n.d.).

ODF Declaration and Celebration

The ultimate goal of CLTS is declaration and celebration of ODF status. Although success and timing vary by community, in many cases communities achieve ODF status within weeks or months of the initial intervention. Whenever it occurs, success is great cause for celebration and community pride. Often, the sense of empowerment and solidarity that results from CLTS may inspire communities to tackle other problems together. Facilitators sometimes recruit natural leaders from successful communities to assist with CLTS interventions in neighboring communities.

Implications for Social Work

It appears that the problem of inadequate sanitation deserves greater attention on the international social work agenda and that CLTS is a potentially useful approach for social workers who work in communities where people practice open defecation.

Critical Role of Sanitation in Water, Sanitation, and Hygiene Efforts

Over the past two decades, an emphasis on safe water has gradually given way to a more comprehensive emphasis on water, sanitation, and hygiene (WASH). Safe water and adequate sanitation are essential for human well-being, and the two are inextricably linked and related to hygiene. Furthermore, unsafe water and inadequate sanitation both contribute to extreme poverty. While government and NGO leaders have traditionally preferred to address water and have downplayed or even ignored sanitation, it is increasingly clear that sanitation plays a critical role in integrated water, sanitation, and health (WASH) efforts. Addressing inadequate sanitation goes a long way toward addressing water problems, especially when inadequate sanitation involves open defecation. As UN Secretary General Ban Ki-moon asserted recently, “Adequate sanitation is crucial for poverty reduction, crucial for sustainable development, and crucial for achieving any and every one of the Millennium Development Goals” (Sanitation Drive 2015, 2013).

Refocus on Basic Needs of the Most Vulnerable Community Members

In general, attention to sanitation is an essential component of a holistic focus on poverty, and including it in the social work agenda will likely contribute to greater success in addressing poverty. More specifically, sanitation is an especially significant problem for the disadvantaged members of impoverished communities who social workers often champion (e.g., women, children, older adults, people who are ill, people with disabilities, rural residents). Inadequate sanitation is both a significant source and a consequence of health and economic disparities, and thus it should represent a significant concern for social workers.

Potential Role as Trainer or Facilitator

Social workers with experience in participatory rural appraisal, community organizing, and Socratic questioning may be well suited for learning to facilitate CLTS interventions. Facilitator training is offered through multiday workshops, and numerous training resources are available at the Community-Led Total Sanitation website (http://www.communityledtotalsanitation.org), hosted by the Institute of Development Studies at the University of Sussex and funded by the Bill and Melinda Gates Foundation.

Follow-Up with Livelihood and Community Development Initiatives

Of significant interest for social workers, CLTS interventions often stimulate community-wide collaboration and successes that create opportunity for and interest in other poverty alleviation initiatives (Deak, 2008; Kar & Pasteur, 2005). In short, they serve to empower and build solidarity in communities.
The community development and livelihood initiatives that emerge in the wake of CLTS interventions provide a more familiar role for social workers in poverty alleviation. It is necessary only that social workers be alert for these opportunities or seek to actively partner with CLTS facilitators.

Part of Social Work’s Environmental Agenda

Finally, it seems clear that work in sanitation fits with social work’s emerging environmental agenda. Inadequate sanitation has grave consequences for humans and for the environment more broadly. With continuing global population growth, adequate sanitation is increasingly critical for sustainability. Addressing inadequate sanitation as a matter of environmental degradation and social justice constitutes another linkage for social workers.

Conclusion

Despite the early precedent set by Jane Addams (Nobel Foundation, n.d.), the social work profession has generally overlooked sanitation. But inadequate sanitation remains a significant contributor to poverty in many parts of the world, and thus it is an appropriate target for professional concern and intervention. Beyond the direct, immediate, and severe health consequences of inadequate sanitation, there are significant consequences for education and employment. As with many other problems, these consequences disproportionately affect women, children, older adults, and people with disabilities. For these and other reasons, it seems appropriate that the social work profession begin to address inadequate sanitation. As a potential approach, CLTS appears to be highly effective and largely consistent with social work values, knowledge, and skills.

References


