sanitation strategies. In this relatively short time, hundreds of thousands have gained the benefits of better sanitation by changing their individual and collective hygiene behaviour, which includestopping open defecation practices, making the 'shit holes' fly proof, hand washing and more rigorous monitoring – and millions are poised to do the same.

Many who worked alongside with Dr. Kar, argued, protested, learned, taught and have taken up the mantle, include senior representatives from the government ministries and departments, non-governmental organisations (NGOs) and development agencies such as UNICEF, as well as community members who have been instrumental in changing their sanitation situations. In southern and eastern Africa, Dr Khairul Islam and Amsalu Negussie of Plan RESA (Region of Eastern and Southern Africa) were instrumental in introducing CLTS into Plan countries of this region, after which it spread in many directions. In Zambia, now considered one of the success stories of CLTS in the region, Dr Peter Harvey – then head of the UNICEF's Water, Sanitation and Hygiene (WASH) programme, and Leonard Mukosha, Giveson Zulu and Chief Macha at district levels, have steered and facilitated a transformation in sanitation practices.

The first concerted attempts to introduce and popularise the approach were made in Tanzania,Ethiopia, Kenya and some other countries of the Plan RESA working area, in 2006, under the impetusof Plan International.

These experiments produced insights into the distinctive features of the CLTS process in different parts of Africa, and began the task of building up the now quite substantial body of experience that is sustaining the roll-out process.

In Africa CLTS has travelled a long way in a remarkably short time. While the government of many African nations have decided to adopt this approach for faster scaling up towards achieving MDG, many new challenges have emerged. Most of these challenges are institutional, professional and methodological. For instance, CLTS is being proven successful in many countries where donor supported subsidized sanitation projects are also being implemented rendering great difficulty in adopting the approach in the national sanitation strategy of the government.

Great initiatives have been started by the national governments of Nigeria, Ghana and Kenya in scaling up of CLTS to state, regions and national levels respectively.

Amongst many others some of the emerging champions of scaling up of CLTS in these countries includeSalihu Lonis (Desk Officer, Sanitation, Federal Ministry of Water Resources),Vinod Alkari (Chief, WASH Section, UNICEF Nigeria) Bisi Agberemi (Program Officer, UNICEF Nigeria), Regional Minister of Northern Region, Hon. Bukari Moses Mabengba, Joseph M. Dasanah (Director,EHSD,MLGRD) Kweku Quansah (Program Officer, EHSD,MLGRD) Theodora Adomako (National Coordinator CWSA), Othniel Habila(Chief, WASH Section, UNICEF Ghana) and Lorretta Roberts (Program Officer, UNICEF, Ghana) and Hon. Public Health and Sanitation Minister, Beth Mugo, Mohamed El Fatih (Chief, WASH Section, UNICEF Kenya), Samuel Gitahi (WASH Specialist, UNICEF Kenya), Farooq Khan (UNICEF CLTS Consultant); Dr.KephaOmbach, Chief Public Health Officer (MoPHS),Dr. John Kariuki, Deputy Chief MOPHS, Adam Mohamed. National CLTS Focal Person, (MOPHS), Ibrahim Baswati (PMU), Edwin Odhiambo (Regional CLTS Focal Person, MOPHS Western & Nyanza), Ambrose Fwamba, Nicholas Makotsi and other District Public Health Officers from Western and Nynza Provinces.

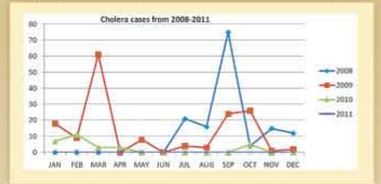
Estimated use of sanitation facilities in sub-Saharan Africa for 1990, 2000 and 2008

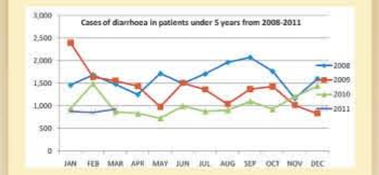
Year			1990	2000	2008
			%	%	%
Urban population as % of total			28	33	37
Urban	Improved		43	43	44
	Unimproved	Shared	29	30	31
		Unimproved	17	17	17
		Open defecation	11	12	8
Rural	Improved		21	23	24
	Unimproved	Shared	10	11	13
		Unimproved	22	23	25
		Open defecation	47	43	38
Total	Improved		28	29	31
	Unimproved	Shared	16	18	20
		Unimproved	20	21	22
		Open defecation	36	32	27
No. gaining access to improved sanitation 1990–2008 (thousand)			114,344		

Source: WHO and UNICEF (2008)

Impact of CLTS in Reducing incidences of Cholera and Diarrhea: the story of Nyando District in Kenya

CLTS (Community Led Total Sanitation) was first introduced in Kenya back in the year 2008 through two major hands-on training workshops held in Mombasa, organized by Plan RESA in collaboration with UNICEF and other agencies. It was in early 2010 when CLTS was first initiated in the 13 WASH pilot districts in Nyanza and Western Province of Kenya by the Ministry of Public Health and Sanitation (MoPHS) and UNICEF.These two provinces near Lake Victoria were selected for the pilot as the prevalence of diarrhea and cholera was highest in the area as compared to other districts of the country. Nyando district topped the list as one of the most endemic district in Nyanza Province.





CLTS without subsidy was introduced in the villages of Nyando Districtin the mid-2010.Community members of ODF villages in the endemic cholera zone realizedfor the first time that the major cause of their misery and child death was due to their practice of Open Defecation (OD). CLTS concept and principles focused on the use of homegrown mechanism to fight diarrhea, cholera and typhoid, and it reduced their dependence on external agencies for sanitary hardware. According to Mr. NicholasMakotsi,District Public Health Officer of Nyando district, 'it worked like magic'. Nyando'ssuccess spread to other districts in Nyanza province and CLTS spread more spontaneously into the neighboring villages of ODF communities.

The following graphs illustrate the sharp drop in the incidences of diarrhea and cholera amongst children under five years between the years 2008 to 2011.

For detailed report write to cltsfoundation@gmail.com

CLTS Foundation is an association of like-minded development professionals and practitioners, focusing on issues around rural and urban sanitation and water globally. Many senior WASH professionals from the government ministries, UNICEF, national and international agencies are now closely linked up and are working together with CLTS Foundations towards scaling up of CLTS across the state, province and country in some African nations. The foundation also builds capacity, undertakes research and action learning initiatives focused towards poverty reduction, rural and urban livelihoods and governance issues with CLTS as an entry point strategy. It is a Trust being managed by a board of Trustees and headed by the Chairman with headquarters in Kolkata, India. For more information go to: **www.cltsfoundation.org**

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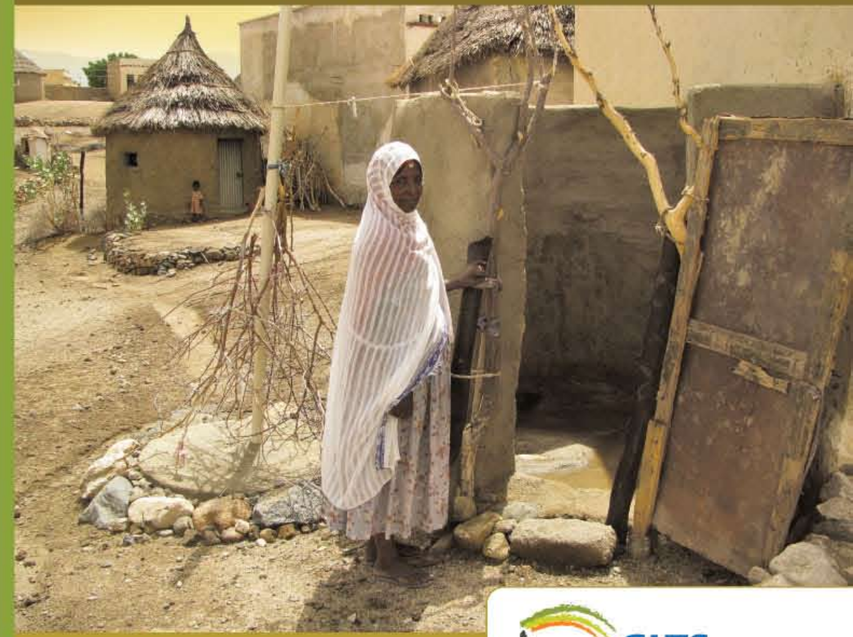
TCP2011

empowering communities

Building an ODF Africa through CLTS



CLTS Foundation
a better tomorrow

www.cltsfoundation.org

Community-led Total Sanitation (CLTS) is an innovative approach for empowering communities to completely eliminate open defecation (OD). It focuses on igniting a change in collective sanitation behaviour, which is achieved through a process of collective local action stimulated by facilitators from within or outside the community. The process involves the whole community and emphasises the collective benefit from stopping OD, rather than focusing on individual behaviour or on acquisition or construction of toilets. People decide together how they will create a clean and hygienic environment that benefits everyone.Certain features have been fundamental to the evolution of CLTS as an approach to sanitation issues.

CLTS involves no up-front, individual household hardware subsidy and does not prescribe latrine models.Social solidarity, help and cooperation among the households in the community are a common and vital element in CLTS. Other important characteristics are: the spontaneous emergence of natural leaders (NLs) as a community proceeds towards open-defecation-free (ODF) status; local innovation in low-cost toilet models using locally available materials; and community-innovated systems of reward, penalty, spread and scaling up. Children always play a very distinctly positive role in achieving ODF status after triggering. CLTS encourages the community to take responsibility and to take action leading towards achieving the common goal of ODF status.

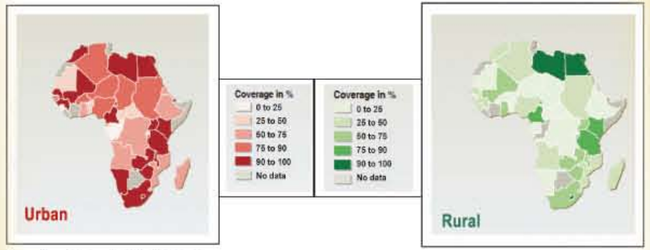
Dr Kamal Kar, Chairman of CLTS Foundation,pioneered CLTS during the evaluation process of the Water and Sanitation Programme of Water Aid and its implementing partner Village Education Resource Center (VERC) in Mosmoil village, Rajshahi district, Bangladesh, in 1999–2000. He was deeply involved in the spread of CLTS first within Bangladesh, then to Asia more widely and then later to Africa, Latin America, the Middle East and the Pacific. The approach is now used in more than 45 countries on various scales benefitting approximately twenty million people.

Introduced in 2006, the CLTSapproach that focuses on community-wide behaviour change to completely stop open defecation began to go to scale in Africa in around 2009.Since its introductionCLTS has spread dramatically and in many countries very successfully, and is now used at some level in at least 30 African countries.

Dr Kar has been extensively involved with the spread of CLTS in Africa to describe the early stages of the process, to elaborate on its developments and to outline insights into the circumstances and features which have facilitated its rapid spread. It has made spectacular progress in the years since then and in a number of countries it has been either scaled up or is planned to cover substantial areas of the country.

Thousands of villages have been declared ODF, and – quite remarkably – at least five national governments of eastern, southern, western and central Africa have now adopted CLTS as *the* main approach in their national

Sanitation coverage in Africa: Urban and Rural Areas (2000)



Developed from WHO (2000)

FEW SNAPSHOTS OF CLTS IN AFRICA

MALI

CHAD

ETHIOPIA

KENYA

NIGERIA

ERITREA

SIERRA LEONE

SUDAN

MOZAMBIQUE

TANZANIA

SOME INDIGENEOUS TOILET MODELS

MAURITANIA

Divided into two broad categories – those countries in which CLTS is well established and those where it is not so well established and those that have full plans and programmes for capacity building and large scale roll out are **Chad, Eritrea, Ethiopia, Gambia, Ghana, Kenya, Liberia, Madagascar, Malawi, Mali, Mauritania, Mozambique, Nigeria, Senegal, Sierra Leone, Sudan, Uganda** and **Zambia.**

Those that have successfully introduced CLTS fairly recently but faced with substantial challenges in terms of a conducive environment for the spread of CLTS are **Angola, Benin, Burkina Faso, Burundi, Cameroon, CentralAfrican Republic, Congo Brazzaville, Cote d'Ivoire, Democratic Republic of Congo, Guinea-Bissau, Guinea-Conakry, Niger, Tanzania, Togo and Zimbabwe.**