

Learning and recommendations on the use of CLTS in emergency and post-conflict/post-emergency situations

First compiled by Frank Greaves, November 2011, and reviewed by members of the Hygiene Promotion Forum and the CLTS Action and Learning Group. This draft completed in May 2012.

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Background

In March 2011, a group of WASH practitioners met at Oxfam GB’s UK office for the first Hygiene Promotion Forum (HP Forum). The main aim of the Forum was to provide an update on learning and practice in relation to health and hygiene promotion, and community involvement in emergency programmes, primarily in WASH. The event combined presentations on experience and learning in various areas, with working group discussions to explore gaps in knowledge, and to outline possible options for addressing these. One of the key areas of presentation and discussion focused on the use of Community-Led Total Sanitation (CLTS) in the emergency / post-emergency context.

The increasing popularity of CLTS since its initial application in Bangladesh in 2000 has surprised even Kamal Kar, the instigator of the process, and those who have been in the forefront of its promotion and development, primarily the CLTS Learning Group at the Institute of Development Studies¹. Whilst CLTS has been used across the world in various settings, numerous issues and challenges have arisen regarding its contextual appropriateness, such as the application in informal settlements in urban areas, and with nomadic or migratory populations. More recently there has been a growing interest in the use of CLTS in emergency, post-emergency and post-conflict situations, and in Fragile States. Indeed, some agencies have seen particular success in these arenas, at least in the early stages, e.g. Tearfund in Afghanistan and in DRC.

However, there are also perceptions that CLTS is fundamentally “mis-matched” to achieving safe sanitation at scale in an emergency, or immediate post-emergency, context. Two primary reasons for this include its core principle that sanitation hardware should not be subsidized if replication to scale and long-term sustainability of improved sanitation is to be realized: how is CLTS practically workable in a situation where participants have often lost all their wealth, and are at the point of greatest dependency on the aid community for their well-being? A second issue is that of “inclusivity”: can the poorest sections of the population obtain facilities for safe sanitation when their community structure and its social capital have been devastated?

Mindful of such challenges, the HP Forum tasked an informal working group to investigate the use of CLTS in the emergency and post-emergency context, and if possible, to give some guidance on its practical applicability in these contexts. By collating experiences of CLTS and distilling some of the key practical suggestions which result, this short report is a first draft towards that practical guidance.

A number of experiences by relief organizations in using CLTS in the emergency or post-emergency context is first considered. Key lessons or suggestions are drawn from each example. Following this, a Discussion section elaborates on some of the key common issues and challenges. Subsequently, there is an attempt to synthesize all key recommendations coming out of the various case experiences and discussions into a “guidance matrix”. Web-links to the source documents or contacts are given in a Reference section at the end.

A note on emergency types and phases

Thus far it seems that discussion around the use of CLTS in emergencies has not focused on the type or phase of an emergency response: the experience of some agencies is based chiefly on their intervention in the recovery or re-construction phase, whilst others have attempted facilitating CLTS at an earlier phase of an emergency, and even in the setting of IDP or refugee camps.

¹ The CLTS Action & Learning Group is co-ordinated by Petra Bongartz (Institute of Development Studies (IDS), at the University of Brighton, Sussex). A number of NGOs actively participate, including Plan, WaterAid, World Vision and Tearfund. For further information, see www.communityledtotalsanitation.org.

Community cohesion and support mechanisms, which may have thrived pre-emergency, may be all but decimated in the early period of a disaster or emergency. In the initial phases, humanitarian response is focused on saving lives, and affected populations live from day to day, trying to gain understanding on what has happened to their lives and their community. This context may hardly seem the basis for facilitating a reflective, self-analytical processes of sanitation and hygiene behaviour. However, as time progresses, priorities and human capacities change, and sanitation itself may become a critical consideration for health and well-being. Hence it is important to begin to investigate not just *how*, but *when*, and in *what circumstances*, it might be appropriate to consider that a self-analytical, behavioural change process such as CLTS has applicability. Equally, processes which can lead to more sustainable behavioural change, and even aid the transition to early recovery (should circumstances allow), are ultimately in the best interest of affected populations².

The Centre for Research on the Epidemiology of Disasters (CRED) maintains the International Disaster Database (EM-DAT). EM-DAT (2011, Ref. 1) distinguish three groups of disasters: “*Natural disasters*”, “*Technological disasters*” and “*Complex emergencies*”.

At least one of the following criteria must be fulfilled for a disaster to be entered into the database;

“Ten or more people reported killed; one hundred or more people reported affected; a state of emergency is declared; or there is a call for international assistance.” (EM-DAT, 2011)

Natural Disasters

Natural disasters are defined as:

“naturally occurring physical phenomena caused either by rapid or slow onset events which can be geophysical ([earthquakes](#), [landslides](#), [tsunamis](#) and [volcanic activity](#)), hydrological ([avalanches](#) and [floods](#)), climatological ([extreme temperatures](#), [drought](#) and [wildfires](#)), meteorological ([cyclones](#) and [storms/wave surges](#)) or biological ([disease epidemics](#) and [insect/animal plaques](#)).” (EM-DAT, 2011). Recent examples of this would be the Japan earthquake, Pakistan floods, and Asian tsunami.

Lantagne, in her recent work on the sustainability of home-based water treatment methods following their initial promotion in emergency contexts (Lantagne 2009, Ref. 1), suggests that epidemics (e.g. Haiti cholera outbreak) merit singular consideration to WASH responses. Certainly, the appropriateness of CLTS in an epidemics context needs very careful consideration

Technological Disasters

Technological disasters are “*catastrophic events that are caused by humans and occur in or close to human settlements*” ([EM-DAT](#), 2011), and may be a result of environmental degradation, pollution, accidents and conflict. Technological or human-made hazards include; famine, displaced populations, industrial accidents (e.g. fires, nuclear radiation) and transport accidents (e.g. oil and chemical spills).

² Reference to Tearfund / WEDC study, and its future relevance to informing the appropriateness of CLTS in emergencies.

Complex Emergencies

Some disasters can result from “a complex combination of both natural and human-made causes and different causes of vulnerability” (EM-DAT, 2011). Such disasters are commonly known as complex emergencies, and normally occur over an extended time period. A complex emergency is defined by the United Nations Inter Agency Standing Committee (IASC) as:

“a humanitarian crisis in a country, region or society where there is total or considerable breakdown of authority resulting from internal or external conflict and which requires an international response that goes beyond the mandate or capacity of any single and/or ongoing UN country programme.” (IASC, 1994)

Complex emergencies are generally characterized by:

“extensive violence and loss of life; massive displacements of people; widespread damage to societies and economies, the need for large scale, multi-faceted humanitarian assistance, and the hindrance or prevention of humanitarian assistance by political and military constraints.” (IASC, 1994)

In our current understanding, some may feel that CLTS and other demand-led, self-analytical approaches to WASH are most appropriate:

- a) in the recovery / rehabilitation phase of Natural Disasters;
- b) with local (host) populations and returnees in Complex Emergencies, and,
- c) in the recovery / rehabilitation / and preparedness phases in areas prone to Epidemics.

Complex Emergencies (aka *Fragile States*) do not fit within the normal “disaster cycle” of relief – recovery – rehabilitation – preparedness. Whilst they are classed as emergencies and funded through emergency mechanisms, they normally involve communities living long-term in highly volatile crisis situations. Tearfund’s recent work in Afghanistan and DRC shows that these communities can be receptive to CLTS and other demand-led WASH interventions, and that CLTS and other demand-led interventions are appropriate in these Complex Emergency situations³.

Whilst it is early days in respect of defining emergency types and phases in which CLTS can be successfully applied, one suggestion might be to adopt the EM-DAT definition of emergency types, adding special consideration to epidemics within the Complex emergency category, to aid our discussion on applicability of CLTS. Within this structure, each emergency type can be divided into two phases: Onset and Recovery (or rehabilitation).

However, it may well be found that such a framework has only limited usefulness in exploring the applicability of CLTS. Some WASH practitioners would advocate for a less “phase-categorisation” basis for linking emergency types and WASH approaches or interventions, particularly agencies that are focusing on approaches that aid the move towards sustainable

³ Murray Burt (Tearfund WASH Programme Manager, Nairobi), Oct. 2011, personal communication.

development from emergency phases. For them, a relief-to-development continuum model would ideally be adopted to assist in the choice of WASH methods to apply.

In a continuum model, a typology of situations affecting the lives of people caught up in the emergency, could be very useful. Robert Chambers, a member of the CLTS Action & Learning Group, suggests basing categorization of the applicability of CLTS on a typology of situations that describe the context of the disaster-affected population. This could include the following examples:

Affected populations:

- Displaced and in camps (Camps capped in numbers, or camps continuing to grow?)
- In socially cohesive groups (e.g. whole or part communities moved en mass), or in mixed social/ethnic groups?
- Living in host communities (Retaining social proximity, or integrated spatially with the host population?)
- Planning/aspiring to return to their home site and to rebuild, or having no such plans, or desires?
- Health status of household members (Growing evidence of WASH-related disease, or stable health status?)

Personal security and conflict:

- Relatively stable / normalized security, or high levels of security risk, in the place where the population wishes to settle (or where they fled to following the emergency)
- People living with fear of security / conflict, or fear of recurrence of natural disaster.

Infrastructure:

- Level of robustness, comfort, and sustainability of household shelters, compared with cost and effort of repairing or rebuilding own shelters, latrines, etc.
- Level of service provision (current and in foreseeable future), including sufficient, safe water supplies and sanitation
- Legal status inferred or potentially inferred, e.g. rights / potential to land ownership

Livelihoods:

- Availability of schooling for children
- Potential for jobs (e.g. service provision, rebuilding programme, access to markets)
- Food security status, including availability of land for establishing household gardens

To begin investigating the applicability of CLTS in emergency / post emergency situations, it is suggested that an initial, basic framework defining at least the key disaster types and phases, characterized by some of the more fundamental situation typologies of the disaster-affected population, is a rational start, and one through which a more simplified guidance framework can be arrived at by cross-referencing as our experience grows.

Experience to date

Community Approaches to Total Sanitation (CATS) Pilot in Haiti

Fiorella Polo, Unicef, Port-au-Prince, March 2010 (Ref. 4)

Context : IDPs in host communities

Methodology / Experience

- Unicef supported CATS facilitation in IDP camps following the earthquake in 2010. In those camps where sanitation facilities already existed, the focus was on the resident community taking ownership of cleaning and maintenance, and the proper use of toilets (Many latrines had previously been dismantled by households, and the materials used for other construction purposes around the home). This helped to stop Open Defecation (OD). In camps where no sanitation facilities existed, the community took the decision of building latrines, and promoting their use. This same experience of facilitating CLTS, not for the end result of building new latrines, but to make use of existing latrines, was witnessed by Oxfam in camps in Pakistan during the 2011 flood response;
- Tools used in CATS campaigns included the “Taboo Walk” (Transect walk), and food/water contamination through flies transferring shit;
- A difficulty in urban sites has been the limited land available for building latrines, or else landlords were sometimes unwilling for latrines to be built. Polo suggests communal latrines are the best way forward in these circumstances. While this requires community participation for construction, cash payment incentives are suggested as being necessary to accomplish the work. Engineers/builders need to be active in the process, and negotiate the design of latrines and their location with the community;
- In rural sites where no latrines exist, family latrines are a better option;
- From the Unicef pilot events, immediate results on the success of the “triggering” phase seemed to be more related to the quality of facilitation than to the type of site;
- Most progress has been seen in sites which already had latrines, particularly in respect of families cleaning toilets;
- Polo warns that focusing on disgust might not be appropriate/ethical to people who have already experienced shock;
- Several concurring supply-driven projects might not encourage people to take ownership.

Key learning to take forward

- Prioritise CATS in sites where sanitation already exists, as at this stage, self-help seems more realistic for cleaning rather than for building one’s own toilets;
- Quality facilitation is the primary concern: it has a decisive impact on the outcome of a CATS/CLTS event. The role of an implementing agency (in this case, Unicef) might be focused on quality training, control/monitoring, and improvement of facilitators. Of course, pre-emergency knowledge of good CLTS Trainer-of-Trainer facilitators in each region or country would be a great advantage;
- Follow-up (by the implementing agency) is critical to the success of the process;
- To reduce the likelihood of latrines being destroyed or dismantled, focus should be given to ensuring adequacy of family homes and shelters;

- To encourage ownership and self-dependency, avoid facilitating CATS/CLTS alongside several supply-driven projects, even though they may not be directly related to sanitation or WASH.

Community Approach to Total Sanitation in Sudan

Eltayib et al, Department of Water & Environmental Sanitation (WES), Sudan, November 2010 (Ref. 5)

Context: Long-term IDPs living within host-communities

Methodology / Experience

- WES has attempted to roll out CATS within the context of a defined scenario for total sanitation in the Sudanese context. The key criteria for total sanitation are as follows:

Water handling & use

- *Use sufficient water for personal hygiene (example: 20 litres per person per day for bathing, hands/face, cooking, drinking)*
- *Maintenance/cleanliness around water point, cleanliness of containers and water transportation, clean storage and use.*

Latrine coverage & use

- *Use of latrines by all members of the family when they are at home.*
- *Safe disposal of child's excreta*
- *Technology choice, including very low-cost options*

Hand washing

- *Washing hands with soap, ash or sand/soil, after defecation and before eating.*

Food hygiene

- *Covering food, washing raw food before eating, limiting time for re-use of food*

Cleanliness of the home environment

- *Separating livestock waste from human contact, solid waste management, wastewater management*

- The absence of any hardware subsidy (not even for the poor) is emphatic in WES's approach here: instead, different sanitation options are explored;
- This is a Moslem context: religious teachings are used to support promotion of ODF. For example, Islamic and Christian teachings are very specific on open defecation free concept:
 - *"Defecation should be done in privacy or while defecating nobody should see you" (Hadits Riwayat Abu Daud)*
 - *"By properly disposing all things that make you dirty as well as wickedness we receive grace of God to save our life" (Yakobus 1:21)*
 - *"Open defecation is not halal, and leads to eating Khara"*
- The participating community prepares an Action Plan based on the following components:
 - Mapping
 - Sanitary Inspection, comprising:

- Physical inspection of Public WASH facilities using a sanitary inspection checklist (Pre-formats in local language are used)
 - Water quality testing using H2S kit
 - Transect walk to defecation area
 - Sanitation and Hygiene Survey/Promotion (SHSP)
 - Group Discussion
- Stemming from the integrated WASH scenario for total sanitation, as outlined above, the Dept. of WES in Sudan link Household Water Treatment (HHWT, or “Point-of-use Water Treatment” (PoUWT), or “Home-based Water Treatment Systems” (HBWTS)) with CATS. The following activities are incorporated in the overall approach:
- *Water quality testing using H2S vial at source and HH levels*
 - *Introduction of chlorination tablets solution/tablets at HH levels*
 - *Provision of solutions/tablets at a sale centre in the town of Mahalia, and at other community shops*
 - *Piloting of other options such as commercial filters*
 - *[Conducting of trials of water faucets in clay jars, with results readily available]*
 - *Preparation of IEC materials on HHWT for promotion*
- Hence, in essence, WES in Sudan encompasses a demand-led, livelihoods approach to their CATS programme. This is worthy of note since CATS, or CLTS, effectively encourages the participating community to step on to the “Sanitation Ladder” of self-help / self-improvement of private sanitation facilities. Hence, by grounding CATS in a wider programme of self-help / self-improvement, it can be argued that participants will more readily embrace the concept that no hardware subsidies will be given for private latrines once triggering has taken place;
- Supporting this concept, WES constructed demonstration latrines using local materials (after assessing the availability of local materials in the vicinity). They costed out the various options of latrines that they were to demonstrate. Certain basic parameters (e.g. depth of pit, diameter, suitable lining options) are agreed/promoted, given WES’s subsequent knowledge of the local materials available, and the prevailing physical ground conditions. Additionally, the WES office in Mahalia town is used as a spare-parts sale counter for different WASH technologies;
- The Community Action Plan (CAP) addresses the entire community, since open defecation and poor hygiene practices affect all of the population. Hence, the CAP also incorporates a plan for improving WASH access at schools and health centres.

Key learning to take forward

- Consultation with the Mahalia Locality Commissioner and community leaders on the open defecation free concept is very important prior to starting the CATS process or selecting a community;
- In collaboration with govt. WASH authorities, implementing NGOs, and local private enterprises, embed the CATS / CLTS process in a wider programme of improved WASH access, based on a demand-led, livelihoods approach. This will involve investing in training and capacity-building of local artisans and service providers to provide WASH services (e.g.

latrine building, and installation of roof-water harvesting systems) to produce not only sanitation hardware components (such as latrine slabs, seats, vent pipes, doors, hand-washing dispensers, etc.), but also other technologies, and particularly those relating to Home-based Water Treatment and Storage (e.g. Ceramic filtration units and containers, Biosand Filters, ferrocement rainwater collection tanks and jars, local types of water storage vessels);

- Encourage the formation of a practical Community Action Plan for monitoring and maintaining ODF status, maintaining a clean environment generally, and for improving WASH access generally;
- Make use of local religious leaders and the influence and opportunities they have in bringing messages of personal cleanliness and well-being to their community. Faith-based Groups are ideally positioned not only to relate messages of health and well-being, but also to demonstrate improved practices of hygiene and sanitation, to advocate for improved WASH access, to assist in project implementation by encouraging community cohesiveness and helping to identify and respond to particularly vulnerable groups, and to take part in monitoring and raising awareness of the impact of ODF and improved WASH access⁴

CLTS in the Red Cross Red Crescent

Libertad Gonzalez, IFRC, March 2011 (Ref. 6)

Methodology / Experience

- IFRC has had mixed success in the adoption of CLTS in Takeo Province, Cambodia: during 2007 the average sanitation coverage in 80 villages where CLTS was implemented rose from 11.6% to 56%. However, by the end of 2009 coverage had reverted to 24% due to a loss of interest and a lack of physical space. Most of the households in the villages could not afford to upgrade their latrine (the basic models and materials being used were found to be vulnerable during the rainy season). But, perhaps not surprisingly, usage amongst those households who still have a latrine remained very high (97%);
- Challenging environments for latrine construction prevailed (e.g. heavy rains, high water tables) affected the willingness or ability to re-construct or replace latrines;
- IFRC found that local adaptation of CLTS was more positively received, when, for example, “smart” subsidies were introduced, and shaming⁵ practice was replaced by peer education and advice;
- IFRC adapted their CLTS process by combining CLTS with components of PHAST (Participatory Hygiene and Sanitation Transformation). Whilst both of these methods utilize

⁴ See Tearfund publication “*Keeping Communities Clean*” on the role of the church and other FBGs in improving access to WASH at:

<http://tilz.tearfund.org/Research/Water+and+Sanitation+reports/Keeping+communities+clean.htm>.

⁵ The concept of “shaming” is often seen as a contentious issue, and as a wholly negative concept. Some practitioners argue that the triggering point is better aligned with the idea that participants are shocked and disgusted at what they realise is happening in their community as OD prevails, and the collaborative decision to adopt ODF ensues from this. And yet, it is the communities themselves who, in the main, acknowledge the role of shame towards achieving a collaborative decision to cease OD in a positive light. Hence, the concept of “shame” is perhaps not fully understood with regard to CLTS, and so a brief discussion on the issue is given in Annex 2.

some common participatory tools, such as the transect walk and community mapping (“Defecation mapping” in CLTS), it should be highlighted that the two processes stem from different techniques and mindsets (i.e. PHAST being based on an educative, learning process, whilst CLTS is based on a self-analytical, belief-centred approach). The fear (and evidence!) is that CLTS itself can be stalled if held back by attempts to educate, rather than facilitate self-analysis, and the triggering process (with its subsequent collaborative decision-making process to adopt ODF status) is compromised. Nevertheless, IFRC maintain greater sustainability in behaviour change with an adapted version of CLTS, incorporating components of PHAST.

Key learning to take forward

- Work with households to build robust and appropriate latrine versions from the start, even though the latrines may be basic. External technical advice is critical in challenging environments [But also ensure full consultation with beneficiaries regarding technical challenges and solutions (*Author*)];
- “Smart” subsidies could be targeted to particularly vulnerable groups, or to households facing significant technical and physical challenges to latrine building.

A note on attempts to combine CLTS and PHAST

A number of agencies attempt to combine these behavioural change methods, with varying success. This is understandable, not least because facilitators of CLTS who have previously worked in hygiene promotion and behavioural change programmes are likely to have utilised PHAST, and will be acquainted with its techniques and tools, and the impact that can be achieved by PHAST. A further argument is the benefit of being able to apply an eclectic response to a specific emergency context, maintaining flexibility in order to meet specific contextual needs.

However, the instigators of CLTS, including both the key CLTS training agency, Plan International, and the Action & Learning co-ordinating group at the Institute of Development Studies, strongly hold the view that these techniques are fundamentally different in their overall approach and the principles on which they are founded, and that they are basically incompatible. Consequently “mixing & matching” CLTS and PHAST has often led to a stalled, or muted impact of CLTS in various contexts. See Annex 3 for a short discussion on the subject.

Tearfund’s experience in Afghanistan

Murray Burt, May 2010 (Ref. 7)

Context: Settled & re-settled villages, continuing to receive returnees

Methodology / Experience

- A key observation for Tearfund is that their success in the impact of CLTS in their project districts in Afghanistan is as part of an overall principle of supporting demand-led,

livelihoods-based, integrated WASH interventions. In this respect, Tearfund's experience and conclusions align well with that of Unicef-WES in Sudan (*See example above*). In their Afghanistan programme, Tearfund focused its efforts on facilitation, promotion, marketing and training, leaving construction, production and distribution for the local community, homeowners, and tradesmen. The programme adopted a social marketing approach, which involves the systematic application of marketing techniques, to achieve specific behavioral changes for a social good. This approach has created sustainable livelihoods for many artisans while also addressing health issues relating to water quality and sanitation;

- This experience applies to communities in a rehabilitation (post emergency) phase, in which initially displaced people were still returning to the villages, but at a much reduced level;
- The CLTS process was incorporated to establish an understanding of the link between open defecation and diarrhoeal disease in order to stimulate demand for safe sanitation;
- Following 'triggering' (the point in the CLTS process at which the community realises the connection between open defecation and poor health and moves towards a collaborative decision to end OD), construction of latrines was left for homeowners and local tradesmen. Most householders opted for an elevated vault latrine design, with a sealed waste collection chamber above ground, which is periodically emptied. Ash is added to the waste to control odour and accelerate the composting process. Householders built their latrines themselves with help from local tradesmen who already had the necessary skills and knowledge. Tearfund also provided training to local tradesmen to ensure that they understood the wider best practice issues with regard to safe sanitation, including latrine siting, design and construction quality;
- After CLTS 'triggering', and once the communities had started work on their action plans, Tearfund staff facilitated a community Participatory Hygiene and Sanitation Transformation (PHAST) process. This process helped the community understand the importance of good hygiene behaviour, and particularly hand washing with soap (or ash). Overall, the classical PHAST process was not followed rigorously, but more generally, with its techniques being used to complement those already introduced through the CLTS, and through programmes supporting the use of the Biosand Filter⁶, with a special focus on hygiene promotion and handwashing⁷;
- Hence, whilst the CLTS campaign stimulated demand for household latrines, and after only three months, the PHAST process and hygiene promotion campaign stimulated demand for hand washing. In their pilot village in Kapisa Province, this resulted not only in universal

⁶ The Biosand Filter (BSF) is a home-based slow-sand filtration unit, developed by the University of Calgary in the 1990s, which has shown to be effective in removing pathogens from contaminated water. Production of the concrete filters by local artisans is encouraged, and has led to the establishment of many self-sufficient programmes world-wide through various relief and development agencies.

⁷ It is worth noting that Tearfund's work with communities in Afghanistan involved a range of sectors, including WASH (integrated programmes of water supply, sanitation, and hygiene promotion), Disaster Risk Reduction (DRR), Livelihoods, and other programmes, many of which have taken place concurrently, and nearly all of which are interrelated. For example, DRR activities such as flood protection interact with WASH, especially where irrigation canals form the primary water source, or where latrines might be flooded or even washed away as a result of flooding. The DRR programme instigated radio campaigns, which were used to push a number of messages including safe hygiene practice (linked to safe sanitation), and promotion of the BSF. Hence the various approaches used in Tearfund's programming have, historically, incorporated significant overlap.

latrine coverage and a cessation of open defecation, but the majority of households also installed a hand washing system outside each latrine;

- Tearfund also worked with the community to promote Global Hand Washing Day, and used many social marketing techniques to promote hand washing with soap (or ash). The increased demand for hand washing facilities was primarily met by local steel workers, who were already producing small steel drums with a faucet designed for hand washing;
- It was important to work closely with the Mullahs to explain the importance of good hygiene behaviour, and then, together with the Mullahs, to carry the same message to the larger population. Throughout Afghanistan, faith-based institutions are central to the social fabric of a community, and the support of religious leaders validated Tearfund's work in the community;
- Based on the success observed in Kapisa Province, Tearfund, in collaboration with Unicef and the Afghan Ministry of Rural Rehabilitation and Development, are encouraging other agencies implementing WASH programmes to use demand-led, social marketing techniques, which also promote sustainable livelihoods. Tearfund has also successfully lobbied the government to amend the National WASH Policy to include CLTS and household water treatment as acceptable WASH interventions. Now Unicef is working with the government to develop a national plan to implement CLTS across the country.

Key learning to take forward

- Similar to the learning from Unicef and the Dept. of WES in Sudan, WASH interventions should ideally be based on an integrated programme which focuses on demand-led, livelihoods based activities and outcomes, where the emphasis falls on facilitation, promotion, marketing and training, leaving construction, production and distribution for the local community, homeowners, and tradesmen;
- Also aligning with Unicef's and WES's experience in Sudan, involve religious leaders to endorse and disseminate hygiene and sanitation practice messages, and to help advocate to government authorities for replication of the process, and subsequent policy change;
- PHAST can be used following CLTS, specifically with respect to consolidating improved personal hygiene practices, such as hand-washing at critical times;
- *See Tearfund's guidelines on the adoption of CLTS, and suggestions for overcoming some of the main challenges of the CLTS process, such as the issues of potential contamination of surface water and shallow groundwater supplies, inclusivity of vulnerable groups, and safe, appropriate latrine structures:*

http://tilz.tearfund.org/webdocs/Tilz/Topics/watsan/CLTS_web.pdf

Oxfam GB's experience in Hyderabad, Pakistan

Sonya Sagan and Qasim barech, OGB Hyderabad, 2011 (Ref. 8)

Context: IDP camps

Methodology / Experience

- Sagan quotes a low level of cohesion in the camp populations, with up to twelve different tribes resident. Consequently, common agreement and unified action is very difficult to achieve;
- Many latrines in the camps are not being used or properly maintained, and open defecation is prolific;
- Preliminary results are based on triggering of nine groups within the camps. Four of the groups subsequently developed action plans for change, which incorporated:
 - *Males holding daily clean-up campaigns and simultaneously raising awareness within the community that they are “eating our own shit”;*
 - *Increased demand for solid waste management kits;*
 - *Children’s initiatives: “OD police”, raising awareness of parents and other adults, daily clean-up campaigns, competitions between children from different blocks for the cleanest block, covering OD with lime or soil;*
 - *OD patrols blowing whistles on OD’ers;*
 - *OD areas cleaned, and subsequently used for recreation (sports grounds, entertainment venues, children’s play areas, etc.).*
- The facilitator is key, and must be dynamic, able to stimulate, motivate and challenge people. Immediate results of triggering seemed heavily reliant on the skills of the facilitator – if facilitation skills were weak, the community did not take action;
- In formal camps, it was difficult to motivate women from different tribes: issues of distance to improved sanitation facilities were important;
- The Oxfam team saw that follow-up after facilitating CLTS must be prioritized.

Key learning to take forward

- As with Unicef’s experience in Haiti, facilitation skills are the primary concern – focus on building capacity of good facilitators;
- Children can have a unique and hugely impacting role in encouraging and maintaining ODF within their community areas;
- Discuss and support women in respect of what safe and comfortable sanitation “looks like” if they are to be persuaded to cease using OD sites.

CLTS intervention in the post- emergency context in Pakistan

By Syed Shah Nasir Khisro, IRSP (Integrated Regional Support Programme) (Ref. 9)

Context: Settled communities affected by flooding

Methodology / Experience

- The flooding in Pakistan not only destroyed houses but also damaged the sanitation infrastructure. Affected communities, including women, were consequently forced to defecate in the open. Hence, it became imperative to sensitize communities regarding the harm of OD, particularly in the flooded areas, and to provide them with the knowledge and capacity to use their own resources for safe management of human excreta;
- Low-cost latrine materials were made accessible to the poorer sections of each community;

- In this post-emergency context, the CLTS approach needs more time and expertise. A more interesting and innovative approach should be applied to reduce the impact of subsidy provided to the affected communities as all WASH related projects in this context are subsidized in nature. The key innovation supported by IRSP was the establishment of a Community Resource Person (CRP): a CRP is identified for each 500 households, and linked to the PHED (Public Health Engineering Department) Community Development Officers. They are trained to trigger CLTS in their respective communities. The CRPs also mobilize communities for hygiene promotion and a campaign at the community level is carried out. The CRPs also facilitate CLTS in schools.
- It is very important that CRPs should know the initial stages of project activities, development of action plans and implementation of a project strategy. The process outlined below is followed by CRPs in triggering CLTS and for sustainability of the programme in one community:
 - *Identifying key persons in their villages (activists)*
 - *Developing the community profile*
 - *Arranging events in school*
 - *Forming WASH clubs in school*
 - *Collecting WASH information about the schools*
 - *Meeting with community on clarifying the objective of sanitation intervention*
 - *Collecting WASH information about the community*
 - *School-level awareness campaign*
 - *Conducting community awareness campaigns*
 - *Planning and facilitating CLTS triggering in the community*
 - *Assisting the community in drawing up an action plan*
 - *Forming part of internal ODF verification committee, and arranging the field visit of the external ODF certification committee, as well as inviting the media*
 - *Orientation of the key stakeholders on their roles and responsibility in the process*
 - *Facilitating the practical demo of latrine construction (various types)*
 - *Facilitate in establishing linkages between the communities with trained masons*
 - *Linking the communities to sanitation mart /entrepreneurs for low cost options*
 - *Follow-up and community monitoring, and interfacing with Village Sanitation Committees*
 - *Sharing & documenting successful case studies*
 - *Planning for enabling the community to climb to the next step of the Sanitation-Ladder*

Key learning to take forward

- Enhancing sustainability of CLTS campaigns through creation of Community Resource Persons as key, trained co-ordinators who plan the CLTS event, encourage maintenance of the ODF status, and further improve their community's access to safe sanitation.

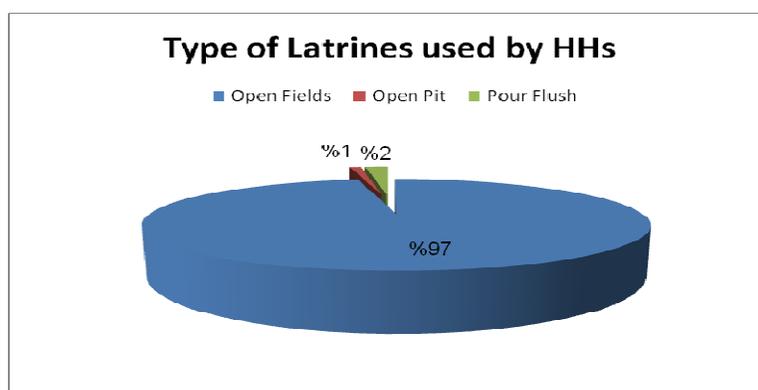
CLTS in 2010 post-flood emergency response effort, Pakistan

By Rashid Khan, World Vision Pakistan, 2012 (Ref. 10)

Context: Settled communities affected by flooding

Methodology / Experience

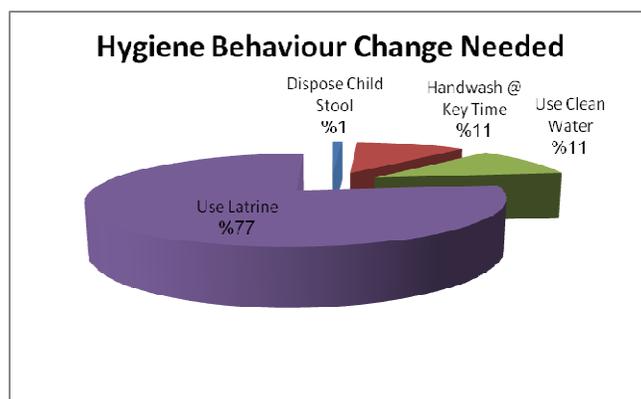
- During the 2010 Pakistan post-flood emergency responses, World Vision Pakistan (WVP) used the CLTS approach to encourage flood-affected communities to adopt and practice safe sanitation. The project was piloted with ten rural communities in the district of Muzaffargarh, Punjab province;
- After the flood, and prior to beginning any CLTS activities, WVP conducted a detailed needs assessment in Punjab province: 97% of rural communities were resorting to open defecation (OD), and among the approximately 10,000 people in the ten pilot communities, more than 80% reported diarrhoea in the previous month⁸;
- The pre-intervention survey was conducted randomly in 50 % households of each village, using pre-designed questionnaire, which consisted of both closed and open ended questions covering social, technical, cultural and institutional aspects of sanitation ladder. Data from the pre CLTS questionnaire were analyzed and presented in graphic form:



- WVP immediately started CLTS triggering activities and within four months the communities succeeded in constructing 525 latrines and organizing clean-up campaigns. One year later all ten communities have reached open defecation free (ODF) status. WVP's early recovery strategy is now focusing on working with these communities to support them improve other aspects of their WASH environment, and scaling up the CLTS programme to other interested communities;

⁸ Results revealed that health and hygiene of the community was at risk due to clogged sanitation drains, environmental degradation, and contaminated drinking water. The survey showed that, of the households who had water sources within their compounds, 45% had been damaged by the flood. No proper solid waste disposal system existed, so garbage was thrown into open fields. 86% the respondents reported practicing open defecation, and 63% of the households confirmed that they have no access to household latrines. 96% of respondents indicated that they do not wash their hands with soap after defecation, and the same 96% indicated that they do wash their hands before cooking! Consequently these conditions led to an increase in the incidence of diarrhoeal diseases as 86% of the respondents reported one or more diarrhoea case in the previous month

- Women and children played a vital role in changing the OD behavior by encouraging men to use latrines and by monitoring OD on a daily basis;
- WVP conducted a post-CLTS KAP survey with the same established questionnaire form randomly in 50 % households in the targeted villages. The same method was applied to investigate the changes after achieving ODF status;



- After achieving ODF status, the village communities started celebrating the success with traditional dances following by role plays and speeches by WASH committee members. The celebrations were attended by more than 4000 individuals from all of walk of life. Women and children showed high interest and commitment to keeping their household and village's environment clean. Children also participated in role plays which formed part of awareness raising initiatives. At the end Tehsil Municipal Administration (TMA) awarded ODF certificates to successful villages.

Key learning to take forward

- Sustaining the ODF status of a village is a big challenge to maintain where people are struggling hard to fulfil their other pressing needs;
- The unavailability of low cost materials just after the devastating floods made it difficult for communities to access essential and construction materials. Government support was weak, posing a threat to the sustainability of project;
- The CLTS process does not deal with the treatment of black and grey water from the households which are also associated major health risks.

Discussion

a) Lukenya Notes: Emerging Issues and Scaling Up CLTS into Different Contexts, Sept. 2011

The following extract is taken from the “Lukenya Notes”: a collection of experiences and key recommendations from the Institute of Development Studies meeting of CLTS practitioners held in Lukenya, Nairobi in July 2011, following the AfricaSan3 meeting. The aim of the workshop was to focus on the key challenges faced in taking CLTS to scale. Insights, case studies and options are clustered by themes which emerged from workshop brainstorming.

In a section on Emerging Issues and Scaling up CLTS into Different Contexts, the following learning and suggestions were made regarding CLTS in emergencies:

CLTS in emergency situations and post-conflict/post-emergency conditions

Extract from “Lukenya Notes” (Ref. 2)

Introduction

Emergency situations include civil conflict, floods, droughts, violent storms, earthquakes, tsunamis and other disasters which afflict and displace people. IDPs (internally displaced people) and refugees across borders number some 40 million. The conditions in which they find themselves vary widely: from severe physical disability from starvation and/or epidemics, to physical health and strength of many members; from being scattered in communities to being concentrated in camps and settlements; and from being largely on their own and self-reliant to having dependent attitudes as a result of the efforts of international agencies, NGOs and governments to provide for them. Generalisations about the relevance and feasibility of CLTS are therefore difficult. However, common experience is that it will be most feasible where people are together in numbers, physically able, with some social cohesion, and free of dependent attitudes. In the past it has been found that displaced people have more energy and more capacity to help themselves and be self-reliant than many NGO workers have understood.

Challenges and questions

- Are ‘Emergency NGOs’ with their reflexes of provision and delivery of subsidised sanitation hardware, sometimes part of the problem, reinforcing a misleading image and so reality of helplessness among the affected population?
- Can CLTS contribute to self-reliance and self-respect, and to wider livelihood development in post-conflict or post-emergency situations?
- To what extent, and in what conditions, may subsidised hardware be needed and desirable, and in what conditions should it be avoided?
- What can be done when dependence is already an institutionalised culture?
- What are the best ways to distinguish between different conditions, so that actions can be more fitting?

Recommendations and ideas

These are early stages in learning to what extent CLTS is feasible, even before trying to take it to scale. Skepticism can be expected from some external actors in emergency and post-emergency conditions. Recommendations and ideas are therefore to:

- Be bold in seeking to introduce CLTS in a range of conditions
- Document and compare the experiences, and what works and what does not
- Learn from current practices and experiences with participation and self-help by affected populations
- Strive for rapid and accurate learning about types of conditions and key parameters, and develop a typology of situations which can be used prescriptively
- Assess the requirements for going to scale in mass displacement conditions. This may include reorientation of those in humanitarian agencies.

b) Linking CLTS with emergency sanitation: what are the circumstances where CLTS is not only appropriate, but beneficial over other approaches?

In the examples above, significant emphasis is given to the socio-cultural appropriateness of CLTS in the emergency/post-emergency context, and rightly so, since this has been shown to be perhaps **the** decisive factor in establishing community-wide safe sanitation practice that is

replicable and sustainable. However, in an early-stage emergency in particular, the sanitation response has to be technically appropriate, and suitable sanitation systems need to be constructed swiftly and at scale, even if these initial systems are designed as a temporary response for safe excreta disposal. CLTS may not achieve this rapidity of coverage, nor the technical safe-guard that collaboratively pre-designed latrines and other emergency sanitation systems may offer, given the prevailing physical constraints. As mentioned in the “*Note on emergency types and phases*”(page 2), we need to come to understand *when* and *how* CLTS can replace conventional emergency sanitation approaches as an appropriate way forward to achieve lasting and effective latrine coverage. (For example, trench latrines are a vital emergency response option, enabling establishment of rapid access to safe sanitation for large numbers of displaced people. Whilst it is perhaps inappropriate to use CLTS to establish field trench latrines for rapid emergency response, CLTS could be an appropriate method for promoting their use).

With this in mind, it is perhaps an ultimate aim of the quest to ascertain how appropriate CLTS is in the various emergency contexts, to see CLTS as an acknowledged option within the sanitation in emergencies field, preferred over others, given the satisfaction of various criteria.

c) Tearfund/WEDC research into WASH interventions and approaches which aid transition to early recovery.

In August 2011, Tearfund and the Water, Engineering and Development Centre (WEDC), began work on a research project entitled: *Sustainable WASH Interventions as Populations Transition from Relief to Early Recovery in Natural Disaster / Conflict Emergency Response*. The research is funded by USAID’s Office of U.S. Foreign Disaster Assistance (OFDA). This is not expressly about CLTS, but it will incorporate consideration of CLTS as one of a number of WASH tools which can assist sustainable transition towards early recovery.

The early stages of emergency response require immediate water, sanitation and hygiene (WASH) interventions which normally use fully subsidised, ‘supply-driven’ methods, such as water distribution, latrine construction and hygiene kit distribution. However, when these methods are applied for a protracted period, they can result in dependency on the implementing agency, a lack of community ownership, and poor overall sustainability of interventions. During the recovery phase of an emergency response, and when working with returnee populations, Tearfund has found success using non-subsidised, ‘demand-led’ methods for WASH interventions, which also promote economic revitalization through development of sustainable livelihoods. Demand-led WASH interventions focus on facilitation, demonstration, and marketing techniques to create demand, and then on training artisans to produce products to meet the new demand. CLTS, which is clearly a demand-led sanitation approach, can easily lead to such socio-economic stimulation in a recovering community.

The research will adopt a case study approach and will review existing/ongoing humanitarian interventions in both the longer term chronic emergency context (e.g. Darfur) and the short term acute emergency context (e.g. Haiti). Amongst other sources, it will draw on Tearfund’s experiences in Afghanistan in particular, and the way in which demand-led, livelihood-based approaches have aided transition to sustainable access in water and sanitation.

Based on the findings of the research and analysis, a framework for strategic analysis and planning of demand-led WASH interventions in the early stages of an emergency response will be developed. The framework could then contribute to the future development of tools to guide and optimise planning of demand-led WASH interventions which make the transition to the recovery phase more effective and, where possible, more swift.

The research is due to be completed by September 2012⁹.

d) Additional notes from the HP Forum held in March 2011

The following additional key points and statements were voiced by participants at the HP Forum in March 2011:

- Two non-negotiable points of emphasis must be emphasized within the CLTS process, or any other sanitation approach in the emergency/post emergency contexts – handwashing with soap, and the safe disposal of children’s faeces!
- PHAST and CLTS may have certain complimentary, rather than contradictory, aspects, despite the fact that significant caution is stipulated by key practitioners against “mixing & matching” the approaches;
- In emergency contexts, it may be more appropriate to focus on Total Sanitation rather than purely on CLTS. Participants at the HP Forum understand that "Total Sanitation" places significant emphasis on hygiene behaviour (e.g. hand-washing at critical times, and the messaging methodology behind this, and safe disposal on children's faeces), and more all-encompassing WASH good practice, i.e. safe handling and storage practices for food and drinking water, and safe practices for disposal of other solid waste and domestic water. In addition to this, Total Sanitation campaigns and processes often refer to an overarching approach which encompasses sanitation marketing, the creation and maintenance of supply chains, and other components of a demand-led/livelihoods approaches to safe sanitation (Water & Sanitation Programme, 2009, Ref. 11)

Hence, the emphasis of Total Sanitation is of an over-arching, integrated WASH package. Perhaps a good example is the “*Village Assaini*” (“Healthy Villages”) approach in the DRC, where, for example, safe water supply and storage is key. See Annex 4 for a brief explanation of the “*Village Assaini*” concept.

- Risk analysis should be incorporated as part of pre-triggering;
- Water Safety Plans and CLTS appear to be mutually supportive processes, and should be beneficially linked in the same programme;
- Do not overlook the need for monitoring and evaluation of CLTS (or any other sanitation approach) in emergencies;

⁹ For further details, contact: Frank Greaves, WASH Adviser, Tearfund, 100 Church Road, Teddington, Middlesex, TW11 8QE. Frank.Greaves@tearfund.org Tel. +44 (0)20 8943 7757

- We need to develop effective urban versions of CLTS.

e) Additional notes from the Oxfam GB's Humanitarian Learning WASH Forum, held in May 2012

In May 2012 the theme of CLTS in Emergencies, and the concept of this report, were presented at Oxfam's annual Humanitarian Learning WASH Forum. The following comments were given by a wide field WASH practitioners (other comments have been incorporated elsewhere in the report):

- It was suggested that, *"CLTS can be used to raise awareness and trigger latrine use, during an emergency (Onset / Immediate post-emergency period). But markets will only be found in a recovery phase."* Some may disagree (e.g. During the Rwandan crisis in 1994, markets sprung up in the Tanzanian refugee camps only months after being populated, and as the crisis continued). However, it is unlikely that the full scope of a livelihoods approach, incorporating training of artisans, local production, local promotion, advertising, and demonstration, will be established prior to the recovery phase;
- CLTS ultimately needs to be context-specific, and guidance of CLTS application and techniques is the key need, i.e. avoid a framework that is too definitively categorised;
- Maintain an emphasis on low-cost technologies;
- What appropriate humanitarian donor costs can be assigned to programming for CLTS? It would be useful to have examples of CLTS programming & budgeting for the emergency & post-emergency context;
- There is an important need to consider economic and market factors, such as the availability / scarcity of construction materials, including, for example, security issues hindering access to them;
- Is there a role of peace-building in this self-analytical process of behavioural change for common well being?
- Consider CLTS as having application which is "transitional", from camp / environment "clean-up" in early emergency phase, to operation & maintenance in the rehabilitation phase;
- Linking CLTS with Cash-for-Work in the emergency / post-emergency context can provide speedy response to digging latrine pits, for example;
- Altogether, CLTS seems more appropriate to slow-onset and complex emergencies, and the less appropriate as rapid-onset emergencies;
- Work with men to ensure they understand the needs of women when it comes to latrine siting and design;
- As with OD, CLTS should examine the harm due to "flying latrines".

Recommendations (Draft) towards CLTS in Emergencies guidelines

At this stage, the recorded experience and learning of CLTS application in the emergency/post-emergency context might be amalgamated into a guidance matrix, such as that sketched out below. This is an initial, fairly crude attempt at forming recommendations from the different

case studies and learning contained in this document, and it is sincerely hoped that colleagues and practitioners working in CLTS will swiftly elaborate the matrix, with the ultimate aim of presenting prescriptive guidelines for applying CLTS.

Draft Guidance Matrix for the application of CLTS in the onset and recovery phases of emergencies

Emergency type	Emergency phase	
	Onset <i>(E.g. camps, displaced populations in host communities)</i>	Recovery (or Rehabilitation) <i>(E.g. Communities returning and re-settling in home or new locations, or long-term camps becoming settled)</i>
Natural disasters, or rapid-onset disasters	<p>Experience:</p> <ul style="list-style-type: none"> • CATS in Haiti (Ref. 4) • Oxfam GB in Hyderabad, Pakistan (Ref. 8) <p>Typical situation typologies encountered:</p> <ul style="list-style-type: none"> • Displaced and in camps; • Displaced population in socially cohesive groups <i>(Less challenging for CLTS than if affected population are placed in mixed ethnic/social groups)</i>; • Living in host communities <i>(Integrated spatially with host pop., or retaining social proximity?)</i>; • Plans to return to home area within short period <i>(Likely to be more challenging than if affected pop. are resigned to long / undefined term of displacement)</i>; • Status of available sanitation facilities <i>(Inadequate access due to overcrowding, or facilities full or in poor maintenance will lead to increasing OD practice)</i>; • Enforcement of by-laws against OD <p>Recommendations:</p> <ul style="list-style-type: none"> • Prioritise CATS in sites where sanitation already exists: CLTS found to be most effective in keeping environment clean rather than for building toilets; • Quality facilitation is the primary concern: the role of an implementing agency might be 	<p>Experience:</p> <ul style="list-style-type: none"> • IRSP in Pakistan (Ref. 9) <p>Typical situation typologies encountered:</p> <ul style="list-style-type: none"> • Affected pop. which experiences lower incidence of WASH-related disease in transient settlement (due to safe and adequate level of services) retains aspiration to re-build with safe, improved sanitation facilities – notion of “<i>build back better</i>”; • Availability of local and natural construction materials; • Effectiveness of local leadership in maintaining social cohesiveness and well-being through community self-improvement and ownership of service provision responsibility; • Effectiveness of establishment and enforcement of bye-laws against OD; • Resumption or creation of livelihood opportunities to either purchase materials or services for sanitation, or to apply new skills / knowledge; • Knowledge or perception of food security <i>(i.e. affecting prioritization of resources both in short- and long-term)</i>; • Availability of land for small-scale cropping / gardening, and space for latrine construction; • Perception of long-term service prospects, e.g. availability of schooling for children, health-care, safe and reliable water supply, access to markets;

	<p>focused on quality training, control/monitoring, and improvement of facilitators;</p> <ul style="list-style-type: none"> • Follow-up is critical to the success of the process; • To reduce the likelihood of latrines being destroyed or dismantled, focus should be given to ensuring adequacy of family homes and shelters; • To encourage ownership and self-dependency, avoid facilitating CATS/CLTS alongside several supply-driven projects, even though they may not be directly related to sanitation or WASH; • Facilitation skills are the primary concern – focus on building capacity of good facilitators; • Focus on Total Sanitation rather than purely on CLTS; • Emphasize handwashing with soap, and the safe disposal of children’s faeces. 	<ul style="list-style-type: none"> • Able-bodied family members to construct new / improved sanitation facilities <p>Recommendations:</p> <ul style="list-style-type: none"> • Enhance sustainability of CLTS campaigns through creation of Community Resource Persons as key, trained co-ordinators who plan the CLTS event, encourage maintenance of the ODF status, and further improve their community’s access to safe sanitation.
<p>Complex disasters, characterized by on-going security crisis</p>	<p>Experience:</p> <ul style="list-style-type: none"> • <i>None submitted as yet, but input sought from responses such as East Africa drought crisis, 2011.</i> <p>Typical situation typologies encountered:</p> <ul style="list-style-type: none"> • Displaced and in camps; • Displaced population in socially cohesive groups (<i>Less challenging for CLTS than if affected population are placed in mixed ethnic/social groups</i>); • Living in host communities (<i>Integrated spatially with host pop., or retaining social proximity?</i>); • Plans to return to home area within short period (<i>Likely to be more challenging than if affected pop. are resigned to long / undefined term of displacement</i>). • Perception of camp security status (<i>People living with fear of security / conflict, or recurrence of a natural disaster, will be less likely to put effort / investment into sanitation facilities, however likely to be “long-term” temporary</i>); • Degree of security maintained within the camp / host community setting • Status of available sanitation 	<p>Experience:</p> <ul style="list-style-type: none"> • Dept. of WES & Unicef, Sudan (Ref. 5) • IFRC, Cambodia (Ref. 6) • Data expected from WEDC/Tearfund research in Darfur, 2011/2012 • Tearfund in Afghanistan (Ref. 7) <p>Typical situation typologies encountered:</p> <ul style="list-style-type: none"> • Affected pop. which experiences lower incidence of WASH-related disease in transient settlement (due to safe and adequate level of services) retains aspiration to re-build with safe, improved sanitation facilities – notion of “<i>build back better</i>”; • Availability of local and natural construction materials; • Effectiveness of local leadership in maintaining social cohesiveness and well-being through community self-improvement and ownership of service provision responsibility; • Effectiveness of establishment and enforcement of bye-laws against OD; • Resumption or creation of livelihood opportunities to either purchase materials or services for sanitation, or to apply new skills / knowledge; • Knowledge or perception of food security (<i>i.e. affecting prioritization of resources both in short- and long-</i>

	<p>facilities (<i>Inadequate access due to overcrowding, or facilities full or in poor maintenance will lead to increasing OD practice</i>);</p> <p>Recommendations:</p> <ul style="list-style-type: none"> • Focus on Total Sanitation rather than purely on CLTS; • Emphasize handwashing with soap, and the safe disposal of children’s faeces. 	<p>term);</p> <ul style="list-style-type: none"> • Availability of land for small-scale cropping / gardening, and space for latrine construction; • Perception of long-term service prospects, e.g. availability of schooling for children, health-care, safe and reliable water supply, access to markets; • Able-bodied family members to construct new / improved sanitation facilities; • Resumption of legal status, both in terms of citizenship and land / property ownership; • People living with fear of conflict, ethnic tension, and under threat of resource loss through raiding of community and looting pf property. <p>Recommendations:</p> <ul style="list-style-type: none"> • Consult with local authority leaders on the open defecation free concept prior to starting the CATS process or selecting a community; • In collaboration with govt. WASH authorities and all other stakeholders, embed the CATS / CLTS process in a wider programme of improved WASH access, based on a demand-led, livelihoods approach; • Focus on demand-led, livelihoods based activities and outcomes, where the emphasis falls on facilitation, promotion, marketing and training, leaving construction, production and distribution for the local community, homeowners, and tradesmen; • Encourage the formation of a practical Community Action Plan for monitoring and maintaining ODF status, maintaining a clean environment generally, and for improving WASH access generally; • Make use of local religious leaders and the influence and opportunities they have in bringing messages of personal cleanliness and well-being to their community; • Involve religious leaders to help advocate to government authorities for replication of the process, and subsequent policy change; • Work with households to build robust and appropriate latrine versions from the start, even though the latrines may be basic. External technical advice is
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		critical in challenging environments; <ul style="list-style-type: none"> • Target “Smart” subsidies to particularly vulnerable groups, or to households facing significant technical and physical challenges to latrine building.
Sub-group: Epidemics	Experience: <ul style="list-style-type: none"> • Is CLTS appropriate at all in this context?? More information needed (e.g. data expected from WEDC/Tearfund research in Haiti, 2011/2012). 	Experience: <ul style="list-style-type: none"> • Data expected from WEDC/Tearfund research in Haiti, 2011/2012; • Other sources?

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Annex 1: CATS (Community Approaches for Total Sanitation) - a working definition of community based sanitation for UNICEF

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.

Working definition/terminology of community based sanitation for UNICEF

- Processes whereby men and women demand, effect and sustain a hygienic and healthy environment for themselves (by creating barriers to prevent transmission of disease)
- The minimum elements of such an approach include:
 - a) That it is driven by collective process (as opposed to targeting individual households)
 - b) That handwashing at critical times is a key component of the programme and;
 - c) That community leadership includes children and caregivers.

The group then developed a new term to replace CBS that captured CBS and what this meant for UNICEF more specifically: **CATS – Community Approaches for Total Sanitation**. CATS encapsulates various approaches to community based sanitation such as CLTS, TSA, TS and others. WES staff felt it was important, in working with governments and partners, to allow this flexibility in approach in developing the most appropriate route for a given setting. CATS 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.

UNICEF’s non-negotiable principles of CATS (Community Approaches for Total Sanitation)

(WASH Section, Programme Division, UNICEF, New York, October 2008, DRAFT)

- 1) The aim is to attain total sanitation, i.e. to achieve open defecation free communities by use of safe, affordable and user-friendly solutions/technologies. It implies that the objective of any sanitation intervention is the sustainable use of sanitation facilities (as opposed to the construction of infrastructure). Safe disposal of human excreta includes the management of children's faeces.
- 2) The definition of 'Communities' (and particularly where community leadership and participation are emphasized) includes a role for schools, health centres, traditional leadership structures, women and girls.
- 3) Communities are in charge of the change process and use their capacity to attain their envisioned objective. They play a central role in planning with special consideration to the needs of vulnerable groups, women and girls and in respect of the community calendar.
- 4) Subsidies (in the form of funds, hardware, etc) are not to be given straight to households. Community rewards and incentives are acceptable only where they encourage collective action, total sanitation and are used to attain sustainable use of sanitation facilities (as opposed to the construction of infrastructure).
- 5) Households will not have externally imposed standards for choice of sanitation infrastructure. Technologies developed by local artisans from locally available materials are encouraged. External agencies provide guidance as opposed to regulation. Where viable, involvement/instigation of a local market with its local entrepreneurs is encouraged.
- 6) Involves the training of community facilitators and local artisans.
- 7) Governments' role and cross fertilisation of experience are essential for scaling up.
- 8) Sanitation as an entry point for greater social change is implicit as a guiding principle.
- 9) CATS must include hygiene (the definition, scope and sequencing of hygiene components is contextual).

Annex 2: The issue of Shame in CLTS

There has been an interesting debate going on about the elements of shame, fear and disgust used during CLTS triggering session. The debate has been between those who believe that the element of shame as applied during a CLTS trigger is unethical as it amounts to degrading and embarrassing the community, and those who believe that the element of shame is actually positive, and that it indeed awakens the community to the realities of open defecation. My take is that both groups are genuinely concerned about acting in the best interest of the community and the differences are based on misunderstandings. These misunderstandings may be due to the following reasons:-

- Whether people have a common and shared understanding of what "shame" means.
- Whether people have the same understanding on how to facilitate CLTS trigger.

The word shame is a controversial term as it is open to different interpretations depending on one's culture or background. For as long as the interpretations vary from individual to

individual, and from culture to culture then we shall remain stuck in a quagmire. So the first thing is to try and develop some common understanding. In an article titled, "Shame may not be so bad after all", Dr. Joyce Brothers argues that there are two kinds of shame. The "good shame" and the "bad shame". She says that good shame "can lead to self discovery and growth" while the bad shame "humiliates and makes you feel bad about the way you look or feel". She goes ahead to assign the following attributes to the good shame:-

- Gives you new insight about yourself.
- Encourages you to make improvements.
- Expands your value system.
- Makes you more sensitive to others.
- Makes you want to elevate the culture around you

Whereas bad shame has the following attributes:-

- Attacks you as a person.
- Eats away at self-esteem.
- Evokes an angry response.
- Gets passed along to your children.
- Leaves you feeling helpless

The people who practice and believe in the efficacy of CLTS are mostly of the view that CLTS triggering evokes the good shame which enables the communities to have insights about their sanitation practices, and consequently make improvements about their sanitation situation. On the other hand the people who are uncomfortable with the element of shame in CLTS triggering, believe that it eats away the self esteem of the community and attacks the community's dignity. As a result of this they may fear that CLTS is likely to evoke an angry response from the community. Due to this underlying fear, they criticize CLTS as ethically unviable and culturally unfriendly to the communities.

I will try to share my thoughts on this topic based on my experience with CLTS. First I want to start by saying that a CLTS trigger can either evoke the good shame or the bad shame. What makes the difference is facilitation! A good facilitator will conduct a CLTS trigger in a way that allows the community to collectively and in a participatory manner analyze their sanitation situation. In this analysis, through the tools employed by CLTS, a community comes to self realization that their acts of open defecation are disgusting. In disgust, I have seen some people spit, others turn away from the direction of shit. Still others have vomited at the sight of shit. Disgust is one of the key elements of a CLTS trigger. Disgust is ignited by the unpleasant sight of shit, more so when the shit is still in its fresh and wet state. On the other hand, the shame that is evoked during a CLTS trigger touches on ones inner emotion which is ignited by a personal realization of an offensive behaviour or action. Shame brings with it feelings of remorse and sorrow. In this case, a person takes personal responsibility for the offensive behaviour that they now feel apologetic for, and consequently desire to take corrective action. It is important to note that in this context a sobering effect bears on a person, and in a way they come back to their senses and desire to do what is right and appropriate. A person who had become

accustomed to open defecation, and had even come to take it for granted as normal behaviour, awakes from his stupor and becomes “enlightened.” This state of enlightenment results in a self realization that open defecation is repugnant, and it unleashes positive energy that seeks to engage in constructive action that will lead to an end to open defecation.

Another critical element that needs to be appreciated is that when the triggering is done right, the emotions of shame and sorrow generated do not result in hostility towards the CLTS facilitator. Instead some of kind of congeniality and friendship develops. Next time the facilitator meets the community, the community is often eager to take him around the village and show him the positive development in the village.

In other words the shame evoked during a CLTS trigger is very different from the one the opponents of CLTS have in mind. It is the good shame. It is not the bad shame that everyone abhors including proponents of CLTS. However, I do admit that sometimes ill prepared CLTS facilitators may create bad shame in the community, and perhaps this is the experience some of the opponents of CLTS have. An ill prepared facilitator conducts the process in a manner that puts down the community. The process is not a genuine participatory session in which the community collectively analyses its sanitation profile. Instead the facilitator pontificates and lectures the community on the hazards of poor sanitation.

I also wish to mention a few examples in which ill prepared facilitators have inadvertently got it wrong. CLTS encourages the use of crude word of shit as it is in the local language. A poor facilitator may insensitively start using this term liberally without first seeking the endorsement of the community. This may elicit negative reaction from the community and may result in bad shame. A good facilitator on the other hand will conduct the process in a way that enables the community on its own to mention the crude name for shit in the local language. Of course most the time the rural community rarely mentions this crude word quickly. Therefore a good facilitator must embody the virtue of patience. Through patience and further probing a community eventually mentions the word “shit” in the local language. When the crude name of “shit” is imposed in a community meeting without going through a participatory process that “legitimizes” it and gives it collective ownership in a meeting, it amounts to humiliating the community. As such a community may feel resentful that an outsider is imposing on them something that is contrary to their values. This ignites bad shame.

Another example that can cause humiliation to the community during CLTS trigger is when a facilitator is quick to tell the community that they eat their own shit. When an outsider comes to a community and confronts them by telling them that they eat their own shit, this is likely to come across as an insult! It is this kind of an approach that creates bad shame. On the other hand, a skilled CLTS facilitator will conduct a process in which the community participates in analyzing its sanitation and hygiene profile and comes to a verdict that they are indeed eating their own shit! The facilitator therefore only takes up the cue that has already been provided by the community. So when he tells the community that they are eating their shit, he is only repeating what the community had said. Facilitation in this manner cannot be seen to be demeaning or humiliating to a community. It does not create bad shame. Instead it creates good shame that inspires the community to improve on their sanitation situation.

I have mentioned the above two examples fully cognizant that there are many other ways in which uninitiated facilitator may humiliate a community during CLTS trigger. In this sense I am sympathetic and indeed concur that CLTS trigger may result in creating bad shame which may serve to reinforce the views of CLTS opponents. However, we need to be clear here that the trouble is not with the CLTS tools per se but with the skills of a CLTS facilitator!

When a community is subjected to bad shame, it feels humiliated, resentful, angry, and develops an attitude of non-cooperation with the facilitator. Bad shame generates feelings of negativity in the community that may result in a confrontation with the facilitator. I remember an incident where an over zealous facilitator carried shit, and brought it close to the noses of the people and started demanding that they smell it. This evoked feelings of hostility in the meeting and some community members openly protested against how the process was being conducted. Unfortunately this happened at a time when CLTS was being showcased to some CLTS sceptics. At the end of it all the sceptics only became more convinced that the approach was untenable and culturally unfriendly.

From my experiences of being involved in CLTS, I would like to distinguish the good shame and bad shame as follows in this table:

GOOD SHAME	BAD SHAME
Results in self awareness and realization of practicing offensive behaviour.	Results in resentment for being lectured about open defecation
Leads to a desire and enthusiasm to change poor sanitation and stop open defecation.	Leads to indifference towards any initiative to improve sanitation situation.
Ignites feelings of congeniality towards the CLTS facilitator.	Ignites feelings of hostility towards the facilitator.
Ignites feelings of sorrow and regret about practicing open defecation.	Ignites feelings of being defensive about open defecation.
Provides a spark for change	Reinforces resistance to change

In conclusion I would like to say that CLTS when well triggered results in creating good shame that awakens the community to the realities of open defecation and inspires them to take appropriate action to stop the practice. I would also wish to invite your comments and to ask that you join in this debate. I appreciate that the debate on good shame and bad shame, and which kind of shame CLTS triggers, is going to be with us for as long as CLTS is still alive and kicking. In my view the debate should therefore be geared towards improving our understanding and practice of CLTS rather than on “silencing” our critics.

Emotional triggers: *Shame, shock, disgust and dignity*

CLTS strategically provokes strong emotions such as shock, disgust, embarrassment and shame and the concurrent (positive) emotions like pride, self-respect and dignity, to trigger community’s collective action towards stopping open defecation.

Many critics of CLTS have latched onto the 'shame' element of CLTS in particular, arguing that this is unethical and a questionable way of creating change. The way these commentators understand it, in CLTS outside facilitators 'shame' communities into taking action. However, this is a misinterpretation and overemphasises the role of shame as it is by no means the key emotion that CLTS facilitation plays with. The rendering visible of shit through the transect walk and other triggering exercises primarily evokes disgust. And disgust, as viewed by anthropologists and psychologists¹⁰ alike is a very healthy life-protecting emotion.

In CLTS, the impulse for change comes from the shock of realising the implications of one's actions, i.e. that open defecation equals eating shit. With that realisation and the powerful emotions prompted by it, the desire for change kicks in. What could be called 'negative' emotions such as shock, disgust, embarrassment and shame, are accompanied by the 'positive' emotions of self-respect, dignity and pride. The latter motivate people to take action. As Kamal Kar puts it, 'no human being wants to live in a dirty environment and eat shit'.

Thus, shock, disgust, embarrassment and shame are really the flipside of the positive emotions that act as an incentive for change. Moreover, the shame, if any, is not shame triggered by or necessarily felt in relation to outsiders (there may be embarrassment when showing visitors how the community deals with their shit), but rather an internal process and feeling that comes with the realisation of the implications of shitting in the open.

Humour is key to CLTS and the facilitator plays the role of a devil's advocate- this does not mean that he or she acts disrespectful towards the community. At the same time, there is no traipsing around on tiptoes or treating people with kid gloves either. Good CLTS facilitators do not judge or comment on the community's sanitation behaviours but reflect and repeat their own reactions back to them. From the start, it is clear that the facilitators are not there to tell people what to do. What they are there to do, is to facilitate a process that empowers the community to come to their own conclusions and make their own informed judgements.

The fact that around 2.6 billion people do not have access to a toilet and that around 1.8 million a year (6,000 people a day), 90% of whom are children, die of fecally-transmitted diseases, really is shameful and justifies radical means! Business as usual will not do. Making the shit and its consequences visible and evoking strong emotional reactions are what produces change.

Annex 3: Combining CLTS and PHAST

The following communication recently took place between a member of the Hygiene Forum (an experienced Hygiene Promotion practitioner), and the co-ordinators of the CLTS Action &

¹⁰ See for example Rozin, P., Haidt, J., & McCauley, C.R. (1993). *Disgust*. In M. Lewis and J. Haviland (Eds.), *Handbook of Emotions*, pp. 575-594. New York: Guilford or Douglas, Mary (1970), *Purity and Danger: An Analysis of Concepts of Pollution and Taboo and Natural Symbols*.

Learning Group. It demonstrates well our general perception of CLTS and PHAST, and why we must be wary of combining the two approaches:

“Dear I am interested in understanding why you feel that classical PHAST and CLTS are incompatible. They both have roots in PLA. They are both focused on enabling communities to explore their own situation and come up with a plan about how to respond. In practice PHAST is often used in a very mechanistic and didactic way, but this is a risk that CLTS also faces I imagine? The critical issue is often the skill of the facilitator in both. I appreciate that there are significant differences of course but I think this is more in terms of the motivation for action.

From what I hear from agencies involved in hygiene behavioural change, and from my own experience, people often mix and match approaches - and use what they like from PHAST or CLTS, or social marketing, etc. Personally I don't see this as necessarily a bad thing in emergencies and have always thought there needs to be an eclectic response based on the specific context. I hope that ongoing research will help us to distil the most successful elements from these varying approaches and highlight the key principles that we need to try and emphasise in HP and when they are most appropriate.

I'd be very grateful for your views on this.”

The answer from the IDS staff, who co-ordinate the CLTS Action & Learning Group, was as follows:

“People often assume that ‘PHAST shares the same participatory learning principles as CLTS’.

No. They share some rhetoric but their learning practices differ quite radically. PHAST comes out of SARAR. CLTS comes out of PRA. SARAR and PRA are very different. SARAR relies on preset cards, charts and pictures (and often paper). PRA uses none of these but relies on people doing their own analysis in media with which they are comfortable, often the ground (and not often paper). SARAR and PHAST have predetermined and extended processes with controlled steps (and a framework – health, diarrhoeas) towards an objective followed over quite a number of meetings, and often involve smaller groups. PRA and CLTS are more open-ended, with a versatile and opportunistic repertoire, take less time, are less controlled and more emergent, and often involve larger groups, touching whole communities. The paradigmatic difference between the two is masked by common language. The PHAST manual talks about facilitation and empowerment but means something very different from the facilitation and empowerment of CLTS.

Their differences show up in facilitators' behaviours. In effective CLTS the approach is very hands-off: ‘We are only here to learn’ ‘We are not here to teach you anything’, and at a certain point, to state: ‘If you want to go on eating one another's shit, that's your affair.’ There is an element of performance, of theatre almost, in good facilitation. Not everyone can do it...but those that can usually see a dramatic and consistent effect (An experienced Indian facilitator – not Kamal – when I asked him if he was nervous before a triggering he was about to do with very influential policy-makers observing said No, it always works! So I asked him how many

triggerings he had done – over 300!). PHAST facilitators need to have a very different relationship.

A major reason why CLTS evolved and was adopted was because PHAST and subsidies were not working. That was why PLAN adopted it. And the sickness-risk-motivation assumed in PHAST simply isn't anything like as strong as disgust/self respect/convenience (especially for females).

The question is whether the two can mix effectively. I am sceptical, even if CLTS comes first. Showing people pictures of latrine/toilet types at the time of triggering can hardly fail to inhibit action. People then want something they cannot go for immediately, and cannot do for themselves. They want to keep up with their neighbours. There is no “explosion in a gas station”, no way. As in a community I visited in Cambodia, people have no latrine because they would feel ashamed with a pit latrine. There is a tipping point which is then misse.”d

The Hygiene Promotor replied:

“So, the key principles for intervention relate to:

- the use of disgust and alternative motivations for action (rather than the risk of sickness)*
- a facilitator who is responsive and not controlling (this seems to have links to other HP approaches – “resist the urge to write” is a motto of motivational interviewing)*
- working with larger groups and communities (and tapping into the larger group influence maybe?)*

Maybe there are other principles that could be identified? And then we need to ask the question, to what extent does this still apply to differing emergency contexts? And maybe, to what extent can other approaches help or hinder the outcome?

Obviously it helps to have a specific framework such as CLTS, and maybe I am trying to be too reductionist about it, but I would really find it helpful to explore these factors/principles in more depth as CLTS won't be suitable in all emergency situations and I am trying to tease out what might be effective and why.

Thanks so much for your response.”

Annex 4: “Village Assaini”: an example of Unicef-supported Total Sanitation in the Democratic Republic of Congo

UNICEF has designed a programme specific to the DRC that profits from its unique geophysical characteristics and political structure. The DRC is blessed with an extensive network of springs, with over 60% of the rural population using these springs as their principle source of water. The country is divided into 11 provinces, and further divided by the Ministry of Health into a series of 515 health zones. The proposed programme works with the Ministry of Health

through a decentralized strategy that targets rural population with low-tech water and sanitation solutions: spring protections and the social marketing of latrine slabs.

The DRC programme is a comprehensive package of projects including rural village WASH, school WASH, policy development and capacity reinforcement. It is based around one key concept called "*Village Assaini*", which can be roughly translated as "Healthy Village". The concept is a minimum standard for water, sanitation and hygiene that a village must reach before it can be declared "*assaini*", or healthy by the government. Using marketing techniques to promote the concept, villagers are motivated to reach the goal and become a healthier community. The concept has been extended to schools, establishing similar criteria for reaching the "*Ecole Assainie*" or "Health School" standard.

The programme has been designed with the intention of eventually being completely managed by the government. There is nothing in the programme that inherently requires external funding, external procurement, or external management. Initially, UNICEF will oversee the program to ensure financial safeguards and quality control, but management responsibility will be handed over to government partners as their capacity allows. The programme is national in scope but implemented at the local village level with community participation and direct management. It is also a strategic approach that allows multiple donors to contribute seamlessly as the program scales up.

Due to the unique geophysical characteristics of the DRC, it is possible to reach a large number of beneficiaries at a low cost. Though over 60% of the rural population uses springs, only 1/3 of these springs are protected. A properly protected spring can provide decades of clean water with little maintenance. A spring protection in the DRC costs roughly 10 times less than drilling a borehole. This fact, and the careful design of a community participative program, allows UNICEF, in collaboration with government partners, to reach a large number of beneficiaries, quickly and at a low cost.