GWI West Africa
October 2011

The Global Water Initiative
A Partnership Funded by the Howard G. Buffett Foundation

# From Demonstration Latrines to Community Led Total Sanitation

# Lessons from GWI West Africa

A triggered latrine in Mali
Photo: GWI Mali

## Contents

# 1. Introduction

In West Africa only 14% of rural people have access to improved sanitation. This has a serious impact on their health and well-being. Poor sanitation is directly related to disease and particularly affects the most vulnerable - young children.

To address this, the Global Water Initiative (GWI), funded by the Howard G. Buffett Foundation, works to ensure that vulnerable people have reliable access to potable water in a way that will preserve their dignity, rights, culture and their natural environment. The initiative works in dry and semi-arid areas in 13 countries in Central America, East Africa and West Africa. It links water and sanitation delivery with policy change, building political support, and working for larger scale change in the water sector. A small group of organisations make up the core-partners of the initiative in West Africa: CARE, Catholic Relief Services, IUCN, IIED, and SOS Sahel-UK.

Here the GWI works in Burkina Faso, Ghana, Mali, Niger and Senegal. While some very small improvement has been made over the last 20 years in these countries, the percentage of people with access to improved sanitation remains low. Progress is far short of reaching the millennium development goal of halving the proportion of the population without sustainable access to improved sanitation by 2015.

**Percentage of population with access to improved sanitation and water sources**

| Country | Year | Rural pop. '000 | Rural pop. as % of total | Access to Improved sanitation | Access to Shared Sanitation | Prevalence of Open Defecation | Other Unimproved Sanitation | Total Access to Unimproved Sanitation |
|---|---|---|---|---|---|---|---|---|
| Burkina Faso | 1990 | 7,596 | 86% | 2% | 2% | 90% | 6% | 98% |
| | 2000 | 9,739 | 83% | 4% | 5% | 83% | 8% | 96% |
| | 2008 | 12,257 | 80% | 6% | 7% | 77% | 10% | 94% |
| Ghana | 1990 | 9,513 | 64% | 4% | 21% | 28% | 47% | 96% |
| | 2000 | 10,945 | 56% | 5% | 31% | 31% | 33% | 95% |
| | 2008 | 11,675 | 50% | 7% | 38% | 34% | 21% | 93% |
| Mali | 1990 | 6,636 | 77% | 23% | 10% | 36% | 31% | 77% |
| | 2000 | 7,591 | 72% | 28% | 12% | 28% | 32% | 72% |
| | 2008 | 8,620 | 68% | 32% | 14% | 21% | 33% | 68% |
| Niger | 1990 | 6,689 | 85% | 2% | 1% | 95% | 2% | 98% |
| | 2000 | 9,246 | 84% | 3% | 1% | 93% | 3% | 97% |
| | 2008 | 12,283 | 84% | 4% | 2% | 91% | 3% | 96% |
| Senegal | 1990 | 4,602 | 61% | 22% | 6% | 58% | 14% | 78% |
| | 2000 | 5,878 | 59% | 31% | 8% | 43% | 18% | 69% |
| | 2008 | 7,046 | 58% | 38% | 10% | 31% | 21% | 62% |
| Total | 1990 | 35,037 | 73% | 9% | 9% | 60% | 22% | 91% |
| | 2000 | 43,399 | 69% | 12% | 12% | 57% | 19% | 88% |
| | 2008 | 51,882 | 66% | 14% | 14% | 55% | 16% | 86% |

Source: Data downloaded from Joint Monitoring Programme www.wssinfo.org on 26 September 2011.

To meet this and other water related challenges the GWI identified three strategic outcomes for West Africa. A measure for the first strategic outcome is the number of communities showing improved hygiene behaviour. The analysis of this improvement in sanitation is the focus for this paper.

**GWI Strategic Outcomes**

**Strategic Outcome 1**
Vulnerable, marginalised groups are actively involved in the design, implementation and evaluation of multiple water use delivery, environmental sustainability, healthy and functioning ecosystem services and strong and equitable governance and equity structure through improved IWRM in West Africa.

**Strategic Outcome 2**
A vibrant, cohesive and well-informed water constituency at local, country and regional levels is actively involved in fostering analysis and learning, and strengthening collaborative partnerships to improve delivery on integrated water management projects in West Africa.

**Strategic Outcome 3**
Donors, investors and governments are strengthening awareness and support for integrated water management programmes through dissemination of sound analysis of effective water delivery through IWRM and with an emphasis on scaling-up in West Africa.

Between 2008 and 2010, the GWI sought to deliver improved sanitation alongside water provision through field interventions in Mali, Niger, Senegal, Burkina Faso and Ghana. Partners used a combination of constructing demonstration latrines in villages lacking sanitation, training local builders in latrine construction, subsidising the cost of concrete latrine slabs, training events on hygiene and establishing hygiene committees in target villages. This combination is referred to as the demonstration latrine approach.

Two years into the project, approximately 550 latrines had been built, often adopting ventilated improved pit latrine (VIP) design with each latrine costing around $140 (see box Any functional latrines out there?). As a result project partners began asking some important questions. At this rate of uptake would total coverage of improved sanitation be achieved by the end of the project? How many people actually use these latrines once they were built? In order for the GWI to achieve sanitation at scale the existing approach was reviewed, and sustainable approaches, at scale, were discussed.

This paper documents the review and shift in approach from using demonstration latrines and subsidies to Community Led Total Sanitation (CLTS) as the main driver to trigger behaviour change. It examines some of the shortcomings of the original approach, briefly outlines the main elements of CLTS and then provides a discussion of the challenges of implementation and some initial lessons learned.

## 2. A need for change

During 2010, the GWI reviewed its approach to sanitation. Field experience and data from the monitoring and evaluation (M&E) baseline study both showed that the demonstration approach was not working. It did not address the crucial elements of behaviour change and empowerment that could bring about sustained access to improved sanitation capable of going to scale.

**Open Defecation**

The practice of open defecation by 1.1 billion people is an affront to human dignity. Moreover, indiscriminate defecation is the root cause of faecal-oral transmission of disease, which can have lethal consequences for the most vulnerable members of society—young children. If open defecation rates continue to decline, the impact on reducing child deaths could be enormous, primarily by preventing diarrhoeal diseases and the stunting and undernutrition that tend to follow. Success stories among some of the poorest and most disadvantaged groups in society show that behaviours can change. What is required is the political will to mobilize the resources needed to stop open defecation, which represents the greatest obstacle to tackling the sanitation problem.

Source: The Millennium Development Goals Report 2010, United Nations

### Monitoring and Evaluation

The first M&E base line study (2010) monitored progress of project implementation towards the strategic outcomes. Changes in behaviour, relationships, or evidence of the uptake, adoption and use of project outputs were assessed. These indicators are measured each year in the same way, in each project area to assess progress.

In 2010, the baseline study showed that only 14.6% of households had good hygiene practice. Of the households interviewed only 34% had access to a latrine. Inspection of defecation areas together with focus group discussions showed that all but two of the communities investigated had significant open defecation.

Another indicator of poor practice is the non-hygienic disposal of the faeces of children under three years old (below this age children are normally too young to use a latrine). The disposal of children's faeces was classified as either hygienic (disposal into a latrine or burial) or unhygienic (any other method). Most households reported throwing these faeces into their rubbish heap or onto open land outside the compound.

Sanitation is crucial to the health and well being of communities. Crucially, it is only when achieving 100% use of improved sanitation facilities, when there is no open defecation at all, that the health benefits can be realised. This sets the bar very high and poses a real challenge for programme partners and communities.

**Rates of open defecation and effects on health**

| | Rate of use of toilets | Prevalence of diarrhoea |
|---|---|---|
| Open defecation in an urban setting | 29 % | 38 % |
| Towns almost free of open air defecation | 95 % | 26 % |
| Towns free of open air defecation | 100 % | 7 % |

Source: Presentation by Nicholas Osbert, UNICEF documented in the GWI 2010 Regional Meeting Report

## Partner survey responses

In September 2011, GWI partners were asked about their experience of using demonstration latrines as an approach and about its short-comings. Their responses focussed on the use of subsidies to promote the construction of latrines. They explained that subsidies were intended to encourage individuals to build their own latrines. This approach is common in sanitation programmes in developing countries but experience from GWI found that it was not able to go to scale nor was it sustainable because of cost and technical requirements.

**Any functional VIP latrines out there?**

Jean-Philippe Debus, Regional Advisor for WASH & Emergencies, Catholic Relief Services

Ventilated Improved Pit Latrines (VIP latrine): a name that sounds good and a technology that is embraced by many sanitation programmes in low-income developing countries. Over the last 30 years in Africa, VIP latrines have popped up everywhere. Many national sanitation policies and the technical literature continue to present the VIP latrine as an appropriate technology. It is seen as better than a simple pit latrine as it controls both flies and smell. But what are the actual outcomes?

As a sanitation worker I have been working in rural Africa for the last 20 years and have explored the growing jungle of latrine vent pipes. Do they really provide ventilated improved pits? From the hundreds of VIP latrines I have seen in the field the answer is no, but why?

The VIP latrine has a number of technical design elements. The squat-hole must be left uncovered to allow air circulation through the pit and up the ventpipe. This circulation can only happen if there is: a) an air-tight superstructure with a single ventilation opening on the entrance side, facing the prevailing winds; b) a ventpipe with a specifically calculated inner diameter and extension height above the latrine roof top; c) free air circulation at the top of the ventpipe; and d) a door that fits well (and is kept closed!) or a bent entrance (chicane). Semi-darkness is crucial inside the latrine so that flies do not see a brightly lit escape route through the squat-hole but only through the top of the ventpipe where light comes in and a flyscreen is fixed.

VIP design is not simple. It is one that needs careful construction and adherence to these many design requirements. This makes it quite expensive with latrines costing around $140-$180 each depending on the country. As a result successful construction of VIP latrines in low-income communities can only happen with heavy subsidies.

A properly constructed VIP is dark and stuffy so inevitably users quickly add openings on different sides of the superstructure because, people, and especially children, do not enjoy being in the dark. These “improvements” prevent the VIP from functioning properly. Ultimately, people end up with a latrine that has cost more than a simple pit latrine but without the advantages of ventilation. It is less safe because the absence of a squat-hole lid allows flies to move in and out of the pit. The seal between the pipe and the cover slab also commonly deteriorates creating another escape for flies and smell. The PVC pipe becomes brittle with time and cracks, and the flyscreen on the vent pipe tears. After a few years, the expensive, subsidized VIP is meeting neither of its objectives to control flies or to reduce smell.

Given these problems, why does the VIP latrine continue to be presented as an appropriate technology for low-income communities? Should we not consider outcomes as more important than engineering?

The areas where the GWI partners work have very high levels of poverty. Even after receiving a subsidy the smaller contribution that families would have to make toward the construction of the latrine is still largely out of reach as GWI works in areas where many people's income equates to less than a dollar a day. As a result the demonstration latrine approach could not attain the wide coverage needed to achieve GWI's first strategic outcome. Throughout the region and in many communities, once the demonstration latrines have been built, very few people go on to build their own. In addition this approach does not lead to sufficient understanding by communities to enable them to change behaviour and end open air defecation.

The monitoring and evaluation study and partners' experiences showed that the demonstration latrine approach was not working. There was a growing awareness that, rather than building infrastructure, the emphasis should be on empowerment and behaviour.

**What is CLTS?**

Community Led Total Sanitation (CLTS) helps communities to completely eliminate open defecation (OD). Communities conduct their own appraisal and analysis of OD and take their own action to become ODF (open defecation free).

Merely providing toilets does not guarantee their use, nor does it result in improved sanitation and hygiene. Earlier approaches prescribed high initial standards and offered subsidies for latrine construction as an incentive. But this often led to uneven adoption, problems with long-term sustainability and only partial use. It also created dependency on subsidies. Open defecation and the cycle of fecal-oral contamination continued to spread disease.

CLTS focuses on the behavioural change needed to ensure real and sustainable improvements: investing in community mobilisation instead of hardware, and shifting the focus from toilet construction to the creation of 'open defecation-free' villages. By raising awareness that as long as even a minority continues to defecate in the open everyone is at risk of disease, CLTS 'triggers' the community's desire for change, propels them into action and encourages innovation, mutual support and appropriate local solutions, thus leading to greater ownership and sustainability.

**Pre triggering: Selecting and getting to know the community**

This is a crucial stage. Communities respond to CLTS triggering in different ways. Some are inspired to make changes immediately while others are reluctant or undecided at first but come round after seeing or hearing how other communities have changed. In general, the more successful villages have enthusiastic leadership. This is sometimes a traditional leader but often new leaders emerge. These natural leaders may be many sorts of people – poor, wealthy, women, men, youth, respected people with skills who provide services like village midwives, religious leaders, teachers and so on.

**Triggering**

Triggering stimulates a collective sense of disgust and shame among community members as they confront the crude facts about open defecation and its negative impacts on the entire community. No human being can stay unmoved once they have learned that they are ingesting other people's shit. The facilitator helps community members see for themselves that open defecation has disgusting consequences and creates an unpleasant environment. Community members then decide how to deal with the problem.

**'Post Triggering'**

The triggering point is the stage at which members of a community either decide to act together to stop open defecation, or express doubts, hesitations, reservations or disagreement. The post-triggering phase is very important. Community dynamics can change rapidly and go in different directions. Sensitive external encouragement and support can be crucial.

Source: www.communityledtotalsanitation.org/page/clts-approach

## 3. The process

Throughout 2010 GWI partners were asked if the demonstration latrine approach was working and if it could go to scale. After consultation and deliberation the resounding answer was no! GWI had to change tack to help communities understand the issue and develop their own solutions rather than providing latrines as a ready made answer to a problem communities did not fully understand. Community led total sanitation was identified as a possible alternative. A first step was to discuss this new approach.

### 2010 regional meeting

During the programme's 2010 regional meeting GWI partners shared and discussed their experiences and those of other organisations regarding behaviour change for total sanitation. After learning about and discussing the potential of CLTS and the tricky issue of subsidies, partners agreed to try it out and develop action plans for implementation.

**Principles to guide CLTS action plans**

1. Aim for 'no open, defecation' as the final outcome.
2. Adopt a village level facilitation approach.
3. GWI should normally require 'no open defecation' to be achieved in a village before supporting drinking water provision.
4. Subsidies should be collective, not individual, and involve credit systems wherever possible. They should specifically target the poorest.
5. Sustained behaviour change, at scale, is the key requirement.
6. Markets for the minimum standard of latrine should be viable and self sustaining.
7. GWI should participate in the recognised national platforms on water and sanitation.

Source: 2010 GWI Regional Meeting Report

### Training

Two members from each country team participated in CLTS training in September 2010. The training was organised around field practice enabling participants to understand the strengths of CLTS in triggering a community's desire for change and collective action.

Interestingly, all villages involved in the training decided to become ODF (open defecation free). A meeting with village representatives is an important part of the initial triggering phase as it formalises the commitments taken by the village. Having representatives of several villages meet each other and compare their plans is also a good motivator. It creates a climate of positive competitiveness and mutual encouragement. None of the villages requested material or financial assistance to end open defecation.

CLTS Training
Photo: GWI Niger

## Implementation

In late 2010 GWI partners began using community led total sanitation. One year later the teams reported on their experience.

### *What worked well?*

**Training and enthusiasm:** The CLTS training was successful as were the discussions and there was a great deal of enthusiasm at the regional workshop. Field workers are now well equipped to trigger communities and start the CLTS ball rolling.

**Leadership:** Identifying and gaining the support of leaders is crucial to the success of CLTS. When partners worked with village and religious leaders to carryout CLTS they gained goodwill, trust and support in the community. These are vital if the triggering process is going to work.

> "CLTS mobilization of many communities provides the opportunity to 'go to scale' with other organisations on common joint action e.g. with UNICEF, GWI or other NGOs in the area and government technical services."
> **GWI/Mali**

**Local government involvement:** The involvement and commitment of local technical services and local government in the monitoring of activities went well. In some areas local government and technical staff also received training in CLTS. Meetings on CLTS at local government level helped to create a positive atmosphere of competition between villages.

**Triggering:** Triggering activities were successful with commitment by community members to end open defecation. Community action plans were drawn up and monitoring plans and committees were established. School children were able to internalise the messages and became powerful change agents.

**Latrine construction:** Many latrines have been constructed using local knowledge and skills. The CLTS approach encourages communities to come up with their own solutions for latrines using local materials and know how. This means that the facilities are more affordable and easier to maintain.

**Finding synergies:** In Mali and Niger partners found synergy with UNICEF programmes which helped to promote CLTS within their programmes.

### *What didn't work?*

**Villagers are time poor**
Competing demands for people's time from other dry season activities e.g. funerals, marriages, house building/maintenance, gold mining, market gardening reduced their ability to undertake CLTS activities.

**Latrine construction can be tricky**
People found cement slabs too expensive for their latrines even though they provide safer and more durable facilities. A lack of adequate digging tools such as pick axes also delayed the construction process and in some areas hard ground and high water tables made construction difficult. Finally expectations of subsidies also hampered the building of latrines

**The walk of shame**
One common triggering activity 'the walk of shame' was not always appropriate i.e. where there were no clear open defecation zones. In addition CLTS did not solve the problem of open defecation during weekly markets when many people from other villages come together.

### *The main drivers of behaviour change*

An important driver of change was the process of **deciding collectively** to end open defecation. This participatory approach to discussing open defecation and the associated health hazards raises the whole community's awareness of the importance of hygiene and sanitation.

Many villages were motivated by the advantages of **dignity and discretion** when using a latrine, i.e. no one knows if you have diarrhoea.

**Honour** (particularly in front of visitors) was another a driver for change.

The **cost benefit analysis** of weighing latrine construction against the cost of treating illnesses caused by oral-faecal contamination was also a decisive factor.

"When I went to a neighbouring village I noticed that that the people had constructed more than 140 latrines, while in our village we had none. This important difference made me aware of how passive our village is. Not being innovative was putting us at risk of looking stupid compared to other villages. I then started awareness raising and gained the acceptance of all the other people in my village and we became CLTS leaders in our area."

**One woman's story**
**Batan Warka village, Niger**
This woman is a leader on hygiene

### *The costs of the minimum 'safe design'*

The cost of the minimum 'safe design' of latrine varies according to local conditions. In areas with unstable sub-soils a lined pit is needed whereas elsewhere a simple unlined pit with wooden covering is adequate. Typical costs in each GWI project area are:

**Niger:** simple traditional latrine from $16 to $36.

**Senegal:** traditional latrine with wooden covering, cemented over, $26 to $46.

**Mali:** a concrete reinforced slab alone costs $15. It should be noted that residents in the project area (Bankass District) stated that $15 was too much to pay for the concrete slab as another NGO in the area was providing them at a subsidised price of $1 each.

**Burkina Faso:** a latrine with lined pit and concrete slab costs $140 of which $78 was for purchased materials and $62 was the household contribution (local materials and labour).

**Ghana:** costs range from $17 to $266 excluding labour.

The variations in these costs reflect differences in context and local conditions. This undermines the logic of a standardised approach to latrine construction as promoted in national policy in both Senegal and Burkina Faso. Diversity in local contexts points to a need to set standards for what latrines should achieve (i.e. outcomes such as safe disposal of faeces) and minimum design specifications rather than detailed construction requirements which may not be the same in every village.

### *Subsidies*

In Mali GWI partners provided a rolling fund of $250 each to committees in four villages to pre-finance construction of concrete latrine slabs for sale at cost to community members. Unfortunately this approach failed. After over 12 months the most slabs sold in any village was only six. People were not willing to pay the full cost price of the slabs because another project provided them at about $1 each, a subsidy of over 90%.

### *Follow up after triggering*

Teams worked with communities to monitor progress on latrine construction after triggering. Return visits were carried out to provide support and advice for implementing the village action plans and to monitor progress. These visits involved not only project staff but also local government officers and health/hygiene staff from local and/or district level. The involvement of other stakeholders is important for building the capacity to carry out CLTS, scaling up to other villages as well as for ensuring the sustainability. In addition technical assistance should also be provided to support the construction of safe and hygienic latrines.

**Key phases in the GWI transition to CLTS**

| Phase | Key points |
|---|---|
| 2008 – June 2010<br>'Business as usual' | An analysis of affordability for rural subsistence farmers concludes that unsubsidized costs per latrine are prohibitive. |
| | The cost of total sanitation by GWI for population served is prohibitive. |
| | Demonstration and subsidised latrines are not creating demand. |
| | GWI has no view on sustainability. |
| June 2010<br>Regional Meeting Bamako<br>'Stop and Take Stock' | GWI invite UNICEF and WaterAid to the 2010 regional meeting to share their experiences. GWI partners visit CLTS "triggered" villages. |
| | Discussions on the need to stop and take stock take place. |
| | A moratorium is placed on latrine subsidy by the cluster coordination. Work on sanitation is stopped until GWI are clear on how to do it sustainably. |
| | Partners decide that CLTS is "powerful" and important to field test. |
| August – October 2010<br>'Think outside the box and cross pollinate' | Each country team drafts a sanitation strategy. |
| | CLTS training session held in Niger for participants from all five GWI countries (Niger, Mali, Senegal, Burkina Faso, Ghana). |
| | Peer review of the country sanitation strategies is carried out to identify strengths and challenges. |
| | A latrine manual is distributed: to provide information to willing households on "how to". |
| December 2010 – now<br>'... and ACTION!' | Field trials start in Senegal, Mali, Burkina Faso, Ghana, Niger |
| | **So where are we? What next?** |
| | **Challenge 1:** How to comply with national policies? This applies in particular to Burkina Faso and Senegal where government policy is to promote VIP latrines as the minimum acceptable design. |
| | **Challenge 2:** How to reach 100% coverage?<br>- We "trigger" only part of the community -> latrines<br>- How to go beyond CLTS for:<br>- 100% coverage?<br>- Sanitation promotion?<br>- Key hygiene practises to keep water clean?<br>- Unless there is 100% open defecation free coverage all is in vain |

## 4. Benefits of CLTS

"Community discussions at CLTS led to deeper discussion on Integrated Water Resource Management than we had achieved with the old method before CLTS."
**GWI/Burkina Faso**

### Participation

In all countries, initial experience of CLTS shows that rates of participation are much, much higher and its quality deeper in comparison with the demonstration latrine approach. Following the shift to CLTS many more people at village level have taken part in activities and there is a stronger sense of 'ownership' by communities.

CLTS is relatively easy to learn and implement. Triggering activities in villages can be conducted in less than 4 hours. As many people from the community as possible are involved (even up to several hundred) including children.

But this reliance on participation and involvement of the whole of the community can also be a weakness. In villages where social cohesion is weak CLTS may be difficult to implement and preliminary work may be required to create the social conditions required to ensure successful outcomes.

### Behaviour change

One of the strengths of CLTS is that people can easily make the link between open defecation and its impacts on health. Triggering activities such as touching a blade of grass on some shit and then putting it in a cup of water explaining that this is what flies do with water and food, quickly illustrate faecal-oral contamination routes and create 'aha moments'. This graphic demonstration helps communities understand the problem and develop their own solutions. Often people commit quickly to changing their behaviour. However, the challenge of 100% sanitation coverage remains. It is important that communities understand that achieving this high standard is the only way to attain substantial health improvements.

**The children's shit monitor**
In Senegal, in the village of *Sare Wallone*, an elderly man who is now too old to go to the fields has volunteered to be a CLTS leader. He walks around the village in search of children defecating in the open. When he sees a child defecating the man goes to look for the mother to ask her to come and pick up her son or daughter's *caca*. This elderly man is the village 'monitor'. Because of his age mothers respect him and comply with his request.

### Sustainability

The sustainability of latrine construction continues to pose challenges. In Senegal the GWI partners found that the latrines built by villagers after 'triggering' were not sustainable, but that the changes in hygiene practices were. Similarly in Niger some newly built latrines collapsed during the rainy season.[1] Here during rains the water table is very high which causes the latrine pit walls to collapse unless they are lined. These technical and context specific problems require continued follow up and accompaniment to enable communities to find suitable, affordable solutions. However, in terms of behaviour and understanding, all countries found that CLTS brought about sustainable change.

[1] To address this issue GWI developed an illustrated guide to help families to build their own safe and hygienic latrines www.crsprogramquality.org/storage/pubs/watsan/Pit%20latrine%20guide_English.pdf

Complementary activities to CLTS can also help to improve sustainability. This approach provides a good entry point for the creation of a sanitation market, e.g. the training of local masons, provision of equipment and parts to construct latrines.

## Gender and cultural sensitivity

CLTS involves the whole community and takes into account the gender and cultural aspects of sanitation. In Senegal, Mali and Niger project teams found that women were important participants in the process. They were more sensitive to the sanitation messages and got more involved in activities ensuring that behaviour change is sustained. In Niger young people were also particularly involved in CLTS activities while in Senegal they found that young children took longer to change their habits.

"Women from Damba village demanded the construction of latrines as part of the dowry when giving their child for marriage."
**GWI/Mali**

A triggered latrine
Photo: GWI Niger

## Value for money

Preliminary results show that CLTS is less costly and more efficient than the demonstration latrine approach. Success in achieving 100% coverage and declaring a village ODF should also mean a reduction in medical costs and loss of productivity due to illness.

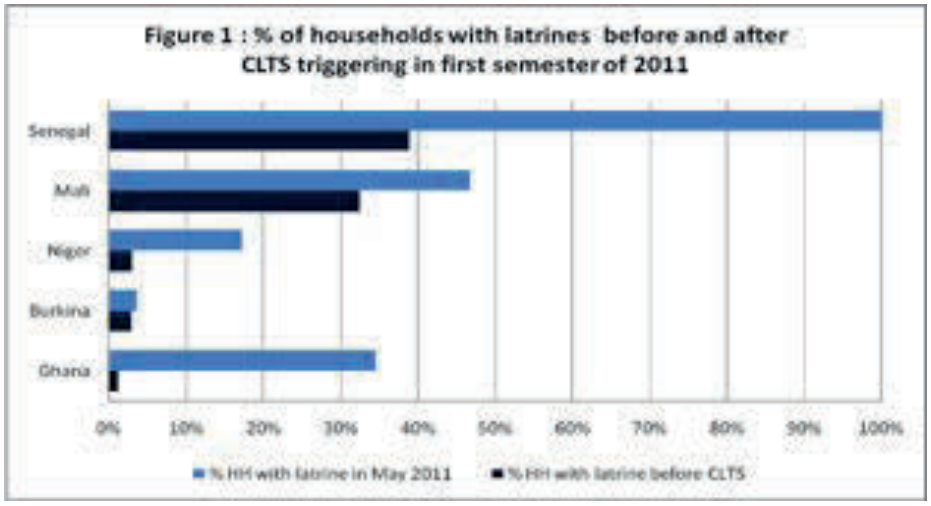
## Latrines: subsidies, ability to pay and construction

The construction of latrines and subsidies remain a challenge. The team in Senegal acknowledged that subsidised latrines are of higher quality than traditional latrines. In Ghana and Mali, project staff found that the first latrines constructed after triggering were made affordably by the community and were the most 'basic' models. Most villagers do not have enough money to construct a high quality latrine on their own. More work needs to be done to provide appropriate technical assistance for suitable latrine construction especially where difficulties arise because of unstable soils or a high water table.

"The communities have become creative, in fact we have observed many different models of latrine design that we have never seen before. Also we have seen innovations to increase the sustainability of the building materials by mixing together several local materials (mud/straw/cow dung)."
**GWI/Niger**

## 5. Key challenges and lessons learned

In May 2011 partners presented their most monitoring data showing progress in latrine construction for each village. As is to be expected so early on in a shift in strategy, no villages have yet been declared ODF - open defecation free.




These initial figures are very encouraging. This research showed that after triggering 100% of households (number = 48) in Senegal, for example had built a latrine. In all other countries the percentage of households with latrines has also increased dramatically.

In terms of costs, the following table illustrates the level of subsidy required to build demonstration latrines compared to that required for CLTS latrines. Two interesting points are shown in the table below:

1. The case of Mali shows that even when subsidised CLTS latrines have a lower subsidy (i.e. demonstration latrine subsidy is $57 per latrine compared to $11 for the CLTS facility). It should be borne in mind that the community bears the cost of constructing non-subsidised CLTS latrines.

2. These figures summarise three years of project activity. Disaggregated figures show the increase in latrines built from one year to the next. Experience in Mali and Niger show that the number of CLTS latrines built in one year can be much greater than for demonstrations latrines and at a lower project cost. In Mali during the first two years they built 118 demonstrations while in years 2 and 3, villagers constructed 1,441 latrines. In Niger in the first two years 102 demonstration latrines were built while in year 3 villagers constructed 918 latrines.

Project cost per latrine

| Country | | Number | Subsidy per latrine $ |
|---|---|---|---|
| Burkina Faso | Demonstration latrines built with subsidy | 46 | $96.33 |
| | CLTS latrines built with subsidy | 0 | |
| | CLTS latrines built without subsidy | 14 | |
| | | | |
| Ghana | Demonstration latrines built with subsidy | 650 | $81.32 |
| | CLTS latrines built with subsidy | 0 | |
| | CLTS latrines built without subsidy | 31 | |
| | | | |
| Mali | Demonstration latrines built with subsidy | 118 | $57.22 |
| | CLTS latrines built with subsidy | 545 | $11.17 |
| | CLTS latrines built without subsidy | 896 | |
| | | | |
| Niger | Demonstration latrines built with subsidy | 102 | $50.27 |
| | CLTS latrines built with subsidy | 0 | |
| | CLTS latrines built without subsidy | 918 | |
| | | | |
| Senegal | Demonstration latrines built with subsidy | 492 | not available |
| | Demonstration latrines built without subsidy | 352 | |
| | CLTS latrines built with subsidy | 0 | |
| | CLTS latrines built without subsidy | 48 | |
| | | | |
| **Total number of latrines built** | | 4,212 | |
| Total number of demonstration latrines | | 1,760 | |
| Total number of CLTS latrines | | 2,452 | |

As a result of these initial experiences, the GWI partners have identified some key challenges and lessons learned for the implementation of CLTS.

## Only 100% will do

One of the greatest challenges to governments and organisations working on sanitation is that only 100% access and use of improved sanitation facilities results in significant health benefits. This is a difficult goal to reach. It can only be achieved if all residents in a community cooperate and are involved. Everyone's participation is critical.

## Participation and leadership

One of the strengths of CLTS is that it is participatory, the whole community is involved including children. It also identifies and nurtures appropriate community leadership. These leaders can be women, children, the elderly or the village chief. The CLTS champions emerge through the process. Linked to this is the importance of local government involvement including both local officials and technical services. Their commitment to behaviour change and raising awareness is crucial to sustained success and to enabling improved sanitation to go to scale.

## CLTS is only one piece of the puzzle

CLTS is not just about faeces. Total sanitation also includes waste management, impacts on water sources, hand washing and drainage of waste water etc. Thought and planning must be given to what follows after triggering and the construction of latrines. CLTS is only one part of a much larger picture.

## Latrines, latrines, latrines

Supporting the construction of latrines and enabling them to go to scale remains a challenge, particularly in areas where local conditions make construction costly. Technical support for communities (including monitoring aquifer contamination) in these situations is crucial. The creation of a demand-oriented slab market is very important, but how to achieve this? GWI needs to reflect more on these challenges and come up with innovative proposals.

"In Tinkoly village there was a well with two hand-pumps installed by another project. The two pumps were broken-down. A few months after the CLTS 'triggering', to our surprise we saw that the people had their pumps repaired without us even having talked about water yet. Due to the 'triggering' of the CLTS process the people decided to work together to solve their water problem themselves."
**GWI/Senegal**

The cost/subsidy issue also remains a problem. How can GWI support the poorest and lowest income households to find solutions and improve their sanitation practices? What is an affordable cost? What is a minimum standard for a latrine? Questions around latrine financing and construction are tricky and require further research and investigation. Solutions are likely to be context specific and will also be a function of the actions of other organisations in the area as demonstrated by GWI Mali's experience in Bankass where another NGO was supplying slabs at only $1.

In addition, governments in Burkina Faso and Senegal have set standards for latrine construction which may not be suitable in all contexts. More thought and policy work needs to be done to ensure that communities do not end up with latrines that are unnecessarily costly or too complex, but are safe and hygienic.

CLTS Triggering
Photo: GWI Senegal

In the end the CLTS approach sets up a kind of "sanitation ladder". Communities start with building the simplest form of latrine they can afford and go from there. Are there minimum safe and hygienic standards that governments should seek to establish? How can governments and NGO's help communities to progress up the sanitation ladder to attain these standards in a way that is sustainable and affordable? If subsidies are required, how best to manage them? The question of latrine construction is a difficult one.

## A note of caution

CLTS is gradually becoming "the" approach in the sanitation sector. But it is only one approach in a larger tool kit of strategies which can be used to support and promote improved sanitation. Success in achieving sustainability in improved sanitation and hygiene will require a mix of approaches and methods, for example, social-marketing and PHAST.

## Conclusion

Enabling communities to increase their access to improved sanitation is one of the key strategic outcomes of the Global Water Initiative's work in West Africa. Traditionally, government and non-government organisations have used variations of the demonstration latrine approach to achieve improved sanitation in low income and poor rural communities. But experience and evidence are pointing to the fact that this method does not work. Latrines and in particular VIP latrines are too costly to construct and are not sustainable. Through their review process GWI partners were able to discuss this problem and work together to identify potential solutions.

CLTS provides an alternative. GWI partners discussed the potential of CLTS and took the time to deliberate and consider its strengths and weaknesses before deciding to take a leap and change their approach to sanitation. Getting consensus among all country partners was not easy but was vital to ensuring the cohesiveness of the programme. Putting a moratorium on latrine construction and latrine subsidies was a brave step toward adopting a new strategy.

Community mapping
Photo: GWI Senegal

Initial results show that CLTS is providing the desired outcomes in terms of the numbers of latrines being built and the rates of behaviour change in communities. Many lessons and challenges have come about as a result of this shift. These will continue to change and evolve as the GWI gains experience of using CLTS. In the coming years villages will go beyond the triggering phase to build on their successes and to make and strengthen the vital links between sanitation and wider water management issues.