Second Review of

Community-Led Total Sanitation
in the East Asia and Pacific Region

Regional Report

December 2015

Review supported by

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WaterAid

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Foreword

This review is aimed as a timely contribution to overall knowledge on the provision of equitable and sustainable sanitation and hygiene for all – highlighting what has worked, and issues that still need attention, especially in the area of Community Led Total Sanitation (CLTS).

Sustainable Development Goal 6 addresses the goal of universal access to safe drinking water, sanitation and hygiene, with proposed targets (by 2030) to eliminate open defecation; achieve universal access to basic drinking water, sanitation and hygiene for households, schools and health facilities; to halve the proportion of the population without access at home to safely managed drinking water and sanitation services; and to progressively eliminate inequalities in access. UNICEF's Strategic Plan (2014-2017), has also set out to significantly reduce open defecation and to improve overall WASH access in communities and schools, in support of children's health and nutrition outcomes.

According to UNICEF's State of the World's Children (2012), nine countries in East Asia Pacific have more than 30% stunting prevalence rates; around 659 million people are without access to improved sanitation, and disparities in communities and schools are stark. Around 83 million people in the region still practice open defecation, with three countries (Indonesia – 51 million, China – 14 million and Cambodia – 7.4 million) being among the 12 in the world with the largest populations practicing open defecation.

Similarly, maternal and child malnutrition rates remain high across parts of the region, with eight countries reporting stunting prevalence of above 30 per cent (Cambodia, Indonesia, Lao PDR, Myanmar, Papua New Guinea, Philippines, Solomon Islands, Timor-Leste). An estimated 28 million children under five years old are stunted. This is especially troubling since a growing body of evidence establishes the linkages between sanitation and stunting, indicating that children in unhygienic environments will not reach their full growth potential even when food is sufficient.

Community Led-Total Sanitation is being implemented in more than 50 countries around the world, including 12 countries in this region. Recognizing the key role CLTS plays in overall efforts for improving sanitation and hygiene behavior, this 2nd Regional Review of Community Led Total Sanitation provides insights on progress and highlights challenges and areas for attention in order to achieve results at scale.

This report benefited greatly from the generous contributions of partners from WSP, Plan International, WaterAid Australia, the Australian Government and other development partners from each of the countries covered under this review. This report compiled by the Water Sanitation and Hygiene team in UNICEF's Regional Office for East Asia Pacific is a response to the Global Community Approaches to Total Sanitation (CATS) evaluation (undertaken in 2014 by UNICEF NYHQ Evaluation Unit). Produced as a response to request by partners, we trust it is a useful contribution for all.

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Acknowledgements

This second regional review of the Community Led Total Sanitation (CLTS) in the East Asia and the Pacific region was commissioned by UNICEF East Asia and the Pacific, and supported by WaterAid Australia, the World Bank Water and Sanitation Program, and Plan International. This report has been produced based on experiences and lessons on the implementation of Community Led Total Sanitation (CLTS) from Cambodia, China, DPR Korea, Indonesia, Kiribati, Lao PDR, Mongolia, Myanmar, the Philippines, Papua New Guinea, Solomon Islands, Timor-Leste, Vanuatu and Viet Nam.

Special appreciation is expressed to the many UNICEF, WSP, WaterAid, Plan International colleagues, and those colleagues at the country levels, for generously providing their time and efforts in collecting the country level data on CLTS implementation and for undertaking reviews of the draft country profiles. Additional thanks goes to those specialists who shared their knowledge and experience towards the nine case studies, with acknowledgment to the workshop participants in Cambodia; IUWASH, the development partner and government colleagues interviewed in Jakarta and selected provinces in Indonesia; World Vision in the Solomon Islands; and for all those met in the Philippines (see Annex 2 for details on Country Review Teams and other contributors).

This 2nd review was initiated by and completed under the overall guidance and coordination from Chander Badloe – Regional Adviser WASH, UNICEF East Asia and the Pacific Regional Office. UNICEF is extremely grateful to Penny Dutton, Water and Sanitation consultant, who undertook this review across 14 countries and multiple partners in the region, and who prepared this report. Finally, we would also like to acknowledge the financial support from Bill & Melinda Gates Foundation (BMGF), the Department for International Development (DFID) and Government of Australia through the Department of Foreign Affairs and Trade (DFAT) for this review and publishing this document.

Data sources and notes

Main sanitation dataset: from Progress on Drinking Water and Sanitation: 2015 Update, from WHO/ UNICEF Joint Monitoring Programme for Water Supply and Sanitation (JMP).

Country-specific data: from interviews and contributions from country teams.

Case study data: from secondary sources, interviews and contributions from key informants in case study countries.

Contents

Acronyms

EAP	East Asia and Pacific
EASAN	East Asia Ministerial Conference on Sanitation and Hygiene
CATS	Community Approaches to Total Sanitation
CBO	community-based organization
CLTS	Community-Led Total Sanitation
CR-SHIP	Global Sanitation Fund Cambodia Rural Sanitation and Hygiene Improvement Program
DFAT	Department of Foreign Affairs and Trade
DHS	Demographic and Health Survey
DSWD	Department of Social Welfare and Development (the Philippines)
iDE	International Development Enterprises
INGO	international non-governmental organization
IUWASH	Indonesian Urban Water, Sanitation, and Hygiene
JMP	WHO-UNICEF Joint Monitoring Program for Water Supply and Sanitation
LGU	local government unit
MICS	Multiple Indicator Cluster Survey
MDG	Millennium Development Goal
MoH	Ministry of Health
NGO	non-governmental organization
ODF	open defecation free
PAKSI	Community Action Plan for Sanitation and Hygiene (Timor-Leste)
PhATS	Phased Approach to Total Sanitation
RWSSH	Rural Water Supply, Sanitation and Hygiene
STBM	Sanitasi Total Berbasis Masyarakat, Community Based Total Sanitation (Indonesia)
SNV	Netherlands Development Organisation
UNICEF	United Nations Children's Fund
USAID	US Agency for International Development
WASH	Water, Sanitation and Hygiene (Sector)
WHO	World Health Organization
WSP	World Bank Water and Sanitation Program
ZOD	Zero Open Defecation

Executive summary

Introduction

Despite rapid economic growth, inadequate sanitation and hygiene remain significant problems in the East Asia and Pacific (EAP) region. Several countries have fallen short of their MDG sanitation targets, and continue to have high open defecation rates. Around 83 million people in the region still practice open defecation, with three countries from this region (Indonesia – 51 million, China – 14 million and Cambodia – 7.4 million) being among the 12 countries in the world with the largest populations practicing open defecation.

Community-Led Total Sanitation (CLTS) is an approach used by 12 countries in this region (Cambodia, China, Indonesia, Timor-Leste, Kiribati, Lao PDR, Viet Nam, Myanmar, the Philippines, Mongolia, Solomon Islands, Papua New Guinea). This review of CLTS in the region, supported by UNICEF, Water and Sanitation Program World Bank, Plan International and WaterAid, builds on an earlier review in 2012/3. Its aim is to examine and report progress on key areas of CLTS implementation, spread and scale, as well as provide some insights through case studies on CLTS practice in selected countries.

Methodology

The regional CLTS review was conducted both remotely (through interviews and a questionnaire) and through in-country visits to gather data for case studies. It was made possible through review teams established in each country – primarily comprised of UNICEF, WaterAid, WSP and Plan WASH specialists – with additional assistance from key government staff, NGOs, and other development partners in some countries. A country CLTS status update was prepared for each of the 14 review countries, which highlights the changes since 2012. The information in these country status updates formed the main basis for the regional analysis. Nine cases studies were prepared on varying aspects of CLTS implementation – ranging from: urban CLTS, CLTS in post emergency settings, sanitation marketing, and techniques for verifying Open Defecation Free status.

Review challenges

The review requires organizing and managing a vast amount of data from multiple review teams for 14 country status updates and nine case studies. Few countries have monitoring systems which can produce reliable quantitative data on the number of communities triggered and ODF achievements, so figures in the report may under or overestimate the true situation.

Key findings

CLTS continues to play an important role in achieving reduction in open defecation and the uptake of sanitation in the region, but accurately quantifying that contribution is difficult. Indonesia has a functioning monitoring system and a basic calculation shows that the 3,140 villages that achieved ODF status between 2012 and 2015, using CLTS as part of a broader government rural sanitation program (STBM), contributed most of the gains to the 4,000,000 people who ceased open defecation between 2012 and 2015 (from JMP estimates).[1]

CLTS is also contributing to village-wide sanitation coverage, which, from a growing number of studies, including within the region, correlates with protection against environmental enteropathy or leaky gut syndrome in young children. Environmental enteropathy appears to be a significant cause of infant and child stunting – far more serious than diarrhoea. CLTS is a particularly appropriate sanitation approach because it aims for village-wide elimination of open defecation – a requirement for combating environmental enteropathy.

[1] Assuming an average village size of 1,500 people.

Over the last three years there has been greater recognition at government level of CLTS as a viable approach; evidenced by the embedding of CLTS in sanitation policies and strategies. Eight of 12 implementing countries have policies that recognize and promote CLTS, compared to three countries previously. The development of implementation guidelines and ODF criteria to help institutionalize CLTS as a common consistent approach have occurred, along with the standardization of facilitator training.

The main drivers for scaling up CLTS were: government support, for example Indonesia has triggered 25,000 communities – an impossible feat without CLTS being a government programme; external funding such as the Global Sanitation Fund in Cambodia; and clarity and consistency in methods such as standardized facilitator training, ODF guidelines, etc. The number of organizations supporting CLTS implementation or directly implementing CLTS is not necessarily a driver, but rather the quality of those organizations is. A country's early adoption of CLTS is also not a prerequisite for scale as evidenced by the progress of countries such as Kiribati who have recently taken up CLTS.

Promising new developments and trends in CLTS include:

- Application of modified CLTS in urban areas;
- CLTS in post emergency situations;
- Better targeting of the poor, for example, through social welfare programmes which integrate sanitation;
- Efforts for improving the sanitation supply side, for example, through promotion of sanitation marketing;
- Ongoing attempts at integrating CLTS with nutrition programmes regarding interventions on hygiene promotion, hand washing and other hygiene behaviours, WASH in schools; and
- The use of microfinance to help the poor.

However challenges remain which need to be addressed:

- Governments are not doing enough to finance CLTS – in many cases, governments are not backing CLTS by funding implementation, monitoring and knowledge sharing.
- Poor strategies exist for rolling out sanitation, including reaching ODF goals. There is often a disconnect between the political targets for sanitation and the practicalities of reaching those targets through CLTS.
- The extent to which sanitation monitoring systems are adequate in capturing data on the implementation progress of CLTS and the number of ODF communities, especially in forthcoming SDGs and universal access contexts. With regards to CLTS, it also seems important to focus on the practice of CLTS (e.g., from triggering to follow-up with communities in becoming ODF, follow-up monitoring on slippage, ensuring inclusiveness/participation, etc.).
- ODF verification and certification processes, together with ODF criteria, are still lacking in some countries, and no country has addressed post ODF follow up.
- More work is needed on integrating CLTS with sanitation marketing and improving access to sanitation products and services that meet different needs.
- Sanitation and CLTS in challenging environments, e.g., flood prone areas, high water table areas and disaster prone areas are yet to be tackled at any scale, despite many people in the region living in challenging environments.
- No country has systematically adopted pro-poor support processes within CLTS yet, although some are experimenting.
- Reliable information about the cost of CLTS is absent. Without this information, it is difficult to advocate to governments that CLTS is a cost effective approach which should be supported.
- CLTS is seen as a largely rural approach to sanitation, yet urban populations are growing in the region and have considerable sanitation challenges with increasing poor populations and higher living densities. The challenge is how to take the demand creation aspect of CLTS and adapt the approach, combined with sanitation solutions and business models to make it fit to an urban context.

- CLTS information sharing within the region is ongoing, however this could still be further strengthened. Unfortunately, there has not been a continuation of the East Asia Ministerial Conference on Sanitation and Hygiene (EASAN), which in the past, provided the opportunity for regional sanitation exchange events. On the other hand, several organizations have continued undertaking exchanges/learning events/study tours, indicating the need for more opportunities for the sharing of practices and paired learning between countries with similar levels of development and CLTS implementation.

Recommendations

The insights provided through this second review provide the basis for several recommendations for further consideration. The following recommendations are considered from a regional perspective.

- Generalizing about the region as a whole is not particularly helpful, given its extreme range of size and the situations of the countries within the region, but there is diversity of experience available. Indonesia still remains the largest implementer of CLTS and there is much to learn from this country in terms of government approach, monitoring, scale of triggering and ODF communities. However, Indonesia's persistently high open defecation and child stunting rates suggest that Indonesia may not have all the answers, despite it having a rich range of experiences. New and emerging countries implementing CLTS may provide fresh insights.
- CLTS continues to be effective through its core attributes of triggering behaviour change and generating collective action. But is there a risk of CLTS fatigue and a loss of interest in the approach in future? Or is it that CLTS becomes so much a part of the way sanitation is achieved that it is no longer singled out as an "approach"? Ultimately this will depend on each country and their own dynamic.

The following are additional observations regarding the improvement of CLTS.

- Implementation has been most effective where governments have supported CLTS but can excel with government commitment to funding, capacity building and accountability.
- A greater effort is needed in monitoring CLTS processes and sanitation access, and documenting and sharing successes (and failures) of CLTS implementation.
- As gains are made on sanitation targets, the hardest to reach and most marginalized communities will be the most difficult to reach. Options to integrate CLTS within sanitation solutions in challenging physical environments for the very poor, and in remote locations, should be explored sooner rather than later.

PART I

1 INTRODUCTION

Despite rapid economic growth, inadequate sanitation and hygiene remain significant problems in the East Asia and Pacific (EAP) region. Several countries have fallen short of their Millennium Development Goal (MDG) sanitation targets, and continue to have high open defecation rates. An estimated 519 million people in the EAP region remain without access to improved sanitation. Glaring disparities between urban and rural populations, poorest and richest quintiles prevail. Around 83 million people in the region still practice open defecation, with three countries from this region (Indonesia – 51 million, China – 14 million and Cambodia – 7.4 million) being among the 12 countries in the world with the largest populations practicing open defecation.

Community-Led Total Sanitation (CLTS) is a widely used approach with 60[2] countries worldwide now adopting it, including 12 countries in this region (e.g., Indonesia, Cambodia, Timor-Leste, Kiribati, Lao PDR, Viet Nam and Myanmar).

Recognizing the important role CLTS plays in eliminating open defecation and for improving sanitation and hygiene, a regional review was undertaken in 2012/2013 to better understand: how CLTS implementation was working in this region; why progress differs across and within countries; and what more could be done to support, improve and scale up CLTS as part of wider approaches to achieve sanitation and hygiene objectives within the region.

The review resulted in a comprehensive up-to-date status of CLTS, lessons and experiences from this region, and as such, helped in accelerating efforts for reaching open defection free (ODF) status, and for maintaining a high level of focus on sanitation and hygiene. The review data showed that CLTS did scale-up well in two early adopting countries, with Cambodia and Indonesia triggering 2,000-7,300 rural communities; and revealed that Myanmar joined the five mid-term countries in implementing CLTS in 200-850 rural communities since 2008. Little progress was noted outside of these eight countries due to the recent introduction of CLTS in Mongolia, Solomon Islands and Kiribati, and the ongoing re-introduction of CLTS in China. The review confirmed that CLTS is working in East Asia and the Pacific. CLTS has already spread to 12 countries, triggered sanitation improvements in more than 12,000 rural and peri-urban communities, and led to more than 3.1 million people living in 2,300 ODF communities.

Country level implementation of CLTS is still ongoing and being intensified. A regional learning event on "Scaling-up sanitation and hygiene in EAP", organized jointly with the World Bank Water and Sanitation Program (WSP), UNICEF, Plan International and WaterAid in December 2013, provided an opportunity for countries from the region to share their progress and plans. Both the regional review and the regional learning event recognized the need for the documentation of lessons and sharing, and emphasized the need for more detailed knowledge on certain areas and on how best to strengthen CLTS enabling environments, improve CLTS effectiveness, tackle sustainability concerns, complement CLTS with other approaches such as Sanitation Marketing, and accelerate scaling up. Similar challenges and needs were also highlighted during the CLTS workshop prior to the 37th Water, Engineering and Development Centre (WEDC) international conference held in September 2014.

[2] http://www.communityledtotalsanitation.org/where

2 OBJECTIVES

The main objectives of this 2015 review of CLTS in the EAP region are to:

Update the 2012/2013 Regional Assessment:

This review aims to examine and report progress on key areas such as CLTS spread, data quality and availability, CLTS scale-up timelines, impact on national sanitation coverage, CLTS influence on national policies, strategies or action plans, sustainability, verification and monitoring, and capacity for scale-up in 14 countries in the region.[3] It also examines some of the latest literature around CLTS implementation, sanitation and hygiene behaviour improvements, and their impact on achieving health and nutrition outcomes.

Develop comprehensive country-specific case studies:

The review aims to document, through in-depth case studies, the status of CLTS in selected countries, highlighting progress, challenges and lessons learned. The comprehensive country case studies examine areas with strong demand for more detailed knowledge in order to inform other countries in the region of CLTS implementation practice and to scale issues of relevance.

3 METHODOLOGY

Stakeholder engagement

The regional CLTS review was carried out both remotely (email, Skype, etc.) and in person through country case study research visits to several countries in the region. The review was only made possible by the considerable assistance provided by many stakeholders and contributors in each country. Country review teams were established during the inception phase to provide technical input and guidance on their country CLTS status update. Review teams primarily comprised of the United Nations Children's Fund (UNICEF), WaterAid, WSP and Plan's Water Sanitation and Hygiene (WASH) specialists in the review countries, with additional assistance from key government staff and other programmes or organizations in several countries. Additional contributors were involved with the research and provision of information for the case studies. These people included government staff, non-governmental organizations (NGOs), specialist WASH personnel and communities themselves. Annex 2 details the composition of the review teams involved in each country and others who contributed to case studies.

Country CLTS status updates

The standard template for the country CLTS overviews used in the 2012 Regional Review was reviewed and formatted to a CLTS Country Status Update template. The adopted format allows the comparison of achievements with the 2012 status, but eliminates the use of country rankings. The reasons for this are that: (i) an ordinal ranking system does not take into account the different country situations and size, and forces countries into a ranking relative to another country when there might be two or more countries performing equally well (or poorly) on CLTS, all factors considered; (ii) the individual (ranked) criteria to achieve an overall country ranking are somewhat subjective – for example, the number of provinces implementing CLTS or the number of implementers may not reveal true scale. The use of traffic light colour coding was adopted as an alternative ranking method so that countries could be ranked equally in different criteria rather than relatively, and 'blocs' of poor performing countries or weak factors across all countries could be clearly identified.

[3] Cambodia, China, Indonesia, Kiribati, DPR Korea, Lao PDR, Mongolia, Myanmar, Papua New Guinea, the Philippines, Solomon Islands, Timor-Leste, Viet Nam and Vanuatu.

Importantly, the internal comparison of a country's CLTS progress is possible through the country status update summary table. Data can be compared between the 2012 review and the 2015 review for indicators such as the numbers of triggered and open defecation free (ODF) communities, achievements at reducing the openly defecating population, and changes in CLTS success rates. This may be more telling about a country's status, and recent changes and trends, than comparing it with other countries.

This current review also directly asked countries about the most significant changes in CLTS in the last three years since the previous review, as well as what the outlook and opportunities were for the next three years.

Each country CLTS status update included the following sections:

i Summary table (CLTS progress) (comparing indicators reported in the 2012 review with the 2015 review – note some 2012 data is from 2010)

ii WHO-UNICEF Joint Monitoring Program for Water Supply and Sanitation (JMP) rural sanitation data (including the openly defecating population)

iii CLTS status and geographical spread

iv CLTS institutional coverage (including implementing organizations)

v Major Non-CLTS programmes

vi CLTS variations and practice

vii CLTS scale (number of ODF communities and size of ODF population)

viii CLTS capacity

ix CLTS scorecard (enabling environment, implementation and sustainability, monitoring and evaluation)

x Most significant changes since 2012

xi Lessons learned

xii CLTS weaknesses and bottlenecks

xiii CLTS opportunities in the next 3-5 years

Data for the country status updates was taken from a questionnaire comprised of 55 questions that was circulated to each of the 14 countries, and from documents and reports provided by the country review teams, which included programme reports, evaluations, research studies, monitoring reports, and project publications. Draft country status updates were shared with project review teams, sometimes several times, and follow-up clarification was done remotely, and in person wherever possible, in order to fill in any gaps and better understand key issues.

Case studies

Case studies, that examine some of the current CLTS issues and emerging trends in more detail, have been included in this review. This reflects the strong interest in peer-to-peer learning between countries, explicitly expressed at the 2013 Sanitation Learning Event in Bangkok convened by UNICEF, World Bank WSP, WaterAid and Plan International.

Initially three "high performing" countries were identified as potential sources for case studies, based on an assessment from the 2012 review, namely: Cambodia, Indonesia and Timor-Leste. Due to slower progress than expected in Timor-Leste, the Philippines was selected as the third case study.

Field visits were made to these three countries between April and June 2015. Different options for data collection were chosen depending on the topic of the case study and the appropriate style of consultation for the country, resulting in:

Cambodia: a one day workshop with sanitation marketing organizations and CLTS implementers to discuss how CLTS is integrated in sanitation marketing. The workshop was held on 23 April in Phnom Penh and attended by UNICEF, the Government of Cambodia's Ministry of Rural Development, WSP, Plan, World Vision, Netherlands Development Organisation (SNV), WaterSHED, and International Development Enterprises (iDE).

Indonesia: a series of meetings with UNICEF Jakarta staff, UNICEF field staff and local government in three regional offices (by telephone), and meetings with the World Bank (PAMSIMAS); WSP; USAID-Indonesian Urban Water, Sanitation and Hygiene (IUWASH); Department of Foreign Affairs and Trade (DFAT); and Plan International to discuss scaling up of CLTS and decentralization, post ODF monitoring, as well as CLTS in urban settings.

The Philippines: meetings in Manila and field visits to Leyte Province (Tacloban area) and Quezon Province. Meetings were held with UNICEF, WSP, the Department of Health (Manila, Leyte Province); Department of Social Welfare and Development (Leyte Province, Quezon Province); and Samaritan's Purse. Site visits were held that included meeting with sanitation entrepreneurs, Pantiwid beneficiaries, households in transit housing, and other households with toilets acquired through loans or donations.

During the course of the review, other countries expressed interest in contributing case studies on different aspects of CLTS. Data was obtained through remote and in person consultations, documents and reports.

The result has been a rich cross section of nine case studies of varying length from Asia and the Pacific, large agencies and NGOs, rural and urban settings as follows:

- *Which comes first: CLTS or sanitation marketing? – Cambodia*
- *CLTS and decentralization – Indonesia*
- *Adapting CLTS for a major urban WASH programme – Indonesia*
- *CLTS in post emergency situations – The Philippines*
- *Closing the Gap – Using CLTS to Fast Track Sanitation for the Poor – The Philippines*
- *CLTS in urban areas – Informal settlements in the Solomon Islands*
- *No Golden Solution – ODF is easy but sustainability is hard in Kiribati's challenging environment*
- *Doing the ODF Two-Step – Myanmar*
- *Testing Viet Nam's ODF Criteria and Certification Process.*

Review limitations

The focus of the review remains firmly on rural sanitation. Much of the data and reported progress is for rural areas, with urban CLTS only reported in special circumstances (e.g., the case study on CLTS in urban areas in Indonesia). The reasons for this are: (i) to enable direct comparison with the 2012 data, which is also rural; (ii) CLTS is still largely a rural phenomena; (iii) rural communities are far less likely to have access to sanitation (e.g., access to improved sanitation in Cambodia is 88 per cent in urban areas compared to 30 per cent for rural areas, for China the access figures are 87 per cent for urban compared to 64 per cent in rural areas, and for Indonesia 72 per cent urban access compared to 47 per cent rural access).

The regional CLTS review commenced in early 2015 and has been drawn out over several months. This is partly due to the difficulty in managing responses from multiple reviewers on 14 country status reports, and nine case studies, and the large documentation task presented by the regional report, case studies and country updates.

Information limitations identified in the 2012 review are still relevant. ODF sustainability and slippage remains an understudied area, with little evidence generated on this topic.

Obtaining monitoring data on triggered and ODF communities, and the number of facilitators was surprisingly difficult. It is still the case that few countries have a centralized monitoring system where data on ODF communities is aggregated. Data on progress was added up from individual contributors to the CLTS review questionnaire. While double counting has been studiously avoided (e.g., ODF counts by funders and then by implementing NGOs) there are probably some implementers whose information is not captured in the data if they are not part of the review team.

The reporting of a community's ODF status in this review includes self-declared ODF communities, verified and certified ODF communities. To only count those ODF communities that have been officially verified and certified would exclude those countries where there is no nationally agreed criteria for ODF nor any verification protocol. Not withstanding that there are different ODF criteria between countries, data from review teams are the most reliable source of information currently available, and extra time spent on exacting the numbers would not have produced much improvement in the results. The ODF numbers should be taken as indicative of the scale of CLTS at a fixed point in time (mid 2015).

What the exercise of asking countries to report on triggerings and ODF communities has shown is that monitoring systems remain poor, with few countries having national databases, or even a central register for CLTS and ODF progress coordinated by non-government entities as a first step.

Focus on ODF progress

The country CLTS overviews continue to deliberately focus on ODF achievements as the main indicator of CLTS progress because it is both fundamental to CLTS and relatively easy to measure. ODF success rates[4] remain an indicator of CLTS progress, as achieving community-wide or a collective sanitation outcome requires that every household and individual stops open defecation and uses a hygienic sanitation facility – one that separates human excreta from human contact. This means that interventions have to be inclusive, and encourage approaches that reach poor and vulnerable households. It has already been noted that CLTS interventions do not always succeed in this aim, but the ODF concept is one of the defining characteristics of the CLTS approach and is becoming an important strategic goal for local and national governments with the explicit objective of achieving universal sanitation coverage.

Country-level CLTS analysis

The CLTS review aggregates information at country level and synthesizes this into a regional report. A major challenge is that CLTS is rarely implemented consistently across an entire country and there are variations between locations and implementers. It should be noted that a country level summary of CLTS is a snapshot of national conditions and achievements that can unintentionally exclude or downplay some outstanding results in local areas or by particular implementing agencies. Where possible these success stories have been documented in the cases studies or in the country status reports.

Review benefits

For a number of countries the CLTS review provided an impetus for serious reflection on performance over the last few years. Feedback to the author from several countries (Viet Nam, Timor-Leste, Cambodia, the Philippines, for example) showed that the review was a catalyst for gathering people to discuss progress and identify some of the remaining bottlenecks to scaling up. This also resulted in improved sector coordination and strengthened relationships amongst sanitation stakeholders.

This is highlighted by the case study engagement in Cambodia. The workshop on sanitation marketing and the integration of CLTS was the first time that CLTS practitioners and sanitation marketers had been brought together to analyse the situation in detail, despite the history of co-existence of both approaches in the country. Feedback from participants was very positive:

> "It further brought home to me how little we know about where and when CLTS has been implemented and, more critically, what influence it has on changing the sanitation landscape in Cambodia. I agree...that CLTS can play a great role in bringing communities to 100 per cent access if we target communities more specifically." Lyn Mclennan – WaterSHED
>
> "It is encouraging to see more discussion on CLTS and Sanitation Marketing. We need to have more consultation among relevant stakeholders." – Chreay Pom, Director, Department of Rural Health Care, Ministry of Rural Development

[4] ODF success rate = proportion of triggered communities that are successful in achieving ODF status.

4 GLOBAL AND REGIONAL UPDATE

The following section summarizes some of the major recent learnings in CLTS.

Since 2012, a number of the major global and regional documents available on CLTS have been published including the UNICEF Global CATS Review 2014, Plan International's *ODF Sustainability Study 2013,* and Plan International USA and The Water Institute at UNC *Testing CLTS Approaches for Scalability (TCAS)* Project. In addition, the meeting reports from the Lilongwe Briefing 2012, Bangkok Sanitation Learning Event 2013, and the Hanoi CLTS Sharing and Learning Workshop 2014 further inform sector development and needs.

4.1 UNICEF CATS

UNICEF evaluated its experiences in understanding and implementing Community Approaches to Total Sanitation (CATS)[5] from when CATS was officially adopted by UNICEF in 2008 until the present. The specific objectives were to evaluate the effectiveness, efficiency, sustainability and outcomes of the efforts in CATS supported by UNICEF – to take stock of CATS achievements globally and enable evidence-based decision making on the further scaling up of CATS.

The findings are across four areas:

Outcome:

CATS is a successful approach adopted in 50 countries which has rapidly decreased open defecation and reoriented the sanitation sector towards demand-led approaches, with a high level of alignment between development partners.

The impact of CATS is constrained by the following:

- Social cohesion and the strong engagement of local leaders are critical factors for success and thus CATS is more applicable to rural areas.
- The implementation of CATS in the presence of other subsidized sanitation programmes (either in neighbouring communities or within the same community) has proven to be a major challenge for UNICEF and its partners, especially where UNICEF's policy/advocacy work has not led to a clear alignment of partners behind CLTS/CATS and where direct subsidies remain predominant (e.g., Senegal, Burkino Faso). Progress in India, where the national sanitation programme has used a subsidy-based approach for decades, shows that it is possible to instil CATS principles into an overall subsidized framework. The constraint is more difficult to overcome where there exists a 'patchwork' of approaches within a country.
- The availability and affordability of materials required to construct durable latrines can sometimes be a major constraint. In many communities, there are some households who simply cannot afford to build a latrine. This is especially the case in conditions where building latrines requires digging in rocky or sandy soil, or extreme seasonal weather, such as flooding, renders simple structures inadequate.
- CATS represents a new approach in many countries, requiring a substantial amount of trained human capacity and other resources. In general, national and local governments in target countries do not have the resources or capacity necessary for implementation.

[5] CATS is an umbrella term used by sanitation practitioners to encompass a wide range of community-based sanitation programming including CLTS, School Led Total Sanitation and Total Sanitation Campaigns which use nine core principals including community participation, no subsidy, government participation, use of local materials and skills, and 100 per cent ODF as the goal.

Efficiency:

- Creating an enabling environment e.g., advocacy, to re-orient local and national policies and strategies; institutional arrangements and partnerships, especially local authorities and partnerships at the level closest to the target communities;
- Increased capacity, especially training of facilitators and trainers, which has been programmatic national capacity building rather than short-term project oriented.
- Less attention has been given to private sector participation, financing mechanisms and supply-related issues. UNICEF needs to do more to make durable materials available for construction.
- CATS programmes are relatively cost effective, especially when compared with latrine building programmes.
- Financial incentives through UNICEF contributing to the cost of training and capacity building was important for programme success.
- Diffusion to other communities through certification ceremonies and school children was effective but unplanned and not a part of CATS programmes.

Effectiveness:

- Changing social norms of the community rather than individual behaviour change was not consistently considered, however this was an important factor in the success of CLTS. An example was communities establishing their own rules against open defecation as early as the triggering stage.
- The drivers of change are consistent across countries and rely mainly on shock and disgust as communities come to understand the fecal-oral route of infection.
- The strength of community leaders (including, in some countries, religious leaders) in mobilizing, supporting and enforcing action by all members of the community is the second main driver of change.

Sustainability:

- Many countries do not have the monitoring systems to capture changes in social norms and the long-term sustainability of ODF.
- CATS's exclusive focus on the bottom of the sanitation ladder means that simple latrines are the entry point to sanitation, yet households are not progressing up the sanitation ladder due to many factors including finance, lack of community pressure, and no expectation to improve. Simple latrines are often not physically durable.
- A natural erosion of ODF status occurs over time due to newcomers to the community or the deterioration of latrines, not because of a failure to adhere to the ODF social norm.
- Monitoring of CATS implementation and ODF into the national M&E framework is occurring but follow-up post-ODF is weak and it is not possible to measure slippage in national monitoring systems.

Other key findings around the impacts of CATS globally are presented below.

Health impacts:

- Stakeholders asserted their belief in the positive impact of CATS programmes on the health status of targeted communities. However, there is very little hard evidence to support a direct impact of ODF on the health of the population. Existing CATS M&E systems generally do not include health indicators through which impact can be assessed. What does change is the community opening up and more freedom to discuss sanitation topics, and better understand the link between WASH activities and health outcomes.

Gender impacts:

- Empowerment of women and children has occurred as they now play an increased role in CATS implementation.
- CATS has improved physical safety through reduced exposure to physical and sexual violence when openly defecating, and avoiding snakes and other animals.

Access for the poor:

- Micro-financing options have been created and are successful in supporting latrine ownership by the poor, but do not seem to be taken to scale elsewhere. Examples include Village Savings and Loans Associations in Sierra Leone, village-managed funds to support poor families in Nepal, and some communities in India which merge all financial awards in a community-managed fund to help support poor families.
- Private sector engagement is widely recognized as a key aspect of the enabling environment of CATS. Private sector actors can be involved at various levels, with a few CATS programmes relying on private sector actors as implementers. A range of private sector actors are involved in the construction of latrines, including masons, latrine builders and shops selling building materials. However, engagement with the private sector is far from systematic.
- The potential to integrate sanitation marketing with CATS to mutually reinforce each other is being considered by UNICEF to improve sustainability.

Financing

- Collective rewards are used in a minority of countries. These rewards vary from monetary awards (such as the Clean Village Award provided by the Government of India) to hygiene kits, bicycles and mobile phones. There is no clear evidence that rewards improve the efficiency of CATS programmes. On the contrary, they have been identified as counterproductive in some countries such as Mozambique, where they have been completely abandoned: "such rewards became well known in advance and expected by communities, contradicting the no-subsidy principle of CATS and influencing communities to move towards immediate quantitative results rather than adopting more durable, embedded behaviour change".

4.2 PLAN INTERNATIONAL POST ODF AND CLTS SUSTAINABILITY STUDY

Plan reviewed the sustainability of its CLTS programmes in four countries – Sierra Leone, Ethiopia, Kenya and Uganda – by collecting data from 4,960 households in 116 villages which had been declared ODF two or more years earlier. The study looked at what percentage of households remained ODF after two years; why they remained ODF; and why some households reverted to open defecation. The first phase of the study checked the status of nearly 5,000 households against the original ODF criteria: having a functioning latrine, a means of keeping flies from the pit, absence of excreta in the vicinity of the house, hand washing facilities with water and soap or a soap substitute, and evidence that the latrine and hand washing facilities were used. The study found that 87 per cent of households had a functioning latrine, but if all five of the criteria were applied then the overall slippage rate across the study was 92 per cent, with only 18 per cent of households remaining ODF. The most commonly cited reasons for slippage were financial constraints, no more support from within the community, inconvenience and discomfort, rebuilding and emptying pits, and sharing.

The second phase of the study looked at the factors that motivated a selection of these households to retain/maintain their latrines or abandon them. The single most significant motivator in triggering was disgust, but after achieving ODF status, health became the main reason why households continued to be ODF with the benefits of reduced illness, fewer health visits and reduced health costs. Enabling factors were the availability of land and materials, as well as technical advice. Demotivating factors for openly defecating households included a lack of money to maintain toilets and a lack of community support for continued use, with the barriers being difficult conditions and a lack of access to finance. Households did not move up the sanitation ladder after building their toilet and some simple latrines were not sustained.

Recommendations include strengthening the promotion of hand washing (as one of the least successful ODF criteria); further investigating health as a motivator for behaviour; increasing systematic post-ODF support (technical and motivational); strengthening community level processes and leadership; providing access to finance (e.g., savings and loans, credit, etc.); and linking CLTS with sanitation marketing to improve the technical quality of latrines and enhanced durability.

4.3 IDS SUSTAINABILITY AND CLTS

Factors contributing to CLTS sustainability are also set out in Cavill, Chambers, and Vernon (2015). Four major sustainability studies are examined: Plan International research on ODF sustainability in Ethiopia, Kenya, Sierra Leone and Uganda; UNICEF CATS Evaluation; WSP commissioned research on CLTS and ODF sustainability in Indonesia; WSP study on CLTS and non-CLTS sustainability in Bangladesh. Other sources included research by WaterAid, GOAL, and WSP's health outcomes.

Three dimensions are examined: enabling conditions (institutions, policy, etc.); physical and technical sustainability (physical conditions, structures, markets, sanitation ladder); social and behavioural sustainability (behavioural norms and dynamics within communities and cultures).

The findings for the enabling conditions were that sustainability improved when sanitation was a strong political priority, e.g., through sanitation as a national policy, national sanitation campaigns with strong political and administrative leadership at national and local levels, and multi-sector and multi-stakeholder approaches. The quality of CLTS processes is fundamental for sustainable outcomes. Adequate pre-triggering preparation and successful triggering are basic requirements, but added to this is maximizing attendance to be inclusive of all community members including women (80 per cent of the community present is needed as a rule of thumb). However this triggering also needs to be followed up with regular visits after triggering and after ODF, and natural leaders, NGOs, local government and other champions taking an active role in supporting the process.

The timing and phasing of marketing and sanitation services, microfinance and post ODF programming, can help sustain CLTS, but so can the timely verification of ODF status so that a community gets quick reinforcement of this new social norm.

Post ODF certification follow-up can help create long term sustainability, but sufficient budgets are needed for NGOs and other implementers to do follow up support, re-verification, provide formalized support to natural leaders and for continued visits by local governments. Post ODF support also includes marketing and supply of materials. In Bangladesh, research recommended follow up village visits at least once per month during the first year after verification.

Access to a range of financing mechanisms can help households get a toilet they want and improve user satisfaction and physical sustainability. Sources may come from a household's own savings, loans from village savings groups and micro-credit, remittances, and sometimes targeted subsidies to replace or upgrade basic toilets, for operation and maintenance (O&M), or to move away from shared toilets to a household having its own toilet. Households do need to be regularly encouraged to move up the sanitation ladder and, in Bangladesh, promotion was through a follow-up programme, a local government champion, and support for entrepreneurs.

To improve physical and technical sustainability, areas affected by natural disasters (cyclones, floods, tidal surges, monsoon rains, landslides or tornados) require appropriate technical designs and often, post-disaster interventions. For the mainstream market, toilet quality, access to technical support and market supply with products which meet the needs of low-income households (including for pit emptying) will result in toilets which are more likely to last and be maintained.

Examples of social and behavioural sustainability include changing social norms, for example, public pledging (West Bengal) for the community to commit to open defecation. Consistent and coherent government cleanliness and sanitation promotion can encourage communities to change behaviour, for example, community promotion which was reinforced by improvements in sanitation in schools and anganwadis (nurseries for small children) in Madhya Pradesh, India, was successful.

Finding the right motivation for individuals and communities to give up open defecation and use sanitation is important, with positive motivators being more effective than negative ones. The WSP study in Bangladesh (Hanchett et al. 2011) found that persuasion, social norms, public education and community level monitoring were more effective ways to motivate sustained ODF communities than threats, coercion, fear and force. The Plan study (Tyndale-Biscoe et al. 2013) found the common motivators to be health; shame/pride/disgust; privacy/security and convenience/comfort. Disgust is also a motivational factor (Curtis 2013). These factors depend on geographic and religious characteristics and evolve over time. Marriage in South Asia is closely related to norms and family status and can be a motivational factor for the adoption of ODF behaviour: there are reports of households putting in a latrine to arrange a good match for their child (e.g., Hanchett et al. 2011).

Natural leaders, chiefs or other respected local persons that perform home visits and door-to-door monitoring to encourage people to maintain and improve on the new behaviours, conditions and facilities that impact sustainability. The role of teachers at influencing behaviour and the part played by children as natural leaders is also important. However the key is to include these key influencers throughout the CLTS process. Very rarely are natural leaders formalized, however in Oromia, Ethiopia, natural leaders have organized themselves into an association that is set up like a business, has legal status and its own bylaws. The association focuses on ODF sustainability and moving communities up the sanitation ladder.

Shared toilets (public toilets) have a low impact on sustaining ODF behaviour change as they are prone to uncleanliness, attract instances for violence and may drive people to continue open defecation practices. Sustainability is increased if the CLTS process integrates equity and inclusion dimensions (particular needs for access to sanitation for people with disabilities, elderly, chronically sick, low income community members).

Sanctions against those who continue open defecation play an important part in social sustainability. Sanctions may be community generated (e.g., whistle blowing or singing to open defecators, or deciding community fines, e.g., refusing licences for those without toilets, withholding and delaying entitlement payments, etc.).

The Institute for Development Studies (IDS) study concluded that the changes in behaviour and thinking required to firmly accept and embed ODF and hygienic practices as social norms requires time, patience and determination.

4.4 SANITATION AND STUNTING

Key findings have recently emerged from studies on the linkages between sanitation and stunting.

Stunting is a critical child development issue because it permanently affects cognitive development and educational development of children (in turn affecting productivity in adulthood) as well as making children more susceptible to diarrhoea, pneumonia, measles and other infectious diseases that can cause death. In adulthood, women of shorter stature (due to stunting) have a greater risk for complications during childbirth due to their smaller pelvis, and are at risk of delivering a baby with a low birth weight. Stunted growth can even be passed on to the next generation through the 'intergenerational cycle of malnutrition'.

The effect of diarrhoea on malnutrition and stunting is well documented. However the wider effects of all fecally transmitted infections on undernourishment and the case for sanitation and hygiene remains a blind spot according to Chambers and Medeazza (2014). Recent studies highlight the effect of environmental enteropathy – when the absence of sanitation facilities and the exposure to fecal contamination by children leads to frequent intestinal infections and causes the inadequate absorption of nutrients leading to children becoming undernourished and stunted.

The effect of sanitation on stunting is documented by Spears (2013). Based on 140 Demographic and Health Surveys, his research has found that open defecation accounts for much of the excess stunting in India. He has shown that open defecation is even more harmful where the population density is high, presenting conditions in which children (and adults) are more likely to be exposed to infections from faeces. The relationship between open defecation and stunting is further confirmed for 112 districts of India (Spears, Ghosh Cumming 2013). The researchers found that a 10 per cent increase in open

defecation was associated with a 0.7 per cent increase in both stunting and severe stunting. Furthermore, Indian research found that having a toilet was not enough to change behaviour and that many households still practiced open defecation despite having a latrine.

Research by Quattri and Smets (2014) using Multiple Indicator Cluster Surveys (MICS) data for rural Lao PDR and Viet Nam found that community-level unimproved sanitation led to stunting in rural villages regardless of if the child's household uses an improved toilet. Controlling the data for all factors that may impact a child's height, the use of unimproved latrines in rural villages in mountainous regions of Viet Nam led to five-year-old children being 3.7 cm shorter than healthy children living in villages where everybody practiced improved sanitation. Children living in rural villages of Lao PDR, where community members defecate in the open and/or use unimproved latrines, were 1.1 cm shorter than healthy children living in rural villages where everybody used improved sanitation.

The study of the relationship between community level improved sanitation and stunting in rural poor communities, concluded that:

- Unimproved sanitation in rural villages leads to shorter children in those villages, even when controlling for other socio-economic, demographic, health and environmental factors.
- Neighbour's poor sanitation negatively affects a child's height even when their own family uses improved sanitation.
- Local area poor sanitation causes children to be shorter at every age and permanently affects the height of children.
- The poorest segments of the population are suffering the most from a lack of improved sanitation.

The implications are that more policy and programmatic focus should be on community-wide (rather than household) behaviour change and include targeted support for the poor. For CLTS, this increases the importance of achieving 100 per cent ODF communities, in particular the importance of everyone having sanitation that is "improved".

An impact evaluation of CLTS in several thousand households in rural Mali (2014) found evidence that the CLTS programme had a positive and significant impact on growth outcomes among children less than five years of age. The findings suggest CLTS improved child growth and reduced child mortality due to diarrhoea. However, the programme did not have a significant impact on self-reported diarrheal illness, thus the programme may have impacted child growth and mortality through pathways other than preventing diarrhoea, such as reducing the subclinical condition of environmental enteropathy via decreased exposure to environmental fecal contamination.

At a more general level, there are correlations between the countries around the world which have the highest numbers of open defecators, the highest numbers of under five deaths and the largest proportions of stunted children: out of the 20 countries with the most open defecators, 17 have stunting rates of 35 per cent or higher (WHO and UNICEF 2012; UNICEF 2012). This trends generally bears out for rural sanitation in the East Asia Pacific region, with Cambodia, Lao PDR, Indonesia, Timor-Leste and Solomon Islands having both high rates of open defecation and stunting above 33 per cent. The exceptions are Papua New Guinea with open defecation only at 13 per cent (but unimproved sanitation at 87 per cent) and stunting at 44 per cent; while Myanmar has 6 per cent open defecation but a stunting rate of 35 per cent.

Taking this recent research into account, CLTS still remains a valid and relevant tool for addressing open defecation with the following attributes at its core:

- "Triggering" through disgust, convenience and other motivators to mobilize individuals to change their behaviour to use a toilet.
- Producing a collective result, whereby whole communities end open defecation and in some cases improve their sanitation standards.

5 FINDINGS

The review covered 14 countries in the East Asia and Pacific region.

EAST ASIA	SOUTH-EAST	ASIA PACIFIC
1 China	4 Cambodia	11 Kiribati
2 DPR Korea	5 Indonesia	12 Papua New Guinea
3 Mongolia	6 Lao PDR	13 Solomon Islands
	7 Myanmar	14 Vanuatu
	8 The Philippines	
	9 Timor-Leste	
	10 Viet Nam	

The findings are presented in the sections that follow, starting with a comparative analysis of country context and CLTS achievements and progress; presentation of the country scorecards on factors for CLTS success; and then discussion on some of the other key CLTS practice issues.

5.1 COUNTRY CONTEXTS

The review highlighted the significantly different contexts and sanitation situations found across the region. *Table 5.1* summarizes some key development indicators: with populations ranging from 100,000 people to 1.37 billion; GNI per capita from US$ 880 to US$ 5,740; the proportion below the international poverty line (US$ 1.25 per day) from 12 to 34 per cent; and stunting rates from 10 to 58 per cent.

Country GNI per capita and populations have risen since the 2012 CLTS review report, however the data shows little change in stunting rates.

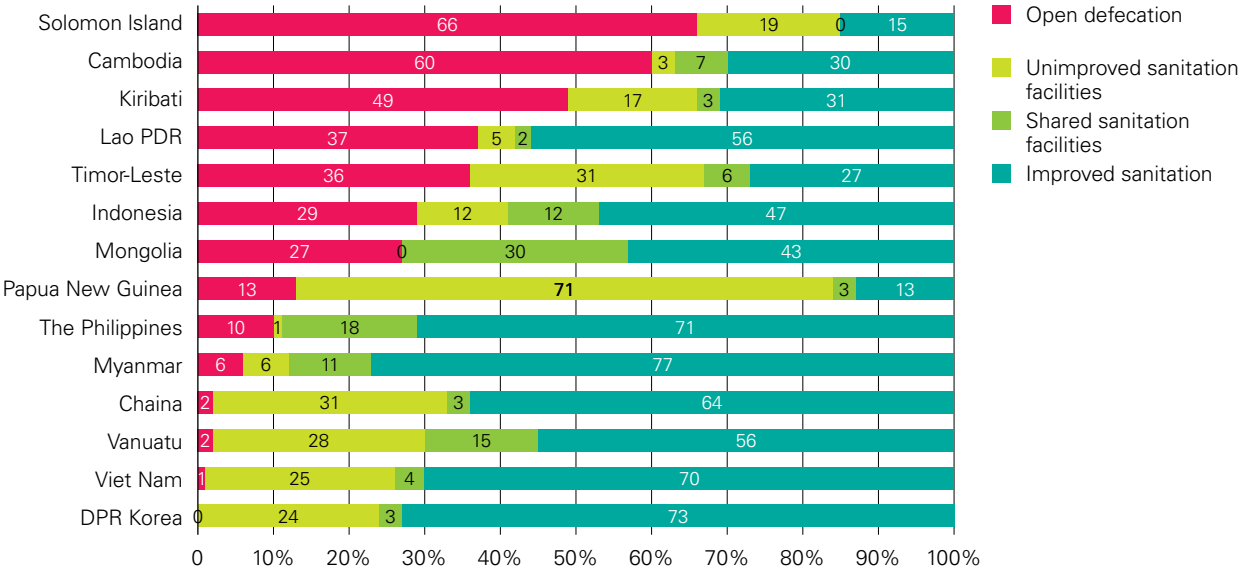
Table 5.1 Key development indicators (ranked by subregion and population)

COUNTRY	POPULATION (2012)	GNI PER CAPITA US$ (2012)	POVERTY (% BELOW US$ 1.25)	STUNTING (%)[6]
East Asia				
China	1,377.0 million	US$ 5,740	12%	10%
DPR Korea	24.8 million	–	–	28%
Mongolia	2.8 million	US$ 3,160	–	15%
South-East Asia				
Cambodia	14.9 million	US$ 880	19%	40%
Indonesia	246.9 million	US$ 3,420	16%	44%
Lao PDR	6.6 million	US$ 1,260	34%	48%
Myanmar	52.8 million	–	–	35%
The Philippines	96.7 million	US$ 2,470	18%	32%
Timor-Leste	1.1 million	US$ 3,670	–	58%
Viet Nam	90.8 million	US$ 1,400	17%	23%
Pacific				
Kiribati	0.1 million	US$ 2,260	–	–
Papua New Guinea	7.2 million	US$ 1,790	–	44%
Solomon Islands	0.5 million	US$ 1,130	–	33%
Vanuatu	0.2 million	US$ 3,080	–	26%
Total	**1,922.4 million**			

Source: UNICEF online country statistics (accessed September 2015)

[6] Moderate and severe (latest data available from www.childinfo.org).

Figure 5.1 Rural population sanitation access by open defecation rate (per cent)



Source: JMP progress report, 2015.

There are also dramatic variations in the sanitation situation in the 14 review countries, with rural open defecation rates varying from 0 to 66 per cent:

- less than 10 per cent open defecation in DPR Korea, China, Vanuatu, Viet Nam and Myanmar;
- 10-30 per cent open defecation in the Philippines, Papua New Guinea, Mongolia and Indonesia;
- 30-50 per cent open defecation in Timor-Leste, Lao PDR and Kiribati; and
- 60 per cent and over open defecation in Solomon Islands and Cambodia.

In total, the 14 review countries contain a rural population of 65 million people practicing open defecation in 16 million households. This is a reduction in people practising open defecation by 71 million people since 2000 (and 5 million people since 2012), contributed mainly by China, Indonesia and Viet Nam. As with the situation in 2012, most of the open defecation population continues to be concentrated in three of the review countries:

- Indonesia: 34.3 million open defecation rural population (54 per cent of regional total)
- China: 12.4 million open defecation rural population (15 per cent of regional total)
- Cambodia: 7.4 million open defecation rural population (12 per cent regional total)

Figure 5.1 also illustrates some variations in the proportions of the rural population using unimproved sanitation facilities:

- > 70 per cent unimproved sanitation coverage = 1 country (Papua New Guinea)
- 12-31 per cent unimproved sanitation coverage = 8 countries (Timor-Leste, China, Vanuatu, Viet Nam, DPR Korea, Solomon Islands, Kiribati and Indonesia)
- < 10 per cent unimproved sanitation coverage = (Cambodia, Lao PDR, the Philippines and Myanmar).

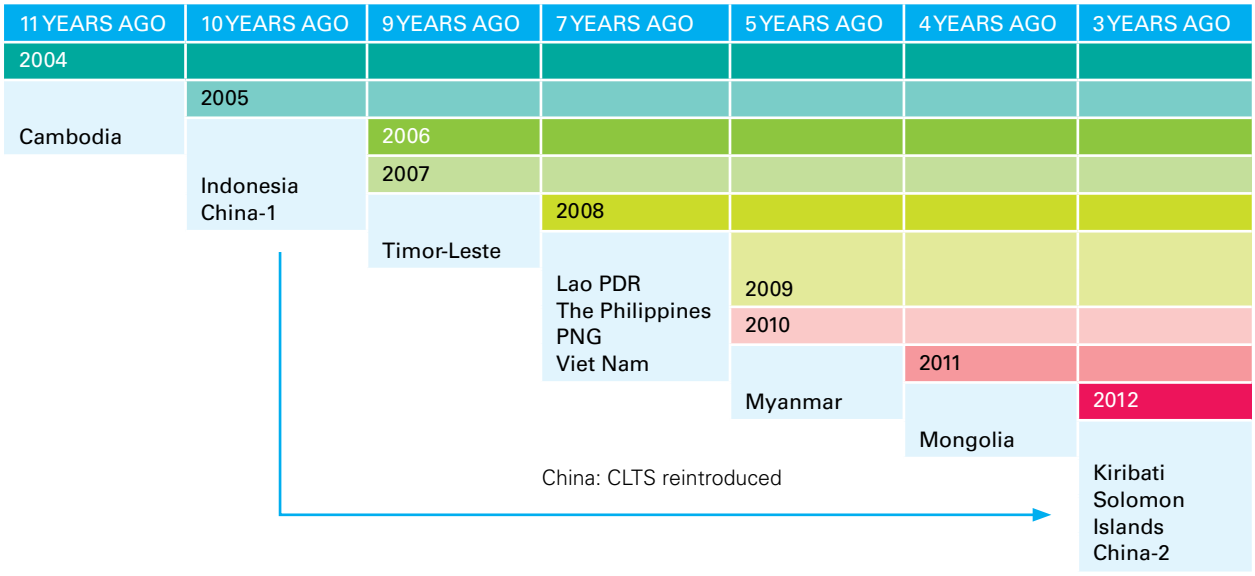
Sharing of sanitation is high some countries, e.g., 30 per cent in Mongolia.

5.2 COUNTRY CLTS OVERVIEWS

5.2.1 Maturity of CLTS

CLTS was first introduced into the region in 2004, reaching 12 of the 14 countries by 2015, as illustrated in the timeline figure below. As with the 2012 review, DPR Korea and Vanuatu remain the only two countries examined by the review where CLTS had not been introduced. Vanuatu is unlikely to introduce CLTS as it has very little open defecation and the focus will be on shifting people from unimproved to improved sanitation. Similarly, DPR Korea also has low open defecation rates, but there is scope to improve sanitation facilities and excreta management.

Figure 5.2 Timeline: Date of introduction of CLTS



The 2012 review identified Cambodia and Indonesia as "Early adopters", Timor-Leste, Lao PDR, the Philippines, Papua New Guinea and Viet Nam as "Mid-term adopters", and Myanmar, Mongolia, Kiribati, Solomon Islands and China as "Late adopters". The results from the latest review suggest that progress is not so dependent on when a country adopts CLTS but on how comprehensive its approach is, and that progress towards scaling up may be more sporadic than linear.

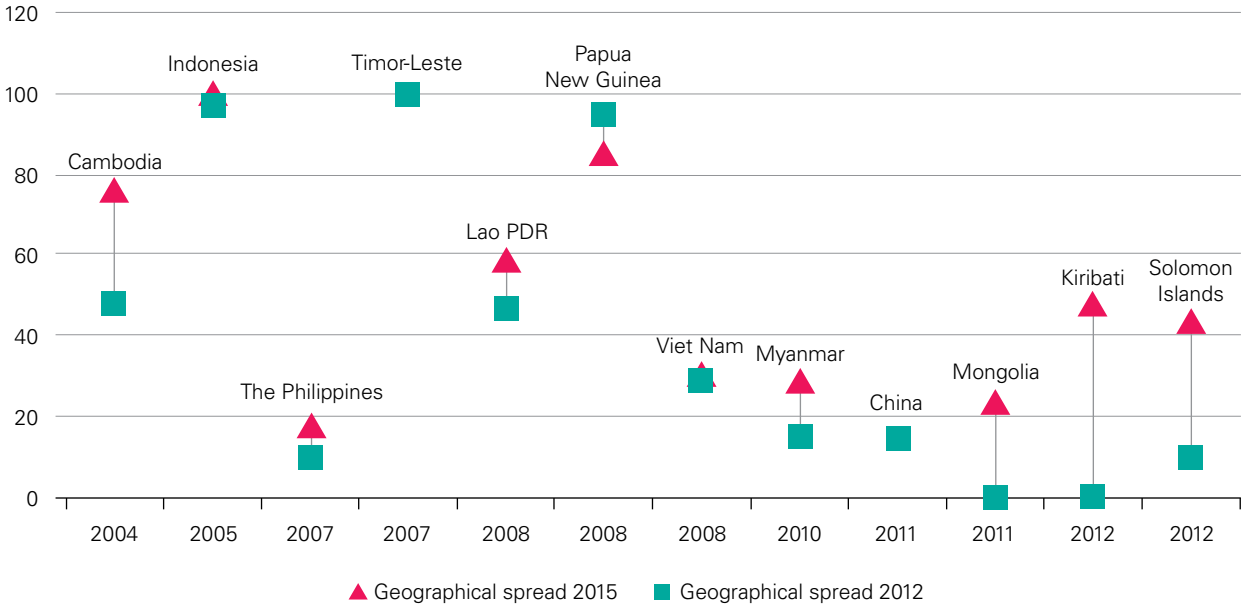
5.2.2 Geographical spread

The review also re-examined the extent to which CLTS has spread within the countries reviewed. This indicator measures the number of provinces or districts (if this is the largest geographical unit, e.g., Timor-Leste) to which CLTS implementation had been introduced – the assumption being that geographical targeting often constrains programme spread to specific provinces.[7]

Whereas the 2012 review found that CLTS has spread furthest in the early and mid-term adopting countries, current information shows that the countries to most recently adopt CLTS have made significant progress at spreading CLTS (Mongolia, Kiribati, Solomon Islands, and to some extent Myanmar). One conclusion for this trend is that late adopting countries have the benefit of lessons learned from other countries and can roll out CLTS more effectively. This may explain some of the progress but would mean that an increase in spread would also be expected from countries such as the Philippines and Viet Nam, who have seven to eight years of experience and have acquired learning in that time. This is not the case, hence the conclusion is that enabling environment factors such as government leadership, policy and financing are constraining the spread in early adopting countries.

[7] Some countries have increased the number of provinces, however this has had little impact on the data.

Figure 5.3 Geographical spread of CLTS implementation (per cent of provinces, 2012 and 2015)



In the Philippines and Viet Nam, CLTS is not yet part of a major government programme and CLTS interventions are currently concentrated in a few provinces, although this is likely to change in the future. The expansion of CLTS in Cambodia is due to major funding through the Global Sanitation Fund Cambodia Rural Sanitation and Hygiene Improvement Program (CR-SHIP) 2012-2015) and UNICEF's WASH Programme implemented by the Ministry of Rural Development, through Provincial Departments of Rural Development in 11 provinces.

The reasons behind geographical programme targeting vary by country and programme, but most sanitation programmes aim to target areas with high rates of open defecation and areas where sub-national governments show demand and commitment to sanitation improvement.

In Cambodia, the national CLTS guidelines provide criteria for village selection based on low sanitation coverage, village accessibility, absence of other programmes, commitment by local authorities and participation by villagers. Some implementers have more specific criteria including: population density, poverty rates, health-related data for children under five years, current or planned water sanitation and hygiene activities by development organizations and NGOs, as well as commitment and capacity of local authorities. SNV's district wide approach results in the selection of districts being made in consultation with the Ministry of Rural Development and provincial partners.

In Myanmar, the choice of location is based on low sanitation coverage and high diarrhoea incidence areas, and additionally for UNICEF, targeting of poor nutrition and poor health access areas that integrate with its health and nutrition programmes.

In the Philippines, UNICEF areas are selected based on the country programme targeting of areas vulnerable to disaster and conflict. In Typhoon Haiyan-affected areas, 40 priority local government units (LGUs) were identified based on a multi-risk assessment done by UNICEF and the government. Other programmes, such as the Scaling Up Rural Sanitation Programme, target poor communities in areas with low sanitation coverage and high open defecation, with health and nutrition added by some implementers. The NGO Action Contra Le Faime (ACF) selects locations using all these criteria, as well as targeting the most vulnerable barangays with high concentrations of indigenous people.

In Viet Nam, priority is given to areas with high open defecation rates, ethnic minority groups, and remote and mountainous areas. At village level, pilot villages tend to be populous with large numbers of children, low rates of latrine coverage, and many poor households.

In Timor-Leste, the focus has been on areas with low sanitation coverage and high malnutrition status according to the Demographic Household Survey 2009-2010. The Ministry of Health (MoH) works with programme implementers to select locations.

In Lao PDR, locations have been selected based on high rates of open defecation and undernutrition, high rates of diarrhoea, and poverty. One exception is Borikhamxay province, it was chosen by the government due to its proximity to the capital as a means of strengthening national capacity for demand-based approaches to sanitation.

In Indonesia, according to national policy, CLTS should be implemented in all communities as the main requirement for achieving ODF status and low access to sanitation is prioritized when selecting districts.

For Papua New Guinea, CLTS is implemented within the catchment areas of local NGOs, international non-governmental organizations (INGOs) and community-based organizations (CBOs), usually as part of WASH components within integrated development programmes. CLTS is therefore implemented on a very location-specific basis.

5.2.3 Institutional coverage

Data on the institutional coverage of CLTS, i.e. the number and type of sector organizations that were known to be actively promoting or implementing CLTS, shows that the number of organizations is less important than the quality and influence of organizations. Several countries such as Indonesia and Timor-Leste have seen the number of organizations involved in CLTS consolidated. This tends to happen as funding opportunities change, particularly for NGOs who move out of WASH and into other programme areas. The opposite is also true when new funding is available. In the Philippines, the development of a Phased Approach to Total Sanitation (PhATS), under the WASH Cluster strategy in response to Typhoon Haiyan, has led to an increase in the number of international NGOs implementing CLTS, including through the adoption of the approach by traditional humanitarian NGOs. The number of organizations has increased in Cambodia as a result of funding from the Global Sanitation Fund.

A new development is the participation of the private sector in both Indonesia and Lao PDR, where a mining company and a hydropower company respectively have actively promoted CLTS in operational areas. Although location specific, there would seem to be opportunities for private sector involvement in the future, especially as part of corporate social responsibility.

Other institutional variants of CLTS include the integration of CLTS in the Philippines Department of Social Welfare and Development (DSWD) Pantawid Program (refer to the case study).

5.2.4 CLTS scale

CLTS scale was measured by collating data on the number of communities where CLTS had been used to trigger sanitation improvement; and on the number of ODF communities. These indicators provide some measure of the scale of CLTS implementation in each country, and the scale of improved outcomes.

Few countries in the region have operational systems to verify ODF status or check whether ODF outcomes are sustained. Therefore, the data presented below are the number of ODF communities reported by the country review teams, based largely on information that they received from implementing agencies. These data include a mixture of self-declared ODF communities, and ODF communities certified by the implementing agencies or local governments. Very few sustainability checks have been carried out, therefore these data may include some communities that were self-declared ODF but have not fully met ODF criteria, and other communities that were genuinely ODF at declaration, but in which some households have since reverted to open defecation.

Figure 5.4 CLTS progress (number of triggered and ODF communities in 2012 and 2015, by year of introduction)

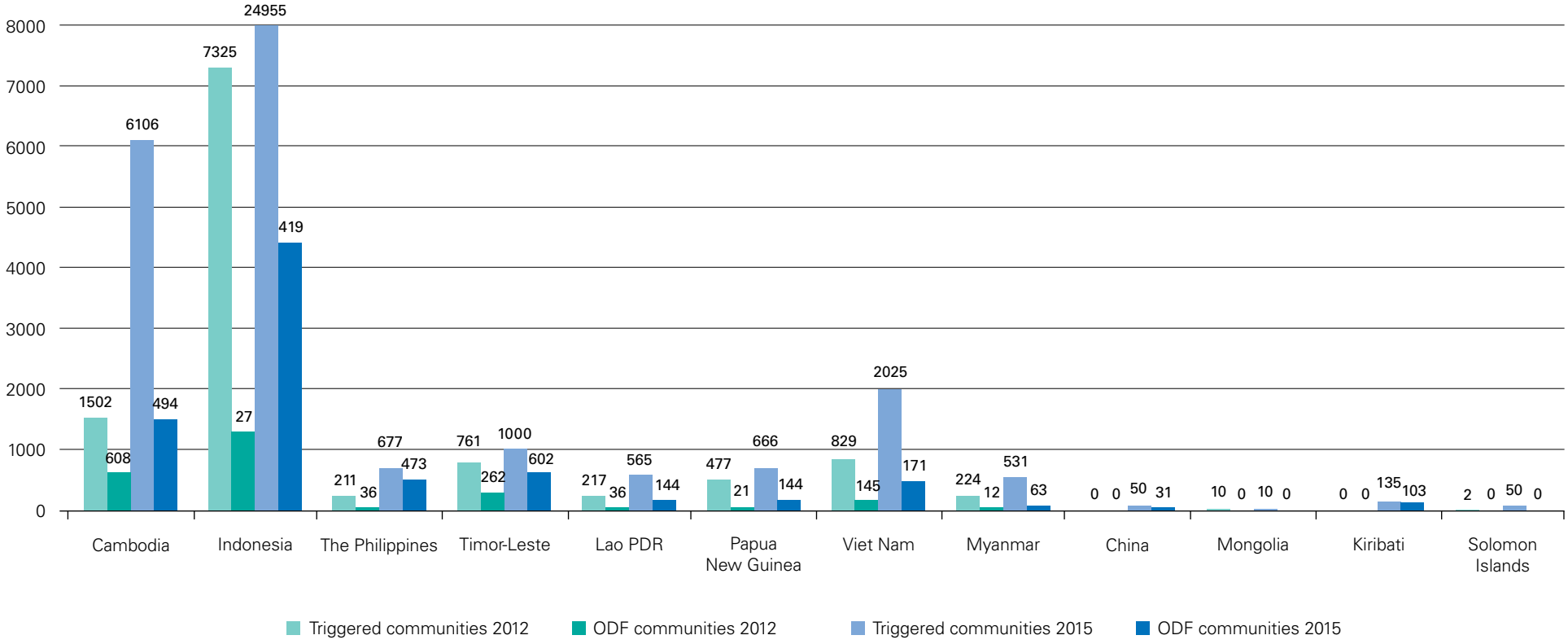


Figure 5.4 charts the scale of CLTS activities by country for 2012 and 2015, in terms of the number of triggered and ODF communities, with the order determined by the year of CLTS introduction. The figures are cumulative.[8] This chart highlights the overall increase in triggering for every country, and an exponential increase in some countries. A significant increase in triggering has occurred between 2012 and 2015 in Viet Nam (240 per cent), Indonesia (340 per cent), and Cambodia (400 per cent). The proportional increase in ODF communities over that period is similar for Viet Nam (320 per cent), and Indonesia (340 per cent), but the data was incomplete for Cambodia. While the increase in percentage terms of triggering and ODF communities is similar over time, the actual numbers of triggered communities suggests a huge requirement for ODF certification. In the case of Indonesia this means there are more than 20,000 triggered communities to be verified and certified, and at least 4,000 in Cambodia.

5.2.5 ODF success rate

The ODF success rate, defined as the proportion of triggered communities that become ODF, is a key indicator of the effectiveness of CLTS implementation. The ODF success rate does not tell us anything about the quality or sustainability of collective sanitation outcomes, but it is a key indicator of CLTS effectiveness that can highlight problems as programmes spread and scale up, and can be used to compare country performance. The data weakness is that some of the communities are self-declared without independent verification.

Data from 2012 and 2015 is aggregated at the country level. Most CLTS reviews find substantial variations in the ODF success rate across both large and small programmes, and even under the same conditions within the same programme. In the case where there are successful programmes or pockets of high effectiveness, these are averaged across the countrywide information.

The success rates for 2012 and 2015 are plotted in *Figure 5.4*. In 2012, the success rate was higher in those countries that adopted CLTS earlier. In 2015, this was not the case. While country success has increased for all countries (except Cambodia) between 2012 and 2015, the countries recently introducing CLTS have also achieved success. It could be that these more recent countries have had the benefit of experience from the early adopters and have been able to leap frog in progress.

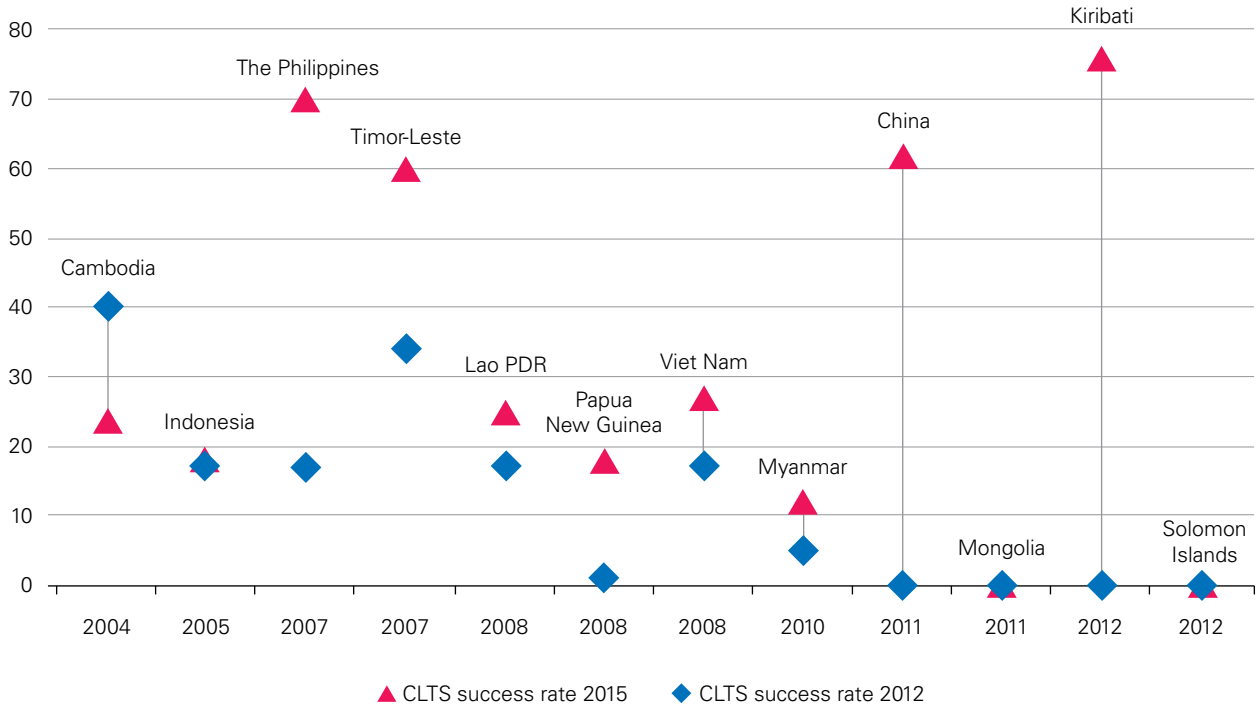
The data shows reduced effectiveness for Cambodia and stagnated success at converting triggered communities to ODF for Indonesia. This could be because these early countries have not adapted as quickly as others, but regardless, this is a concern for Indonesia, because of the many thousands of communities that have been triggered to date.[9] The Philippines has achieved a high ODF success rate (70 per cent), largely due to the results from triggering and ODF achievement in Typhoon Haiyan-affected areas where the success rate is 84 per cent. The reasons for high and swift ODF achievement in Haiyan-affected areas are the development of sanitation action plans at community level and a focus on local government service delivery, combined with intense investment and support from implementers to achieve this result. By comparison, UNICEF's normal development activities in the Philippines had a success rate of 29 per cent and WSP at a 54 per cent success rate.

A drawback in the success ratio is that this indicator conceals progress towards increased sanitation coverage and reduction in open defecation, but without reaching 100 per cent. An example from Timor-Leste highlights this point – in some UNICEF sites, open defecation has reduced from a baseline of 71 per cent in 2011 to an endline of 4 per cent in 2014. Across the Alieu district in Timor-Leste, sanitation coverage was barely 20 per cent in 2009, but by 2015 it was estimated to be 85 per cent, even taking slippage into account. This represents a significant change in uptake of sanitation and ceasing open defecation that is not captured in the data. The situation is believed to be similar for other countries, (although not specifically documented) and highlights the importance of follow-up interventions in project communities that do not achieve ODF status following CLTS interventions, in order to reach the remaining 10-20 per cent of households.

[8] The bar for Indonesia is truncated due to scale.

[9] Data issues for Cambodia may also explain the apparent backslide in 'success'.

Figure 5.5 ODF success rate for 2012 and 2015 (percentage, by year of CLTS introduction)



5.2.6 Successful triggers

Effective triggers vary between countries, although disgust is universal. Several countries found that shame was ineffective and that a more positive approach was needed, otherwise communities could be alienated from CLTS altogether. Desire for good health and the stigma of continuing open defecation practices while others in the community ceased the practice were consistently mentioned as triggers. The different types of triggers mentioned by countries is shown in *Figure 5.6*.

Involving children in triggering is effective, as parents find it difficult to resist if their child asks them to stop openly defecating and acquire a toilet. Related to this is that parents are strongly motivated by the desire to protect the health of their children. In the Philippines, post-triggering hygiene promotion sessions among children, in the form of creative activities such as singing, dancing, theatre, film showing, etc. has a strong impact on parents and other adults in the community. In Cambodia, triggering children results in children pleading to their parents to build a toilet for them.

Collective village benefits, new social norms, village pride and competition between villages become important when leaders have an interest in improving sanitation and can influence the situation. In Timor-Leste triggering around social norms and reaching sanitation standards has become important to mobilize village and community leaders to achieve the Bobonaro District Administrator's goal that the district become ODF by 2016.

In the Philippines, effective triggering strategies include: calculation of faeces and the amount spent on medical expenses, transect walk, glass of water demonstration, and food and faeces demonstration. In Papua New Guinea, community mapping and the transect walk generates shame and disgust.

Figure 5.6 Word cloud of effective triggers

5.3 CLTS SCORECARD

The following sections summarize the review findings on the CLTS scorecard for each country. The scorecard covers the enabling environment, implementation and sustainability, and monitoring and evaluation.[10] The table below summarizes the scorecard by indicator for national level implementation. This assessment was made based on the actual situation for mid-2015, with planned developments described in the text of individual country reports but not counted in the assessment.

The 'red' sections in the table below *(Table 5.2)* highlight gaps and the large amount of work still required to strengthen and improve CLTS enabling environments, processes and systems across the region.

5.3.1 CLTS in government policy

The country CLTS overviews suggest that a government sanitation policy is an important factor in the scaling up and effectiveness of CLTS programmes, as it is the first step in the official government endorsement of the CLTS approach. In 2012, only three countries had government policies that recognized and promoted the principles of the CLTS approach – Cambodia, Indonesia and Timor-Leste. The number is now up to eight out of the 12 CLTS implementing countries, indicating a significant shift in acceptance of CLTS and movement away from heavily subsidized programmes.

Several country policies do allow subsidies, but only when targeted to the poor, disadvantaged, and in technically challenging environments (Cambodia, Timor-Leste, Papua New Guinea and Solomon Islands).

[10] The scorecard concept was developed based on the UNICEF WASH Bottleneck Analysis Tool and the World Bank WSP Service Delivery Assessment scorecard.

Table 5.2 Summary of CLTS scorecards

			Cambodia	China	DPR Korea	Indonesia	Kiribati	Lao PDR	Mongolia	Myanmar	Papua New Guinea	The Philippines	Solomon Islands	Timor-Leste	Vanuatu	Viet Nam
ENABLING ENVIRONMENT	Policy	*CLTS in government policy*														
	Strategy	*CLTS targets in government strategies or development plans*														
	Leadership	*CLTS led by government*														
	Finance	*CLTS financed by government*														
	Coordination	*Mechanisms for stakeholder coordination*														
IMPLEMENTATION AND SUSTAINABILITY	Integration	*CLTS integrated with other approaches*														
	Triggering	*Standardized Facilitator training*														
		Facilitator quality control														
	ODF	*Clear ODF criteria*														
		Verification protocol														
		Post ODF support														
	Technical Support	*Availability of products and services*														
MONITORING AND EVALUATION	Monitoring	*Robust and regular monitoring of ODF achievements*														
		Post ODF Monitoring of quality and sustainability														
	Evaluations and knowledge sharing	*Evaluations, reviews and learning*														
		Information on costs and resources for CLTS														

Key: red = little or no evidence of the criteria met, or the policies, tools and systems are not in place;
yellow = criteria partially met, there is some movement towards achieving the criteria e.g. draft/planned/maybe; or
green = criteria is met and systems tool, policies etc. are formalized and in use.

Table 5.3 Sanitation policies by country

COUNTRY	RURAL SANITATION POLICY
FORMAL POLICY	
Indonesia	The 2008 National Strategy for Community-Led Total Sanitation (STBM strategy) in Indonesia provided a definition for an improved latrine – an effective sanitary facility to break the transmission of disease – and stated that subsidies should not be provided for household sanitary facilities.
Cambodia	The 2013 National Strategy for Rural Water Supply, Sanitation and Hygiene (RWSSH) 2011-2025 states use of sanitation behaviour change approaches (e.g. CLTS) and the promotion of local markets to deliver sanitation products and services so that households buy, construct and use latrines. Public finance should mainly be used to stimulate demand and develop the enabling environment. Direct hardware subsidies can only be used in a targeted manner to support the poor.
Timor-Leste	2012 National Basic Sanitation Policy – the first of four main objectives of the policy is for the achievement of "an open defecation free environment"; with households responsible for the construction and maintenance of their own sanitation facilities, including a hygienic toilet and handwashing facility. The policy allows for household sanitation facilities to be subsidized only where households are disadvantaged.
Lao PDR	2014 MOH Operational Program Guideline provided a systematic framework for the planning, implementation, monitoring and evaluation of rural sanitation programmes under the umbrella of the 2012 National Plan of Action for Rural Water Supply, Sanitation and Hygiene. The demand creation and behaviour change approach is through CLTS.
Papua New Guinea	The 2015 National WASH Policy aims for 100 per cent total sanitation; with a focus on changing behaviour through the promotion of safe sanitation facilities, leading to zero open defecation. Subsidies for sanitation should be limited but can be considered if carefully targeted to promote access for the poorest and disabled, improved menstrual hygiene, innovation, and sanitation in challenging environments.
The Philippines	The Department of Health Administrative Order 2010-0021 Declaring National Sustainable Sanitation as a National Policy defines sustainable sanitation as achieving ODF communities. CLTS is the major pillar of sustainable sanitation programme development.
Solomon Islands	The 2014 National RWASH Policy identifies CLTS as one participatory approach that can be used to improve sanitation coverage. The policy's vision is for all Solomon Islanders to have easy access to appropriate sanitation, as delivered through participatory zero-subsidy approaches. Subsidies will still be considered "where the only environmentally appropriate technical solution falls outside the financial means of the average household, education facilities and health facilities".
Viet Nam	Rural Water Supply and Sanitation National Target Program III Phase 2012-2015 Decision 366 describes toilets as a household responsibility. The programme focus is on sanitation targets, particularly household latrines with priority to low-cost models and preferential credit to improve the access of the poor, and behaviour change sanitation promotion. The MoH 2013 National Guideline for Planning and Implementation on Rural Sanitation includes "creation of collective demand for rural sanitation, using community approaches such as CLTS."
NON-SUPPORTIVE POLICY FRAMEWORK	
China	Collective sanitation is set as a principle in the sanitation authority's (NPHCCO) policy on the rural sanitation movement. It requests whole village improvement but does not specify CLTS. 2003 technical standards require leak-proof latrine pits and tanks, and National Patriotic Health Campaign Committee promotes relatively expensive standard designs, which limits the role of CLTS. In 2009, the central government listed "Rebuilding sanitary toilets in rural areas" as one of six national important public health services programmes, however sanitation subsidy is acceptable.
Kiribati	2010 National Sanitation Policy. General policy that promotes "enhanced community awareness of sanitation and public health and hygiene requirements" but does not contain any specific references to programme methodologies or detailed technical requirements.
Mongolia	1998 Law of Mongolia on Sanitation. Sanitation defined as "activities to eliminate the adverse natural and social factors having potential impact on public health, and to prevent the public health from diseases". Normal sanitary conditions: "a healthy and safe environment for a human to work and to live".
Vanuatu	The MoH's National Environmental Health Policy and Strategy 2012-2016 includes water, hygiene and sanitation as one of its core health prevention strategies, specifically aimed at MDG7 for increasing access to improved sanitation. The strategy has a goal of 80 per cent of the rural population having access to improved sanitation by 2016. The strategy to achieve this is by developing national sanitation standards for toilets, and improving sanitation facilities in communities, schools and health facilities.
DPR Korea	Government building codes define construction standards in rural areas. The sanitary double pit latrine was selected for demonstration and adaptation to the DPRK context as the highest standard for rural sanitation.
NO SANITATION POLICY	
Myanmar	No national sanitation policy

5.3.2 CLTS in government plans and strategies

A number of countries have sanitation targets and sanitation strategies but only Indonesia, the Philippines, and Solomon Islands have strategies with clear ODF targets. Cambodia is currently developing a National Action Plan which will set out annual ODF targets, while Timor-Leste is currently reviewing the 2012 draft National Strategic Sanitation Plan which will plan and cost how to achieve the countries broader sanitation targets.

Table 5.4 Rural sanitation strategies and plans

COUNTRY	RURAL SANITATION STRATEGIES AND PLANS
Indonesia	2010-2014 National Mid-Term Development Plan (RPJM-N) sets the target of 100 per cent ODF villages nationally by 2014. The new RPJMN-3 2015-2019 has the goal of universal access by 2019, however the interpretation of this is unclear.
Solomon Islands	National Rural WASH strategy has targets for nationwide sanitation coverage by 2024. 100 per cent ODF status is required.
The Philippines	2011 National Sustainable Sanitation Plan of the Department of Health aims for 60 per cent Zero Open Defecation (ZOD) barangays by 2016 and 100 per cent ODF by 2022.
Viet Nam	85 per cent of hygienic toilets by 2020, with the draft five year sanitation plan 2016-2020 including annual targets and roadmaps for ODF by 2025.
Cambodia	100 per cent of sanitation coverage by 2025, but no ODF targets in national strategy for RWSSH. A new National Action Plan (under development) will include specific indicators and targets for ODF.
Lao PDR	The government does not currently have a target for achieving ODF but has set a target for achieving 80 per cent sanitation coverage by 2020.
Kiribati	National Sanitation Implementation Plan, but no specific ODF targets. The President has called for an ODF Kiribati by 2015.
China	12th Five Year Plan aims to have a 75 per cent sanitary latrine coverage in rural areas by 2015.
Timor-Leste	No sanitation strategy. Draft National Strategic Sanitation Plan developed in 2012 is being revised.
Papua New Guinea	No sanitation strategy.
Myanmar	No sanitation strategy.

As found in the 2012 review, the operationalization of national level targets through strategies and plans is poor. Many national targets are ambitious, and where sanitation strategies and plans appear supportive, there is little evidence that these planning frameworks translate into larger scale or more effective programmes or outcomes.

For example, Indonesia has already fallen short of its 2014 ODF target of 100 per cent, with only 4,500 villages out of 80,000 (5.6 per cent) certified as ODF. Similarly, the Philippines aims for 60 per cent of barangays to be ODF by 2016, but currently only 470 out of 42,000 (1.1 per cent) have achieved this.

The 2012 review suggested that there was a significant disconnect between national sanitation targets, sanitation strategies and plans (where they exist), sector investments and implementation programming, with few national sanitation strategies or plans that appear to be based on realistic, costed assessments of how targets will be reached, or any attempt to map out the strategic priorities en route to these targets. There appears to be no change to this situation in 2015 and sanitation planning remains weak.

Countries that are developing detailed plans (Cambodia and Timor-Leste) may provide guidance for other countries to follow.

5.3.3 Leadership

The highest level of government involvement in leadership of CLTS is found in Indonesia, the Philippines and Kiribati.

Indonesia: CLTS (STBM) is a government programme under the MoH, which sets policy and strategy. Government is involved at central level, provincial and local level. Provincial and district governments are active in some but not all areas.

The Philippines: At the central level, the Department of Health develops and implements policies, and provides operational strategy for scaling up rural sanitation programme nationwide. DOH regional coordinators are in charge of rolling out CLTS in their respective provinces. Government WASH taskforces at provincial and municipal level are responsible for planning, monitoring and for allocating resources. LGUs are actively involved in some areas.

Kiribati: CLTS is led by the Ministry of Public Works, and MoH and medical services, with a high level of commitment from the President of Kiribati. Island Councils (Ministry of Internal Affairs) play a key role and lead the process locally.

Viet Nam, Cambodia, Lao PDR, Timor-Leste, Solomon islands and China have some level of government involvement in CLTS, usually at the central level and, in some of these countries, in selected districts. In Papua New Guinea, Myanmar and Mongolia, the process is lead by NGOs or other implementers with CLTS not implemented as a government programme under the leadership of government.

5.3.4 CLTS financed by government

Government financing for CLTS remains one of the weakest areas of the enabling environment in the EAP region. Despite the growing acceptance of CLTS as an approach to sanitation (evidenced by its inclusion in policies), commitment to financing CLTS remains low.

Four countries contribute direct finance: Indonesia invests directly in CLTS activities, through support to STBM activities, and counterpart financing to the World Bank supported PAMSIMAS programmes. The Philippines Department of Health allocates an average of Php 1 million (< US$ 22,000) every year at the national level for the CLTS programme, which is used for capacity building and guidance. The Government of Kiribati is providing complementary funding to support the EU-KIRIWATSAN-1 programme to extend CLTS implementation to additional outer islands. In the Solomon Islands, the MoH and medical services have allocated approximately 17 per cent of the Environmental Health Budget for CLTS. Of this, 41 per cent is for consultancy/staff, 23 per cent for transport, and the remainder for supplies.

In both Indonesia and the Philippines, subnational level governments are contributing funding to CLTS implementation through annual investment planning processes, but this is typically for where there has been substantial external advocacy, combined with capacity building support for annual planning and budgeting.

In other countries where there is a sanitation budget, finance may be provided for CLTS but at a much smaller scale or for specific purposes such as training and communication (Viet Nam), post triggering follow-up, and ODF verification (Lao PDR). Both Cambodia and Lao PDR use the majority of their sanitation budget for hardware subsidies.

Unsurprisingly, in countries where CLTS is outside the government system, e.g., Papua New Guinea, Myanmar, Mongolia, and China, no government funding is provided to CLTS implementation. The stand out exception is Timor-Leste, where there has been strong engagement with government, development of a sanitation policy and a draft sanitation strategy, and hardware subsidies have been eliminated, but this progress is yet to translate into a funding commitment from government. Development partners continue to underwrite CLTS to a large extent.

5.3.5 CLTS coordination

In most countries CLTS coordination occurs through WASH or sanitation working groups, where CLTS is one of a number of topics discussed. Given the growing integration of CLTS into more complex sanitation approaches, the need for standalone CLTS coordination events is questionable (except on specific technical issues). More important is the need for: regular coordination meetings; depth of coordination (different levels of government from the central to local); and government leadership of coordination.

Regular coordination is a feature in Indonesia, Lao PDR, Kiribati and the Philippines. In Indonesia, the AMPL Pokja or WASH working group provides an important forum for the coordination of government agencies and development partners, with a structure mirrored from the national level to province and district level government, although the quality and consistency varies at subnational level. In Lao PDR, a government led WASH Technical Working Group meets regularly and discusses sanitation issues including CLTS and subsidies. In Kiribati, a core technical team of 73 people from the government and NGOs regularly coordinate and lead CLTS.

In the Philippines, coordination is more prevalent at the subnational level, including through WASH taskforces at the provincial, municipal, and barangay levels in locations where CLTS is being supported. The Solomon Islands has both a government coordinated WASH Stakeholder Group that meets quarterly and a national hygiene and sanitation technical group. In Viet Nam, coordination is less regular, occurring through annual reviews.

In other countries (Papua New Guinea, Myanmar, Mongolia) coordination is ad hoc or non-existent, with no formal mechanism.

5.3.6 CLTS integrated with other approaches

This review found a number of examples of integration of CLTS into other programmes and approaches. However many of these country examples are on a small scale – carried out by selected projects or NGOS – or are in the early stages of integration, such as much of the work around nutrition.

Table 5.5 Integration of CLTS

COUNTRY	SANITATION MARKETING	HYGIENE/ HWWS	NUTRITION	MOTHERS EARLY CHILDHOOD	WASH IN SCHOOLS	POVERTY REDUCTION	WASH SAFETY PLANS
Cambodia	◆	◆	◆	◆			
China		◆			◆	◆	
Indonesia	◆	◆	◆				
Kiribati							◆
Lao PDR	◆	◆	◆		◆	◆	
Mongolia							
Myanmar		◆	◆	◆	◆		
Papua New Guinea		◆		◆			
The Philippines	◆	◆		◆	◆	◆	
Solomon Islands							
Timor-Leste		◆			◆		
Viet Nam	◆	◆			◆		

Some examples of large scale or emerging integration include:[11]

- Cambodia – combining sanitation demand creation, sanitation supply chain strengthening, hygiene behavioural change communication, and WASH governance through SNV's Sustainable Sanitation and Hygiene for All (SSH4A) initiative (sanitation marketing);
- The Philippines – CLTS triggering in Family Development Sessions for Department of Social Welfare beneficiaries (poverty reduction); and
- Cambodia – several NGOs combine CLTS with nutrition interventions, and a new USAID NOURISH program will integrate CLTS and nutrition at scale (nutrition).

5.3.7 CLTS triggering

It has long been confirmed that the quality of facilitators is one of the critical factors in delivering effective triggering as a precursor to sustainable sanitation. This review considered the degree to which there was consistency and quality of facilitator training, and whether training is institutionalized or even professionalized, including the quality control of the triggering of facilitators. Across the 12 countries implementing CLTS, there exists a full spectrum of facilitator 'quality'. Even in those countries with standardized training, on the job monitoring and follow-up receive the least attention.

At the advanced end of the spectrum, Indonesia has been institutionalizing facilitator skill development since 2013 through the MoH with support from the World Bank, and its approach is somewhat of a model for other countries to consider. Institutionalization of capacity building of STBM human resources has three distinct target groups: (i) current STBM implementers (in-service); (ii) environmental health students at health polytechnic schools who will be future sanitarians (pre-service); and (iii) those interested in STBM and other members of the general public as a secondary audience. To reach these target groups, three instruments were developed: (i) accredited training for STBM implementers; (ii) integrating STBM into environmental health curriculums at health polytechnics; and (iii) e-learning for both groups and for the general public (refer to *Figure 5.7*).

Health polytechnics were selected as training centres as this is where, since 2013, Government sanitarians, who are key actors of STBM as implementers of environmental health programmes, must graduate from. New graduates now automatically receive STBM training.

Distance learning aims to increase the outreach of learning opportunities and resolve geographical and financial challenges around face-to-face training. Learning is in two stages: e-learning (online) focusing on the concept of STBM or cognitive aspects, and conventional learning (offline) emphasizing STBM skills such as triggering, marketing and monitoring. The e-learning module has to be completed before further practical STBM training is undertaken. Trainees of e-learning receive a certificate of participation and trainees who complete the off-line training receive a certificate of competence.

Indonesia has standardized and accredited its curricula and modules to not only improve the quality of delivery but also to motivate trainees through formal recognition, as well as linking the completion of training to the MoH incentive system for career development opportunities for civil servants and enhanced training opportunities for non-civil servants.

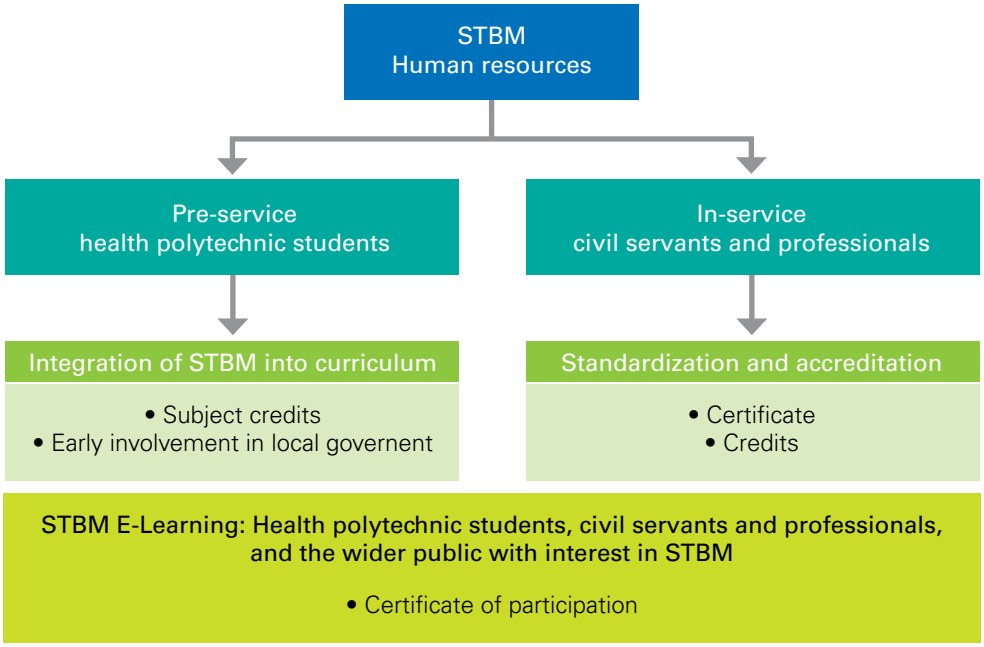
For civil servants such as sanitarians, the training is recognized under existing civil servant evaluation mechanisms, and counts towards 'credit points' for career advancement. For non-civil servants, training certificates can be used as documentation to become a certified trainer for STBM training or to become an STBM implementer.

Indonesia is in the early stage of implementing this system and faces several challenges:

- Training and accreditation needs to be rolled out and strengthened across the country;
- Capacity of existing sanitarians varies widely and not all are motivated to improve their skills by further training; and
- The scale of the sanitation challenge requires very large numbers of skilled personnel (thousands) and the output of trainees needs to be increased.

[11] Refer to case studies for more detail on integration examples.

Figure 5.7 Institutionalization of capacity building for rural sanitation human resources



Source: World Bank (2015) *Institutionalization of Rural Sanitation Capacity Building in Indonesia.*

Timor-Leste has not only invested a lot of effort into developing a Community Action Plan for Sanitation and Hygiene (PAKSI) Facilitation Guidebook which is used consistently by all implementers, but also into establishing a government-accredited 6-day PAKSI Facilitation course through the National Health Institute. A 10-day Advanced PAKSI Facilitation Training course has also been developed for a Quality Control Team (government and NGOs), which will be trained to monitor the quality of PAKSI delivery and provide mentoring support based on identified needs. With help from development partners, the MoH and the National Health Institute are developing workplace based assessments to assess the quality of facilitators and identify further training/mentoring needs.

For Viet Nam, a standard CLTS training manual and supporting materials have been developed by MoH and is used by implementers for training. The College of Agriculture and Rural Development is a centre for CLTS master training and a database of CLTS master trainers is maintained.

In Cambodia, having CLTS Guidelines on what facilitators are meant to do has been a major factor in obtaining unity and consistency between implementing agencies. The National CLTS Guidelines provide a module for facilitators, including selection criteria for facilitators, description of duties and community procedures. However, implementation is still conducted by NGOs with no systematic follow-up on facilitator quality – except by individual NGOs through performance reviews. A triggering performance checklist in the guidelines is used by implementers to monitor quality.

At the lowest level of quality, Papua New Guinea and Solomon Islands lack any standard facilitator training module or consistent approach to facilitator training, and follow-up on quality is very much dependent on the implementing NGO.

Lao PDR and Timor-Leste are developing a group of very experienced master trainers. This emphasizes quality rather than the number of facilitators.

In Myanmar and China, the CLTS Guidelines have been translated into the local language without adaptation, while in Kiribati there has been some tailoring for the country context.

5.3.8 ODF criteria

A comparative review of CLTS in the region highlights whether ODF criteria is consistently applied within each country and between countries, and also how achieving the criteria is independently verified. Since 2012, there has been an improvement in the definition and verification of ODF within countries through the documentation of ODF criteria and verification guidelines. However, ODF criteria differs between countries due to varying policy contexts.

Three factors were found to be important for ensuring consistent application of ODF criteria: (1) official government endorsement of criteria; (2) sufficient detail and clarity of the guidelines and criteria; and (3) fewer ODF criteria.

Government endorsed ODF criteria are in use by Indonesia, Timor-Leste, the Philippines, Cambodia and Lao PDR. As found by Cambodia, when the country recently adopted official ODF guidelines, a common and consistent approach between implementers became possible – something that had been lacking previously and a cause of frustration by implementers. Kiribati and China use project-based ODF criteria, but these still need to be developed for Papua New Guinea, Solomon Islands and Mongolia. In countries where national criteria had not yet been agreed, different implementing agencies were reported to adopt different criteria and follow different processes, with some reported to be less rigorous than others.

This review has found that guidelines on ODF criteria and the certification process need to be well thought out with full details on definitions and interpretations, sampling methods and time periods, and roles and responsibilities so that there can be no uncertainty during the ODF certification process. This is the case for Cambodia, and both Viet Nam and Myanmar are in the process of finalizing specific ODF criteria following practical trials of the criteria in the field. Timor-Leste's guidelines are not detailed and the review found that the criteria for ODF was open to interpretation and not applied consistently between implementing partners.

Having too many criteria can make verification complex and difficult to achieve. Questions have been raised about the weighting of other criteria aside from ceasing open defecation, and the need to equally promote all criteria such as handwashing, to achieve all criteria, not just ending open defecation. For example, in Lao PDR, verification of handwashing with soap was less strict because this had not been as thoroughly promoted as a behaviour when compared with ceasing open defecation. This reinforces the finding from the Plan study that even though open defecation behaviour has been sustained, overall slippage can be high if several criteria are scored. This is a measurement issue for the sector.

The different ODF criteria in use in the region are shown in *Figure 5.8*. In some countries, the sharing of latrines is permitted, provided there is a minimum level of households with their own toilet, e.g., Lao PDR at 85 per cent.

All countries have weak guidelines when it comes to specifying how, when and who does post ODF follow-up to improve sustainability. Most guidelines are useful up to the point when a community has its ODF status verified, with an expectation that follow-up is either not necessary or will just happen. In some cases, NGOs conduct three or six monthly post ODF checks (even if not required by guidelines), however, this is limited. This is an area that could be strengthened in future.

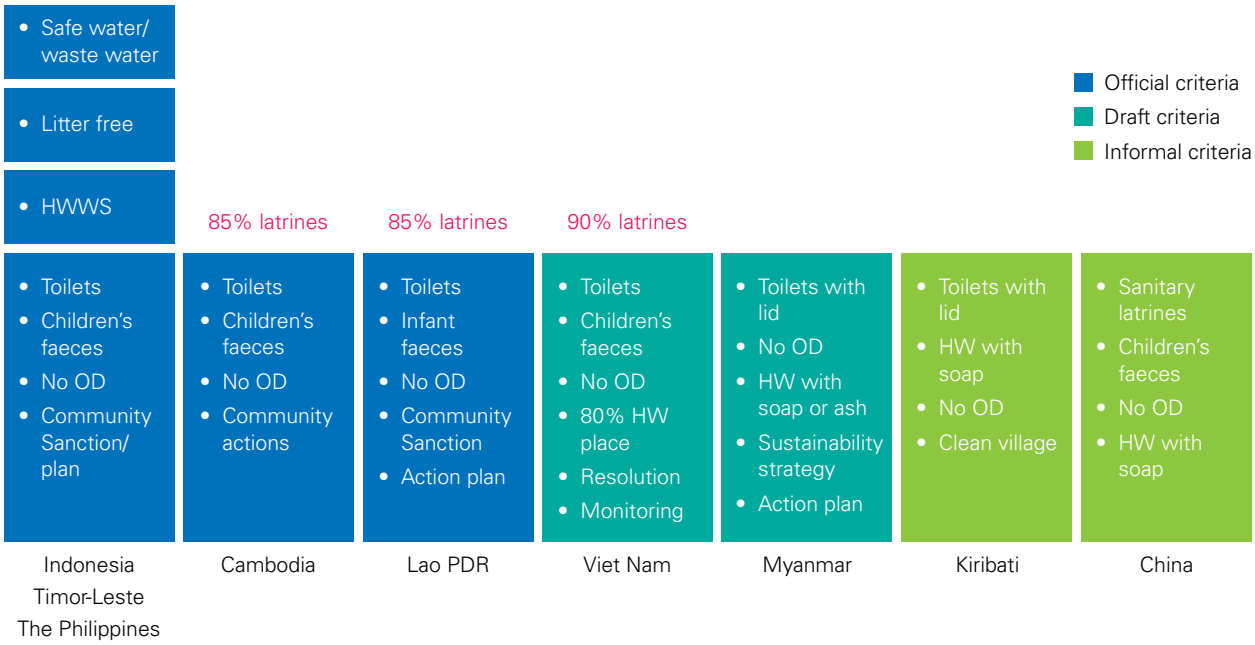
5.3.9 Technical support

Previous studies have found that market and service access for affordable sanitation products, goods and services can be a precondition for durable construction, moving up the sanitation ladder and the sustainable use of sanitation.[12] The availability of technical services and sanitation products was included in this review to further test this finding.

The availability of products and services is generally poor in most countries with limited access to varied and affordable technical options. In some countries (for example Indonesia and Cambodia) the concept of a sanitation ladder is not applicable and householders prefer to get a better quality and more durable toilet if possible, and may defer purchase until they can afford their preference.

[12] Documented in IDS (2015) Frontiers of CLTS: Issue 4 CLTS and Sustainability.

Figure 5.8 ODF criteria by country



In some countries, access to a range of products and services is reasonable, but with limited options for the poorest households and those distant from the sanitation supply. Sanitation marketing is introduced to varying degrees in Indonesia, the Philippines, Cambodia, Lao PDR, Viet Nam and China.

In Myanmar, Papua New Guinea and Timor-Leste, the sanitation market is underdeveloped with either limited accessibility to markets by the rural population, very few affordable sanitation options, or both. Kiribati has a unique challenge of having few viable choices of sanitation technology due to the need to protect the underground water supply.[13] CLTS (and sanitation generally) in challenging environments is yet to be tackled by the sector.

5.3.10 CLTS monitoring

Basic CLTS monitoring data were not readily available at either national or programme levels. Ten out of 12 review countries struggled to provide current CLTS progress data. By asking countries to report on triggered and ODF communities (as core indicators of progress), the difficulty in collecting this data was more revealing about country monitoring systems than the data itself, as the data collection process was complicated despite the best efforts of review teams.[14]

Indonesia has an online national monitoring system through STBM that shows triggered and ODF communities and types of sanitation by location. Lao PDR was able to provide a spreadsheet which had clear details for all implementers by location and needed only minor number updates.

The lack of a centralized place for consolidating data and monitoring progress in several countries was striking, especially those with a longer history of CLTS such as Cambodia and Timor-Leste. Timor-Leste has two data systems – Sistema Informasaun Bee no Saneamentu (SIBS) and a Sector Planning Tool – but neither could provide the information required.

Even where CLTS is not a government programme, implementers do not automatically share data in a central repository, but they could, and should. As a minimum, these data should show which agencies are working in which locations. A common complaint of government is that they do not know who is working where, but it appears in several countries neither do sector actors.

[13] Refer to study on Kiribati.

[14] The author would like to acknowledge the considerable and urgent efforts made by the country review teams in chasing, collating and verifying the CLTS progress data used in this review.

Data also needs to be accurate by being current, but also avoid double counting as is highly likely when implementers report by agency rather than location (e.g., both funding agency and NGOs claim overlapping ODF achievements), or under counting, where NGOs are implementing CLTS outside of mainstream reporting.

The review confirms that the limited demand for, and utilization of, these CLTS progress data (or other sanitation progress data) diminishes incentives to maintain monitoring systems through regular collection, processing and reporting. Only where there has been a national monitoring system established is data widely collected, however even in the case of Indonesia, there is little evidence that the data is analysed and used for decision making or rethinking strategic approaches.

The issues of monitoring data will become more critical with Sustainable Development Goal 6: Ensure access to water and sanitation for all. The target is:

> *By 2030, achieve access to adequate and equitable sanitation and hygiene for all and end open defecation, paying special attention to the needs of women and girls and those in vulnerable situations.*

The conclusion from this review is that countries in the EAP region need to invest much more in developing and maintaining monitoring systems that can show progress towards this goal and when open defecation is eliminated.

Post ODF monitoring for sustainability is very rare and has only been carried out in individual programmes e.g., UNICEF's endline surveys in Timor-Leste. Most countries do not have the systematic follow-up of ODF communities to monitor slippage.

5.3.11 Evaluations

Forms of evaluations and reviews of CLTS range from periodic meetings amongst implementers to independent consultant reviews of programmes, and annual sector reviews. However a number of countries have yet to critically assess performance.

There is extremely limited or useful information on the costs of achieving ODF communities, despite this being necessary prerequisite information for developing strategic plans and scaling up to reach larger ODF targets. By simply asking the question of how much it cost to implement CLTS, the answers showed there is a lack of information sharing within countries, differences in how costs were calculated (were per diems included, etc.), and thus wild differences in estimates. If CLTS is to be justified as a cost effective approach to sanitation then much more effort is needed in developing comprehensive costs norms, and then analysing whether CLTS is a value for money approach.

Only Lao PDR was able to clearly express the delivery cost, and what stages and activities were included in the costs, but also estimated the costs for scaling up.

All cost estimates were programme delivery costs for reaching ODF and did not consider additional costs such as verification, supervision and monitoring.

5.4 REGIONAL CLTS PROGRESS OVERVIEW

5.4.1 Most significant change

Each country was canvassed on what it thought was the most significant change to occur in developing CLTS since 2012. The most significant changes have been in attitudes towards, and greater acceptance of, CLTS, reform of the enabling environment, and strengthening of CLTS practice. These changes are common among countries and are summarized as follows:

All changes recorded were positive. Several created breakthroughs which can lead to further development, e.g., passing the National WASH policy in Papua New Guinea has created the potential for not only the development of the WASH sector generally, but also the acceptance of CLTS as an approach which can be widely adopted.

Table 5.6 Most significant changes in the last three years

CHANGE	Cambodia	China	Indonesia	Kiribati	DPR Korea	Lao PDR	Mongolia	Myanmar	Papua New Guinea	The Philippines	Solomon Islands	Timor-Leste	Viet Nam
Wider acceptance of CLTS/change in thinking		◆	◆		◆	◆				◆		◆	
Increased government ownership/ commitment				◆						◆			
Passing of National policy			◆						◆		◆		
Development of National CLTS guidelines	◆					◆		◆		◆			◆
Increased spread of CLTS/scaling up	◆			◆			◆	◆			◆		
More trained facilitators/better facilitation/new triggering	◆						◆					◆	
Better access to sanitation products/ sanitation marketing	◆									◆			
Improved coordination			◆									◆	
Improved monitoring			◆							◆			
Integration in to other programmes		◆								◆			

5.4.2 Lessons learned

Although lessons learned are as diverse as each country context, maturity and scale of CLTS implementation, there are some common themes that emerged.

Government commitment – recognition by governments (both national and local) of the need to achieve ODF communities and having targets directed at this goal are fundamental for moving CLTS forward. In Viet Nam, government commitment to become ODF by 2025 has resulted in CLTS being mainstreamed into large sanitation programmes. In Indonesia, commitments by provincial governors and district leaders to become ODF have resulted in regulations that filter down to the lower levels of government and unlock budget and resources for implementation and monitoring of sanitation efforts. In China, government officials involved in CATS project implementation are positively disposed towards scaling up compared to their counterparts in non-project areas. Kiribati has found that a constant commitment by Island Councils to monitoring, verifying and checking ODF communities is needed to sustain behaviour change for the long term. In both Timor-Leste and Myanmar, the lack of government commitment and associated budget and human resources is seen as holding back the scaling up of CLTS and taking it beyond the hands of development partners and NGOs into a national approach.

Triggering quality and capacity – the quality of facilitators and their skill in triggering to influence behaviour change remains a cornerstone in CLTS practice, as well as an on-going challenge. The need for well trained facilitators, including from governments, with regular refresher training was noted in Myanmar, Mongolia and Lao PDR. Viet Nam found that the lack of systematic reviews of facilitator performance and uneven support and monitoring of facilitators undermined triggering quality. Lao PDR and the Philippines identified the need for on-going mentoring support and monitoring for CLTS facilitators to be incorporated into plans and budgets for scaling up. The Philippines also found that selecting good quality facilitators in the first place (through wide talent searches and prequalification before training) helped ensure effectiveness of triggering during rollout.

Sanitation hardware – most countries now acknowledge that sanitation hardware is an important component in the improved sustainability of ODF communities, and in fact several would like to have this aspect strengthened through sanitation marketing. CLTS can no longer be seen as a stand-alone process. In Myanmar, construction of low quality latrines with pits that flood in high water table areas or collapse in sandy soils resulted in reversion to open defecation. In Indonesia, one of the reasons for slippage is that the toilet is not what the household wants and it deteriorates over time and is abandoned. In Lao PDR, there remains a strong preference for pour-flush latrines, which are unaffordable to most poor households. Technical assistance in the design and marketing of more affordable, hygienic latrines would potentially be very useful and help to make scaling up possible. In Viet Nam, the availability of low-cost, socio-culturally appropriate latrine options using locally available materials has helped increase sanitation for a wider range of people with different levels of affordability and has made CLTS more effective. In the Philippines, sanitation marketing that introduces low cost and easy-to-construct toilets after triggering has helped dispel myths about the high cost of toilets. Cambodia has found that if CLTS and sanitation marketing are integrated, then the achievements can be quick and sustainability can be improved.

5.5 KEY ISSUES

5.5.1 Urbanization and CLTS

CLTS has long been regarded as a rural approach to sanitation, however it is increasingly being piloted and implemented in urban and peri-urban areas, most recently in settlements in Nairobi, peri-urban communities in Eritrea, low income communities in Kenya, small towns in Ghana, and cities in India, Zambia and Mauritania. Within the EAP region, CLTS is being deployed as part of a complete urban sanitation approach in Indonesia and in settlements and peri-urban communities in the Solomon Islands (see case studies). Other countries in the region are also implementing CLTS on a limited scale in peri-urban areas or district and subdistrict centres, usually on a pilot basis by an NGO or because the scope of a rural sanitation programme encroaches into peri-urban areas. The countries beginning to test urban CLTS approaches are: Mongolia, Papua New Guinea, the Philippines, Timor-Leste and Viet Nam.

Experience with CLTS in urban environments provides consistent feedback on the need to adapt CLTS to an urban context where there is less community cohesion and more technical constraints. Some of the common challenges with implementing CLTS in urban settings include:

- The large size of urban communities and their heterogeneity necessitates more intense and time consuming engagement;
- Open defection is not necessarily related to a lack of toilets but how faecal waste is managed and disposed;
- More people participate in the wage economy and are less available to attend triggering sessions and participate in other ways;
- Sanitation standards are higher for urban areas and toilets are more costly;
- Often there is a lack of space to construct latrines;
- Tenants and those without secure land tenure are unwilling to construct latrines;
- Institutional leadership is critical, including local government leaders and church leaders;
- Local regulations are usually needed to reinforce change; and
- Pit emptying, sludge removal and other maintenance have to be planned for.

Where the CLTS method has been adapted for the urban context, some of the outcomes from urban CLTS have been: increased community awareness of sanitation impacts, a reduction in open defecation, increase in landlords building toilets for tenants, space being provided for communal toilets, and the empowerment of women's organizations. In several communities, the management of solid waste has also improved as a result of community mobilization arising from CLTS.

Urbanization is already a significant trend in several countries in the EAP region. Countries such as Indonesia and China have declining numbers of people living in rural areas, both in real terms of the number of people, but also in percentage terms (see *Table 5.7*). Indonesia now has more people living

Table 5.7 Selected urbanization rates

COUNTRY	% URBAN POPULATION 2000	% URBAN POPULATION 2015	% URBAN POPULATION 2030	URBAN POPULATION '000 2015	URBAN POPULATION '000 2030
China	35.9	55.6	68.7	779,479	998,925
Indonesia	42.0	53.7	63.0	137,422	184,912
The Philippines	48.0	44.4	46.3	45,173	59,220
Lao PDR	22.0	38.6	50.9	2,711	4,479
Papua New Guinea	13.2	13.0	15.0	993	1,503
Solomon Islands	15.8	22.3	28.6	131	218

Source: UN Population Division, (2014) World Urbanisation Prospects, Annual Percentage of Population at Mid-Year Residing in Urban Areas.

in urban areas than rural areas (53.7 per cent in 2015 compared to 42 per cent in 2000).[15] The predictions for the number of people requiring access to improved sanitation in urban areas in the next 15 years indicates a looming challenge on the horizon. Even in small countries such as Papua New Guinea, an additional 500,000 people in urban areas will put pressure on already inadequate sanitation services.

It is likely that urban CLTS will develop further as a sub-practice out of the need to address sanitation in low-income urban areas in the region. There is an opportunity to learn from the growing body of experience with urban CLTS within the EAP region, and in other regions such as Africa.

5.5.2 Adaptation of CLTS

CLTS is increasingly being applied as an approach within broad sanitation programmes to spark disgust and other emotions that motivate communities to change behaviour. Application of 'pure' CLTS is being overtaken by CLTS integration into total sanitation approaches. The unique contribution that CLTS can make is recognized, but the need for sanitation marketing and institutional development are also seen as part of the total picture to improve and sustain sanitation.

In the Philippines, CLTS is applied in the Scaling Up Rural Sanitation Program primarily as an approach for creating sanitation demand in targeted poor communities. LGUs are taught how to target and prioritize barangays where the CLTS approach can be used as tool for igniting behaviour change in sanitation and hygiene practices.

5.5.3 Use of incentives and sanctions to reinforce social norms

Countries in the region have a range of experience with incentives and sanctions to reinforce ODF communities. These 'carrots' and 'sticks' are generally created locally by the community itself, or within the context of ODF certification and recognition. This means incentives and rewards are appropriate for individual communities, while it also means that the application of incentives and sanctions varies across a country and between implementers. Only where there are national programmes for Healthy Villages (Pacific), Model Villages (Viet Nam), and Barangay with Best Sanitation Practices (the Philippines) and other similar programmes, are rewards and incentives formalized. In Timor-Leste, the national sanitation policy provides an opportunity for incentives for ODF villages, however no national system for implementing these incentives has been established. For other programmes e.g., the President's Community Nutrition Award, village ODF status is required, but is omitted from the Hygienic Suco Programme that focuses on solid waste removal.

Findings suggest that in terms of incentives and rewards, village-level collective incentives and rewards work best. Where individual community members receive gifts or other incentives, this creates problems for implementation in a community. Incentives and rewards do not have to be monetary based, with recognition, particularly from higher authorities outside of the village, being effective.

Communities usually devise their own sanctions, regulations and fines, but in most cases fines are not implemented because it is rare that they are needed as behaviour has changed before this point.

[15] UN Population Division, (2014) World Urbanisation Prospects, Annual Percentage of Population at Mid-Year Residing in Urban Areas.

The range of incentives, rewards, and sanctions includes:[16]

Encouragement from influencers

- Local and higher level government issuing letters of encouragement to stop open defecation (Cambodia); or convincing/encouraging households to build a toilet (the Philippines).
- Role modelling of toilet ownership and use by sanitation sales agent (Cambodia).

Public shaming and peer pressure

- Development and display of a village sanitation map (Cambodia, the Philippines).
- Publically listing households without toilets (and displaying the list at a community store, rural health unit) (the Philippines).
- Households with a toilet encourage other households to adopt the use of toilets/cease open defecation (Viet Nam) and peer pressure from households with toilets to those without (the Philippines).
- Diaries/journals from individual households on their commitment to build toilets (the Philippines).
- Public accountability and reporting on sanitation at local government meetings (Cambodia).

Targeted messaging

- Linking sanitation messages with administration processes, e.g., when people want approval letters for marriage or to build a new house they are encouraged to build a latrine first (Cambodia).
- Sanitation and hygiene messages through schools (Cambodia).

Recognition of achievement

- Village receives a 'Certificate of ODF' (Cambodia, Viet Nam, Lao PDR, Myanmar) (this is particularly effective if the certificate is awarded by district or provincial government).
- Displaying a signboard which highlights the village has achieved ODF status (Cambodia, Papua New Guinea, Myanmar).
- Award a community with the status of a 'cultural village' (Viet Nam).

Formal commitments and contracts

- Public declaration or signed pledge by the community of its commitment to cease open defecation (Indonesia, the Philippines, Viet Nam) (This may include pledges signed by all households, or a community-wide pledge signed by the village head).
- Village regulations (Indonesia) and the creation of sanitation ordinances reinforcing the continuous use of sanitary latrines in communities (the Philippines).
- Traditional local law "Tara Bandhu" applied against open defecation with sanctions for community members who openly defecate. During the ODF declaration ceremony, the local leaders take an oath to ensure that their community maintains ODF status (Timor-Leste).
- Signing of a social contract to maintain ODF status once a village is declared ODF (the Philippines).

Rewards

- Cash and in-kind materials (e.g., toilet bowls, PVC pipes) given by the municipal office for a village to be able to move from ODF (Grade 1) to the Grade 2 level of Sustainable Sanitation (all households have hygienic toilets and institutions have sustainable toilets). Rewards given by the municipal office are later shared to the community through targeted subsidies aimed at the poorest families (the Philippines).
- Rewards for whole villages including gifts of soap, hand washing devices, water filters, loudspeakers to leaders in communes/villages (Viet Nam).

[16] Source: Country Status update questionnaire.

- National level rewards through the Department of Health for the winners of the National Search for the Barangay with Best Sanitation Practices (the Philippines). The award gives recognition to barangays (villages) that have demonstrated exemplary contributions in helping to obtain and sustain targets under the MDGs on WASH, and have demonstrated good environmental sanitation practices. Barangays are judged based on several weighted criteria: sanitary toilets, 25 per cent; water supply, 25 per cent; improvement in toilet coverage, 25 per cent; approved barangay budget for water and sanitation projects and programmes, 10 per cent; and other local sanitation initiatives/projects, 15 per cent.
- ODF achievement is linked with receiving water supply improvement (Indonesia, Papua New Guinea).

Fines

- Community-imposed fines for open defecation (Cambodia; Kiribati, Papua New Guinea, Lao PDR). In parts of Kiribati, half of the US$ 5 fine goes to a general sanitation fund and half goes to the person who caught the open defecator. In Lao PDR, although mechanisms for fines exist, they have rarely been enacted as they turn out to be unnecessary.
- Fines for households leaving animals wandering around and polluting their village (Viet Nam).
- Fines for households without toilets (the Philippines, Papua New Guinea) (This was found effective in most rural areas in North Cotabato, in the Philippines, but not in the way expected. Households without a toilet would be fined, but due to shame, the fine money would be used by the household to build a toilet).

An example from Papua New Guinea highlights the use of practical incentives and rewards for external volunteers who support the promotion of sanitation and hygiene in villages to maintain interest and commitment. The NGO Touching the Untouchables has been providing Community Health Post staff and village birth attendants with uniforms, identification cards and certificates of completion of training and ODF status, as well as footwear and second hand clothing when possible. The district health service provides free transportation for volunteers whenever they are travelling through the local level government area or visiting CLTS villages. These incentives help to strengthen teamwork and visibly reinforce the seriousness given to having good toilets and improving sanitary and hygienic practises.

5.5.4 Local actors

This review has been able to explore the role of local actors in CLTS. The findings are that local actors are immensely important to all stages of the CLTS process. Their roles range from influencing, empowering, supporting, helping, monitoring, following up and reporting on CLTS activities in a community. They are fundamental to the role of the facilitator and field staff, and can follow up after triggering and keep the community on track after the facilitator has departed. Key local actors are village leaders, teachers, women (including women's associations and unions), youth, medical staff, and religious leaders (Christian, Islam, Buddhist).

In Lao PDR, facilitators need the support of local actors (e.g., natural leaders and village leaders) to call on representatives from each household to attend triggering activities. During post triggering, local actors also play a crucial role in supporting the follow-up and monitoring of agreed actions by the communities, including establishing village rules on toilets and their use. In the Philippines, natural leaders help village leaders by supporting the community to develop its Zero Open Defecation (ZOD) Plan and then follow up the plan's implementation, including through informal influencing. Teachers provide a key link to schools by reinforcing the importance of latrines as part of hygiene education, empowering children to become messengers to their parents, and supporting school sanitation improvement.

Feedback concludes that natural leaders and local actors should be brought into the CLTS process as early as possible – from first triggering, if not before. They should be invited to actively participate in triggering sessions. The benefit from involving local actors is that they can directly influence village plans, but also influence behaviour change through their regular interactions with the community.

The following word cloud highlights the types of local actors and their roles.

Figure 5.9 Word cloud on local actors and their roles

5.5.5 Time to reach ODF

The time between triggering and a community declaring ODF is between one month and 12 months. Some communities, despite intensive triggering and follow-up, have not reached ODF status after more than 12 months. Indonesia reported a case where a community had not reached ODF since 2008, while one community in the Philippines took five years to reach ODF. Factors which help quicken the achievement of ODF are: activeness of village authorities and established village CLTS committee; close post-triggering follow-up by facilitators and mobilization work done by the village CLTS committee; availability of sanitation options/materials/suppliers; and absence of technically challenging environments such as flood prone areas. The presence of subsidies in neighbouring villages or districts can inhibit communities becoming ODF as they take no action in expectation of a subsidy.

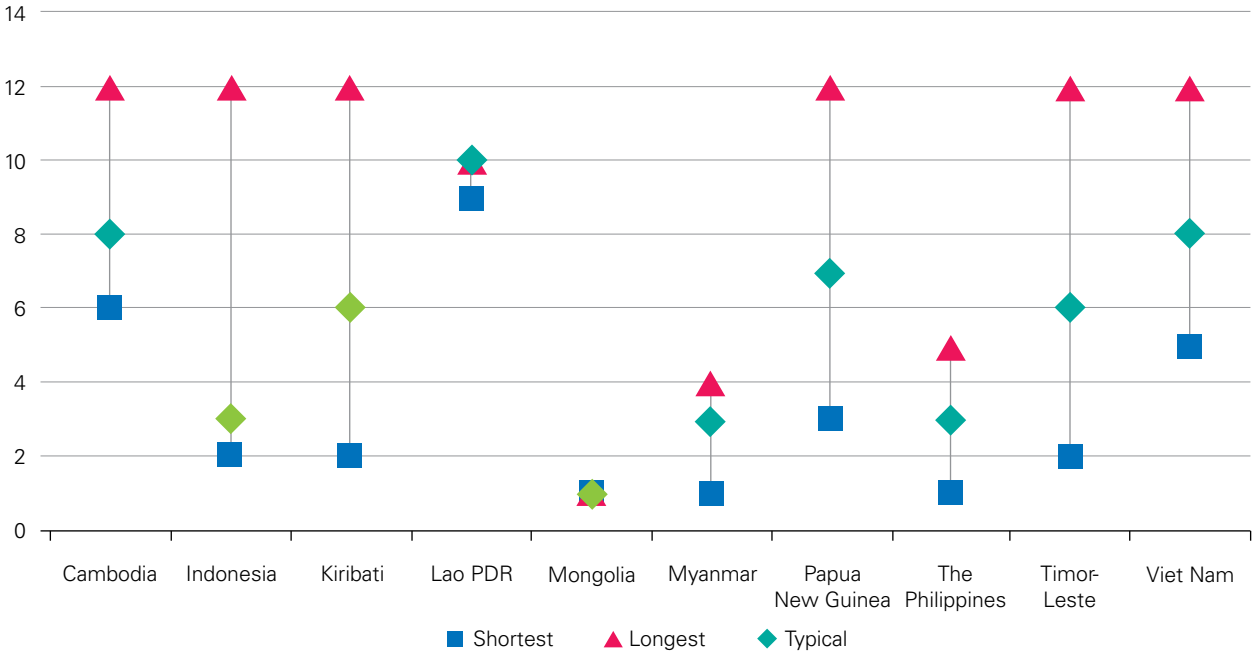
The shortest and longest times for ODF achievement by country are shown in *Figure 5.9*, together with the typical or average time point (generally three to eight months). Additional time is needed for verification and certification processes and also front-end pre-triggering activities, meaning for some countries, the total time in which to achieve ODF may be over 12 months.

5.5.6 Subsidies

The provision of subsidies for sanitation continues to undermine CLTS in some countries, particularly where there is a transition towards non-subsidized approaches and practice has not caught up with policy. Upfront hardware subsidies on toilets have negative impacts on the CLTS approach because they create a culture of dependency for nearby villages who wait for handouts before they take action on sanitation. In some countries, national policy directs non-subsidized sanitation, with targeted subsidies for poor households, but this has not been implemented yet.

For example, the Solomon Islands national WASH policy states that subsidies will still be considered "where the only environmentally appropriate technical solution falls outside the financial means of the average household (e.g., compost toilets, toilets suitable for people with disabilities), education facilities and health facilities". However, subsidies continue to be provided by some organizations for sanitation hardware, often linked to political objectives.

Figure 5.10 Time to reach ODF from triggering (months)



Some national CLTS programmes such as the STBM in Indonesia exclude the use of any subsidies, with intra village help organized informally with cross subsidization of the poor by the rich or other community support systems.

A grey area impacting on CLTS are subsidies provided during and after an emergency. This has been disruptive in the Solomon Islands and Myanmar, but in the Philippines, CLTS combined with small, targeted subsidies for vulnerable households in post-cyclone emergencies has been relatively effective, although the delivery and timing of the subsidies varied between implementers and caused some public confusion (refer to case study).

A number of countries are considering the use of targeted partial subsidies for very poor households with no capacity to build a toilet. The general preference is that these subsidies are provided once households have and use their own toilet, or by applying some form of smart subsidy. An argument proposed by the Philippines is that waiting for very poor households to save enough to afford constructing their own toilets may have a greater negative impact on the community than exercising a smart subsidy that would propel the community to be ODF.

Overall there has been a greater acceptance of the need to have some assistance for the poor through highly targeted subsidies that are equitably and transparently applied. However no country has yet systematically or successfully adopted a subsidy process, although some are experimenting. This area warrants further inquiry and monitoring in the future. There are learnings to be drawn from the Philippines' approach to subsidies following Typhoon Haiyan; Viet Nam will experiment further with rewards through the Scaling Up Sanitation Program; and Timor-Leste has considered a social scheme in the past.

Targeting of the poor, who are the least likely to have access to sanitation, may require subsidies of some form, however most implementers would agree that more thought needs to go into the type and timing of subsidies, and that any subsidy programme needs to be equitable, accountable and transparent, and linked to positive behaviour changes.

5.5.7 Support for the poor

Support for the poor to gain access to sanitation through CLTS is currently ad hoc. In Myanmar, village leaders can generate community support for individuals in the form of labour, materials or cash, but this depends on the strength of the local leader. In the Philippines, UNICEF and partner NGOs develop the capacity of local leaders to collaborate with sanitation suppliers on hardware price, cost efficient delivery to remote areas, and identifying credit options.

Despite some challenges with attracting microfinance institutes (MFIs) to sanitation, loans are a potential alternative option for the poor to access sanitation, provided the conditions for collateral are not too onerous and repayments are feasible. Even in Typhoon Haiyan-affected areas in Tacloban, the Philippines, poor households are taking out loans for toilets. Toilet loans are also made available through the Viet Nam Bank for Social Policy. In a WSP pilot area in the Philippines, a local Micro Financing Co – The Negros Women for Tomorrow – has developed a Sanitation Loan programme, which is a special loan for women who have been members of the fund for more than two years and have a history of making repayments. Loans can be taken at 2.5 per cent interest per month, with a loan term of three to 12 months to build two different toilet package options costing US$ 108 (for a pour flush toilet with concrete slabs and rings) and up to US$ 210.

In Indonesia, support for poor households is largely through self-help community groups such as savings and loan groups. The local production of sanitation components is also employed to help create equitable access to sanitation.

It is rare to find villages with excess funds for sanitation that can be redirected to the poor, although Papua province in Indonesia has large Special Autonomy funding from national and subnational government for village development. The challenge then becomes how to influence the use of these village funds to support the poorest households to access sanitation facilities. UNICEF has been successful in influencing that these funds be used for sanitation activities, especially STBM, with the Governor decreeing that a proportion of the health funds earmarked from the Special Autonomy must be used towards STBM. This type of advocacy approach to redirect funding sources may also be applicable in other places where there are large injections of cash, such as villages with royalties from extractive resources in Papua New Guinea.

5.5.8 Diffusion

There is some evidence of diffusion from CLTS communities to non-CLTS communities, however the scale is quite limited. The main methods of diffusion are through local governments replicating CLTS in non-programme areas, local sanitation champions spreading the word, friends and family from nearby villages visiting CLTS villages or attending triggering sessions, and publicity through the media.

In the Philippines and Indonesia, local and district governments have been taking the initiative to go beyond programme-supported areas and have triggered other villages. In the Philippines, it has even been reported that some villages have declared ODF without even being triggered, apparently because the community heard the benefits that the nearby communities have been enjoying – and also decided to build toilets on their own so that nobody defecates in the open and their village can also be clean and free of diseases. Local sanitation champions such as local chief executives who are strong believers of the CLTS approach are sharing their own stories and narratives to other local chief executives from other provinces and towns.

In both Viet Nam and Papua New Guinea, visitors from non-CLTS villages or bordering villages have been impressed by the triggering process and sanitation improvements in CLTS villages, and feel a sense of competition to improve their own communities.

Media are also having some impact on diffusion through publicity of sanitation news.

6 CONCLUSIONS

This second review of CLTS in the EAP region finds that CLTS continues to play an important role in achieving reduction in open defecation and uptake of sanitation. But exactly what is this contribution? Much of the value of CLTS is in the collective response to ending open defecation as has been shown by the importance of everyone in a village having improved sanitation to protect against environmental enteropathy and child stunting. A numerical analysis of CLTS contribution to reducing open defecation in individual countries is unreliable due to incomplete data and competing population growth. However a basic calculation for Indonesia shows that the 3,140 villages that achieved ODF status between 2012 and 2015 using the local CLTS method (STBM) contributed most of the gains to the 4,000,000 people who ceased open defecation between 2012 and 2015 (from JMP estimates).

Changes in CLTS in the region over the last three years include greater recognition at government level of CLTS as a viable approach; evidenced by the embedding of CLTS in sanitation policies and strategies. Eight of the 12 implementing countries have policies that recognize and promote CLTS, where previously only three countries did. Interestingly, some recent policies permit and encourage subsidies or targeted assistance for the poor in recognition of the difficulty the poor have in accessing sustainable sanitation.

Other developments include implementation guidelines and ODF criteria to help institutionalize CLTS as a common and consistent approach, as well as more standardizations of facilitator training. The importance of government ownership can be seen by the progress of countries that have recently taken up CLTS such as Kiribati – that progress can be quick when the government is behind the effort. Governments are essential for scaling up.

In recent years there have been some promising new developments and trends in CLTS that should be monitored in the future such as:

- Application of modified CLTS in urban areas;
- CLTS in post emergency situations;
- Better targeting of the poor, for example, through social welfare programmes which integrate sanitation;
- Efforts for improving the sanitation supply side, for example, through promotion of sanitation marketing;
- Ongoing attempts at integrating CLTS with nutrition programmes regarding interventions on hygiene promotion, hand washing and other hygiene behaviours, WASH in schools; and
- The use of microfinance to help the poor.

However challenges remain which need to be addressed:

- Governments are not doing enough to finance CLTS – in many cases, governments are not backing CLTS by funding implementation, monitoring and knowledge sharing.
- Poor strategies exist for rolling out sanitation, including reaching ODF goals. There is often a disconnect between the political targets for sanitation and the practicalities of reaching those targets through CLTS.
- The extent to which sanitation monitoring systems are adequate in capturing data on the implementation progress of CLTS and the number of ODF communities, especially in forthcoming SDGs and universal access contexts. With regards to CLTS, it also seems important to focus on the practice of CLTS (e.g., from triggering to follow-up with communities in becoming ODF, follow-up monitoring on slippage, ensuring inclusiveness/participation, etc.).
- ODF verification and certification processes, together with ODF criteria, are still lacking in some countries, and no country has addressed post ODF follow up.
- More work is needed on integrating CLTS with sanitation marketing and improving access to sanitation products and services that meet different needs.

- Sanitation and CLTS in challenging environments, e.g., flood prone areas, high water table areas and disaster prone areas are yet to be tackled at any scale, despite many people in the region living in challenging environments.
- No country has systematically adopted pro-poor support processes within CLTS yet, although some are experimenting.
- Reliable information about the cost of CLTS is absent. Without this information, it is difficult to advocate to governments that CLTS is a cost effective approach which should be supported.
- CLTS is seen as a largely rural approach to sanitation, yet urban populations are growing in the region and have considerable sanitation challenges with increasing poor populations and higher living densities. The challenge is how to take the demand creation aspect of CLTS and adapt the approach, combined with sanitation solutions and business models to make it fit to an urban context.
- CLTS information sharing within the region is ongoing, however this could still be further strengthened. Unfortunately, there has not been a continuation of the EASAN, which in the past, provided the opportunity for regional sanitation exchange events. On the other hand, several organizations have continued undertaking exchanges/learning events/study tours, indicating the need for more opportunities for the sharing of practices and paired learning between countries with similar levels of development and CLTS implementation.

For the region looking forward, two points should be considered:

Generalizing about the region as a whole is not particularly helpful, given its extreme range of size and the situations of the countries within the region, but there is diversity of experience available. Indonesia still remains the largest implementer of CLTS and there is much to learn from this country in terms of government approach, monitoring, scale of triggering and ODF communities. However, Indonesia's persistently high open defecation and child stunting rates suggest that Indonesia may not have all the answers, despite it having a rich range of experiences. New and emerging countries implementing CLTS may provide fresh insights.

CLTS continues to be effective through its core attributes of triggering behaviour change and generating collective action. But is there a risk of CLTS fatigue and a loss of interest in the approach in future? Or is it that CLTS becomes so much a part of the way sanitation is achieved that it is no longer singled out as an "approach"? Ultimately this will depend on each country and their own dynamic.

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PART II

ANNEX 1: COUNTRY CLTS OVERVIEW

CAMBODIA

CAMBODIA: Country CLTS overview

CLTS summary

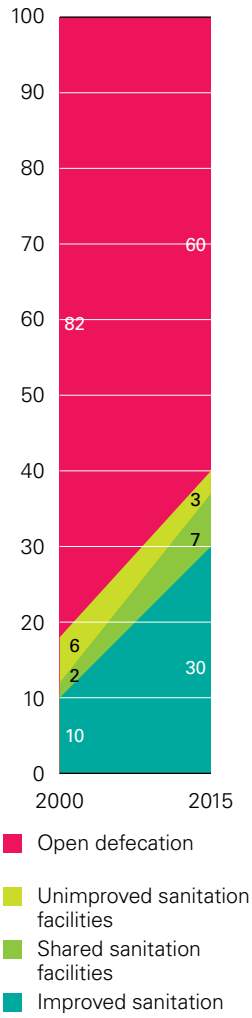
		2012	2015
Status and scale	CLTS date of introduction	2004	Not yet
	CLTS spread: % of country	48%	76%
	CLTS in urban areas	No	No
	CLTS coverage: major organizations	16	19
	OD population rural *(2010 and 2015, mill)*	8.1 m	7.5 m
	Villages triggered *(number)*	1,502	6,160
	ODF villages *(number)*	608	1,494
	Capacity developed *(trained facilitators)*	214	260
Enabling	CLTS in government policy	Yes	Yes
	CLTS targets in government plans	No	No
	CLTS financed by government	Indirect	Some
	CLTS integrated with other approaches	May be	Yes
	CLTS sustainable monitoring	May be	No
Effectiveness	ODF success rate	40%	24%

Scale of rural sanitation challenge

Category	2015 Rural sanitation coverage			2012 Population
	Per cent	Households	Population	
Open defecation	60%	1,553,542	7,457,002	8,132,400
Unimproved sanitation facilities	3%	77,677	372,850	451,800
Shared sanitation facilities	7%	181,247	869,984	451,800
Total without improved sanitation	**70%**	**1,812,466**	**8,699,835**	**9,036,000**

Source: 2015 JMP estimate; United Nations Population Division (2014) Annual Rural Population – 2015; 2012 UN Population Forecast.

JMP estimate: Rural sanitation



Rural: improved sanitation coverage

The JMP estimate suggests a steady increase in improved sanitation coverage in rural areas since 2000 from 10 per cent to 30 per cent in 2015. Open defecation has reduced from 82 per cent to 60 per cent and estimates suggest that more than 1.6 million rural households (7.5 million people) do not use any form of sanitation facility.

National development plans set the goal of 30 per cent rural sanitation coverage by 2015, and 100 per cent by 2025. The JMP estimates for 2015 suggest Cambodia has met its own 2015 goal, however the National Strategic Development Plan goal of 60 per cent by 2018 will still require rapid acceleration.

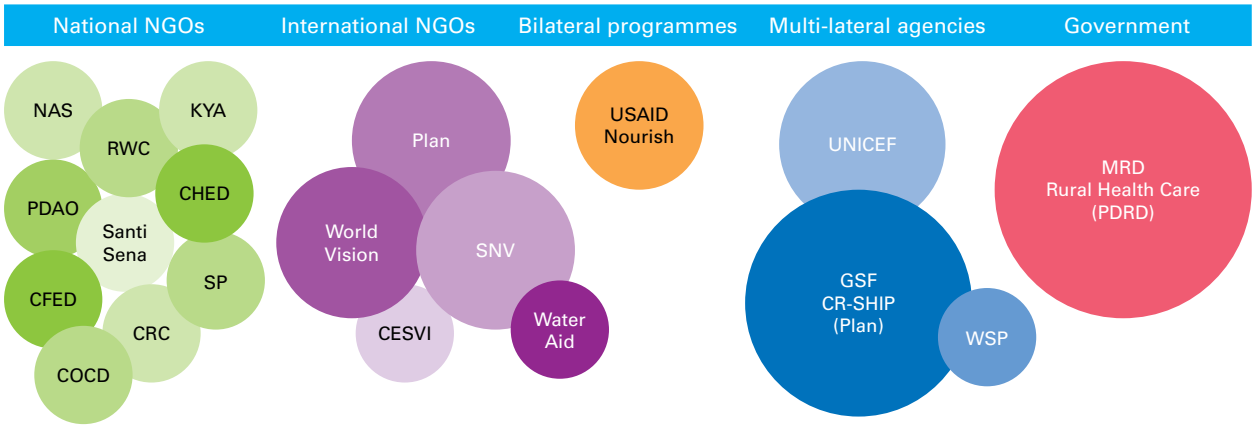
Where is CLTS implemented and by whom

CLTS status and geographic spread

CLTS was first introduced by CONCERN Worldwide in 2004, but without immediate follow up. UNICEF and Plan Cambodia started to implement at a larger scale in 2006. In 2012, CLTS had spread to 11 out of 23 provinces in Cambodia (introduced in 48 per cent of the provinces), and is now currently in 19 out of

25 provinces and the capital (increasing spread to 76 per cent). Provinces include: Banteaymeanchey, Battambang, Kampong Cham, Kampong Chhnang, Kampong Speu, Kampong Thom, Kampot, Kandal, Mondulkiri, Otdar Meanchey, Pailin, Preah Vihear, Prey Veng, Pursat, Rattanakiri, Siem Reap, Svay Rieng, Takeo and Tboung Khmum.

CLTS institutional coverage



Major funding through the Global Sanitation Fund (GSF), Cambodia Rural Sanitation and Hygiene Improvement Program (CR-SHIP 2012-2015), and UNICEF's WASH programme have contributed to expansions in CLTS in both spread in the country and number of implementers. UNICEF's WASH programme is implemented by the Ministry of Rural Development, through the Provincial Department of Rural Development, and covers 11 provinces. CR-SHIP has reached five provinces but a three year expansion from 2015-2018 will see it reach five more. Under CR-SHIP, the number of national NGOs implementing CLTS has increased. Since 2012, the number of international NGOs has consolidated.

MAJOR EXCEPTIONS
Programmes with subsidy elements:
Multilateral: ADB RWSSP-2
International NGO: EMW CHOBA
Sanitation marketing

CLTS is not currently implemented in urban areas in Cambodia.

Major non-CLTS programmes

A few major implementation programmes in Cambodia have used a subsidy-based approach, notably the ADB RWSSP-2 (US$ 5.25 million sanitation component).

- ADB RWSSP-2: a programme methodology based around a "CLTS-hybrid" approach that is intended to use elements from the CLTS approach to create sanitation demand, which is followed by project support (subsidies) for latrine construction. The project design envisaged that a US$ 75 sanitation grant will be provided to each household covering the cost of an improved and hygienic dry-pit latrine with a concrete ring-lined pit (sub-ground structure only). The sanitation grant may be applied in the construction of a water-sealed or a pour-flush latrine based on household preference and affordability levels. In practice, the sanitation grant is a prominent feature of the programme with support for latrine construction and may start before a village achieves 100 per cent open defecation free status.
- East Meets West is implementing Community Hygiene Output Based Aid (CHOBA) (2012-2016) in five provinces. CHOBA encourages households to build improved household sanitation facilities and connect them with both approved local construction contractors and consumer lenders. Households are offered a consumer rebate (or an upfront "discount" when the rebate is channelled through suppliers) upon verification of a properly built and used toilet with an associated handwashing station, and financial rewards are offered for the achievement of community-wide improved sanitation coverage benchmarks.

- Two main organizations, iDE and WaterSHED, are implementing sanitation marketing programmes in 15 provinces which are designed to generate demand for pour-flush toilets, strengthen the supply of sanitation goods and services, and assist local producers and their sales networks to sell toilets that increase the number of the population using improved sanitation facilities. These programmes have utilized some CLTS inspired tools in demand creation and latrine promotion activities, but the main objective of these sanitation marketing programmes is incremental increases in sanitation coverage through private toilet sales. These programmes do not have collective action goals (ODF community targets) and contain few specific pro-poor or equity objectives. The World Toilet Organization previously piloted a franchise model of Sanishops but is now operating in Kampong Chhnang province only.

CLTS variations and practice

1 Global Sanitation Fund CR-SHIP: CLTS + Sanitation Marketing

GSF Cambodia Rural Sanitation and Hygiene Improvement Programme (CR-SHIP) phase 1 plans to implement CLTS in 2,020 villages. Sanitation marketing projects are implemented by partners to improve the availability and affordability of sanitation goods and services in the programme provinces. By the end of December 2014, triggering occurred in 1,739 villages (up from 700 at the end of 2013), resulting in a total of 445 villages with ODF status (up from 128 at the end of 2013).

2 SNV's Sustainable Sanitation and Hygiene For All (SSH4A)

This programme combines sanitation demand creation through CLTS with private sector development for sanitation supply chain and finance, hygiene behavioural change communication, and improved governance to scale up access to sanitation in the rural areas of Cambodia. The SSH4A programme emphasizes the capacity building of partner agencies at provincial, district and commune levels to plan, implement and monitor sanitation and hygiene interventions so that they can continue to promote sanitation and hygiene for the long term. The first ODF commune was declared in Trapeang Sala Khang Lech commune in Banteay Mas District in 2013. In this commune, previously only 25 per cent of households had access to a toilet and now 98 per cent own their own with 2 per cent sharing. The programme now operates in six provinces.

3 Plan: Sanitation in Emergency Food Assistance Project-Additional Financing (EFAP-AF)

Plan supported CLTS, hygiene promotion and smart sanitation financing integrated in the ADB funded, Ministry of Economy and Finance executed, Emergency Food Assistance Project-Additional Financing (EFAP-AF) 2013-2015. This programme improves food security of poor and vulnerable people affected by high food prices. The sanitation component involves CLTS triggering, with targeting of ID Poor 1 and 2 households for conditional cash transfers through an incentive payment of US$25 to buy materials for latrines (50 per cent of the cost), if they have committed to sustainably applying the main hygiene and sanitation messages (e.g., participation in CLTS events, availability of handwashing facilities, availability of potable water, latrine pit dug) for the first 3-4 months of project implementation. Financial incentives are delivered through a microfinance institution. Achievements include 1,083 communities triggered and 22,859 ID Poor households having received incentives, of which 61 per cent built latrines (53 per cent pour flush, 8 per cent dry pit).

4 USAID NOURISH Program

USAID is funding a five-year, US$16.3 million integrated nutrition, sanitation and hygiene project called NOURISH to address the complex, multi-faceted causes of chronic malnutrition in Cambodia, targeting rural areas in the poorest districts of Battambang, Siem Reap and Pursat provinces. The programme, targeting ID Poor women and their children in the first 1,000 days of life, was launched in late 2014 and is being led by Save the Children, with technical support from SNV. Sanitation activities include product development and marketing through private sector promotion, as well as strengthening the capacity of local partners to implement and create sanitation demand through CLTS approaches.

CLTS scale

An estimated 1,494[18] villages have claimed ODF, although not all have been verified and there is no reliable source of data on this number. Guidelines to define ODF were introduced in 2014.

[18] MRD 610; Plan/GSF 491; WV-C 207; SNV 186

ODF success rate

There is no centralized information on the number of villages triggered or ODF status, but estimates are that 6,160 villages have been triggered with 1,494 ODF, giving a rate of 24 per cent achievement.

CLTS capacity

An estimated 260 facilitators have been trained to date. Most (70-80 per cent) trained facilitators are from government (PDRD and DoRD), however only about 30-35 per cent of trained facilitators are still active. Figures from the GSF programme suggests better retention of female facilitators. Only 18 per cent of trained facilitators are women, yet women make up 32 per cent of active facilitators.

CLTS scorecard

ENABLING ENVIRONMENT			
Policy CLTS in government policy		1 National Strategic Plan for RWSSH 2014-2025 (2013). 2 National Policy on Water Supply and Sanitation (2003). 3 Government CLTS guidelines and training manual (2014).	1 National Strategy for RWSSH – For Sanitation: Use sanitation behaviour change approaches (e.g., CLTS) and promote local markets to deliver sanitation products and services so that households buy, construct and use latrines. *Principles: "Each household should pay for its own toilet. Public finance is only used to create demand for better sanitation and hygiene behaviors, to facilitate the private sector in delivering sanitation services, and to improve the capacity of the sub-national government to promote, coordinate, monitor and report progress of sanitation interventions. Direct hardware subsidies can only be used in a targeted manner to support the poor".* 2 2003 NPWSS: every person in rural communities will have access to safe water supply and sanitation services by 2025. 3 National CLTS Guidelines (2014)
Strategy CLTS targets in government strategies or development plans		National Action Plan for Rural Water Supply, Sanitation and Hygiene (to be issued by the end of 2015).	100 per cent of sanitation coverage by 2025, but no ODF targets in national strategy for RWSSH. A new National Action Plan (under development) will include specific indicators and targets for ODF.
Leadership CLTS led by government		Ministry of Rural Development. Department of Rural Health Care.	DRHC leading sanitation and CLTS direction. PDRD/DoRD sets strategies, trains facilitators, implements, monitors and verifies. District government leadership not proactive, although a pilot with functional transfer of sanitation responsibilities to districts started mid-2015 (10 districts).
Finance CLTS financed by government		Government support to programmes.	The Department of Rural Health Care (DRHC) provides central support to CLTS and other rural sanitation programmes, with local implementation support provided through provincial rural development offices (PDRD). Government budget for sanitation has increased from US$320,000 in 2014 to US$580,000 in 2015, however this is generally for hardware. DRHC is advocating the targeting of the poor and greater allocation for software (e.g., CLTS) but this is yet to happen. The budget for 2016 is expected to increase.
Coordination Mechanisms for stakeholder coordination		1 WatSan Group. 2 Technical Working Group on RWSSS (hosted by MRD, with participation of other ministries and development partners).	Implementers meet on technical issues but are generally fragmented. No annual sector review although foreseen as part of the NAP-process. TWG addresses high-level issues, such as National Action Plan development, decentralization reform.

IMPLEMENTATION AND SUSTAINABILITY			
Integration CLTS integrated with other approaches		1 Sanitation marketing. 2 Hardware subsidies. 3 Nutrition. 4 Early childhood.	1 iDE sanitation marketing pilot used a shortened CLTS approach to create demand for the Easy Latrine. The GSF programme combines CLTS and sanitation marketing with supply strengthening provided by its partners. 2 Several programmes, notably the ADB RWSSP-2, are planning to use CLTS to trigger demand for latrine subsidies. 3 Several NGOs combine CLTS with nutrition interventions. A new USAID NOURISH programme will integrate CLTS and nutrition at scale. 4 Plan has been integrating Nutrition, Early Childhood stimulation and WASH (iNEW) since 2013.
Triggering Standardized facilitator training		National CLTS Guidelines Annex. 3 Facilitators Notes (2014).	Facilitator training is standardized in so far as the National CLTS Guidelines provide a module for facilitators, including selection criteria for facilitators, description of duties and community procedures. There is no centralized institution for training of facilitators or professionalization of training.
Facilitator quality control		National CLTS Guidelines Annex. 3 Facilitators Notes (2014).	Individual organizations check the quality of facilitators through a triggering performance checklist included in CLTS guidelines. Only some implementers are providing sustained capacity building of facilitators. Only 30 per cent of trained facilitators are still active. There is no central register of facilitators.
ODF Clear ODF criteria		National CLTS Guidelines (2014).	New national guidelines on CLTS processes including ODF criteria: a) 100 per cent do not practice open defecation and at least 85 per cent have access to functional, improved latrines, and the remaining 15 per cent through shared latrines; b) All households dispose of infant feces into owned and shared latrines; c) There is no evidence of human excreta in the village environment; and, d) Communities have formulated and enforced informal or formal actions against open defecation. Main implementers of CLTS follow guidelines (government and NGOs). Exceptions include ADB RWSSP and NGOs that do not focus on collective outcomes.
Verification protocol		National CLTS Guidelines (2014).	Village ODF verification process clearly documented. The verification process is expected to be done twice; once after a village declares itself as ODF and the next after six months of being ODF, although there is no evidence that this has happened yet as the guidelines have only recently been agreed. Verifiers include PDRD/DoRD, local authorities, village focal point and programme staff. There is no verification protocol for commune or district level ODF achievements.
Post ODF support		National CLTS Guidelines (2014).	No formal process. Implementing partners informally follow up with PDRD and commune/village leaders. Some partners, such as SNV, formalize post ODF support by establishing post ODF committees and developing strategies for the continuation of ODF with reporting to commune level.
Technical support Availability of products and services		Low-cost affordable and package solution is widespread and available through sanitation marketing initiatives.	Limited choice of technology options, especially for the very poor. Physically challenging environments (e.g., flood areas lack a cost effective solution).

MONITORING AND EVALUATION			
Monitoring Robust and regular monitoring of ODF achievements			In the past, DFID finance was used to establish a CLTS database to track progress in Cambodia, but this database is no longer used. Manual monitoring of ODF criteria occurs on a project or programme level, but each implementer uses different systems. There is no coordinated, national monitoring of ODF status. A National WASH Management Information System is under development.
Post ODF monitoring of quality and sustainability			Not systematic. National CLTS guidelines do not address how and when to follow up post ODF: "Periodic check on the sustainability of ODF status needs to be agreed and followed in the programme". Slippage is not routinely monitored. There is no procedure for a community to lose its ODF status.
Evaluations and knowledge sharing Evaluations, reviews and learning		WatSan Group meetings.	Lessons are shared through WatSan Group meetings, quarterly and annual programme meetings. Several studies by implementing partners contribute to sector knowledge, e.g., Plan's: *Testing CLTS Approaches for Scalability: Cambodia (2014).*
Information on costs and resources for CLTS			Unit costs and resource calculations are not centrally available.

Most significant changes since 2012

1 National CLTS guidelines	Previously there was no official guide for the CLTS implementation process. The National Guidelines have resulted in a common sanctioned approach which is clear and easy for implementers to follow. The Cambodian definition of ODF has been agreed and the verification process is clear. This has brought unity and conformity to the sector.
2 Improved facilitation	Facilitation has improved through the National CLTS Guidelines selection criteria for facilitators and through clear statement of duties. A core group of master trainers at the national lever has developed their capacity and skills over time. The training of facilitators is more thorough, resulting in improved triggering at community level.
3 Large programmes scale up CLTS	Major programmes, such as the GSF C-SHIP, have boosted CLTS implementation and driven evolution in Cambodia. The number of national NGOs with CLTS experience has also increased.
4 Increased access to durable and affordable sanitation products	Coverage of sanitation and the number of ODF villages has increased significantly in the last three years. Much of this increase is in durable and affordable pour flush toilets.
5 Change in thinking	CLTS is seen as one element in a sustainable, sanitation solution and there is wider thinking about linking LCTS with the need to improve the supply chain, as well as behaviour change communication efforts and the use of pro-poor support mechanisms. National BCC guidelines are in development which recognize various approaches and methods, including CLTS, as one to address collective change.

Lessons learned

1 Households prefer pour flush toilets	The sanitation ladder concept is not applicable in Cambodia. Households will frequently delay purchase until they have their preferred pour flush latrine. This can delay the achievements of ODF but can lead to improved sustainability of sanitation behaviour.
2 Triggering	Triggers that work best to mobilize the community include: disgust, shame, self esteem, desire for good health, privacy and convenience. Triggering with children appears effective, resulting in children urging their parents to build a toilet.
3 District based sanitation is effective and the role of district administrations for rural sanitation should be enhanced	A district-wide, local government-led approach is more effective and sustainable in comparison with targeted support only for a few selected poor communes or villages. Partnership with local authorities and market suppliers increases government capacity to steer and scale up sanitation initiatives, and builds local momentum to reach all with improved sanitation. Commitment and leadership of the provincial and district authorities is important, but can only be achieved when the programme covers a larger area. SNV's SSH4A approach has led to stronger commitment and ownership in all target districts. In 2013, after introducing the results based sanitation and hygiene planning at district level, the impact and results were more than triple those from the previous year. To strengthen the district-wide approach, a gradual transfer of rural sanitation mandate to district administrations could help to scale-up government-led service delivery.

Lessons learned *(continued)*

4 Local context is important	CLTS demand creation approaches need to accommodate local solutions to local problems, and the solutions depend upon a clear understanding on the sanitation situation and the community's socio-cultural norms, values and motivations. One size does not fit all.
5 CLTS and sanitation marketing is a powerful combination	If CLTS and sanitation marketing are integrated, the achievements can be quick and sustainability can be improved.
6 Share best practices through peer to peer learning to accelerate progress	Learning exchanges between government officials at commune, district and provincial levels accelerate rural sanitation and hygiene achievements. Joint progress review meetings and visits between the districts and provinces create "healthy competition" for increased sanitation coverage.
7 Diffusion	Neighbouring, non-triggered villages copy sanitation improvements from triggered communities.
8 Promotion	Publicity on national days/international days (e.g., global handwashing day) is effective at spreading information to communities, including about sanitation.

CLTS weaknesses and bottlenecks

1 ODF not a key indicator	National level targets and monitoring focuses on sanitation coverage, not ODF achievements.
2 Continued use of subsidies	Acceleration of progress and effective scaling up of sanitation is undermined by competing or contradictory approaches in the same location, particularly the use of hardware subsidies that are not employed in a targeted manner for the poor and delivered in a smart way. There is more consensus in the sector that a pro-poor mechanism is needed and a guideline will be drafted in 2015.
3 Lack of national monitoring system	There is no central place for monitoring and tracking ODF statuses of villages, therefore it is difficult to obtain a national picture of the progress of CLTS and ODF status or to identify lagging areas within the country.
4 No post-ODF monitoring	No procedure for monitoring sustainability and slippage of previously verified ODF communities. Post ODF monitoring is uneven and not formalized.
5 Limited latrine technologies	There are few latrine options available for households. Affordable technology solutions are yet to be developed for challenging environments i.e. flooding areas, floating areas, mountains.

CLTS opportunities over the next 3-5 years

1 National Action Plan	A National Action Plan to be developed in 2015 will set ODF targets and guide the allocation of government funds, and mobilize funds from other donors to support sanitation. The NAP will be an umbrella to mobilize a common approach.
2 Management Information System	An MIS (currently under development) will monitor and capture national progress on ODF achievements. The MIS will be trialled in provinces where GSF is operating. Up until now, CLTS has relied on anecdotal information with market based programmes having much better quantitative dates (e.g., sales).
3 Increased funding	Continued support of donors, such as the expansion of GSF programmes to five new provinces, and more funds expected from the Government.
4 Improved coordination	More coordination is necessary, particularly at district level, in order to create a synergy and reach the sanitation vision. The existing good collaboration between government and partners can further support governments in developing sanitation in the future. MRD has submitted their functional review document to the Government in which rural sanitation is a proposed function for transfer to district administrations. Piloting of this transfer from 2015-2016 in 10 districts will be foreseen before such transfers would be enacted nationally.
5 Sanitation integrated with other approaches e.g., nutrition and early childhood	Nutrition is receiving increasing attention and links with sanitation are much better understood by policy makers. The US-AID NOURISH programme is anticipated to provide learning on links between sanitation and nutrition and how to integrate them. Plan Cambodia has been implementing iNEW for integrating WASH with nutrition and early childhood, and has developed iNEW tools using positive approaches.
6 Cost norms	A costing exercise to gather unit costs for implementation of CLTS by different partners could contribute to accurate scaling up and targeting costs for the National Action Plan. Cambodia has a sufficient history of CLTS implementation to provide this information. Plan estimates costs per village for triggering and post-triggering follow up visits to be around US$1,200 to US$1,500, which includes ODF status and staffing costs for implementing partners.

CHINA

CHINA: Country CLTS overview

CLTS summary

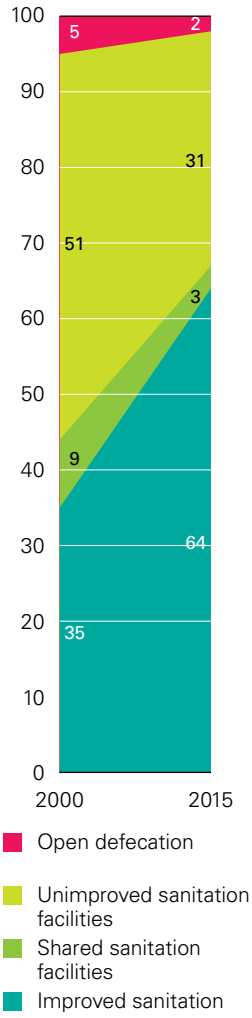
		2012	2015
Status and scale	CLTS date of introduction	2011	Not yet
	CLTS spread: % of country	15%	15%
	CLTS in urban areas	No	No
	CLTS coverage: major organizations	2	2
	OD population rural *(2010 and 2015, mill)*	13.5 m	12.4 m
	Villages triggered *(number)*	0	50
	ODF villages *(number)*	0	31
	Capacity developed *(trained facilitators)*	53	210
Enabling	CLTS in government policy	No	No
	CLTS targets in government plans	No	Some
	CLTS financed by government	No	No
	CLTS integrated with other approaches	No	No
	CLTS sustainable monitoring	No	No
Effectiveness	ODF success rate	0%	%

Scale of rural sanitation challenge

Category	2015 Rural sanitation coverage			2012 Population
	Per cent	Households	Population	
Open defecation	2%	3,770,351	12,442,160	13,483,000
Unimproved sanitation facilities	31%	58,440,447	192,853,475	188,762,000
Shared sanitation facilities	3%	5,655,527	18,663,240	94,381,000
Total without improved sanitation	**36%**	**67,866,326**	**223,958,875**	

Source: 2015 JMP estimate; United Nations Population Division (2014) Annual Rural Population – 2015; 2012 UN Population Forecast.

JMP estimate: Rural sanitation



Rural: improved sanitation coverage

The JMP estimate for China suggests a rise in improved sanitation coverage in rural areas from 35 per cent in 2000 to 64 per cent in 2015. A significant proportion of the rural population in China continue to use unimproved sanitation facilities, but this has been reduced from 51 per cent to 31 per cent (296 million people down to 223 million), with the open defecation rate estimated at only 2 per cent in rural areas. Nevertheless, the huge population means that more than 3.7 million rural households practice open defecation and a further 64 million rural households use either unimproved or shared sanitation facilities.

Open defecation is limited in rural areas of China because of the long history of using human excreta as organic fertilizer in farming. It has been reported that 93 per cent of rural human excreta is used as organic fertilizer, with most households using some form of latrine to collect the excreta. However, some research suggests that the use of human excreta is now practiced by only around 30 per cent of the population.

Where is CLTS implemented and by whom

CLTS status and geographic spread

First introduced by Plan China in Shaanxi province in 2005, however the approach was not adopted after the initial pilots due to over-riding government and NGO preference for latrine subsidies. No further progress was made until 2011, when UNICEF and its government counterparts organized another training workshop in Jilin province to build capacity for a Community Approaches to Total Sanitation

(CATS) programme in 50 villages across five provinces (out of 33 provinces). UNICEF is continuing to support CLTS in five provinces, but within three of these provinces the approach has been extended to other villages.

The project counties were selected based on many conditions such as geographical focus (as well as linking with health and nutrition projects), economic conditions, ethnic groups, willingness of local partners, coverage of improved sanitation, etc.

CLTS institutional coverage

The China Rural Water Supply Technical Center (CRWSTC), under the China Center of Disease Control (CDC), was entrusted by the National Patriotic Health Campaign Committee Office (NPHCCO) to be the line agency at the central level in implementing CATS projects in cooperation with UNICEF. In the five provinces and five counties, county PHCCOs and/or county CDCs are responsible for the routine implementation of CATS, including setting targets, planning, coordination, triggering, technical support, monitoring, verification, documentation, diffusion, etc.

CLTS scale

An estimated 31 communities have been certified as ODF under UNICEF's CATS programme.

ODF success rate

- Triggering is small scale with the UNICEF project responsible for triggering of 50 project villages. The water/food-flies-faeces tool works best in China. Farmers are disgusted at eating faeces and have a desire for good health. Convenience is also an important trigger.
- Time from triggering to ODF status varies, with some communities rapidly achieving ODF when they integrate the national sanitation programme for latrine coverage, whilst in other villages, where there is no external programme supporting latrine building, there has been inaction.

CLTS capacity

An estimated 210 facilitators from CRWSTC, provincial and county CDCs have been trained on CATS methodologies as facilitators. Out of the 210 trained, only 10 are still active in implementing the demonstration project, however the remainder integrate triggering skills into their daily work in sanitation promotion and health education.

CLTS scorecard

ENABLING ENVIRONMENT			
Policy CLTS in government policy		1 2003 Hygienic standard for rural household latrines (GB19379-2003). 2 "Rebuilding Sanitary Toilets in Rural Areas" national programme 2009.	1 Requirements of sanitary latrines: walls, roofs, leak-proof tanks, airtight covers, clean, free from flies and maggots, odourless, and harmless treatment of faeces. National Patriotic Health Campaign Committee (NPHCC) promotes six types of harmless sanitary latrine. The Government of China has set very high standards for sanitary latrines, hence the cost is high. 2 In 2009, the central government listed "Rebuilding sanitary toilets in rural areas" as one of six national important public health services programmes. In the same year, the subsidy fund was allocated at a number of 1.56 billion RMB to support 4.11 million households to rebuild harmless sanitary toilets nationwide. 3 Collective sanitation is set as a principle in the sanitation authority's (NPHCCO) policy on rural sanitation movements. It requests for whole village improvement, however, CLTS triggering methodology is not officially used yet as a nationwide approach, which is linked to the government's financing mechanism.
Strategy CLTS targets in government strategies or development plans		1 Healthy China by the year 2020. 2 12th Five-Year-Plan, 2011- 2015. 3 Some provincial acceptance of the strategy.	1 Medium and long-term plan for the health sector until 2020. 2 12th Five Year Plan aims to have 75 per cent sanitary latrine coverage in rural areas by 2015. 3 CATS has been accepted in some provinces, e.g., Jiangsu province, and in some project counties as a sanitation promotion approach.
Leadership CLTS led by government		National Patriotic Health Campaign Committee Office (NPHCCO). China Rural Water Supply Technical Center (CRWSTC) under the China Center of Disease Control (CDC).	The China Rural Water Supply Technical Center (CRWSTC), under the China Center of Disease Control (CDC), was entrusted by the National Patriotic Health Campaign Committee Office (NPHCCO) to be the line agency at the central level to implement CATS projects in cooperation with UNICEF. In the five provinces and five counties, county PHCCOs and/or county CDCs are responsible for the routine implementation of CATS, however the government heavily relies on UNICEF to lead CATS promotion.
Finance CLTS financed by government		No finance directly for CLTS.	No direct finance of CLTS activities from central government, but local government provides subsidies for sanitation hardware. Water, sanitation and hygiene are three out of the 66 elements of healthy behaviour promoted by the government-financed health education programme.
Coordination Mechanisms for stakeholder coordination		Limited.	Project level coordination only.
IMPLEMENTATION AND SUSTAINABILITY			
Integration CLTS integrated with other approaches		Health sector. Poverty reduction.	CATS triggering methodology and key messages are integrated in handwashing, WASH in schools and WASH in township hospital projects. The CATS approach has also been introduced to government poverty reduction projects, government local health institution director training and university student classes majoring in health education and journalist training. It is now being integrated in joint sanitation and nutrition projects.
Triggering Standardized facilitator training		CLTS guidelines.	Kamal Kar's triggering guideline has been translated into Chinese and has been used in the pilot project.
Facilitator quality control			No formal monitoring system. Feedback at project annual planning and review meetings shows that facilitators do not purely use CATS triggering skills when they work in the field, and most local project staff integrate one or several tools of triggering into their routine health education work on sanitation promotion. There is no central register of facilitators.

IMPLEMENTATION AND SUSTAINABILITY *(continued)*			
ODF Clear ODF criteria			No standards from government, but UNICEF's Three star ODF standard is adopted in project counties. The standard's four indicators are: 1 sanitary latrines/covered pit latrines; 2 safe disposal of children's faeces; 3 no faeces in public places; and 4 handwashing facilities with soap/liquid soap in/nearby latrine/room/yard. Once the village reaches level one it can request for nomination of ODF. • One star ODF village: no sanitary latrine but all households cover their pit latrines. Plus all other hygienic behaviours adopted (2, 3, 4). • Two star ODF village: some households having built and used sanitary latrines, while the rest cover their pit latrines. Plus all other hygienic behaviours adopted (2, 3, 4). • Three star ODF village: all households having built and used sanitary latrines. Plus all other hygienic behaviours adopted (2, 3, 4).
Verification protocol			No national protocol. In UNICEF's project counties, the community submits request to County PHCCO (local implementation management office) through local township government for verification of ODF. The County PHCCO then asks the county Center for Disease Control to do verification (at least 10 per cent of the households) within one month of the request. Once verified, County PHCCO awards an ODF title to the community.
Post ODF support			No national guidelines but principles only. UNICEF has developed a clear project protocol for support in project counties. After three months of ODF declaration, the County PHCCO entrusts the County CDC to conduct monitoring of the village. If issues are identified, the village is asked to improve within a given period. One year later, the same monitoring will be conducted by the County CDC. At least 10 per cent of the households should be visited. If more than 20 per cent of the visited households have faeces exposure or there is faeces in public places, the title of ODF village will be removed.
Technical support Availability of products and services		Government support to supply chain.	Through sanitation marketing forums and government sanitation programmes, private suppliers and local government implementers interact and build a chain for the provision of supplies. Technical information is usually provided as part of the CATS promotion process. Almost all provinces have developed and printed advocacy materials including technical options and 3D-dimensions of drawings for sanitation promotion, which are posted on the walls in the villages before the triggering. Lectures are also given to beneficiaries during or after the triggering.
MONITORING AND EVALUATION			
Monitoring Robust and regular monitoring of ODF achievements		1 National Bureau of Statistics on sanitation coverage. 2 Pilot ODF monitoring only.	1 NBS conducts annual household surveys in accordance with the JMP sanitation definitions. The government routinely monitors environmental sanitation risk and sanitation coverage. 2 Under the pilot, local government is requested to verify ODF before nomination and conduct monitoring periodically after certification. County CDCs are responsible for monitoring but this is only at project county level and is recorded manually.
Post ODF monitoring of quality and sustainability			Not systematic monitoring and no formal procedures, but quality of sanitation is good and slippage is assumed to be low.

MONITORING AND EVALUATION *(continued)*		
Evaluations and knowledge sharing Evaluations, reviews and learning		No evaluations of CLTS yet. Lessons learned are shared through joint meetings, communication, or input/comments for government documents, etc.
Information on costs and resources for CLTS		No data on unit costs and resources for CLTS.

Most significant changes since 2012

1 Increased acceptance of CLTS	Government officers like the concept of ODF. CATS triggering tools are now well accepted by local sanitation practitioners in UNICEF project areas. In the new State Council's paper on patriotic health, the community total sanitation is set as a principle.
2 Integration in other settings	The CLTS concept and the triggering methodology have been applied to WASH in schools and in local health facilities. This is currently on a limited scale but has the potential for wider integration.

Lessons learned

1 Better results when integrated in to government programmes	Without integrating into government programmes, such as health and schools, it is difficult to achieve scale up of ODF.
2 Attitude of government officials affects scaling up	The mindset of government officials in-charge affects progress in scaling up. Government officials involved in project implementation are positive in scaling up CATS as they properly understand how CATS works. Government officials in non-project areas are reluctant to use CATS procedures to promote sanitation as CATS is thought to be time-consuming, complex, not necessary, etc. This suggests that more exposure to CATS/CLTS is needed outside of project areas. Government managers in the financing sector would like to finance the hardware component of the sanitation promotion rather than financing software.
3 New culture and social norms are important in CATS promotion	New culture and social norms are effective. Some of the communities set village regulations and social norms to commit to ODF and clean/tidy village environment, etc. In some counties, several households are selected as clean model households to show other villagers how to improve household sanitation.
4 Coordination among government departments	Many sectors or departments implement various programmes which can integrate sanitation into planning, however sanitation may not be their mandate.

CLTS weaknesses and bottlenecks

1 ODF not a key indicator	No national ODF criteria.
2 Government subsidy programme	The government has been subsidizing the construction of household latrines since 2003, especially after 2009, which has created a tendency among local villagers to wait for the government subsidy programme to come and has created dependency on government financing.
3 Lack of government leadership in scaling up	Government needs to take the lead for scaling-up by planning for the CLTS approach with targets set for different areas, adequate working budgets and trained staff as facilitators to conduct triggering. The Government tends to push for total sanitation in a community through various programmes. CATS triggering needs to be strengthened.
4 Unaffordability of high standard latrines for some areas and for some households	The Government sanitation standard adheres to strict technical specifications for toilet construction, making the cost for latrine construction high. This is a challenge for rural poor households to have the money to reach the required latrine standard. Hygienic standards for rural household latrines requires that all latrines have seepage-free and leak-proof tanks or pits, which greatly constrains the construction of simple pit latrines made from local materials.
5 Rural village life no longer cohesive	A challenge to the collective action approach of CLTS/CATS is that the traditional set up of a village no longer exists, with villagers working in their own fields and seldom undertaking collective activities, or contributing free labour for public works. Families leaving rural villages to work as urban "migrant workers" only come back for a short time during the Spring Festival, which affects village cohesion.

CLTS opportunities over the next 3-5 years

1 Make ODF an indicator in national planning and monitoring	Integration of ODF as an indicator in government monitoring systems; adoption of ODF as an indicator for assessment of national programmes.
2 Wider integration	Integrate CATS with MCH and nutrition programmes to maximize the CATS impact. Integrate CATS into rural community development programmes through many authorities that are not mainstream sanitation actors, but who can help effect change.

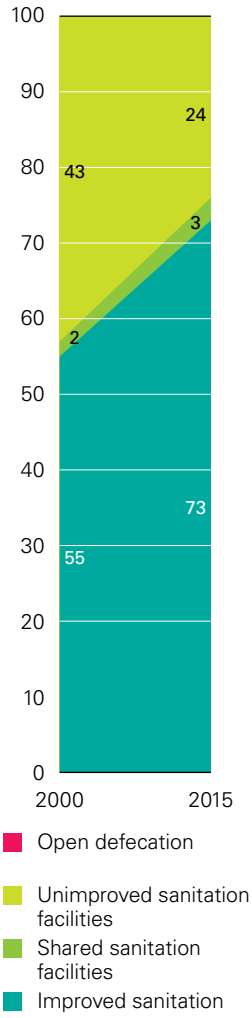
DPR KOREA

DPR KOREA: Country CLTS overview

CLTS summary

		2012	2015
Status and scale	CLTS date of introduction	Not yet	Not yet
	CLTS spread: % of country		
	CLTS in urban areas		
	CLTS coverage: major organizations		
	OD population rural *(2010 and 2015, mill)*	0 m	0 m
	Villages triggered *(number)*		
	ODF villages *(number)*		
	Capacity developed *(trained facilitators)*		
Enabling	CLTS in government policy	No	No
	CLTS targets in government plans	No	No
	CLTS financed by government	No	No
	CLTS integrated with other approaches	No	No
	CLTS sustainable monitoring	No	No
Effectiveness	ODF success rate		

JMP estimate: Rural sanitation



Scale of rural sanitation challenge

Category	2015 Rural sanitation coverage			2012 Population
	Per cent	Households	Population	
Open defecation	0%	0	0	0
Unimproved sanitation facilities	24%	576,118	2,362,084	2,518,400
Shared sanitation facilities	3%	72,015	295,260	290,600
Total without improved sanitation	**27%**	**648,133**	**2,657,344**	**2,809,000**

Source: 2015 JMP estimate; United Nations Population Division (2014) Annual Rural Population – 2015; 2012 UN Population Forecast.

Rural: improved sanitation coverage

The JMP estimate suggests a rapid rise in improved sanitation coverage in rural areas from a 55 per cent in 1995 to 73 per cent in 2015. A significant proportion of the rural population in DRP Korea continue to use unimproved sanitation facilities, but this has been reduced from 43 per cent to 24 per cent, with no open defecation reported in rural areas. Nearly 650,000 rural households use unimproved or shared sanitation facilities.

Where is CLTS implemented and by whom

CLTS status and geographic spread

CLTS has not been introduced in DPR Korea. Very low rates of open defecation meant that few stakeholders recognized rural sanitation as an important issue. There is now increasing recognition of the relatively high proportion of unimproved sanitation facilities and of the health problems caused by the widespread use of untreated human excreta in agriculture.

Institutional mapping

There are relatively few development partners working in the rural sanitation sector: UNICEF, SDC, IFRC, Save the Children and CONCERN.

Key sanitation issues

The use of human excreta for fertilizer is highly prevalent – some estimates suggest it is practiced by up to 80 per cent of rural households, with systematic excreta collection and use in many rural communes. However, it remains a sensitive cultural and socio-political issue: the practice is sometimes linked to shortages of chemical fertilizers and there is little awareness of the health risks related to the handling and application of untreated human excreta. In many areas, shallow latrine pits are utilized, sometimes using earthen pots to collect urine and faeces, which only provide one or two months storage, thus requiring regular emptying without sufficient composting time to kill off pathogens.

Enabling environment

UNICEF has been raising awareness about the risks of existing sanitation practices and the benefits of investment in sanitation improvement among local authorities and the rural populations. UNICEF supported the development of rural sanitation guidelines based around safe management of human excreta that was launched by the Ministry of City Management (MoCM), the government's lead WASH agency, in 2011, after a long period of advocacy and negotiation. The guidelines, which provide straightforward advice on the risks associated with untreated human excreta and outlines some low-cost, appropriate treatment options, are now being disseminated nationally to local governments, community leaders and farmers.

In 2014, UNICEF facilitated a study visit to China to assess the possibilities of improvised sanitation design. The study visit was followed by an in-country technical workshop where several design options were considered. The MoCM selected the sanitary double pit latrine for demonstration and adaptation to the DPRK context as the highest standard for rural sanitation that will ensure safe latrines as well as safe handling of excreta (sludge) used as manure in agriculture. The model will be piloted in the three districts under the WASH for All Initiative and demonstrated in all UNICEF focus counties and districts. The piloting will include developing and adapting the harmless sanitary double urn latrine model using local materials and technology, which will be introduced in all counties. A training workshop was conducted with technical assistance from UNICEF China on latrine design and strategy development for improving household and institutional sanitation. UNICEF will support the preparation of training modules and technical manuals.

The MoCM has recently started an inter-ministerial consultative meeting with other agencies active in sanitation and hygiene. This collaboration of sector ministries in sanitation and hygiene is under the WASH for All Initiative introduced with UNICEF. This is part of the expansion of partnerships for implementing hygiene and sanitation promotion. With an emerging consensus among government ministries, departments and agencies, with various roles in sanitation and hygiene to prioritize the development of a national action plan for the improvement of latrines in the rural areas, the timeframe for updating the policies was set at December 2015.

Opportunities

Potential for CLTS

UNICEF hopes that the pilot "improved sanitation for all" project will demonstrate that it is possible to achieve 100 per cent ODF and improved sanitation status without compromising the use of treated excreta as a valuable fertilizer and soil conditioner. Once the Government is convinced that community-wide outcomes are possible, then it is hoped that CLTS can be introduced as a tool for scaling up sustainable behaviour change and sanitation improvement across the country.

Opportunities for integrating CLTS with efforts to tackle poor nutrition are possible. According to the 2012 National Nutrition Survey, 28 per cent and 4 per cent of children under five years suffer from chronic malnutrition (stunting) and acute malnutrition (wasting), respectively.

Most significant changes since 2012

1 Increased interest of government	Growing awareness of government on the need to improve fecal sludge management. This is evident through increased collaboration and formal consultations between agencies, as well as support in a UNICEF pilot for improving latrine models.

INDONESIA

INDONESIA: Country CLTS overview

CLTS summary

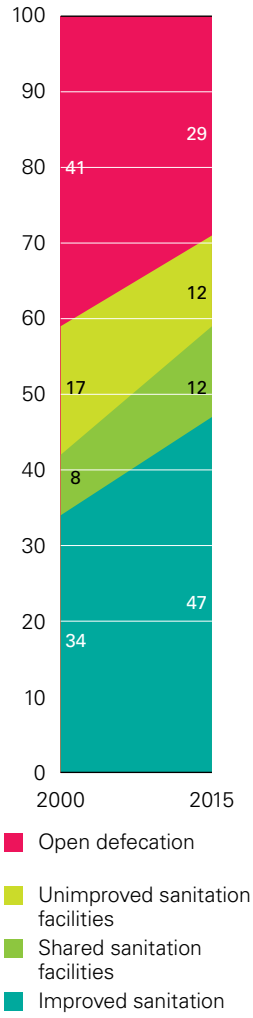
		2012	2015
Status and scale	CLTS date of introduction	2005	Not yet
	CLTS spread: % of country	97%	100%
	CLTS in urban areas	No	Yes
	CLTS coverage: major organizations	9	14
	OD population rural *(2010 and 2015, mill)*	38.3 m	34.3 m
	Villages triggered *(number)*	7,325	24,955
	ODF villages *(number)*	1,279	4,419
	Capacity developed *(trained facilitators)*	530	>2,000
Enabling	CLTS in government policy	Yes	Yes
	CLTS targets in government plans	Yes	Yes
	CLTS financed by government	Yes	Yes
	CLTS integrated with other approaches	Yes	Yes
	CLTS sustainable monitoring	Yes	Yes
Effectiveness	ODF success rate	17%	18%

Scale of rural sanitation challenge

Category	2015 Rural sanitation coverage			2012 Population
	Per cent	Households	Population	
Open defecation	29%	8,575,792	34,303,167	38,322,880
Unimproved sanitation facilities	12%	3,548,603	14,194,414	15,568,670
Shared sanitation facilities	12%	3,548,603	14,194,414	13,173,490
Total without improved sanitation	**53%**	**15,672,999**	**62,691,995**	**67,065,040**

Source: 2015 JMP estimate; United Nations Population Division (2014) Annual Rural Population – 2015; 2012 UN Population Forecast.

JMP estimate: Rural sanitation



Rural: improved sanitation coverage

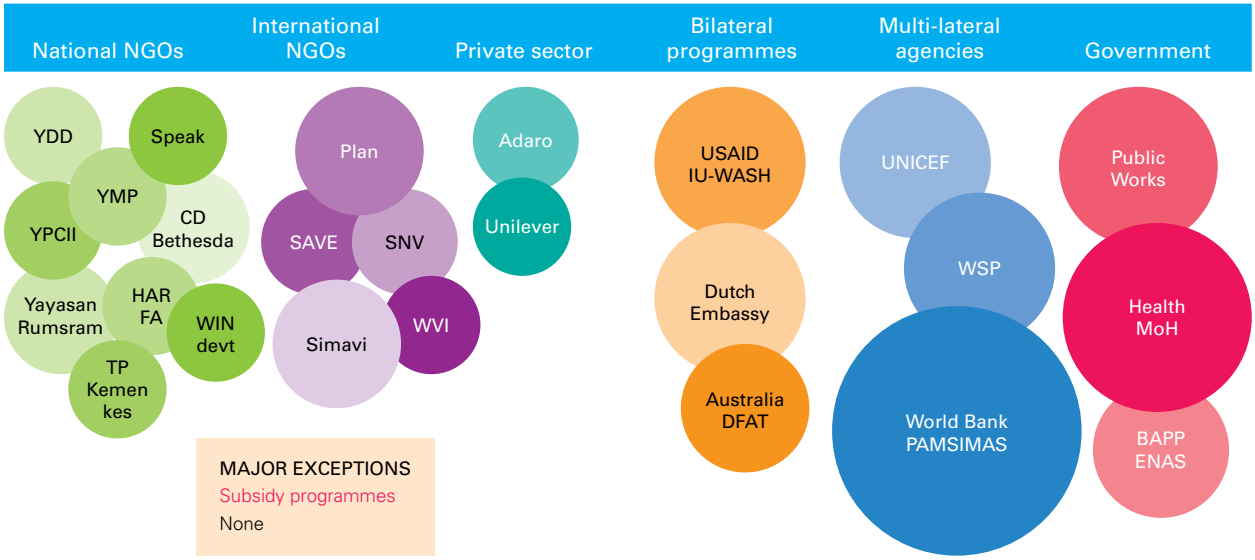
The JMP estimates suggest an increase in improved sanitation coverage in rural areas from 34 per cent in 2000 to 47 per cent in 2015. A further 24 per cent of the rural population use either shared sanitation facilities or unimproved facilities. Open defecation is estimated to be 29 per cent, which suggests that more than 8 million rural households (34 million people) do not use any form of sanitation facility. However, according to JMP data, since 2012 approximately 4 million rural people have stopped open defecation, and since 1990 approximately 21 million rural people have gained access to sanitation.

Where is CLTS implemented and by whom

CLTS status and geographic spread

Introduced by WSP in 2005, CLTS had reached 54 districts (kabupaten) by 2007 (13 per cent of the total number of Districts); by 2012 it spread to 234 out of 405 districts in Indonesia (58 per cent nationally) including 32 out of the 33 provinces (97 per cent of provinces), and as of mid 2015 it has spread to 492 out of 514 rural and urban districts across all 34 provinces (reference: STBM http://stbm-indonesia.org/monev/).

CLTS institutional coverage



Since 2008 CLTS has been implemented through a National Strategy for Community-Based Total Sanitation and Hygiene – Sanitasi Total Berbasis Masyarakat, STBM – which includes five pillars:

1 Open defecation free (ODF) communities;

2 Hand washing with soap at critical moments;

3 Household water treatment and safe storage of water and food;

4 Solid waste management; and

5 Liquid waste management.

The programme advocates a subsidy-free approach to sanitation and generally concentrates on achieving ODF villages with implementation at the district and village levels. Implementation is highly decentralized and dependent on district mayor support to approve funding for STBM activities, resulting in uneven implementation across the country. At central government level, a secretariat in the Ministry of Health has been set up to assist the implementation and acceleration of the STBM programme. This is key for the scale up and acceleration of STBM at the nationwide level, however the STBM secretariat requires continued assistance to build capacity and coordinate implementation. There is a need to further strengthen strategy at central levels on how to scale up nationally and how to improve consistency, quality and sustainability of sanitarian training, policy setting and monitoring with follow up.

Since 2012, the private sector is a new entrant with organizations such as the mining company Adaro implementing CLTS to improve sanitation in its operational areas in South Kalimantan, done through its corporate social responsibility programme.

Major support programmes include:

- World Bank PAMSIMAS Program: The Ministry of Public Works (PU) is the main implementation agency for PAMSIMAS, with the sanitation component being the responsibility of Ministry of Health. PAMSIMAS is currently in its second iteration and, since 2013/2014, implements the programme through existing government structures, such as sanitarian and health cadres to promote unsubsidized sanitation and ODF villages. According to PAMSIMAS staff, this approach has been more effective than externally employed health facilitators and builds the capacity of the health network in the long term.[19] PAMSIMAS is operating in 280 districts in the country. A third phase is being planned (2016-2019) to respond to the goal of universal access to water and sanitation. Phase 3 will increase PAMSIMAS to cover 5,000 more villages in 110 districts throughout 15 provinces.

[19] World Bank (2015) *Interim Implementation Completion and Results Report for Indonesia PAMSIMAS Project.*

- UNICEF: Direct support to national and sub-national government on the implementation of CLTS/STBM. In partnership with the Government and civil society, learning is being derived from six districts with 12 additional indirect districts in the provinces of South Sulawesi, Nusa Tenggara Timur and Papua (including West Papua). UNICEF provides technical assistance and funding to its local planning office (Bappeda) for a full time provincial coordinator, and supports the training of sanitarians on implementation at district level. Replication and scaling up to other districts and sub-districts is achieved through advocating for the prioritization of STBM programmes and capacity building for local government staff, including planning and budgeting skills, coordination and monitoring. UNICEF is also supporting policy development, clearer roadmap creation for planning and strategizing, capacity building, and advocacy at the national level.

- World Bank Water and Sanitation Program (WSP): Support comes in the form of technical assistance to the national STBM secretariat and provincial level technical assistance for CLTS implementation in the provinces of East Java, West Java, Central Java, Nusa Tenggara Barat and Bali. This includes supporting PAMSIMAS in these provinces. At central level, support includes improving monitoring, training and capacity building of sanitarians, and advocacy.

- Dutch Sanitation, Hygiene and Water Program for Eastern Indonesia (SHAW): SHAW was launched in 2010 and ended in December 2014. This programme claims to be the only civil society programme in Indonesia implementing all five STBM pillars simultaneously. The programme was implemented by a Dutch NGO, Simavi, and five Indonesian/international NGOs. At its conclusion, it reached 1,042 villages, with 489 villages being verified as achieving all 5 pillars (including ODF), and an overall access to sanitation of 88 per cent. 40 sub-districts were also declared STBM. SHAW was working in nine districts across three provinces: Nusa Tenggara Timur, Nusa Tenggara Barat and Papua, as well as the national level.

Major non-CLTS programmes
None

CLTS variations and practice

1 **USAID IU-WASH programme: urban CLTS with some modifications (linking to citywide sanitation strategies and utility projects)**

The USAID IU-WASH programme is working with local water utilities (PDAMs), local technical waste water implementation units (UPTD PAL) and other sector stakeholders on urban CLTS. Indonesia Urban Water, Sanitation and Hygiene (IUWASH) is a five year (2011-2016) development programme funded by the US Agency for International Development (USAID). IUWASH's sanitation component aims to create access to improved sanitation facilities and services for 250,000 people (50,000 families) in 54 cities/districts spread within the IUWASH regions of North Sumatra, West Java/Banten/DKI, Central Java, East Java and South Sulawesi/East Indonesia. CLTS-type triggering is included as part of demand creation strategies for household sanitation improvements.

2 **Community engagement and Village empowerment, NTT**

UNICEF is working with the NTT Province to integrate STBM into Desa/Kelurahan Mandiri (Empowered Village) called ANGGUR MERAH programme. The Anggur Merah is funded from province budgets, allocating IDR 300 million per villages and inclues IDR 50 million for housing direct support for poor families. Other openings in this province include stronger linkages with nutrition, especially to support both WASH infrastructure in health facilities and communities through nutritional platforms (e.g. nutrition messages with a strong handwashing component), and improving how health staff integrate these messages.

CLTS scale
As of mid 2015, the government monitoring system shows that 24,955 villages in Indonesia have been triggered (out of 80,276) with 4,419 verified as ODF and a further 1,784 villages claiming ODF. Indonesia has a moderate ODF success rate: 18 per cent of triggered villages have been verified ODF, with up to 25 per cent if claimed and verified villages are counted.

CLTS capacity
Very large numbers of CLTS facilitators have been trained in Indonesia by both development agencies and, more recently, through the Ministry of Health training course for sanitarians, with replication at provincial levels.

CLTS scorecard

ENABLING ENVIRONMENT		
Policy CLTS in government policy	National Strategy for Community-Based Total Sanitation (STBM) 2008.	STBM: "No hardware subsidy for household toilets". The STBM sets a clear no-subsidy policy for all rural sanitation programmes in Indonesia.
Strategy CLTS targets in government strategies or development plans	2010-2014 National Medium-Term Development Plan (RPJMN-2). 2015-2019 National Medium-Term Development Plan (RPJMN3).	RPJMN-2: the previous 5-year development plan set the target of 100 per cent ODF villages nationally by 2014. New RPJMN-3 2015-2019 has the goal of universal access by 2019, however the interpretation of this is unclear. In response to this new policy, the Government has proposed to scale up the PAMSIMAS Project to about 5,000 villages nationwide, starting from the year 2016 to 2019.
Leadership CLTS led by government	1 National 2 Provincial	STBM is a government led programme under the Ministry of Health. The Government has issued key supporting documents to guide implementation at subnational level: • Universal access of drinking water and sanitation in RPJMN (100-0-100) • President Regulation No. 185 Tahun 2014: on acceleration of provision of drinking water and sanitation • Village Minister Regulation No. 5 Tahun 2015: on Priority of Village Fund Utilization • Circular letter from Health Minister to Governor and Bupati No. 184/ 2015 on Funding for Preventive Health Services • Advocacy letter of Minister of Health to village leaders No. 323/ 2015 on STBM implementation. There is evidence of regulations on STBM implementation at provincial and district level governments in some locations. While the structure for government leadership exists, it is not carried through consistently across the country and depends on the local priority given to sanitation.
Finance CLTS financed by government	1 GOI 2 World Bank PAMSIMAS 3 Village programme	1 MoH funds through provincial health offices and district health offices to conduct trainings, triggering (including pre and post triggering) activities and SMS based monitoring. Some district health offices have allocated some of their district funds to finance CLTS/STBM activities. 2 PAMSIMAS: Loan of funds to GOI for implementation, including CLTS. 3 The newly elected government is proposing direct funding to villages of US$100,000 annually for all local development, including some provisions for sanitation. Villages may have limited capacity to implement and monitor.
Coordination Mechanisms for stakeholder coordination	National and provincial Pokja.	Coordination at national levels through Pokja AMPL. At province and district levels, governments established Kelompok Kerja (Pokja) AMPL or WASH working groups, however these are very active in some locations and not active in others, creating uneven coordination across the country.
IMPLEMENTATION AND SUSTAINABILITY		
Integration CLTS integrated with other approaches	1 Sanitation marketing 2 Empowered Village 3 Urban	1 WSP pioneered Total Sanitation and Sanitation Marketing in all 29 districts of East Java, and now forms of STBM and certain aspects of sanitation marketing have been adopted by MoH. 2 UNICEF is working with NTT Province Bappeda to strengthen community engagement via linking STBM into Desa/Kelurahan Mandiri (Empowered Village) called the ANGGUR MERAH programme. The Anggur Merah is funded by the province budgets, allocating IDR 300 million per village, including IDR 50 million for housing direct support for poor families, as well as linkages to broader community interventions. 3 CLTS integrated in USAID IUWASH urban sanitation programmes.

IMPLEMENTATION AND SUSTAINABILITY *(continued)*			
Triggering Standardized facilitator training		MoH Training Module.	MoH has developed and launched a Training of Trainer and Training of Facilitator STBM module in 2013, which is followed by all implementers. Full training package for sanitarians is five days. STBM is already included in the curricula of Poltekes (Health Polytechnic) for health environmental studies.
Facilitator quality control		Checking of facilitators and sanitarians.	UNICEF and NGOs conduct self-evaluation of STBM facilitation principles and skills amongst facilitators. DHO evaluates the quality of CLTS triggering done by sanitarians. WSP is developing, with MoH, an accreditation system for sanitarians which would incentivize and reward sanitarians, e.g. status and salary improvements. Online skills development and resources are also available. Skill levels of sanitarians vary widely. Since 2013, MoH connects the STBM capacity building programme to the Ministry's human resource development schemes through accredited training, individual government officer' performance credit mechanisms, e-learning, and by including it into the health polytechnic schools curricula.
ODF Clear ODF criteria		MoH STBM ODF guidelines (these are currently being revised and strengthened and will contain improved direction on verification of all 5 pillars of STBM).	National MoH guidelines on ODF include three criteria: 1 No OD practices found in the community areas. 2 Everyone has access to improved sanitation facilities. 3 There is a social control/norm to ensure the sustainability of ODF. Some additional local criteria (e.g. sanitation facilities) must be available in every public building (e.g. community health center, village office and schools). ODF declarations for 100 per cent of households applying for ODF and STBM declarations for communities that adopt all 5 pillars of STBM should also be available.
Verification protocol		MoH STBM verification guidelines	Clear process in MoH verification guidelines (currently being revised and strengthened): 1 Villages claim ODF request verifications from Community Health Center (CHC) at sub-district level. 2 The CHC reports to DHO and arranges verification. 3 DHO team (consisting of 2-3 people) visits the claimed villages for verification. Team can include members from other ODF communities and STBM sub-district team. 4 Result of ODF verification is shared and discussed with the community.
Post ODF support		Sanitarians and community health centres	Post ODF support and monitoring is meant to be provided by sanitarians and community health centres, but follow-up varies widely. For most communities, emphasis is on getting to ODF with weak follow-up and redress of any slippage, while some communities have regular follow-up towards reaching subsequent pillars.
Technical support Availability of products and services		Some product availability and follow-up	Availability varies by area. Sanitation marketing is integrated with CLTS in some areas (e.g. parts of NTT). In some districts, sanitarians and local masons are trained in sanitation marketing. Dependent on the capability of the sanitarian to provide information to the community on technology choices during follow-up of triggering.
MONITORING AND EVALUATION			
Monitoring Robust and regular monitoring of ODF achievements		STBM secretariat national online monitoring system	The STBM Secretariat (hosted by MoH) has an SMS and web based monitoring system to track STBM progress nationally. Indicators include: progress of triggering, number of latrines and OD population, verification and declaration dates. Latrine access is categorized by: permanent toilets, semi permanent, sharing and OD. There is open access to the website, but some concerns remain about the quality of data and the availability of databases throughout the country. PAMSIMAS also has a more comprehensive MIS system which attempts to include behaviour change monitoring indicators into the system, but the programme is still finding appropriate indicators to do this and to identify who will

MONITORING AND EVALUATION *(continued)*			
Post ODF monitoring of quality and sustainability		Post ODF monitoring weak	STBM monitoring systems can show slippage of ODF villages, but this is rarely reported on. Reporting by sanitarians is only required annually. PAMSIMAS carries out three monthly follow-ups, including on ODF statuses.
Evaluations and knowledge sharing Evaluations, reviews and learning		Some reviews and evaluations	The national Pokja undertakes a coordinated, regular, annual review for the sector, involving several main government agencies related to sanitation. Studies and reviews have been conducted by development partners and projects including Plan, WSP, Pamsimas and SHAW. Results of the reviews are usually, but not always sufficiently, shared and agreed corrective actions from respective agencies at national and local levels are not always followed through diligently. UNICEF facilitates monitoring and evaluation meetings and visits from national and sub-national levels on STBM implementation in target provinces every year. Where STBM is being supported, there are opportunities to share lessons learned at WASH working group meetings at provincial and district levels, and through newsletters and knowledge sharing. There are currently insufficient studies on slippage.
Information on costs and resources for CLTS		Limited cost information	Some information on costs at district and provincial level but not standardized, given the diversity of the country.

Most significant changes since 2012

1 Increased prioritization of sanitation	Sanitation is higher on the agenda. The Government has established new targets for water supply and sanitation in the National Mid Term Development Plan 2015-2019 (Rencana Pembangunan Jangka Menengah Nasional, RPJMN) which is universal accessible, though it is expected that unimproved sanitation will remain. However, the meaning of the targets are unclear despite their ambition. New targets have raised awareness on sanitation in some areas of government.
2 Focus on behaviour change, not subsidies, for rural sanitation	Specific partners, such as Public Works, are working to better support sanitation behaviour change through STBM and not just to allocate budgets for the construction of physical facilities (usually communal). In the past, latrines/community toilets built through subsidies and full grants were not well maintained or used in many cases.
3 PAMSIMAS programme change	PAMSIMAS 2 is working with sanitarians within the government system through a more programmatic approach, which is a change from PAMSIMAS 1 which used external health facilitators for implementation. Sanitarians are MoH staff that have responsibility for sanitation. This approach improves sustainability after the programme finishes and builds the capacity of government staff. PAMSIMAS 2 also has better alignment with community driven development programme PNPM – village selection is demand led and under PNPM (which subsidized sanitation), and now has to work through PAMSIMAS (unsubsidized).
4 Strengthening of STBM approach	Wider uptake of an STBM approach, strengthening of national monitoring systems and increased support to sanitarians (e.g. through resources and training). Sector coordination has overall become stronger.
5 Responsibility for urban sanitation	Urban sanitation systems are increasingly seen as a responsibility of Public Works and/or local governments, rather than being left to the community/household. This includes septage removal and treatment. Still much work remains to be done on this issue.
6 New Village Law 6/2014	A new village law will direct funds to villages (Unam Desa). Although in the process of being implemented, this change will mean more emphasis on strengthening STBM teams in villages and improving budgeting practices.

Lessons learned

1 Engaging at the provincial level takes time	Long term change is achieved by building increased ownership, accountability and associated capacity at the provincial level in order to take responsibility for all districts within a province, but this takes more time than going directly to the district level. There is a tendency for actors to bypass provinces and go to the district level directly for implementation.
2 Advocacy of provincial governors can scale up	Most NGOs and development partners now have a strong focus on advocacy. Once a provincial governor and district mayor understand the benefits of sanitation and the need for prioritization, they can have a larger impact on activities in their areas. When they put into place a regulation for ODF communities and follow the STBM programme, this becomes a critical tool for communicating with local governments to improve their budgets and implement the programmes. Dissemination of the regulation to all districts and villages results in similar regulations on STBM. District government and villages then provide budgets for STBM.

Lessons learned *(continued)*

3 District leader capacity and commitment is important but varies	There is a strong correlation between ODF districts and the strength of the Bupati (district head). Bupati issue regulations related to sanitation and hygiene practice, and provide incentives for villages or sub-districts that achieve ODF status. If the Bupati advocates for ODF and it becomes one of the programmes for the office of Bupati, budgets will be made available, regulations will be developed and it will become the priority of the sub-district and village government due to the strong push from the head of the district on the importance of becoming ODF. Replication of STBM in other villages and sub-districts can be done without external support. In several districts in NTT, for example, the average time to reach ODF from triggering was one year, but in some villages in Sumba Timur, ODF status was gained within four months due to district regulations and communication through churches.
4 Slippage	There is evidence of slippage in some places, but the monitoring system is not attuned to pick this up. Reasons for slippage: living near waterways which provide alternate toilets; toilet is not what the household wants and it deteriorates over time; absence of regular monitoring or encouragement afterwards ODF; no threat of loss of ODF status for head of village.
5 Promotion	CLTS is only one tool for influencing open defecation. Other communication involving religious leaders has increased the effectiveness of CLTS at changing open defecation practice.

CLTS weaknesses and bottlenecks

1 Scale of challenge	The scale of sanitation is a huge challenge because of the size of Indonesia's population and the diversity within the country. 34 million rural people still openly defecate, with 63 million not accessing improved sanitation. Achieving universal access to sanitation for all by 2019 is a huge challenge.
2 National government needs to accelerate STBM	The capacity of the secretariat of the community-based Total Sanitation & Hygiene Strategy (STBM) needs to be strengthened to coordinate and assist the implementation of STBM in Indonesia at scale.
3 Variable quality and capacity of sanitarians	Sanitarians are government health officers with other roles and are not always available, motivated or monitored for CLTS triggering and follow up. In most areas, a sanitarian may be responsible for 20 villages. Quality and capacity of sanitarians vary across locations and within programmes. MoH, with support from partners, has developed standardized training content and modules, but more investment is needed in longer term capacity development and in the monitoring of performance, including incentives for sanitarians based on achievements. The number of skilled sanitarians graduating from training is insufficient in meeting demand for implementation and there is an overall shortfall in numbers of sanitarians needed.
4 Use of subsidies/alternate funding	Where communities have received funds and projects from many development agencies for years, including from the Government, this has created a dependency (e.g. Papua and Papua Barat in 2004 after special autonomy applied). Subsidies and aid have undermined the social spirit of these communities, with working together *(gotong royong)* being very rare and an expectation of outside support. This is a challenge for the CLTS philosophy. After triggering, communities seek some support or expect village funds to be used to support them.
5 No post-ODF monitoring	There is no clear procedure for monitoring sustainability and slippage of previously verified ODF communities. Post ODF monitoring is uneven and not formalized. STBM reporting is only required annually, which is not sufficiently regular to address issues which caused the slippage. The emphasis is on reaching ODF, with follow-up being generally ignored. Also there is no natural progression to the other pillars of STBM.
6 Sanitation marketing	Pockets of sanitation marketing only. In Papua, and many other provinces, the focus has been more on building the capacity of sanitation entrepreneurs to produce simple and affordable latrines, with less effort on supporting the marketing of the products.
7 Poverty and income	Households need to bear the brunt of sanitation costs. In some parts of the country poverty is high and a major barrier for households accessing sanitation.

CLTS opportunities over the next 3-5 years

1 ODF in targets	ODF is already a target in RPJMN 2014-2019. This means the Government is responsible in supporting the creation of an enabling environment and is required to monitor progress and allocate sufficient funds to adequately manage and accelerate the STBM programme. The RPJMN provides an opportunity to refocus efforts on sanitation and ODF communities.
2 Potential for different partnerships	There is potential for the private sector to become more involved in STBM and sanitation. For example, the Indonesian mining company Adaro carried out STBM in Tabalong regency to improve sanitation and health outcomes as part of its corporate social responsibility. There is also potential for other private companies to contribute expertise (e.g. messaging on WASH). Partnerships with religious leaders are very important. These are critical in Islamic areas where voluntary donations are made for less fortunate communities, but the community needs to be organized in spending the money effectively; work is underway on such guidance. In several areas, the police and army have also taken a keen interest in sanitation, which may be further harnessed in a positive and participatory way. Further decentralization of funding to the village level means the local village head will also be an important player within STBM partnerships in the future.
3 Stronger integration into health and nutrition	There are almost 9 million stunted children estimated in Indonesia. UNICEF's statistical analysis found a 40 per cent greater chance of being stunted if a child grows up in a house without improved sanitation. UNICEF has developed an approach paper with ideas on how to better link WASH and nutrition interventions. There is strong potential to further develop the integration of CLTS and nutrition, building on the pilot work begun in NTT in 2015. More outreach on STBM via midwives – as has been the case of positive examples from Aceh – and better WASH facilities in health centres – are also critical here.
4 Capacity building of sanitarians	Potential for the professionalization of sanitarians through training, civil service job performance assessments and better selection of trainee sanitarians.

Plan Indonesia, 2012, *Improving CLTS from a Community Perspective Approach in Indonesia*.

World Bank Water and Sanitation Program, 2014, *Water Supply and Sanitation in Indonesia Service Delivery Assessment*.

UNICEF 2015 *Review of STBM in Aceh Timur*.

KIRIBATI

KIRIBATI: Country CLTS overview

CLTS summary

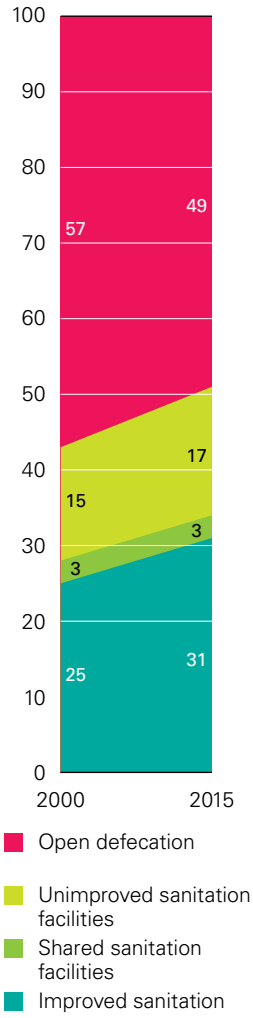
		2012	2015
Status and scale	CLTS date of introduction	2012	Not yet
	CLTS spread: % of country	0%	48%
	CLTS in urban areas	No	Yes
	CLTS coverage: major organizations	3	4
	OD population rural *(2010 and 2015, mill)*	0.029 m	0.029 m
	Villages triggered *(number)*	0	135
	ODF villages *(number)*	0	103
	Capacity developed *(trained facilitators)*	0	280
Enabling	CLTS in government policy	No	No
	CLTS targets in government plans	No	Yes
	CLTS financed by government	No	Yes
	CLTS integrated with other approaches	No	Yes
	CLTS sustainable monitoring	No	No
Effectiveness	ODF success rate	0%	76%

Scale of rural sanitation challenge

Category	2015 Rural sanitation coverage			2012 Population
	Per cent	Households	Population	
Open defecation	49%	4,573	28,807	29,128
Unimproved sanitation facilities	17%	1,586	9,994	12,640
Shared sanitation facilities	3%	280	1,764	1,099
Total without improved sanitation	**69%**	**6,439**	**40,565**	**42,867**

Source: 2015 JMP estimate; United Nations Population Division (2014) Annual Rural Population – 2015; 2010 UN Population Forecast.

JMP estimate: Rural sanitation



Rural: improved sanitation coverage

The JMP estimate for Kiribati suggests a decline in open defecation from 57 per cent in 2000 to 49 per cent in 2015, with a significant increase in improved sanitation from 25 per cent to 31 per cent during the period. In terms of population, there appears to be little impact since 2010 on the absolute numbers of people in rural areas openly defecating in Kiribati. However, due to gaps and lags in sanitation access data and the small population size, some caution is needed when interpreting these figures.

Where is CLTS implemented and by whom

CLTS status and geographic spread

A concept introduced by UNICEF through the EU-KIRIWATSAN-1 programme in June 2012. In early 2013, Kamal Kar was invited by UNICEF and the Government of Kiribati for an advocacy and capacity building mission to Kiribati. The Ministry of Public Works and Utilities together with the Ministry of Health, Island Councils, UNICEF, and other national WASH sector partners, piloted CLTS in North Tarawa. North Tarawa, with a population of 5,000 people in 13 communities and an OD rate of 64 per cent, was declared Kiribati's first ODF island in May 2013. The success in North Tarawa led MPWU and UNICEF to plan a roll-out throughout the Gilbert Islands, using funding from the European Union (EU-KIRIWATSAN-2) and the Government of Kiribati. One year later, over 70 communities on six outer islands declared themselves to be free of open defecation, and the spread is continuing with CLTS in 16 (48 per cent) outer islands (out of 33 nationwide). The EU-funded KIRIWATSAN project aims to increase access to safe and sustainable water and sanitation, and aims to reduce WASH-related diseases in at least 70 of 139 villages across 16 islands of the Gilbert group by 2016.

CLTS has been tried in urban areas during training with Kamal Kar when six urban villages were triggered as practical demonstrations (the Bairiki Community, Temwaiku, Taborio, a part of Eita, a small community in Nawerewere, and Bonriki at the Tiantaake community). Communities were active at first but later abandoned the toilets.

CLTS institutional coverage

National NGOs	International NGOs	Bilateral programmes	Multi-lateral agencies	Government
MAJOR EXCEPTIONS Sanitation programmes ADB South Tarawa Sanitation Improvement Sector Project. Kiribati Red Cross pilot in South Tarawa.			UNICEF Secretariat of the Pacific Community	Ministry of Public Works and Utilities Ministry of Health and Medical Services MIA – Ministry of Internal Affairs

Major non-CLTS programmes

- The South Tarawa Sanitation Improvement Sector Project is doing WASH community awareness and will pilot trial toilets.
- Kiribati Red Cross is starting a pilot project in some communities in South Tarawa, but is not using CLTS.

CLTS scale

As of December 2014, 103 villages on 11 islands had been declared open defecation free by their Island Councils, out of a total of 16 outer islands in the Gilbert Group. Due to limited follow-up, however, reports of return to open defecation are frequent.

ODF success rate

ODF achievement rates have been rapid despite the prominence and community acceptance of open defecation. In some communities, open defecation rates were as high as 70 per cent. The biggest challenge to sustaining ODF rates is the limited choice of technology in fragile coral atolls. Households initially chose to construct simple pit latrines, since they are cheap and can be built quickly, but these can do more harm to public health if they contaminate a freshwater lens that people depend on for drinking water. At the other side of the so-called "sanitation ladder", flush toilets are inappropriate for outer islands since they require scarce water for flushing, as well as costly septic tanks that are prone to leaking.

CLTS capacity

Around 280 facilitators have been trained to date. Around 45 are still active (32 facilitators, 12 natural leaders from Abaiang, Maiana and North Tarawa, and water technicians).

At the national level, there is a group of 73 trained CLTS trainers called the Core Technical Group (CTG). On each outer island, 20 facilitators are trained prior to triggering to support the team in each community. As the highest ranking medical officer on the island, the medical assistants are the primary counterpart for the CTG members, in addition to the Island Councils. In the communities, the Village Welfare Groups are responsible for ongoing support and follow up with the community, though this has been of varying capacity and quality.

CLTS scorecard

ENABLING ENVIRONMENT		
Policy CLTS in government policy	2010 National Sanitation Policy.	General policy that promotes "enhanced community awareness of sanitation, public health and hygiene requirements" but does not contain any specific references to programme methodologies or detailed technical requirements.
Strategy CLTS targets in government strategies or development plans	1 National Sanitation Implementation Plan (10-year). 2 Government plans. 3 EU-KIRIWATSAN -2 Program.	1 No specific ODF targets. Plan recognizes that simple and less costly solutions will be the most appropriate and sustainable; and that service improvement requires ongoing community motivation and commitment. 2 The President of Kiribati and the Cabinet have committed to achieving an "Open Defecation Free Kiribati" by 2015, using CLTS as the main approach for increasing sanitation coverage in line with the National Sanitation Policy. 3 The EU-funded KIRIWATSAN Phase I Project aims to have safe sanitation in at least 70 of 139 villages across 16 outer islands by 2016.
Leadership CLTS led by government	Led by MPWU with presidential endorsement.	CLTS is led by the Ministry of Public Works, and the Ministry of Health and Medical Services, with high level commitment from the President of Kiribati. Island councils (Ministry of Internal Affairs) play a key role and lead the process locally.
Finance CLTS financed by government	GOK contributions.	The Government of Kiribati is providing complementary funding to support the EU-KIRIWATSAN-1 programme because the EU project only works in about half of the communities in the Gilbert Group (16 islands). MPWU has put in funding to include the other half of the communities in the CLTS programme.
Coordination Mechanisms for stakeholder coordination	Core Technical Group.	A core technical team of 73 people from government and NGOs coordinate and lead CLTS. Regular coordination meetings.
IMPLEMENTATION AND SUSTAINABILITY		
Integration CLTS integrated with other approaches	WASH safety plans.	To reduce the risk to communities from wet toilets that can lead to contamination of freshwater lenses, CLTS is being combined with participatory WASH safety planning to identify the locations of water sources and locations of contaminants, e.g., toilets or pig pens. Communities are triggered to protect water sources by the better siting of toilets.
Triggering Standardized facilitator training	Standardized and locally adapted training guide.	The Training of Facilitators guidance and methodology for community triggering is done by using the CLTS training guide prepared by Kamal Kar, but modified to Kiribati contexts and experiences. The facilitators guide has been translated into Kiribati for use by the team.
Facilitator quality control	Developmental support for facilitators.	Support during facilitator development, but no follow up for quality control or accreditation. For two or three times, the facilitator is provided support by the WASH team until he or she is confident. Facilitators are allowed to lead the team, provided the administrative requirements are in place, e.g., release, approval to travel, the island clerk on an island is informed prior to arrival. Trip reports are also a requirement.
ODF Clear ODF criteria	ODF criteria.	Criteria for ODF has been developed and is being used by the KIRIWATSAN Phase I project, though inconsistently. ODF criteria – three criteria for a toilet: 1 all households have a toilet with a lid to cover from flies and available covering material to stop smells (toilets used by all members of the household); 2 water with soap is close by for handwashing; and 3 the surroundings or village is clean (proper waste disposal sites).

IMPLEMENTATION AND SUSTAINABILITY *(continued)*			
Verification protocol		Verification process developed.	Criteria for ODF has been developed and is being used by the KIRIWATSAN Phase I project, though inconsistently. Verification is by the Technical Working Group. The first phase is to become ODF and the second is to attain "Model Clean Island" status. No islands have attained Model Clean Island status. Monitoring/assessments or spot check template development is used on the island, whereby the Village Working Group (committee), including the medical assistant or nurse and any member of the committee on the job, is trained on its use. At this stage there is no ODF certificate provided.
Post ODF support			Post ODF follow-up and monitoring assessments are inconsistently and infrequently carried out. As with triggering, these are done with the support of trained personnel from the Core Technical Group, which encompasses different ministries, natural leaders and local engineers, medical assistants, water technicians, and trained ODF committee members on outer islands. Activities include meeting with island authorities and communities, including village chairs and unimwane (elders), for CLTS progress, household visits and general assessments and spot checks to validate and monitor CLTS progress for Level 2 ODF Model Clean Islands. One check on four islands found sustained ODF of between 5 per cent and 80 per cent.
Technical support Availability of products and services		Limited technical solutions.	Researchers are working on suitable low cost technical sanitation options to protect freshwater lenses of coral atolls with support from the New Zealand-funded Kiribati WASH in Schools Project. Current preferences of pit latrines and pour flush toilets are harmful to groundwater. Supply chain development of waterless sanitation alternatives is needed.
MONITORING AND EVALUATION			
Monitoring Robust and regular monitoring of ODF achievements			Inconsistently done. No centralized reporting mechanism. Monitoring/assessments or spot check template development is used on the island, whereby the Village WASH Group (committee), including the medical assistant or nurse and any member of the committee on the job, is trained on its use. Weak reporting links between VWG and Island Councils. Many VWGs are inactive.
Post ODF monitoring of quality and sustainability			The island councillors are not sure of their roles in sustaining, monitoring, and strengthening or supporting their VWG. Some island councils agree to put aside support money during VWG monitoring activities.
Evaluations and knowledge sharing Evaluations, reviews and learning		None	A CLTS implementation review is proposed within the next year
Information on costs and resources for CLTS		None	No available cost norms, but mid-term review EU reports include budget utilization reports.

Most significant changes since 2012

1 Scaling up of CLTS	CLTS has scaled up rapidly from zero ODF communities to more than 100 within three years, but the quality of the programme has not been maintained because of the focus on triggering without a follow-up plan.
2 High level commitment	The President of Kiribati has endorsed CLTS and called for an ODF Kiribati by the end of 2015. Government ministries, e.g., Public Works, Health, Agriculture, are actively participating in CLTS promotion and sanitation improvements in various ways.

Lessons learned

1 Ongoing follow up needed to sustain ODF	A constant commitment to monitoring, verifying and checking ODF communities is needed in order to sustain behaviour change for the long term. Post triggering follow-up and monitoring assessment is needed on each island, rather than from teams based in South Tarawa, given the logistical constraints of operating in the country. As the KIRIWATSAN project ends in June 2016, island councils need to independently continue to monitor the sustainability of behaviour change.
2 Holistic WASH planning is effective	Based on trials during KIRIWATSAN I and II, CLTS triggering together with participatory WASH safety planning will allow communities to analyse their WASH situation and understand the link between location and types of sanitation and groundwater sources. Villages make their own decisions about sanitation within the context of groundwater protection.
3 Community imposed fines for open defecation are effective	Some communities have enacted fines (ranging from US$ 5-US$ 50) for defecating in the open in order to reinforce the new social norm, e.g., in Bonriki where the water lens is very vulnerable, fines of US$ 5 have been imposed – US$ 2.50 goes to a general sanitation fund and US$ 2.50 goes to the person who caught the open defecator. There are also fines of US$ 50.00 at Antekana and Ukiangang on Butaritari Island and US$ 20.00 on Abaiang, where US$ 25.00 or US$ 10.00, respectively, goes to the reporter, and the other half to the community. Local bylaws are revised to include fines. Not all fines are effectively implemented however.
4 CLTS is difficult in urban areas	Following triggering by Kamal Kar in urban areas, communities were active when first triggered and started building their pit toilets and were using them, but later they abandoned the toilets due to: • people prefering pour flush/water seal latrines, but being unable get these from the Ministry of Health as it has stopped casting the goosenecks for toilets; • ash used for the covers being impractical; • groundwater tables being quite high in most of these villages; and • overcrowding and space being a serious issue in the Bairiki community.

CLTS weaknesses and bottlenecks

1 Inadequate sanitation options are contaminating groundwater	Pollution associated with sanitation systems threatens scarce and vulnerable groundwater resources in the atoll islands. No technical solution has been found which satisfactorily addresses environmental impact, low cost and community preferences. Household awareness of groundwater pollution from their own sanitation leads to reversion back to open defecation. The CLTS programme should not have been started until acceptable improved sanitation options (i.e., appropriately designed composting/waterless toilets) were developed and available at an affordable cost in-country.
2 Strong cultural values	The Kiribati hold strong cultural views on acceptable sanitation and hygiene practices. Handwashing is rarely practiced and households with a toilet may still have members that continue to defecate on the beach. The mindset will take a long time to change.
3 Logistics and costs of follow up with outer islands	Kiribati's 33 islands and coral atolls are spread over a vast area in the Pacific Ocean, making visits to the outer islands for follow-up, verification and monitoring extremely costly and time consuming.
4 Natural disasters	Tropical Cyclone Pam destroyed all toilets on the coastal side of almost all islands in Kiribati. Cyclones are an annual risk in Kiribati.
5 Monitoring	Maintaining effective monitoring is challenging. Effort is needed to work with Core Technical Group members and island authorities, medical assistant (MoH) officers, and water technicians to ensure ways of sustaining CLTS monitoring.

CLTS opportunities over the next 3-5 years

1 Sanitation solution options available	A coalition of government, development partners, NGOs and researchers are experimenting with alternative sanitation options which can provide better groundwater protection than existing sanitation. This is needed before scaling up CLTS. It may be possible to combine CLTS with sanitation marketing in South Tarawa.

LAO PDR

LAO PDR: Country CLTS overview

CLTS summary

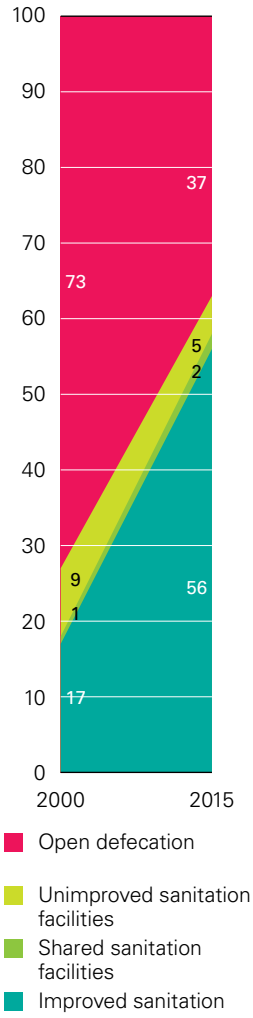
		2012	2015
Status and scale	CLTS date of introduction	2008	Not yet
	CLTS spread: % of country	47%	59%
	CLTS in urban areas	No	No
	CLTS coverage: major organizations	7	9
	OD population rural *(2010 and 2015, mill)*	1.7 m	1.6 m
	Villages triggered *(number)*	217	565
	ODF villages *(number)*	36	144
	Capacity developed *(trained facilitators)*	143	306
Enabling	CLTS in government policy	May be	Yes
	CLTS targets in government plans	Yes	No
	CLTS financed by government	Indirect	No
	CLTS integrated with other approaches	May be	Yes
	CLTS sustainable monitoring	Planned	No
Effectiveness	ODF success rate	17%	25%

Scale of rural sanitation challenge

Category	2015 Rural sanitation coverage			2012 Population
	Per cent	Households	Population	
Open defecation	37%	270,231	1,594,361	1,698,600
Unimproved sanitation facilities	5%	36,518	215,454	331,400
Shared sanitation facilities	2%	14,607	86,182	41,400
Total without improved sanitation	**44%**	**321,355**	**1,895,997**	**2,071,400**

Source: 2015 JMP estimate; United Nations Population Division (2014) Annual Rural Population – 2015; 2010 UN Population Forecast.

JMP estimate: Rural sanitation



Rural: improved sanitation coverage

The JMP estimate suggests a rapid increase in improved sanitation coverage in rural areas from a low of 17 per cent in 2000 to 56 per cent in 2015. The main contributor to this increase has been the reduction of open defecation. The latest JMP estimates that open defecation sits at 37 per cent, which suggests that 270,000 rural households (1.6 million people) do not use a sanitation facility.

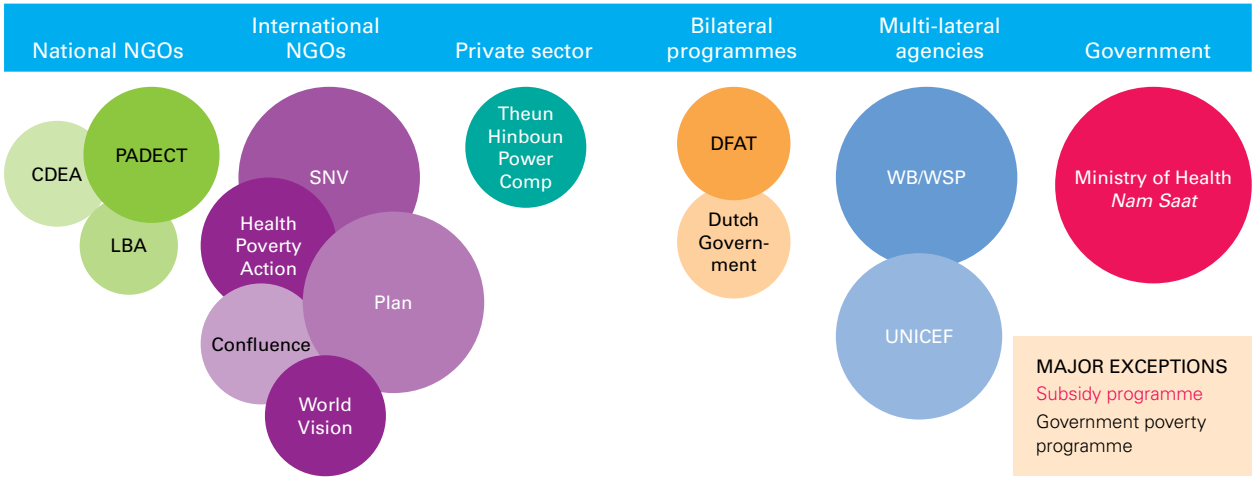
Where is CLTS implemented and by whom

CLTS status and geographic spread

Introduced by WSP and CONCERN Worldwide in 2008, CLTS has since spread to 31 districts out of 143 nationally, in 10 out of the 17 provinces in Lao PDR (59 per cent nationally), although in some provinces CLTS is only being implemented in one district in a limited number of villages. The biggest concentration of effort is by WSP and SNV, and the Nam Saat in Champasak and Sekong provinces, covering 174 villages across 10 districts. During 2015-2016, the Provincial Nam Saat in Champasak and Sekong are planning to carry out CLTS triggering in 250 villages across 10 districts, pending government budget availability.

CLTS is not promoted in urban areas.

CLTS institutional coverage



Implementation of CLTS remains a relatively a concentrated effort in Lao PDR, however since 2012, the Ministry of Health, *Nam Saat*, has played a much greater role, especially through direct implementation of CLTS by district health offices (including setting targets, formulation of operational plans, and carrying out CLTS processes such as pre-triggering, triggering, follow-up/supervision, ODF verification). Provincial health offices have the role of management, coordination, providing periodic supervision, training and performance monitoring. UNICEF is a new entrant, having dropped its latrine subsidy programme in 2011. Private sector involvement is a new feature with the Theun Hinboun Power Company, implementing CLTS in selected villages in two districts of Borlikhamxay province. THPC piloted CLTS in Nonxong village, which is home to around 650 people who moved to the village from other areas in 2009, during the expansion of the Theun-Hinboun hydropower project. Nonxong has subsequently become ODF. WSP commissioned two local associations, namely the Community Development and Environment Association (CDEA) and the Lao Biodiversity Association (LBA) to implement CLTS in 40 villages during 2011-2013. More recently, WSP commissioned SNV together with the Participatory Development Training Center (PADECT). Plan implements CLTS in selected districts across three provinces: Bokeo, Oudomxay and Saravanne.

WSP is providing technical assistance at the national level (Dept. of Hygiene and Health Promotion and the National Centre for Environmental Health and Water Supply), including capacity building (TOT on CLTS national facilitators), developing CLTS national guidelines, ODF verification, and monitoring frameworks and operational programme guidelines on scaling up rural sanitation in the country. UNICEF, together with development partners, is working with MoH and other ministries to come up with an overarching WASH Policy and implementation strategy, which includes rural sanitation.

Major non-CLTS programmes

The government's programme on supporting rural sanitation targets 64 focal sites around the country. These focal sites are identified and prioritized by the government due to their remoteness and poverty level. The approach undertaken to address rural sanitation is through hardware subsidies for poor households.

CLTS variations and practice

1 **WSP: CLTS + sanitation marketing (+ handwashing with soap)**

CLTS has been integrated with handwashing with soap (this is in the pilot stage) and is piloting integration of CLTS into the Poverty Reduction Fund (PRF) programme in collaboration with the National Centre for Environmental Health and Water Supply (Central Nam Saat). The PRF pilot project covers 40 villages of six districts across four provinces (Attapeua, Saravan, Sekong and Savannakhet). Sanitation marketing has been carried out by WSP alongside CLTS work in Champasak and Sekong provinces. This has involved strengthening the skills and services of sanitation producers, and integrating informed choice and technical knowledge with CLTS triggering. In addition, WSP, together with East Meet West (EMW), has piloted a sanitation output-based approach. This approach encompasses sanitation marketing with demand generation through CLTS, but adds a suite of innovative features designed to help poor households to overcome financial barriers to accessing improved sanitation and to incentivize communities and community volunteers to become ODF.

2 SNV: Sustainable Sanitation and Hygiene For All programme (SSH4A)

The Sustainable Sanitation and Hygiene for All (SSH4A) programme is implemented in collaboration with the Provincial Rural Development and Poverty Reduction Office in Savannakhet province, together with its subordinate offices in the three target districts (Atsaphon, Phin and Xonabouri). Other programme stakeholders and partners include personnel from the local branches of the ministries of Health, Education, Planning and Investment, Lao Women's Union, and the Lao Youth Union. SNV provides capacity building, organizational and technical support from its team, which includes associate advisors, consultants and local capacity builders. Provincial and district governments conduct CLTS triggering, post-triggering, ODF verification and declaration based on government standards and guideline. Provincial and district governments develop work-plan and monitoring systems with technical support from SNV.

3 UNICEF

CTLS was integrated with WASH in schools and linked as a prerequisite for water supply provision.

4 Plan International: CLTS + SLTS

Plan focused on CLTS in communities and SLTS in schools through four topics, using toilets, handwashing, safe drinking water and clean environments within all target schools and villages for Bokeo and Oudomxay provinces.

CLTS scale

Due to a reliable database dating back to 2009, data shows that more than 565 villages have been triggered using the CLTS approach since 2009, with a quarter of these in the period between mid-2014 and 2015. Approximately 144 villages have been declared ODF, although not all of the declared ODF villages in 2015 have been certified yet as many were only recently declared ODF.

ODF success rate

Lao PDR has a moderate ODF success rate: 25 per cent of triggered villages have been declared ODF. However the rate is misleading in that a number of villages were triggered in the period between mid-2014 and early 2015, and are still pending being declared ODF. The length of time to reach ODF from triggering is 9-10 months, but this depends on factors such as:

- the activeness of village authorities and established village CLTS committees;
- close post-triggering follow-up by facilitators and mobilization work by village CLTS committees; and
- availability of sanitation options/materials/suppliers.

Successful triggers include: disgust, privacy, and stigma of continuing open defecation.

CLTS capacity

A total of 306 CLTS facilitators have been trained in Lao PDR through capacity development activities supported by CONCERN Worldwide, WSP, Plan, SNV and World Vision. The main CLTS trainers have been from the Participatory Development Training Centre (PADETC), SNV and the National Centre for Environmental Health and Water Supply *(Nam Saat)*. Of these, the sector has jointly trained 17 trainers from five provinces who are now certified as national master trainers. Many of the others trained are district-level facilitators (averaging 10 per district). Lao has records of the gender break down on two thirds of the facilitators trained. Where records are available, most of the facilitators are males, with just 29 per cent being female. WSP, SNV and Plan report that of the combined 171 facilitators trained between them, all are still active. For other partners, the number of facilitators still active is unknown.

CLTS scorecard

ENABLING ENVIRONMENT			
Policy CLTS in government policy		National Plan of Action. MoH operational programme guideline.	In the National Plan of Action for Rural WASH, the government is promoting the shift from subsidy to a demand based approach. However, there is still inconsistency in terms of intervention approaches on rural sanitation in the country. For example, even within the same district or province some programmes promote CLTS and others use a subsidy approach. The operational programme guideline on scaling up rural sanitation adopted by MoH served as a blue print for designing and implementing CLTS in the country.
Strategy CLTS targets in government strategies or development plans		No targets for ODF.	The government does not currently have a target for achieving ODF but has set a target for achieving 80 per cent sanitation coverage by 2020.
Leadership CLTS led by government		Nam Saat and provincial health offices.	The government is actively involved in CLTS development at national levels and in implementing within provinces where support is given by partner agencies.
Finance CLTS financed by government		Limited budget support.	A significant portion of the government budget used for rural sanitation is for the procurement of latrine hardware for subsidies. Government budget allocation for CLTS is very low and comprises an estimated 10 per cent of the cost of implementation. Budget is primarily used for post triggering follow-up and ODF verification.
Coordination Mechanisms for stakeholder coordination		WASH Technical Working Group.	A WASH Technical Working Group meets regularly and discusses sanitation issues, including CLTS and subsidies. The meeting is chaired by representatives from the government agencies (Dept. of Hygiene and Health Promotion and the Dept. of Housing and Urban Planning).
IMPLEMENTATION AND SUSTAINABILITY			
Integration CLTS integrated with other approaches		1 WASH in schools 2 Handwashing with soap/ hygiene promotion 3 Sanitation marketing 4 Poverty reduction fund 5 Nutrition	Implementers are trialling a variety of ways to integrate CLTS, including UNICEF-supported WASH in schools; WSP piloting integration of handwashing with soap in Champasak and Sekong provinces; sanitation marketing be carried out alongside CLTS; and piloting integration with poverty reduction through the Poverty Reduction Fund programme in collaboration with the National Centre for Environmental Health and Water Supply (Central Nam Saat). Discussions are occurring on the possibility of integrating/using CLTS approaches in nutrition, plus a new World Bank health and nutrition project includes a component on behaviour change which also promotes behaviour change in addressing rural sanitation.
Triggering Standardized facilitator training		Technical manuals and training guides.	WASH partners supported the development of a set of technical manuals and training guides which have been used to train facilitators. A Training of Trainers workshop has resulted in the creation of master trainers with high level competencies and skills. Nam Saat central, with support from WSP and SNV, is consolidating all CLTS related manuals and guidelines into a CLTS package.
Facilitator quality control		Facilitator coaching and checks.	SNV conducts periodic coaching and observation of all trained facilitators and quarterly review meetings. Quality control is not yet systematically undertaken and Central Nam Saat is yet to take the lead in developing a facilitator monitoring system that can be applied nationally.

IMPLEMENTATION AND SUSTAINABILITY *(continued)*			
ODF Clear ODF criteria		National CLTS manual (2013).	Government approved standard criteria which is consistently used by partners. Criteria includes: • 100 per cent of households having toilets and all household members using them regularly. • Toilets used for the disposal of children's faeces. • Villages establishing a responsible committee that is active in implementing CLTS. • The village establishing rules about toilets and their use. • Villages being a model village of the 3 Cleans Program. • 80 per cent of families being acknowledged as culture model families. • Villages with good environments that are not dirty. • House yards being clean with no animals kept under the houses. • No places for open defecation. • Toilets located 10-15 metres from water sources. Some criteria such as using toilets for the disposal of children's faeces is not strictly scored if this aspect of CLTS is not actively promoted.
Verification protocol		Verification process.	An agreed verification system is being used. Villages make a request to the district health office and verification is done by a health team plus representatives from surrounding villages. All households are inspected and feedback is given on adherence to the criteria and improvements needed. A district CLTS team conducts a second assessment and approves verification. The district governor certifies the village as ODF. In theory, ODF status can be removed if the village reverts to open defecation.
Post ODF support		Informal support only.	There is no formal or systematic post-ODF follow-up or support. It is expected that district governments visit the ODF villages while they are on other tasks (mother and child check-ups, vaccinations, etc.). Plan continues to follow up every six months to one a year after ODF is declared and conducts checks using a monitoring ODF form.
Technical support Availability of products and services		Sanitation marketing. National consumer research and supply chain analysis.	In WSP provinces, technical support is provided to communities by trained facilitators introducing technical information to village CLTS committees after triggering, including: sanitation informed choices, technical support to build toilets and information regarding all available supplies and suppliers in the area. WSP has supported supply side strengthening through private business capacity building in 10 districts of Champasak and Sekong provinces, resulting in eight districts having sanitation producers selling latrine products through sales agents. Sanitation marketing activities have included: the recruitment of interested enterprises and sales agents, training for enterprises and sales agents (sales events, business start-up, marketing/ promotion, tools development, etc.), and sales and promotion activities in both triggered (one week after triggering) and non-triggered villages. Sanitation products are still limited outside of areas supported by WSP. There is no formal study of households moving up the sanitation ladder from dry pit to pour flush latrines, but reported cases are due to availability of materials and suppliers. The national consumer research and supply chain analysis found most rural households overwhelmingly prefer a pour-flush latrine. Learning exchange and exposure visits have been organized to enable concerned government staff and the private sector to understand the sanitation marketing approach.

MONITORING AND EVALUATION			
Monitoring Robust and regular monitoring of ODF achievements		Project based monitoring but consolidated reports available.	No national systematic monitoring system but up-to-date consolidated project records are available on CLTS activities since 2009. Project implementers work with government partners at village and district level to monitor ODF.
Post ODF monitoring of quality and sustainability		No systematic ODF checking.	Post ODF checks are done but not systematically and are project based only. The National CLTS Manual (2103) states that, post-ODF, the following activities shall be undertaken: participatory action planning within communities, supervision/follow-up on agreed actions, conduct verification and certification, and declaration. There is no comprehensive study of open defecation reversion rates, but WSP gives likely reasons as: 1 Broken latrines; 2 Full latrines; 3 Difficulty in getting latrines fixed, getting materials for fixing/new installations, getting emptying service; 4 No reinforcement of village regulations; and 5 Poor maintenance and cleaning.
Evaluations and knowledge sharing Evaluations, reviews and learning		1 Review of CLTS pilot 2011. 2 Scaling Up Rural Sanitation Workshop 2014. 3 Exposure visits on CLTS and sanitation marketing. 4 Government learning exchange in CLTS provinces. 5. Coordination meetings.	1 External review in 2011 for the first CLTS pilot project (six villages) to create lessons learned and understand challenges in scaling up sanitation. 2 Learning workshop on Scaling Up Rural Sanitation in Lao PDR 2014. Government and development partners implementing CLTS agreed to three key components for the improvement of rural sanitation and hygiene: • Strengthening enabling environments toward a sustainable, cost effective national programme for scaling up rural sanitation. • Strengthening supply chains: increase market supply and facilitate consumer intake of affordable, aspirational and accessible sanitation facilities for all consumer groups, including poor and remote areas. • Demanding creation: create community demand to stop open defecation and create effective consumer demand, including poor consumers, for improved sanitation facilities. 3 Exposure visits for the government technical staff at provincial and district levels to learn about CLTS and sanitation marketing. 4 Learning exchange for government agencies: rural development office under the Poverty Reduction Fund and provincial health office in WSP provinces. 5 Information exchange through quarterly and annual meetings at district and provincial level, plus a Technical Working Group meeting. There is currently discussion among WASH partners to organize another forum to exchange lessons learned.
Information on costs and resources for CLTS		Costs estimates for implementation and scaling up.	World Bank analysis estimates cost/village of US$ 600 to achieve ODF status within 10 months (based on Nam Saat's capacity to cover 10 villages per year). The cost covers all stages of the CLTS process (roadshow events, pre-triggering, triggering, follow-up and ODF verification), including per diem, travel/fuel, meeting costs, administrative costs. Costs are for the district level only, excluding any costs at provincial level, e.g., supervision, etc. Costs for scaling up (calculation based on a scale of 25 villages/district, with an increase of 2.5 times the number of staff needed) is US$ 28,000 per district (or US$ 1,120 per village), covering the whole process of CLTS implementation from the kick-off meeting to ODF village declaration.

Most significant changes since 2012

1 CLTS guidelines	The development of a standardized set of guidelines and manuals on CLTS for Lao PDR, including a package for the training of trainers, has helped make the approach to CLTS more consistent. An Operational Guideline for Scaling Up Rural Sanitation has also been developed and approved by the Department of Hygiene-Health Promotion (MoH) that helps to guide and unify the sector.
2 Wider acceptance of CLTS	Momentum is gaining in the sector and more partners are becoming aware of the progress made using the CLTS approach. More NGOs are applying the approach in their projects. The government is open to and promotes the CLTS approach, recognizing that it is one among other approaches to generate demand for sustainable sanitation.

Lessons learned

1 Cost efficiencies in scaling up	There are economies of scale when scaling up CLTS. Based on simple cost-efficiency calculations: • If implementing CLTS in 60 villages, it costs US$ 58,965 (US$ 982/village) • If implementing in 240 villages, it costs US$ 104,102 (US$ 434/village) The cost for CLTS is reasonable if compared with the result in changes of behaviour of villagers from open defecation to ODF.
2 Government support needed to scale up	To scale up, support is needed from governments to be involved throughout the whole process. Government commitment to sanitation and water supply is an important complement to CLTS as government decisions have legitimacy at community level. The challenge for the future is to make best use of both CLTS and government commitment. Advocacy for the government at senior levels (central and provincial authorities) to allocate funding to support demand creation for rural sanitation is crucial for working at scale.
3 CLTS stimulates latrine innovation	The introduction of CLTS, and the avoidance of hardware subsidies, has stimulated some innovation in latrine design and construction, and most families have been able to build toilets without employing a mason. However, there remains a strong preference for pour-flush latrines which are unaffordable to most poor households. Technical assistance in the design and marketing of more affordable, hygienic latrines would potentially be very useful and help to make scaling up possible.
4 Good facilitation skills essential	Good quality training, followed by ongoing mentoring support, is essential for CLTS facilitators and should be incorporated into plans and budgets for scaling up.
5 Triggering alone is not sufficient	Triggering alone is not enough to secure community-wide, long term change in defecation habits. Substantial follow-up is needed to strengthen community motivation for change and (in some cases) to provide technical advice or logistical support with latrine construction.
6 Hygiene behaviours need special attention	CLTS is good at delivering ODF communities but does not necessarily impact other hygienic behaviours. There may be scope for including a hygiene promotion component in post-triggering follow-up, focusing as a minimum on the key issues of handwashing with soap or ash at critical times. Experience from other countries indicate that this can be facilitated as a community-led process.
7 Community leaders are important	Community leaders play a pivotal role in the achievement of ODF status. This role should be nurtured and encouraged, not only to accelerate progress in the leaders' own villages, but also for scaling up promotion to surrounding communities.
8 Capacity building takes time	Enhancing local government capacities to fully implement the programme requires continued, long-term commitment.

CLTS weaknesses and bottlenecks

1 Multiple criteria difficult to meet	In order for communities to be declared ODF there are several criteria which have to be met which are not directly related to ceasing open defecation behaviour. This takes a long time for villages in Lao PDR to meet all these criteria (longer compared to other countries to achieve ODF).
2 Government lacks money	The government lacks funds to support implementation. Financing systems are needed.
3 Lack of capacity at district level	There is limited capacity for government agencies (both in quantity and quality) to carry out CLTS work, especially at the district level. The limited number of district staff available in Nam Saat presents a challenge for scaling up. Partnerships with competent INGOs could potentially be very useful if they could deploy additional field workers to support Nam Saat.
4 More affordable design needed	For the poorest, cost is still the biggest challenge in adopting improved sanitation. Limited availability and range of products in terms of affordability and desirability is a constraint.

CLTS weaknesses and bottlenecks *(continued)*

5 High transport costs	Transport costs (both for staff to communities and supplies/suppliers to communities) increases the cost of implementation and puts pressure on scaling up.
6 Monitoring system missing	Monitoring and evaluation systems and tools are not yet in place, making it difficult to assess progress and gaps.

CLTS opportunities over the next 3-5 years

1 WASH Policy and Sanitation Implementation Strategy	UNICEF, together with development partners, is working with MoH and other ministries to devise an overarching WASH policy and implementation strategy. Rural sanitation will be a strong component of the policy. In the UNICEF-Lao Government 2015-2016 work plan, support will be provided to MoH for the development of a National Sanitation Strategy (Sanitation Road Map). This strategy will pave a way to move forward with short, medium and long term action plans to eliminate open defecation.
2 Integrate CLTS with nutrition and poverty reduction	The World Bank is in the process of consultation with the Government to develop a new programme of support for the Ministry of Health on Health and Nutrition, as well as to the National Rural Development Office on Poverty Reduction Program, which will have a multi-sectoral approach. Sanitation will be one of the main priority areas of intervention.

MONGOLIA

MONGOLIA: Country CLTS overview

CLTS summary

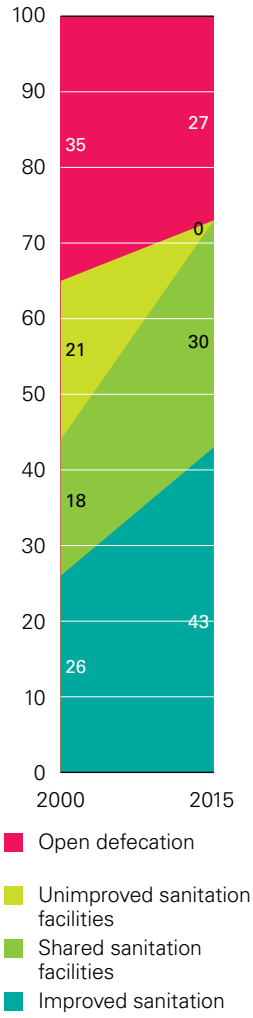
		2012	2015
Status and scale	CLTS date of introduction	2011	Not yet
	CLTS spread: % of country	0%	24%
	CLTS in urban areas	No	Yes
	CLTS coverage: major organizations	3	3
	OD population rural *(2010 and 2015, mill)*	0.27 m	0.22 m
	Villages triggered *(number)*	10	N/A
	ODF villages *(number)*	1	0
	Capacity developed *(trained facilitators)*	15	35
Enabling	CLTS in government policy	No	No
	CLTS targets in government plans	No	No
	CLTS financed by government	No	No
	CLTS integrated with other approaches	No	No
	CLTS sustainable monitoring	No	No
Effectiveness	ODF success rate	10%	N/A

Scale of rural sanitation challenge

Category	2015 Rural sanitation coverage			2012 Population
	Per cent	Households	Population	
Open defecation	27%	50,151	220,663	272,200
Unimproved sanitation facilities	0%	0	0	240,800
Shared sanitation facilities	30%	55,723	245,182	230,300
Total without improved sanitation	**57%**	**105,874**	**465,845**	**743,300**

Source: 2015 JMP estimate; United Nations Population Division (2014) Annual Rural Population – 2015; 2012 UN Population Forecast.

JMP estimate: Rural sanitation



Rural: improved sanitation coverage

The JMP estimate suggests an increase in improved sanitation coverage in rural areas from a baseline of 26 per cent in 2000 to 43 per cent in 2015. A further 30 per cent of the rural population use either shared or unimproved sanitation facilities. The open defecation rate was estimated to be 27 per cent, which equates to 50,151 rural households (220,000 people) who do not use any form of sanitation facility.

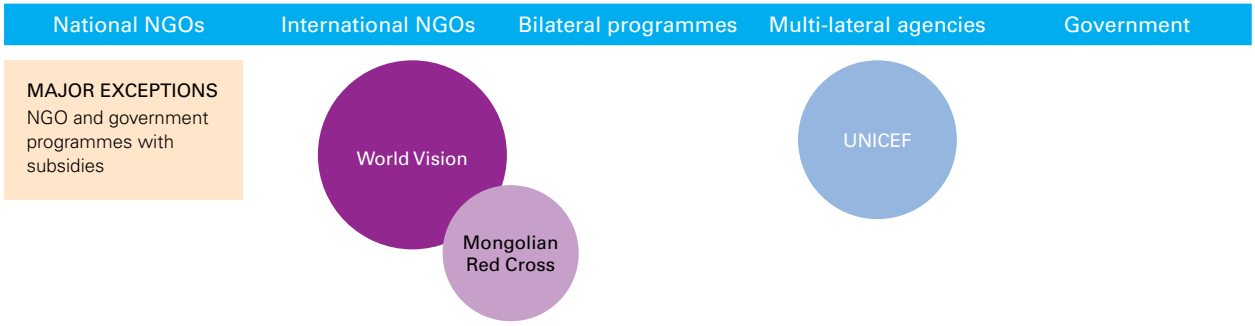
Where is CLTS implemented and by whom

CLTS status and geographic spread

First introduced by World Vision in September 2011. By 2013, the Mongolian Red Cross Society (MRCS) conducted training of trainer courses on CLTS, targeting Nalaikh district in Khuvgsul province with support from UNICEF. In 2015, UNICEF plans to continue CLTS activities with the MRCS. World Vision has implemented CLTS in a number of districts across five provinces since 2011, including Zuunkharaa, Khuvsgul, Bayan Ulgii, Bayankhongor and Uvurkahngai. In total, CLTS is implemented in nearly a quarter of the 21 provinces in Mongolia.

World Vision is implementing CLTS in one of nine urban districts in Mongolia.

CLTS institutional coverage



Major non-CLTS programmes

CLTS is a new approach in Mongolia with only World Vision and Mongolia Red Cross/UNICEF taking it up.

CLTS variations and practice

UNICEF Mongolia's 2012-2016 County Programme focuses on WASH in Schools, however it is supporting Mongolian Red Cross to implement community based CLTS in Nalaikh dictrict in Khuvgsul province.

CLTS scale

More than 5,000 households have been triggered but there are no communities that have achieved ODF status.

CLTS capacity

A total of 35 CLTS facilitators have been trained in Mongolia – 15 by World Vision and up to 20 by Mongolia Red Cross. Ten of the World Vision facilitators are active in promoting CLTS within World Vision programmes, however the number of active facilitators within Red Cross is unknown.

CLTS scorecard

ENABLING ENVIRONMENT		
Policy CLTS in government policy	1998 Law of Mongolia on Sanitation.	Sanitation defined as "activities to eliminate adverse natural and social factors having potential impact on public health, and to prevent the public health from diseases". Normal sanitary conditions are defined as "a healthy and safe environment for a human to work and to live in".
Strategy CLTS targets in government strategies or development plans	No WASH strategy or plan.	No CLTS targets in government strategies or national development plans.
Leadership CLTS led by government	No	CLTS not lead by government at central level, however there is interest in CLTS from local level government in areas where it is implemented.
Finance CLTS financed by government	No	There is no government financial support to CLTS and no formal CLTS programme yet.
Coordination Mechanisms for stakeholder coordination	No	Very little sector coordination generally, with a number of NGOs implementing without cooperation. No CLTS working group.
IMPLEMENTATION AND SUSTAINABILITY		
Integration CLTS integrated with other approaches	No	No combined approaches.
Triggering Standardized facilitator training	No standard training.	There is no standard training for facilitators, however the CLTS manual has been translated into Mongolian.
Facilitator quality control	No	There is no proper mechanism to check and maintain the performance and quality of facilitators. World Vision has an annual review of CLTS progress which includes facilitator review.

IMPLEMENTATION AND SUSTAINABILITY *(continued)*			
ODF Clear ODF criteria		No criteria.	No national criteria for ODF developed yet.
Verification protocol		No	No verification protocol developed yet.
Post ODF support		No	No post ODF support system yet.
Technical support Availability of products and services		No	No sanitation marketing.
MONITORING AND EVALUATION			
Monitoring Robust and regular monitoring of ODF achievements		No progress data.	No national monitoring system.
Post ODF monitoring of quality and sustainability		No	No sustainability monitoring.
Evaluations and knowledge sharing Evaluations, reviews and learning		No	No reviews and evaluations.
Information on costs and resources for CLTS		No	No information available on costs.

Most significant changes since 2012

1 Some increase in spread of CLTS	The number of communities implementing CLTS has increased, with World Vision implementing in 5 out of 21 provinces, including one urban area.
2 Increase in trained facilitators	As a result of training by World Vision and Mongolian Red Cross, the number of trained facilitators and the capacity to implement CLTS has increased.

Lessons learned

1 Facilitator skills are important for success	The effectiveness of CLTS and the speed of households to become ODF depends on facilitators' skills and regular follow-up.

CLTS weaknesses and bottlenecks

1 CLTS not mainstreamed in government plans and programmes	CLTS is yet to be implemented on a scale which can produce evidence that advocates the use of the approach. There is limited interest in the approach from national level government.
2 Continued use of subsidies	The provision of latrine subsidies remains the default approach to sanitation improvement.
3 Climate	Technical challenges created by sub-zero temperatures in winter which freezes water seal toilets and excreta.
4 Population density and mobility	Mongolia has the lowest population density in the world. Improving sanitation behaviours of large nomadic and semi-nomadic populations is a challenge.
5 Poverty	Acute poverty in rural and peri-urban communities is a barrier to obtaining sanitation.

CLTS opportunities over the next 3-5 years

1 Begin to formalize CLTS	Establish common systems and approaches for CLTS based on past experience, e.g., facilitator training, ODF criteria.
2 Build on interest at local government level	Where CLTS is implemented, local governments are showing interest in the approach. There is potential to build momentum from this interest.

MYANMAR

MYANMAR: Country CLTS overview

CLTS summary

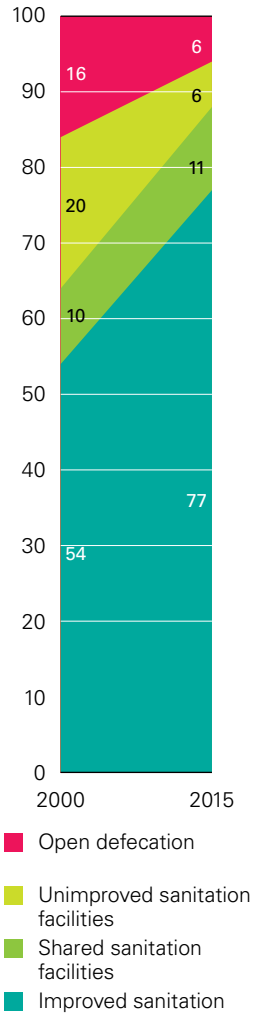
		2012	2015
Status and scale	CLTS date of introduction	2010	Not yet
	CLTS spread: % of country	12%	29%
	CLTS in urban areas	No	No
	CLTS coverage: major organizations	7	3
	OD population rural *(2010 and 2015, mill)*	2.5 m	2.1 m
	Villages triggered *(number)*	224	531
	ODF villages *(number)*	12	63
	Capacity developed *(trained facilitators)*	158	579
Enabling	CLTS in government policy	May be	No
	CLTS targets in government plans	No	No
	CLTS financed by government	Indirect	No
	CLTS integrated with other approaches	No	No
	CLTS sustainable monitoring	No	No
Effectiveness	ODF success rate	5%	12%

Scale of rural sanitation challenge

Category	2015 Rural sanitation coverage			2012 Population
	Per cent	Households	Population	
Open defecation	6%	455,684	2,141,715	2,546,000
Unimproved sanitation facilities	6%	455,684	2,141,715	1,591,250
Shared sanitation facilities	11%	835,421	3,926,478	4,455,500
Total without improved sanitation	**23%**	**1,746,789**	**8,209,908**	**8,592,750**

Source: 2015 JMP estimate; United Nations Population Division (2014) Annual Rural Population – 2015; 2012 UN Population Forecast.

JMP estimate: Rural sanitation



Rural: improved sanitation coverage

The JMP estimate suggests a rapid increase in improved sanitation coverage in rural areas from a relatively high baseline of 54 per cent in 2000 to 77 per cent in 2010. A further 17 per cent of the rural population use either shared or unimproved sanitation facilities. The open defecation rate was estimated to be 6 per cent, which equates to 456,000 rural households (2.1 million people) who do not use any form of sanitation facility.

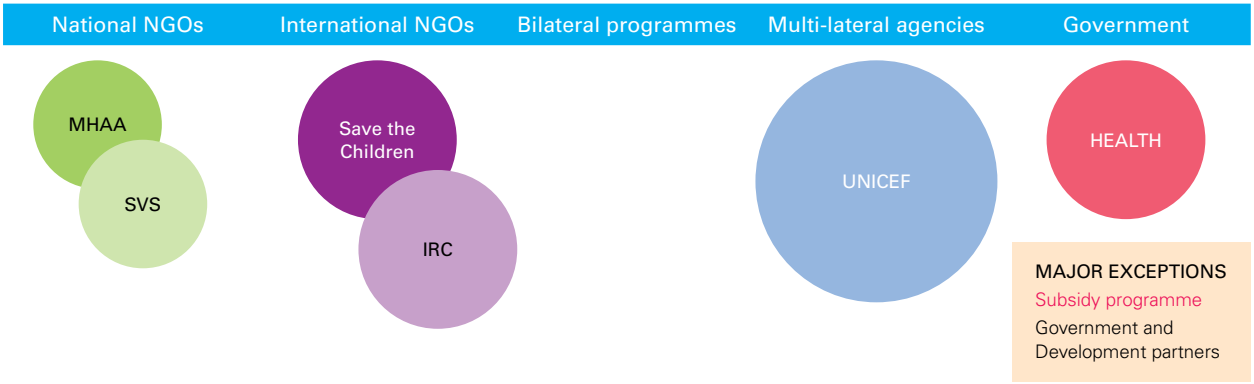
Where is CLTS implemented and by whom

CLTS status and geographic spread

Introduced by UNICEF and Save the Children in 2010. By 2012 CLTS had spread to eight districts in four regions and states (12 per cent geographical coverage). In 2015, CLTS had spread to 25 townships, and more than 530 villages in five states and regions (29 per cent). UNICEF is the largest implementer of CLTS in more than 480 villages but this is a small fraction of the total 64,000 villages. Local government has a role in the monitoring and verification of direct implementation. Township medical officers in particular are involved in the whole process of CLTS including monitoring and follow up, as well as ODF declaration in areas where implementation is carried out by NGOs.

CLTS is not currently implemented in urban areas in Myanmar.

CLTS institutional coverage



Major non-CLTS programmes

Government still subsidizes toilet construction in some areas. Most of the WASH actors including development partners still provide subsidies for sanitation both in development and humanitarian programmes.

CLTS variations and practice

Some modification to CLTS with partial subsidies for materials, especially latrine superstructure, after triggering stage.

Some NGOs link CLTS implementation as a prerequisite for obtaining community water supply.

CLTS scale

More than 530 villages have been triggered but only 33 villages are certified as ODF while a further 60 villages have achieved ODF status but not yet certified. In addition, 200 villages will be ready to declare ODF in 2015. The average period to do pre-triggering, triggering and post-triggering is six to nine months (depending on geographic location).

CLTS capacity

A total of 579 CLTS facilitators have been trained in Myanmar, although only 71 of these facilitators are currently active. Of those trained, 520 are from the Department of Health, Department of Rural Development and Department of Education.

CLTS scorecard

ENABLING ENVIRONMENT			
Policy CLTS in government policy		No national sanitation policy	No national sanitation or CLTS policy. No policy on the use of subsidies.
Strategy CLTS targets in government strategies or development plans		No WASH strategy or plan	No rural sanitation strategy. Department of Rural Development, DoH and Department of Basic Education are now planning to develop Rural Water Supply and Sanitation Strategy in 2015.
Leadership CLTS led by government		1 Department of Health, Environmental Sanitation Division (ESD) 2 Township level	1 CLTS not lead by government at central level. The DoH ESD is not yet convinced about CLTS. 2 In some townships supported by UNICEF and NGOs, township medical officers are actively supporting CLTS implementation.
Finance CLTS financed by government		No government financial support to CLTS	The government allocates very little money to the sanitation sector with zero allocation for CLTS. DoH is planning to provide a smart subsidy for households with children under 5 and the Department of Rural Development is providing subsidies to households with people with disabilities, households with elder people and households in conflict and disaster affected areas.
Coordination Mechanisms for stakeholder coordination		No CLTS working group	There are WASH technical working groups but no CLTS working groups. No annual review of CLTS implementation.

IMPLEMENTATION AND SUSTAINABILITY			
Integration CLTS integrated with other approaches		Child survival Health and hygiene Nutrition	CLTS is integrated with Young Child Survival and Development programme under DoH, WASH in schools projects, and community water supply projects. Hygiene promotion such as '4 cleans' (clean hands, clean water, clean toilet and clean food) is an integral part of all CLTS projects. Some NGOs integrate CLTS with hand washing/hygiene, health and nutrition integrated projects. Due to the limited scale of CLTS, integration is also on a small scale.
Triggering Standardized facilitator training		Facilitator training modules	CLTS standard training modules have been developed both in English and the Myanmar language based on standard CLTS training of Kamal Kar. UNICEF, together with the DoH, is developing a CLTS toolkit that will include training modules, guideline, verification checklist, etc. There is no institution for capacity building of CLTS trainers.
Facilitator quality control		None	There is no proper mechanism to check and maintain the performance and quality of facilitators.
ODF Clear ODF criteria		National ODF criteria drafted	A national ODF criteria has been drafted and used by most implementers in Myanmar but it has not yet been approved and adopted by government. The interim ODF criteria includes: 1 No evidence of open defecation in the whole village. 2 Every latrine has a proper lid for the latrine pan and cover on the ventilation pipe of the pit to prevent flies entering in the pit. 3 Child's faeces are disposed in the latrine pit or properly covered. 4 Everyone must wash their hands with soap or other soap substitutes such as ash or sand after visiting the toilet, as indicated by the presence of soap and water at the latrine.
Verification protocol		Interim verification protocol	Interim protocol developed which will be formalized after a CLTS review. Members of the verification team include: Representatives from the DoH (Central Health Education Bureau & Environmental Sanitation Division) in collaboration with state/regional health education bureau, township medical officers, basic health staff such as a health assistant, lady health visitor and midwife; other local governmental officials such as township administrators, township education officers who are already trained as CLTS facilitators. Sub teams check the entire village for compliance with all elements of ODF criteria. ODF certification is for a one-year probation period.
Post ODF support			ODF villages are visited by basic health staff from the DoH such as lady health visitors, midwives or Public Health Supervisors in a monthly basis to monitor and maintain the ODF status. The community is encouraged to build more new latrines to replace shared latrines. Regular follow up by basic health staff is still weak as the staff are overloaded with many tasks. Implementers do not have the funds to conduct continuous monitoring after the village achieves ODF.
Technical support Availability of products and services		No sanitation marketing	Very limited product range with the main latrine model a simple fly proof latrine. No sanitation marketing support. During rainy season, and in areas of high ground water table eg. Ayerwaddy Delta, direct bamboo lined pits are unsuitable. Alternative pour flush latrines with offset concrete pit are unaffordable.

MONITORING AND EVALUATION			
Monitoring Robust and regular monitoring of ODF achievements		No national monitoring system	Manual monitoring at programme and project level only by NGO staff and basic health staff. No development or implementation of a national M&E system.
Post ODF monitoring of quality and sustainability		No official guideline or policy	DoH staff such as lady health visitors, midwives or Public Health Supervisors are assigned to ODF declared villages to monitor the ODF status on a monthly basis, but there is no guideline or policy to reinforce the monitoring process. No sustainability checks of ODF; slippage is also not monitored.
Evaluations and knowledge sharing Evaluations, reviews and learning		CLTS review planned in 2015	MoH and UNICEF are conducting a CLTS review during 2015. The findings and recommendations will be shared with WASH implementers and government. Dialogue on the CLTS approach is occurring at a national level on a limited basis.
Information on costs and resources for CLTS		No national cost norms but data available from UNICEF	The estimated unit cost per village to implement CLTS is around US$ 1,200-1,300 (6 month period)/village; US$ 1,500-16,00 (8 month period)/village (UNICEF).

Most significant changes since 2012

1 Trialling of CLTS procedures	Development of draft processes and procedures for CLTS implementation including a training manual, draft ODF criteria, and certification process. There are some discussion on CLTS at the national level.
2 Some increase in spread of CLTS	The number of communities implementing CLTS has increased.

Lessons learned

1 Lack of policy prevents scaling up	Without a supportive policy environment, it is difficult to scale up CLTS. Unless the government adopts the approach, supports it with resources and policy implementation, it will remain piecemeal and at the project level.
2 Local health and community resources are key	CLTS is more successful where there is the full engagement of the township medical officer and basic health staff, and where the local authority is involved in the whole process. A strong WASH/CLTS committee can motivate the community to achieve or declare the ODF status in a very short time.
3 CLTS training	Strong training is important. CLTS trainers should preferably be part of a government-led team at the state/regional level to conduct CLTS training and support for ODF verification. Refresher training is needed for CLTS ToT training, for CLTS working groups and networks that are led by the DoH with the support of UNICEF.
4 Large villages are challenging	It difficult to implement CLTS in large villages (more than 200 households) and achieve 100 per cent ODF status in a short period, without sufficient and skilled staff.
5 Rewards and recognition of ODF status are effective	Timely rewards and recognition of ODF villages at the local and national levels supports maintenance of ODF status. Village ODF acknowledgement ceremonies should be held as soon as the villages are declared for ODF. Acknowledgement and reward of ODF villages from national level government motivates the continuation of ODF status, helps motivate other communities, and attracts national attention through the media to other parts of Myanmar. Inviting declared villages to take part in the DoH's National Sanitation Campaign is effective. Exchange visits among all CLTS implemented villages are useful for learning and motivation to sustain ODF status.
6 Low quality latrines result in OD slippage	The construction of low quality latrines, especially digging pits in high water table areas and in sandy soil leads to collapse. When the latrines cannot be used for several months it results in a reversion to OD.

CLTS weaknesses and bottlenecks

1 CLTS not mainstreamed in government plans and programmes	CLTS is yet to be adopted as a national approach and included in strategic plans and targets. Although township medical officers are actively supporting CLTS implementation in some townships, policy makers and high ranking Government officials need to buy in to CLTS implementation. Many organizations are still counting the number of latrines rather than ODF achievements. Implementation is on a short-term project basis and not part of a longer term Government programme.
2 Continued use of subsidies	The acceleration of progress and effective scaling up of sanitation is undermined by competing or contradictory approaches in the same location, particularly the use of hardware subsidies that are not employed in a targeted manner to the poor, nor delivered in a smart way.
3 Lack of Government resources to implement	Basic health staff and other relevant Government staff are overloaded with many tasks and do not have the time to dedicate to CLTS.
4 Limited latrine technologies	There are few latrine options available for households. Affordable technology solutions are yet to be developed for challenging environments i.e. flooding and high water table areas.

CLTS opportunities over the next 3-5 years

1 CLTS review to shape future direction	Recommendations from a proposed CLTS review in 2015 will guide the revision of documents such as a training guidebook, facilitator handbook, ODF verification checklist, TOR of ODF verification teams, and the definition of ODF. This will strengthen and standardize the CLTS implementation processes. A CLTS tool kit relevant to Myanmar will be prepared following the review.
2 Rural WASH Strategy	Myanmar is in the process of developing a national Rural WASH strategy. Inclusion of the CLTS approach in the Rural WASH Strategy will improve implementation, especially after modifications following the CLTS review in 2015.
3 CLTS Technical Working Group	The establishment of a national level CLTS technical working group or network will help to coordinate field level implementation, share the lessons learnt and provide technical support needed at the field level.
4 Improved leadership	The leadership and guidance from national level to state/regional level is vital to implement CLTS at scale except in flooded areas, conflict affected areas and remote areas, etc.
5 Additional CLTS pilots	Additional CLTS townships/villages in the next few years will contribute as pilots for learning and advocacy. There is more of a consensus in the sector that a pro-poor mechanism is needed, a guideline will be drafted in 2015 which could then be piloted.
6 Scaling up through integration	Integration with other programmes such as livelihoods cash for work activities can increase the scale of CLTS.

PAPUA NEW GUINEA

PAPUA NEW GUINEA: Country CLTS overview

CLTS summary

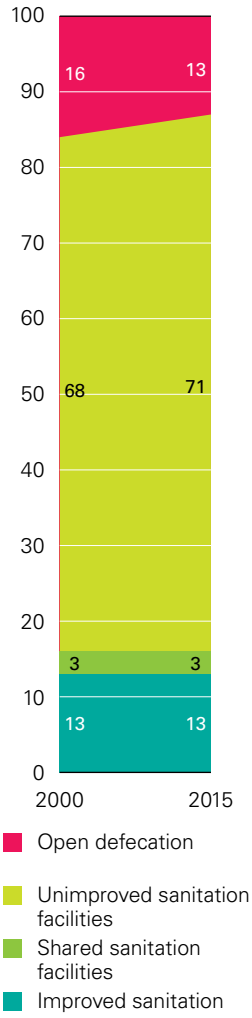
		2012	2015
Status and scale	CLTS date of introduction	2008	Not yet
	CLTS spread: % of country	95%	86%
	CLTS in urban areas	No	No
	CLTS coverage: major organizations	8	6
	OD population rural *(2010 and 2015, mill)*	1.1 m	0.86 m
	Villages triggered *(number)*	477	666
	ODF villages *(number)*	21	144
	Capacity developed *(trained facilitators)*	310	510
Enabling	CLTS in government policy	No	Yes
	CLTS targets in government plans	No	No
	CLTS financed by government	Indirect	No
	CLTS integrated with other approaches	No	Yes
	CLTS sustainable monitoring	No	No
Effectiveness	ODF success rate	1%	18%

Scale of rural sanitation challenge

Category	2015 Rural sanitation coverage			2012 Population
	Per cent	Households	Population	
Open defecation	13%	154,126	863,107	1,079,800
Unimproved sanitation facilities	71%	841,766	4,713,890	2,459,600
Shared sanitation facilities	3%	35,568	199,178	–
Total without improved sanitation	**57%**	**105,874**	**465,845**	**743,300**

Source: 2015 JMP estimate; United Nations Population Division (2014) Annual Rural Population – 2015; 2010 UN Population Forecast.

JMP estimate: Rural sanitation



Rural: improved sanitation coverage

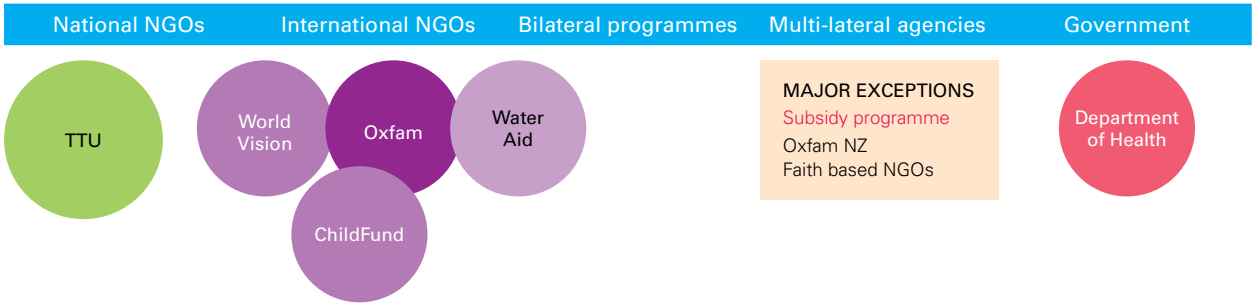
The 2015 JMP estimates indicate that there has been no change in access to improved sanitation in rural areas of Papua New Guinea since 2000 with the rate remaining at 13 per cent. Open defecation is estimated at 13 per cent while the biggest gap is in the use of unimproved sanitation, which has increased to 71 per cent. There are still 154,000 households (860,000 people) who do not have access to any form of sanitation in rural areas.

Where is CLTS implemented and by whom

CLTS status and geographic spread

CLTS was introduced by Oxfam in 2008, with implementation expanded by ChildFund and Live and Learn in 2009. By 2012 CLTS was being implemented in 19 provinces, largely through the efforts of an EU-Rural Water Supply and Sanitation Program. Currently CLTS is supported in around 12 of the 22 provinces in Papua New Guinea, but only in selected districts within those provinces. The widest reach is by local NGO Touching the Untouchables (TTU) who is working in two districts of Eastern Highlands province, and in one district covering 30 wards, but altogether covering 12.5 per cent of the entire province.

CLTS institutional coverage



CLTS implementation is led by NGOs including WaterAid, ChildFund, World Vision and TTU in the Eastern Highlands province. Government involvement is at the local level through partnerships with NGOs, and the training of Provincial Environmental Health Officers at the national level for roll out within provinces. The extent of the roll out by provincial Environmental Health Officers is unknown, but it is believed to be limited.

CLTS has only been trialled on a small scale in urban settlements by World Vision, whose staff have been trained to try out the feasibility in WVs urban projects.

Major non-CLTS programmes

Oxfam NZ in Bougainville is using CLTS to generate demand alongside the provision of subsidized latrine slabs and vent pipes for VIP latrines.

CLTS variations and practice

CLTS implementers in Papua New Guinea require that latrines meet two minimum technical criteria: provision of a sealed pit and a vent pipe.

1 CLTS + Healthy Islands concept

The Healthy Islands concept encourages health promotion in sub-settings such as homes, schools, villages and markets; and covers safe motherhood, child health, immunization, protection against communicable diseases, and quality of life. CLTS fits well with many of the activities and principles of this Pacific-specific approach. Implementation of the concept has lacked finance and support, however a framework of action for revitalizing implementation of the concept was agreed in 2011. Strategy 7.3.1 of the National Health Plan 2011-2020 is to increase the roll out of the Healthy Islands strategy, however the extent to which this approach is utilized in Papua New Guinea is uncertain.

2. WASH, Community Health and Maternal Health

CLTS is integrated into other programmes of NGOs:

- WaterAid integrates CLTS into WASH programmes.
- TTU has built CLTS into all of its village health worker (VHV), village birth attendant (VBA) and community health worker (CHW) training workshops. ODF villages are selected and presented to Oxfam (PNG) to provide rainwater harvest systems to these villages. So far five villages have benefited from this strategy.
- World Vision implements CLTS in all (100 per cent) of its WASH projects. Sanitation is linked to the provision of water supply, with water supply hardware being subsidized. World Vision also includes sanitation and hygiene components in its Maternal, New Born and Child Health (MNCH) projects in Bougainville, Port Moresby Urban Settlements and Madang.
- ChildFund PNG integrates CLTS with hand washing/hygiene, provision of water supply and other projects such as nutrition and livelihoods.

Local modifications of CLTS include: promoting improved sanitation in locations where households already have toilets, adapting to the local context, using local materials as teaching aids during training. TTU also introduces a minimum standard ventilated improve pit latrine structure design during the community engagement so the participants can see what a health promoting toilet looks like.

CLTS scale

As of 2012 more than 470 villages were reported to have been triggered using the CLTS approach, with a further 189 triggered since then. There is no central register of ODF communities.

ODF success rate

As of June 2015 an estimated 144 villages have been certified as ODF (123 added since 2012). The success rate of ODF communities from those triggered is 18 per cent. The most experienced NGO (TTU) reports 23 out of 97 villages triggered have been certified as ODF – a success rate of 24 per cent. Other NGOs have not achieved full community ODF but the amount of OD has reduced at the household level. The time between triggering and achieving ODF ranges substantially from three months to as much as 12 months where a community has difficult conditions such as flooding. It has also been observed that the usage of latrines at night is an issue due to fear of being bitten by snakes and sorcery. More typically the average time to reach ODF as reported by World Vision and TTU is five to six months.

Successful triggers include: disgust, privacy, convenience, pride and stigma of continuing OD, good health, but also status in terms of wealth and respect.

CLTS capacity

A total of 510 CLTS facilitators and community representatives have been trained in Papua New Guinea. Community representatives are village health promoters, and village birth attendants who are trained for awareness rather than to conduct triggering. It is uncertain how main trained remain active but probably half to one third are still active.

CLTS scorecard

ENABLING ENVIRONMENT		
Policy CLTS in government policy	WASH Policy 2015	PNG's First National WASH Policy was passed in early 2015. The policy aims for 100 per cent total sanitation; with a focus on changing behaviour through the promotion of safe sanitation facilities, leading to ZOD. Subsidies for sanitation should be limited but can be considered if carefully targeted to promote access for the poorest, disabled, for improved menstrual hygiene, for innovation, for sanitation in challenging environments.
Strategy CLTS targets in government strategies or development plans	GOPNG Development Strategic Plan 2010-2030	No ODF targets. Only targets for 70 per cent of population with access to improved sanitation by 2030.
Leadership CLTS led by government	No government leadership	Government is not leading CLTS. DoH supports CLTS but does not lead implementation.
Finance CLTS financed by government	No government finance	No government funding for CLTS.
Coordination Mechanisms for stakeholder coordination	No formal coordination mechanism	No coordination mechanism on CLTS. NGOs conduct implementation independently. Some improved WASH coordination with recent WASH policy but not specifically for CLTS.
IMPLEMENTATION AND SUSTAINABILITY		
Integration CLTS integrated with other approaches	WASH and Maternal Health	Integrated with WASH, handwashing, maternal health, and village health as part of NGO programmes.
Triggering Standardized facilitator training	No standard training	No organized capacity building training for CLTS. There are no standard training modules.
Facilitator quality control	NGO-only quality control	Facilitator performance is checked by individual NGOs who also provide refresher training in some cases. There is no consistent approach to monitor quality although TTU as a trainer has developed a monitoring and reporting template, which includes a tool to assess the learning competency of CLTS facilitators in the community. Upon assessment and verification by the trainers (TTU), the facilitators will be certified as CLTS practitioners. There is no centralized training institution although the Environmental Health Department of the Faculty of Health Sciences at Divine Word University could be considered.

IMPLEMENTATION AND SUSTAINABILITY *(continued)*			
ODF Clear ODF criteria		No formal ODF criteria	There is no nationally defined ODF criteria. Implementers use their own criteria, which vary from no obvious faeces (including children's), covered latrines and tippy taps through to every household having a VIP latrine, management of human and animal faeces, and handwashing facilities with soap. Inconsistency of ODF criteria between NGOs.
Verification protocol		No agreed ODF verification process	No consistent verification protocol, partly due to variable ODF criteria. Verification differs between implementers but usually involves Provincial or District Health staff or district WASH committee in the verification process. No mechanism for losing ODF status however the general view is that communities will take pride in their achievement and try to maintain the status.
Post ODF support		Not systematic follow up	Where NGOs have achieved ODF villages, post ODF support is through local implementers, or this is left to local health promotion authorities to follow up. Only TTU has a process which includes monthly visits by staff to facilitate the continuity of ODF, assess the community understanding of ODF, see if the community has initiated other projects either in relation to health, education, agriculture or others and provide information and advice where needed.
Technical support Availability of products and services		Limited information on products	Some technical information on latrine options introduced after triggering by NGOs, for example models of VIP latrines, and training on latrine building. No standardized approach or research on low cost suitable options or markets. Some areas better served by sanitation suppliers than others, but usually limited to major townships. Household innovation is high but yet to be capitalized on. Some NGOs subsidizing latrine products and transport, but also adapting sanitation to some difficult environments.
MONITORING AND EVALUATION			
Monitoring Robust and regular monitoring of ODF achievements		No national monitoring system	No centralized register or database for ODF villages. ODF criteria is monitored at the project level by individual implementers through their own staff or local partners, but not always effectively. Monitoring is done manually then entered onto computer. No data on slippage.
Post ODF monitoring of quality and sustainability		Project level checks	Some post ODF monitoring through WASH Sustainability Assessments (WaterAid) and sustainability checks (TTU) of ODF villages.
Evaluations and knowledge sharing Evaluations, reviews and learning		Very limited sector information	No known evaluations of CLTS, except as part of individual NGO programme WASH evaluations. Some sharing of lessons learned though events such as WSP sustainability workshops or reporting at government meetings but not with a view to improve CLTS practise on a regular sector-wide basis. Site visits to sustained ODF villages contributed information to the WASH policy.
Information on costs and resources for CLTS		No standard costs	No information available.

Most significant changes since 2012

1 National WASH Policy 2015	The recently approved PNG National WASH Policy 2015 is the first WASH policy in the country. The policy gives official recognition to CLTS as a suitable sanitation approach to achieve the objective of reaching ODF communities. The policy gives clarity about the use of subsidies and only employing them if targeting the very poor, in challenging environments and for other special conditions. The policy development brought stakeholders together and awareness on sanitation to the forefront, and it is hoped that this collaboration and awareness will continue.

Lessons learned

1 CLTS can reduce conflict	CLTS can be applied in socially challenging environments. TTU has six tribal fighting villages that have been trained in CLTS and now have toilets, animals fenced, rubbish holes, footpaths lined with flowers and drainage. As a result of CLTS the communities have agreed to stop fighting and have reached a ceasefire agreement and are now working towards a peace agreement. These communities were influenced by the sanitary and hygiene transformation that happened in their homes and village.
2 Self reliance and innovative development	In a country where Government services are poor, CLTS has shown people that they can be self-reliant and improve sanitation for themselves without waiting for the Government. Communities have shown innovation in building VIP toilets, but have also improved their homes and village environments. Collective goals in the CLTS process have also sets a foundation for other developments to build on e.g. literacy, agriculture, tourism, law and order and peace, and gender equity and equality.
3 Integration supports sustainability	CLTS cannot be a stand-alone activity or programme. It needs projects like safe motherhood, rural water supply system projects and livelihood projects to support sustainability of ODF villages.

CLTS weaknesses and bottlenecks

1 Sanitation is not a government priority	Sanitation has not been a priority for the Government in the past and it has not received any attention. There are misconceptions within the Government about subsidies and the roles of Government departments.
2 Facilitator capacity still weak	Influencing the community mindset leading to behaviour change is not an easy task and needs facilitators who are skillful. It is difficult to cultivate and sustain good facilitators.
3 Subsidies not standard in practise	Subsidies are still given by NGOs for sanitation e.g. ChildFund PNG's WASH project gives every household in its participating communities hardware materials to self-construct latrines with some community contribution. Hardware material for a standard designed VIP latrine costs about K800.00 (US$ 290).
4 Difficult to scale up without Government	CLTS is entirely NGO implemented, and therefore lacks budget and scale. Without financial support from the Government, INGO's and the private sector for CLTS in Papua New Guinea it will be difficult to scale up. A consistent and sustained driver (Government at all levels) is needed to drive the progress in scaling up CLTS.
5 Weak sanitation supply chain	Despite community innovation there are few latrine choices, especially low cost toilets for households. The sanitation supply chain in undeveloped.
6 Land issues	Most of Papua New Guinea is customary land. It is sometimes difficult to apply CLTS where there are land issues and disputes. Settlers on other peoples' land only construct makeshift sanitation facilities for temporary use and these are not sustainable.

CLTS opportunities over the next 3-5 years

1 WASH policy sets future direction	Approval of the WASH Policy and CLTS being one of the standard approaches to be implemented for sanitation with proper planning that can be taken to scale. The policy will help to create opportunities to make CLTS a standard approach in implementation in Papua New Guinea.
2 Improve sector practise	The WASH Policy provides the framework to begin strategy development and other enabling environment factors such as standardization of facilitator training, ODF guidelines, verification processes, monitoring, and learning to improve sector practise.
3 Institutionalize facilitator training	Potential opportunities to improve facilitator training include establishing a CLTS training module through the Environmental Health Department of the Faculty of Health Sciences at Divine Word University; and through the establishment of a CLTS foundation in Goroka, Eastern Highlands province to provide capacity building support for TTU and other organizations that are implementing CLTS. TTU sees the opportunity for CLTS training to be conducted in educational institutions in the district, particularly in lower and upper primary schools and vocational schools, in the church and through youth groups.
4 Potential for ODF district	Through the NGO TTU, Henganofi district in the Eastern Highlands province may be the first ODF district in PNG by 2016. This could be a potential model and inspiration for other districts to become ODF and integrate CLTS with rural water supply and livelihood projects.

THE PHILIPPINES

THE PHILIPPINES: Country CLTS overview

CLTS summary

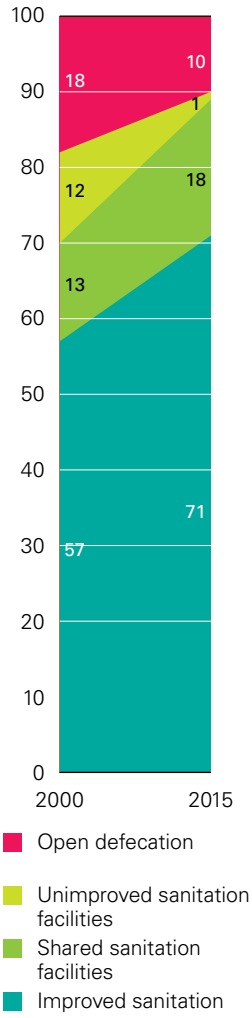
		2012	2015
Status and scale	CLTS date of introduction	2008	Not yet
	CLTS spread: % of country	10%	18%
	CLTS in urban areas	No	Yes
	CLTS coverage: major organizations	10	21
	OD population rural *(2010 and 2015, mill)*	5.7 m	5.7 m
	Villages triggered *(number)*	211	677
	ODF villages *(number)*	36	473
	Capacity developed *(trained facilitators)*	377	978
Enabling	CLTS in government policy	No	Yes
	CLTS targets in government plans	Yes	Yes
	CLTS financed by government	Indirect	Yes
	CLTS integrated with other approaches	No	Yes
	CLTS sustainable monitoring	No	Yes
Effectiveness	ODF success rate	17%	70%

Scale of rural sanitation challenge

Category	2015 Rural sanitation coverage			2012 Population
	Per cent	Households	Population	
Open defecation	10%	1,155,715	5,663,003	5,718,300
Unimproved sanitation facilities	1%	115,571	566,300	1,429,600
Shared sanitation facilities	18%	2,080,287	10,193,405	7,624,500
Total without improved sanitation	**29%**	**3,351,573**	**16,422,709**	**14,772,400**

Source: 2015 JMP estimate; United Nations Population Division (2014) Annual Rural Population – 2015; 2012 UN Population Forecast.

JMP estimate: Rural sanitation



Rural: improved sanitation coverage

The JMP estimate suggests a steady increase in improved sanitation coverage in rural areas from 45 per cent in 1990 to 69 per cent in 2010, and 71 per cent by 2015. Open defecation has reduced from 18-8 per cent of rural households between 2000 and 2015, although there are still 5.7 million rural people that do not use any form of sanitation facility. As of 2015 71 per cent of rural households use improved sanitation.

The National Sustainable Sanitation Plan sets a goal of all barangays or villages being ODF by 2022, in seven years time.

Where is CLTS implemented and by whom

CLTS status and geographic spread

Introduced through the development of the Sustainable Sanitation in East Asia – Philippines programme led by the Department of Health in 2007, with support from WSP. Training of facilitators was given by Kamal Kar in 2010, supported by UNICEF. Since then, CLTS has spread to 15 out of 82 provinces and cities in the Philippines (18 per cent geographical coverage). In some provinces CLTS has been scaled up throughout the province, e.g. Quezon province, as part of the Department of Social Welfare and Development (DSWD) Pantawid Program and through the Integrated Provincial Health Office (IPHO) in all 39 municipalities. Masbate province recently adopted a Rural Sanitation Graduation Framework, also known as the phased approach, as its strategy – this includes CLTS as an important step to go from Grade 0 (open defecation) to Grade 1 (zero open defecation). The Masbate scale up is being

implemented through the Provincial Health Office. In Typhoon Yolanda (Haiyan) affected areas, CLTS is also implemented widely across a number of provinces, including Leyte and Eastern Samar, as part of the Haiyan recovery programme phased approach to total sanitation (PhATS).

Through the National Sustainable Sanitation Plan, the Department of Health (DoH) has supported the roll-out of CLTS in all provinces through capacity building for the 15 Regional DoH Coordinators who are tasked to scale-up CLTS in the respective provinces in their regions. The roll out strategy depends on cascading training for implementers at provincial level who in turn train health staff at municipality and *barangay* level. However, there is currently no national mechanism to monitor this roll out following the initial training (and no obligation of subnational level to report upwards), therefore the scale of actual CLTS implementation through the DoH programme is unknown.

Main implementing agencies prioritize areas for CLTS is based on various combinations of high open defecation, low health and nutrition status, high poverty rates and vulnerable disaster areas.

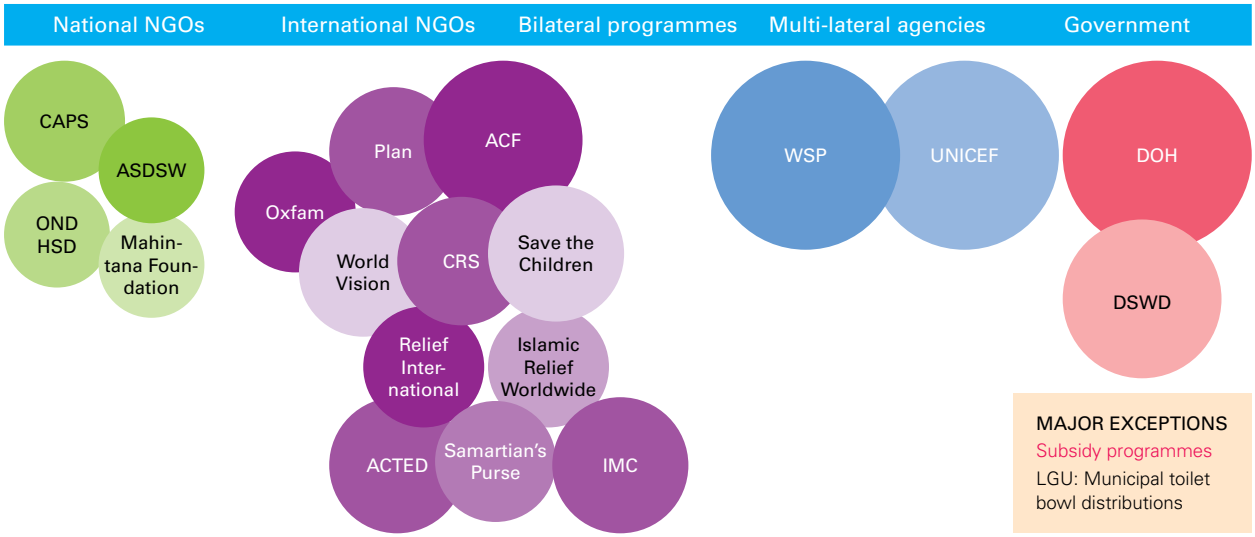
CLTS institutional coverage

Two major programmes – both of which aim to support the DoH's Zero Open Defecation Program – have contributed to the expansion of CLTS – the UNICEF-supported PhATS being implemented in Masbate, Cotobato and in Haiyan-affected areas, and the WSP-World Bank supported Scaling Rural Sanitation Program being implemented in six provinces.

The development of PhATS under the WASH Cluster strategy has led to an increase in the number of international NGOs implementing CLTS, including through the adoption of the approach by traditional humanitarian NGOs. Integration of CLTS in the Department of Social Welfare and Development (DSWD) Pantawid Program has the potential to significantly increase coverage of CLTS messages across the five regions participating in the pilot programme, and eventually beyond.

CLTS is not promoted in Metro Manila since it is a peri-urban region, which implements the National Sewerage and Septage Management Plan. However, as part of UNICEF's shift from emergency response to development in peri-urban areas such as Tacloban City and Zamboanga City, CLTS is being adapted and included as part of the overall recovery strategy.

CLTS institutional coverage



Major Non-CLTS programmes

Local Government Units (LGUs), including municipalities and provinces, continue to finance the distribution of free 'toilet bowls' in rural communities even where CLTS has been introduced, as some stakeholders remain unconvinced that a non-subsidized approach can provide the level of sustainable service that is demanded by rural households and expected by local governments. In UNICEF areas implementing the phased approach, it has been agreed that LGU distribution of toilet bowls/materials/ cash rewards will only come after the certification/verification of ODF.

UNICEF also implements WASH in Schools, Day Care, and Tahderiyyah (Muslim Day Care Centres) – which complements CLTS.

A number of CSOs continue to have a supply driven approach to sanitation programming – for example, building high-cost toilets for families as part of emergency recovery programmes. Where these are being implemented in the same or neighbouring geographic areas as the CLTS-based programmes, this has created challenges for getting communities to engage in building their own toilets.

CLTS variations and practice

1 Total Sanitation

In the Haiyan-affected areas, PhATS follows the Rural Sanitation Graduation Framework of three levels of sanitation from G1 Zero Open Defecation to G2 Sustainable Sanitation, and G3 Total Sanitation which includes solid waste management and waste water treatment. The Rural Sanitation Graduation Framework was developed prior to the Haiyan emergency and was being piloted in Masbate and Cotobato (however, this is not yet adopted at the national level as the standard approach). In accordance with national guidelines, ZOD certification (G1) includes handwashing (with one of the indicators for certification being 100 per cent presence of water and soap in/near toilets), as well as safe disposal of child and elderly persons' faeces. The approach strictly encourages no external subsidy from G0 (open defecation) to G1 – however the community is encouraged to help each other to be able to build toilets (called *'bayanihan'* in Tagalog). Collective rewards and incentives are provided after achieving ZOD (G1) status to encourage the communities to move from G1 to the next level of the framework (G2), which includes sustainable sanitation solutions. The incentive system aims to make it possible for everyone to have improved toilets, even the poorest of the poor. The follow-on stages also address other relevant WASH problems, such as having toilets in government institutions (such as schools, day care centres, rural health units, etc.), solid waste management and waste water treatment, safe management of animal excreta, protected water sources and water points, and water quality testing.

2 Social Welfare Programmes

As part of a pilot programme, sanitation has been integrated in the Family Development Sessions (FDS) of the Department of Social Welfare and Development (DSWD)'s Conditional Cash Transfer Program (locally dubbed as the Pantawid Pamilyang Pilipino Program or 4Ps). FDS include hygiene and sanitation messages, and some of the triggering tools used in the CLTS Approach, BCC Campaigns Tools and choice catalogue for low cost sanitation options for rural areas where 4Ps grantees are found and organized as Parents Groups at the *barangay* level. WSP is assisting the DSWD in the WASH integration within its three core protection programmes – Conditional Cash Transfers, Kalahi CIDSS community driven development programme, and Sustainable Livelihoods Program. WASH Integration in DSWD Programs is piloted in six regions, 14 provinces, 37 municipalities with approximately 80,210 Pantawid grantees to gain access to a toilet by 2016. The 4P programme targets individual households, however DSWD staff have had some success at advocating to local mayors or chief executives to aim for ZOD for whole municipalities with DoH staff triggering non-Pantawid community members.

3 School/ECCD Hygiene Promotion

The Department of Education implements the Essential Healthcare programme which institutionalizes daily group handwashing and toothbrushing in schools. In UNICEF-supported areas, implementing partners engage schools and Early Childhood Care and Development (ECCD) Centers by providing capacities to day care workers, school health promoters, parents, and caregivers in institutionalizing hygiene promotion for school-aged and under five year old children, in support of the EHCP programme. These activities complement the CLTS approach being implemented at the community level.

4 Disaster Risk Reduction

The CLTS approach encourages poor communities to build their own toilets without being so dependent on external subsidies. They realize that they can build their own toilets using indigenous materials which will increase resiliency among families. In this way, they can bounce back immediately after a disaster since they have enhanced their indigenous knowledge and capacities to address their hygiene and sanitation needs without waiting for outside help. The community WASH plan is also integrated in the *barangay* Disaster Risk Reduction and Management Plans as well as Contingency Plans, giving an extensive reach on WASH-related issues.

CLTS scale

According to development agencies as of May 2015 an estimated 473 barangays have been certified as ODF, however there are more than 42,000 *barangays* in the Philippines and the national target is for 60 per cent of *barangays* (25,000) to be ZOD by 2016. There is no centralized monitoring database that records the ODF status of *barangays* at the national level, while regional DoH offices have different ways of monitoring ODF *barangays*. Although the number of ODF *barangays* could be higher than reported, the country appears likely to fall short of its target by 2016.

ODF success rate

As of May 2015 the Philippines has triggered 677 *barangays* and 473 (70 per cent) have been certified ODF. Haiyan area has been most successful with 364 *barangays* so far declared ZOD out of 431 triggered (84 per cent success rate). UNICEF's development programme has a 29 per cent success rate (101 triggered, 30 ODF); and WSP a 54 per cent success rate (145 triggered, 79 ODF). Average triggering to ODF is two to five months, but longer for 'difficult' *barangays*. Achieving ODF in WSP pilot areas in Sarangani was very slow with five years for some *barangays* to reach ODF. Achievement was accelerated through the development of sanitation action plans at *barangay* level and focussing on LGU service delivery. In Haiyan affected areas, where PhATS advocates are appointed in the *barangay*, triggering to ODF self-declaration can be achieved in 2-6 weeks – but these areas have benefitted from massive investment and support from CSOs (UNICEF implementing partners) to achieve these results.

CLTS capacity

The Philippines has significant CLTS capacity with at least 978 facilitators trained through multiple training courses since 2008. DoH has 30 trained Regional Coordinators (master trainers); UNICEF's regular programme has trained 403 facilitators consisting of *barangay* officials, community health volunteers, rural health midwives, rural health nurses, school teachers, and heads of line agencies and community health committees; the UNICEF Haiyan programme has trained 160 facilitators from Region VI to VIII (129 facilitators from the villages and municipalities and 31 NGO partners); with 385 facilitators in WSP-supported areas (Quezon – 163; Negros Occidental – 157; Negros Oriental – 30; and Sarangani – 35). DSWD has conducted additional training on their own through the Municipal Links however the number of facilitators is unknown.

All the DSWD trained facilitators remain active, as do the 160 UNICEF trained facilitators for Haiyan areas. Only 16 of DoH's facilitators are active due to attrition form retirement or facilitators moving to a new position. Only 60 facilitators (15 per cent) of facilitators from UNICEF's regular programme are still active.

CLTS scorecard

ENABLING ENVIRONMENT			
Policy CLTS in government policy		1 DoH Administrative Order 2010-0021) 2 Local policies and executive orders	1 National policy under DoH Administrative Order 2010-0021 Declaring National Sustainable Sanitation as a National Policy. CLTS stated as an approach to reach ZOD towards sustainable sanitation. 2 In some areas barangay and municipal level executive orders on achieving ZOD are institutionalizing planning, resource and budget allocation.
Strategy CLTS targets in government strategies or development plans		1 National Sustainable Sanitation Plan 2010-2016 2 Municipal five-year strategic plans	1 NSSP produced by the DoH includes the following objectives to have been achieved by June 2016: • All LGUs have declared sustainable sanitation as a policy • 60 per cent of *barangays* declared Zero Open Defecation (ZOD) By 2022 100 per cent of *barangays* to be ZOD. 2 At the local level, the Municipal WASH Task Force sets ZOD targets within their five-year strategic plan.

ENABLING ENVIRONMENT *(continued)*			
Leadership CLTS led by government		1 Lead by DoH at central level 2 Local leadership	1 At central level DoH develops and implements policies, including the National Sustainable Sanitation Plan. DoH provides operational strategy for scaling up rural sanitation programme nationwide. DoH regional Coordinators are in charge of rolling out CLTS in their respective provinces however not all are able to do training due to lack of funds at provincial level. 2 WASH taskforces at Provincial and Municipal level for planning, monitoring for allocating resources for the programme to ensure implementation and sustainability. Barangay WASH Taskforces monitor the programme implementation. In Haiyan-affected areas LGUs lead work planning, and budget allocation.
Finance CLTS financed by government		1 Central level funding for CLTS 2 Municipal budget allocation	1 DoH allocates an average of Php 1 million (<US$ 22,000) every year at the national level for the CLTS programme (capacity building and guidance). 2 Local governments under the UNICEF program and WSP pilot areas are using and increasing annual investment on WASH – providing budget for implementation of the programme, staff salary, hardware subsidy, transport, facilitator training, and rewards/incentives for ZOD *barangays*.
Coordination Mechanisms for stakeholder coordination		Subnational coordination	Stakeholder coordination at subnational level but lacking government led national coordination or annual reviews: • WASH taskforces at provincial, municipal and *barangay* level. • Monthly stakeholder meetings in the Haiyan-affected area.
IMPLEMENTATION AND SUSTAINABILITY			
Integration CLTS integrated with other approaches		1 DSWD Pantawid Program 2 Rural Sanitation Graduation Framework (known as PhATS in Haiyan areas) 3 WASH in Schools and early Childhood and Development Centres	1. Integrated with conditional cash transfer programme to target very poorest households. Also integrated with other DSWD programs including community driven development and sustainable livelihoods programmes. 2. Integrated with total sanitation which envisions the creation of an ODF environment with promotion of supply-side interventions, safe disposal of liquid and solid wastes; the promotion of health and hygiene practices; and the strengthening of the enabling environment for sanitation and hygiene, through a phased and holistic approach to sanitation development. 3. Programmes that support WASH in Schools and Day Care Centres aim to reinforce ZOD behaviours and messages, and to enable children to become agents of change within their communities.
Triggering Standardized facilitator training		1 EOHO standard CLTS training courses 2 Regional training centres and knowledge hubs 3 National Sanitarian course	1 DoH standard 4-day training module which has been progressively localized and enhanced from the trainings conducted by Kamal Kar since 2008. A selection criteria for the trainees is also set. Environmental and Occupational Hazard Office (EOHO) of the DoH organizes the CLTS trainings using the standard module. 2 PhATS Manual developed for CLTS/Demand Creation including facilitator training in Haiyan-affected areas. 3 Regional hubs with the capacity to be a CLTS training school (e.g. Bicol University). The University of the Philippines Manila through its School of Health Sciences is being capacitated to become a CLTS/PhATS training school to provide quality-controlled training and serve as one of the leading CLTS knowledge hubs in the country. 4 National Sanitarian Training Course by the University of the Philippines-College of Public Health includes CLTS.
Facilitator quality control		Facilitator follow up not fully formalized or consistent	1 DoH trained facilitators are monitored six months after the training and requested to prepare an action plan or re-entry plan, however follow-up is not consistent. 2 CLTS Facilitators Exchange in Masbate province with practical triggering experience and structured reflection.

IMPLEMENTATION AND SUSTAINABILITY *(continued)*			
ODF Clear ODF criteria		Guidelines on Verification and Certification of *Barangay* ZOD Status – DoH Department Memorandum No. 2015-0221	Nationally approved criteria for ZOD barangay certification: • Use of functional toilet • Availability of soap and water at or near the toilet (for handwashing) • Proper disposal of babies' and elderly's faeces • No visible faeces in the surrounding area • Evidence of a barangay action plan to move up the sanitation ladder towards Sustainable Sanitation Additional guidelines in selected areas to enforce stricter implementation and sustainability: • Ordinance enforcing the availability of toilets to all households and penalizing open defecation practices. • Shared household toilets should be shared by 10 people or less (20 people or less in emergency situations).
Verification protocol		Guidelines on Verification and Certification of *Barangay* ZOD Status – DoH Department Memorandum No. 2015-0221	ZOD criteria in National Guidelines includes self-declaration after all households checked by *barangay* leaders or sanitation volunteers, sample of 10 per cent by verification team, certification and reward (including cash); reporting to province, regional and central level. Municipal level verification teams comprise Municipal/City Health Officer, Sanitation Inspector, DOH Representative, plus one third-party member (e.g. staff from the Province, regional or national DoH (DoH representative based in the/province), civil society organization, NGO, district). Haiyan-affected areas includes G2 certification for sustainable sanitation. No criteria yet for certifying municipalities, provinces or regions.
Post ODF support		DoH Guidelines	ZOD status and its improvement should be monitored every 3 months by Sanitary Inspectors and the data reported to the Municipality/City. The ZOD status can be revoked if the *barangay* does not sustain its status according to set criteria. ZOD Barangay is expected to proceed to next ladder step leading to total sanitation and possible nomination to the DoH-National Search for *Barangay* with Best Sanitation Practices (NSBBSP). Local ordinances are in place to ensure post-ODF support and scaling up. However, frequency of monitoring is lower compared to post triggering.
Technical support Availability of products and services		Unli Asenso campaign Sanitation marketing in Haiyan-affected areas	Sanitary products generally available. DoH can provide technical support on sanitation marketing and toilet construction. In Haiyan-affected areas supply chain strengthening has occurred. Sanitation marketing training is provided under programmes. Technical support is integrated into the DSWD Family Development Sessions. Using the Unli Asenso Choice Catalog, households are made aware of options that can meet their various needs (coastal or flood prone areas, mountainous, or plain geographical areas; waterless areas; transients and the landlord would not allow digging in their temporary dwelling places). Costs: not more than P5,000 (US$ 109) for complete package options using indigenous materials. Aspirational concrete structures as high as P8,000 (US$ 174) but not more P10,000 (US$ 218).
MONITORING AND EVALUATION			
Monitoring Robust and regular monitoring of ODF achievements		Programme-based monitoring	No centralized national ZOD monitoring system by the DoH. Individual agencies supporting the ZOD Program have their own monitoring systems. All ZOD criteria are monitored. The WSP SURS monitoring tool tracks the progress of sanitation programme from the conduct of CLTS Facilitators' training to the actual access of toilets and the verification of ZOD status. UNICEF piloting mobile data collection system in Regions 6 and 8 by gathering sanitation and ODF data from the *barangay* up to the municipal/city level. Data management is done by the provinces while oversight monitoring is done by the region.

MONITORING AND EVALUATION *(continued)*			
Post ODF monitoring of quality and sustainability			ZOD *barangays* are required to be visited by sanitation inspectors every three months, after ZOD certification. In Haiyan areas sustainable sanitation (G2) monitored every 3 months by Sanitary Inspectors and the data reported to the Municipal/City. The G1 or G2 status can be revoked if the *barangay* does not sustain its status according to set criteria.
Evaluations and knowledge sharing Evaluations, reviews and learning			Evaluation of CLTS not done yet. Evaluations and reviews of programme approaches: 1 Rapid Assessment (2014) of WSP-DSWD convergence areas to measure the outcome of the Enhanced-Family Development Sessions (E-FDS), i.e. incorporating CLTS and BCC in the Pantawid process 2 Enabling Environment for Scaling Up Sustainable Sanitation and Hygiene in the Philippines (Robinson for UNICEF, July 2012); 3 Scaling-Up Demand and Supply for Rural Sanitation (REECS-DOH-WSP-UNICEF, April 2013); 4 Development of a Multi-Stakeholder Implementation Strategy for Scaling-Up Rural Sanitation (Robinson for UNICEF, August 2013); 5 Research on Development of Hygiene Behaviour Change of Elementary Schoolchildren in the Philippines (International Water Center for UNICEF, 2013). DoH holds annual consultative summits with Regional and Provincial Sanitary Engineers. It includes the sharing of best practices in the implementation of sanitation programmes. The recent PRO-WATER programme brings WASH actors together to review the respective programmes that have been done so far. In Haiyan-affected areas, UNICEF implementing partners and other INGOs convene regular monthly meetings, which provide a forum for sharing experiences, lessons, challenges, and best practices in the implementation of the programme. WSP and UNICEF assisting local and national (DoH) knowledge exchanges including review of ZOD verifications, local M&E activities, tools and systems in place for municipality of Malungon (Sarangani province) and municipalities of Aroroy, Cawayan, Milagros and Monreal (Masbate province).
Information on costs and resources for CLTS		Programme costs available but no standardized costs norms	No standard costs/norms developed but costs for UNICEF's regular programme are approximately US$ 227 per village with US$ 25 per household for post-triggering (this includes the costs of establishing capacities and systems at municipal and *barangay* levels, and the cost of implementing the complete Graduated Rural Sanitation Framework – not just the CLTS component). WSP's inclusive estimates for village triggering (excluding DSWD programme delivery costs) are US$ 1.10 per household. Costs for Haiyan-affected areas have an average of US$ 10 per beneficiary including CLTS and other support (i.e. implementation of the complete Graduated Rural Sanitation Framework).

Most significant changes since 2012

1 National CLTS Guidelines	Previously there was no official guide for CLTS implementation process. DoH has approved the National Guidelines for Verification and Certification, as an Administrative Order in January 2015. The guidelines have to be reviewed to consider feedback from LGUs based on their experiences in verifying and certifying ZOD *barangays*. A consultation with regional sanitary engineers and partners on the implementation of the guidelines is yet to be conducted.
2 Need for capacity building	CLTS rollout needs to be more than just a one-time training for potential trainers – but needs to be supported by ongoing capacity building and the development of systems to support and monitor rollout, as well as by more adequate dedicated resources for this programme.

Most significant changes since 2012 *(continued)*

3 CLTS is one part of the sanitation solution	It is now recognized that CLTS is only one piece of the overall sanitation programming required to ensure that the Philippines reaches its NSSP targets. In addition to behaviour change through CLTS, there needs to be sustained communication to reinforce hygiene and sanitation messages; strengthening of the availability of affordable sanitation products and services for low-income households, and development of the enabling environment for supportive WASH governance and municipal services such as solid waste management and wastewater treatment.
4 Local government ownership	Local governments now take the ZOD programme to scale by implementing using their own funding. The introduction of CLTS paves the way for conducting a Municipal Sanitation Action Plan in which CLTS is treated as a major component of the action plan.
5 Integration of CLTS in various programmes	CLTS is integrated with conditional cash transfers, WASH in Learning Environments, and Graduated Rural Sanitation framework (including the PhATS programme). CLTS is seen as one part of a comprehensive WASH programme which can be implemented in a phased approach.
6 Marrying CLTS with sanitation marketing	Bringing CLTS together with sanitation marketing has helped increase coverage and rate of uptake of hygienic latrines. Lessons have also emerged on efficient sequencing of the twp approaches, including the enhancement of the enabling environment.
7 Improved monitoring	ZOD monitoring has been developed using a participatory approach (e.g. forms) and trying to use real-time monitoring tools (e.g. the use of smartphones using the ODK software) – however, these pilots need to be further developed and integrated into a national system.

Lessons learned

1 Subsidies undermine CLTS uptake	Initial resistance to CLTS could be expected as it discourages traditional sanitation hardware subsidies. Subsidies continue to be an issue. The Government's and other major agencies' commitment to shifting towards a 'no subsidy' approach will be a major determinant of the future of CLTS. CLTS will be more effective if communities are not covered by subsidized sanitation programmes or are less exposed to such programmes.
2 Diffusion is effective for scaling up	LGUs and local sanitation champions are contributing to the spread and success of CLTS. Once they have the idea and skills for CLTS, local leaders and champions see the results of the programme and decide to take it to scale. LGUs have independently triggered *barangays*, and some villages have declared ZOD without being triggered because the community has heard of the benefits of ZOD that nearby communities have been enjoying e.g. the village is clean and free of diseases. Local chief executives (LCEs) who believe in the ZOD Program and CLTS approach are embracing this and sharing their own stories and narratives with other LCEs from other provinces and towns. The media is also gradually picking up sanitation news.
3 Sanitation marketing information important for sustaining change	In areas where OD is still practised, people in general have a notion that the construction of sanitary toilets is costly. CLTS under the concept of TSSM, recognizes that there are low cost and easy-to-construct toilets that could help address OD in communities. CLTS is useful in areas where there OD is common. After triggering, addressing the demand for improved sanitation and new positive behaviour has to be sustained through BCC/Communication for Development campaigns (i.e. Unli Asenso Pag May Inidoro; Goodbye Dumi, Hello Healthy) and reinforced by local ordinance. It has to be embedded in the municipal development plans/annual investment plan.
4 High quality facilitators are critical	Participants to the CLTS Facilitators' Training must be strictly pre-qualified in order to ensure effectiveness during rollout. There is a need for cooperation and collaboration among government organizations on sourcing talented facilitators. Experience suggests that quality facilitators are one of the key success factors for CLTS, however facilitators also need support mechanisms in place in order to roll out CLTS e.g. budget, technical assistance, monitoring etc.
5 Timely monitoring	The monitoring mechanisms and monitoring skills of facilitators and focal persons need to be improved to respond better to issues that the community faces during CLTS implementation. The importance of timely follow-up and partnership of all stakeholders (e.g. formation of WASH Taskforces) for monitoring hastens the process.
6 Children can influence parents	Children and teachers are important in changing the behaviour towards OD. In UNICEF areas, separate triggering of children at the same time as parents has a strong impact on parents' emotions and motivations. If children are at school and not present for triggering then one-time real food and faeces demonstration/triggering of children in school can be considered in CLTS. The role of teachers is very important for the follow-up and strengthening the feeling of disgust and the stigma of OD practice.

CLTS weaknesses and bottlenecks

1 Recurring annual natural disasters	Major natural disasters that annually impact human lives, properties and productivity create unique challenges and setbacks for sanitation progress.
2 Continued subsidies	Communities and people are used to highly subsidized programmes and wait for money despite it being made clear in the CLTS triggering sessions that no subsidies would be provided.
3 Weak human resources	Human resource capacity is lacking in some areas. Quality training and careful selection is needed to ensure appropriate skills for key roles of: DoH regional coordinators, sanitary inspectors, CLTS facilitators, and local actors.
4 Soil type and toilet construction	The type of soil in areas where toilets are built requires expensive innovation e.g. septic tank, reinforced pits etc. There had been requests to DoH to support technical trainings at the LGU level on the construction of improved toilets over the pit latrines.

CLTS opportunities over the next 3-5 years

1 Building on success to replicate and scale	Successes of CLTS particularly in ODF communities *(sitios/barangays)* can be used in replicating CLTS in other rural communities. In particular there is an opportunity for LGUs that have successfully implemented CLTS to speak up/advocate for the programme to be taken up by their peers.
2 Institutionalization	Having an institutional structure and delivery mechanism in place would greatly help – selected and trained CLTS facilitators from within the DoH organization and local level could create a permanent support structure and delivery mechanism that can be utilized in scaling-up CLTS in the country.
3 National Coordination mechanism	If a national inter-agency committee/platform for coordination could be established, it would help to ensure that the various national programmes that support NSSP are properly aligned and linked, and investments are maximized in terms of impact/results.
4 DSWD integration scaling up	DSWD programmes integrating WASH in achieving targets for social adequacy can be rolled out on a large scale.

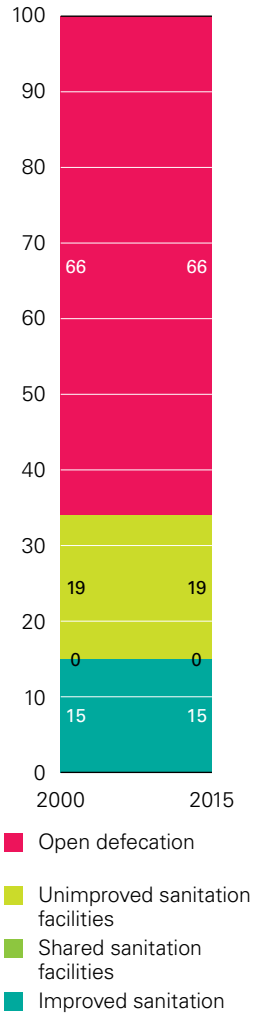
SOLOMON ISLANDS

SOLOMON ISLANDS: Country CLTS overview

CLTS summary

		2012	2015
Status and scale	CLTS date of introduction	2012	Not yet
	CLTS spread: % of country	10%	44%
	CLTS in urban areas	No	Yes
	CLTS coverage: major organizations	2	4
	OD population rural *(2010 and 2015, mill)*	0.14 m	0.3 m
	Villages triggered *(number)*	2	50
	ODF villages *(number)*	0	0
	Capacity developed *(trained facilitators)*	40	41
Enabling	CLTS in government policy	No	Yes
	CLTS targets in government plans	No	Yes
	CLTS financed by government	Indirect	Yes
	CLTS integrated with other approaches	No	No
	CLTS sustainable monitoring	No	No
Effectiveness	ODF success rate	0%	0%

JMP estimate: Rural sanitation



Scale of rural sanitation challenge

Category	2015 Rural sanitation coverage			2012 Population
	Per cent	Households	Population	
Open defecation	66%	47,559	299,624	143,700
Unimproved sanitation facilities	19%	13,691	86,255	107,000
Shared sanitation facilities	0%	0	0	61,100
Total without improved sanitation	**85%**	**61,251**	**385,879**	**311,800**

Source: 2015 JMP estimate; United Nations Population Division (2014) Annual Rural Population – 2015.
Source: 2009 Population and Housing Census.

Rural: improved sanitation coverage

The JMP estimate suggests no change in improved sanitation coverage in rural areas between 2000 and 2015. Open defecation is still high at 66 per cent in rural areas with more than 47,000 rural households (300,000 people) not using any form of sanitation facility.

Where is CLTS implemented and by whom

CLTS status and geographic spread

Introduced by an Australian Volunteer for International Development (AVID) with support from the Government's Environmental Health Division (Rural Water Supply and Sanitation Program) in May 2012 in two communities in Malaita province.

In 2013, the UNICEF brought Kamal Kar to the Solomon Islands to introduce CLTS and conduct a CLTS national training of trainers workshop with representatives from Government and a range of NGOs. During this workshop, eight communities close to Honiara were triggered; four of these were included in the World Vision peri-urban WASH programme and continuous programme support has been provided. The other four communities were in the UNICEF and Live & Learn project school areas, but no specific CLTS follow-up was done.

Currently the two main implementers are World Vision Solomon Islands (Temotu 20 villages; Makira 10 villages; Guadalcanal five villages), and Live and Learn (five villages in Isabel). UNICEF provides support to both NGOs and Government.

CLTS is yet to be implemented at scale beyond the pilot stage, however in February 2014, a national Rural WASH Policy was endorsed stipulating a no-subsidy approach, and in March 2015, a five-year national RWASH Strategy was approved which focused on nation-wide roll-out of a standardized CLTS approach.

CLTS institutional coverage

National NGOs	International NGOs	Bilateral programmes	Multi-lateral agencies	Government
MAJOR EXCEPTIONS Subsidy programmes ADRA Rotary Club Caritas Churches Constituency Development Fund	World Vision, Red Cross, Live and Learn, Save the Children		UNICEF	Ministry of Health and Medical

CLTS variations and practice

Almost all CLTS programmes in Solomon Islands are modified: in some communities CLTS is used in combination with PHAST; NGOs specify how communities should construct latrines and handwashing facilities; indirect subsidies may also be included.

CLTS scale

CLTS has been implemented in four out of nine provinces but on a small scale with approximately 50 out of 1,800 communities triggered (2.7 per cent). No communities have achieved ODF status yet.

CLTS capacity

A total of 41 CLTS facilitators have been trained in the Solomon Islands, with about five facilitators still active.

CLTS scorecard

ENABLING ENVIRONMENT			
Policy CLTS in government policy		National RWASH Policy (Feb. 2014)	CLTS is identified as one participatory approach that can be used to improve sanitation coverage. The policy is endorsed, and is in the early stages of implementation. The policy's vision is for all Solomon Islanders to have easy access to appropriate sanitation, as delivered through participatory zero-subsidy approaches. Subsidies will still be considered "where the only environmentally appropriate technical solution falls outside the financial means of the average household (e.g. Compost toilets, toilets suitable for people with disabilities), education facilities and health facilities".
Strategy CLTS targets in government strategies or development plans		National RWASH Strategy (March 2015)	The five-year national RWASH Strategy approved in March 2015 focuses on a nationwide rollout of a standardized CLTS approach and has targets for nationwide sanitation coverage by 2024. 100 per cent ODF status is required.
Leadership CLTS led by government		SIG Leading Policy, Strategy and Targets	The Solomon Islands Government (SIG) with support from UNICEF has led the setting of CLTS strategies and targets. In the next phase, SIG will lead the coordination of the National RWASH Strategy, with support from provincial teams and NGOs. The SIG MoH and Medical Services (MHMS)/Environmental Health Department (EHD) will focus only on contracting and the M&E of the RWASH in the country, and software components of CLTS.
Finance CLTS financed by government		Ministry of Health and Medical Services funding for implementation	For 2015, the SIG MHMS has allocated approximately 17 per cent of the Environmental Health Budget for CLTS. Of this, 41 per cent is for consultancy/staff, 23 per cent for transport, and the remainder for supplies.

ENABLING ENVIRONMENT *(continued)*			
Coordination Mechanisms for stakeholder coordination		WASH Stakeholder Group	A Government coordinated WASH Stakeholder Group meets quarterly. CLTS and National RWASH policy objectives are included in discussions. A National Sanitation and Hygiene Campaign Technical Working Group was formed in 2015 to progress demand-led sanitation programmes, including CLTS.
IMPLEMENTATION AND SUSTAINABILITY			
Integration CLTS integrated with other approaches			Limited implementation and therefore no integration with other programmes as yet.
Triggering Standardized facilitator training			No standardized facilitator training as yet, but there is ongoing development by the MHMS. Following the approval of the National RWASH Strategy, standardized training modules and methods will be developed.
Facilitator quality control			Facilitators are employed by partner NGOs. There is no systematic performance and feedback mechanism for quality of CLTS facilitation, however it is assumed that NGOs monitor performance. UNICEF developed a database of CLTS trainers, which will be maintained by SIG in the future.
ODF Clear ODF criteria			There is no nationally adopted ODF criteria, however this will be specified as part of the development of the national RWASH Strategy.
Verification protocol			No verification protocol has been agreed yet. It is to be developed under the RWASH Strategy, and will involve standard criteria and designation of responsibilities e.g. NGO programme managers and provincial RWASH managers.
Post ODF support			Not yet defined; no community has achieved ODF status
Technical support Availability of products and services			Technical resources are still being established and it is anticipated that these will be provided throughout the implementation of the CLTS approach. There are plans to strengthen the sanitation supply chain in the next 2-3 years, but CLTS implementation is only in infancy.
MONITORING AND EVALUATION			
Monitoring Robust and regular monitoring of ODF achievements			None. A monitoring system will be developed after the pilot project in the central province and NGO project sites in other provinces reach full scale. Monitoring will be coordinated at the national level, but implemented at a provincial and community-level through Government and service delivery partners. The guidelines for monitoring are yet to be established. Initially, monitoring will be done manually, although the government is investigating a combination of manual and electronic data collection for the future.
Post ODF monitoring of quality and sustainability			No ODF communities.
Evaluations and knowledge sharing Evaluations, reviews and learning		CLTS Triggering	Two evaluations of CLTS triggering are available, but no documented evaluations post-triggering. Lessons can be shared in the WASH Stakeholder Group.
Information on costs and resources for CLTS			Not available due to the limited implementation of CLTS. The costs of scaling up to meet SIG target of ODF in 10 years has not been calculated. MoH's Strategic Plan for rural Water supply, sanitation and hygiene (NHMS 2015) identifies US$ 6 mil plus technical assistance to deliver the CLTS approach.

Most significant changes since 2012

1 National RWASH Policy and Strategy	The country has now identified the need for large scale improvements in sanitation, as reflected in funding for the sector and government policy. The RWASH Policy and Strategy endorse CLTS as a method of implementation and ODF as a target, and intend to resolve a number of the previous barriers to addressing the lack of sanitation and poor health status.
2 CLTS trials	The number of triggered communities has increased since 2012. This experience allows lessons learned to be fed into national strategies and guidelines for scaling up.

Lessons learned

1 Continual engagement	Better results are achieved when implementers continue to monitor, interact and work with communities to achieve ODF status. CLTS does not stop at triggering and sustained community interaction is needed throughout the process until the community reaches ODF.
2 Triggering	Triggers that work best to mobilize the community include: disgust (after the demonstration of flies landing on faeces); desire for good health of children; and medical costs.

CLTS weaknesses and bottlenecks

1 Lack of coordinated national approach	While the National RWASH Policy and Strategy help guide the sector there is still no coordinated national approach for CLTS.
2 Ad hoc implementation	CLTS is still implemented on a small scale without the deliberate targeting of priority areas. Location depends on where implementing NGOs operate and where pilots are accessible for implementation and monitoring.
3 Lack of monitoring and review	There is no systematic review, monitoring, and sharing of lessons from implementation.

CLTS opportunities over the next 3-5 years

1 Scaling up and improving sanitation coverage	Clear commitment to CLTS in SIG policy, proposed sector coordination through RWASH, and sufficient resources, provides an opportunity for CLTS to be used consistently across the country to achieve ODF. There are currently no ODF communities in Solomon Islands, so there are opportunities for CLTS to improve sanitation coverage. It is believed CLTS will spread rapidly once triggered and people know they have been ingesting faecal matter.
2 Economic and gender benefits	CLTS provides an opportunity to improve family health and economy, prevent harassment of girls and women using remote latrine locations, facilitate menstrual hygiene privacy for women and girls, facilitate other economic benefits such as savings and reduce security risks for vulnerable people.

TIMOR-LESTE

TIMOR-LESTE: Country CLTS overview

CLTS summary

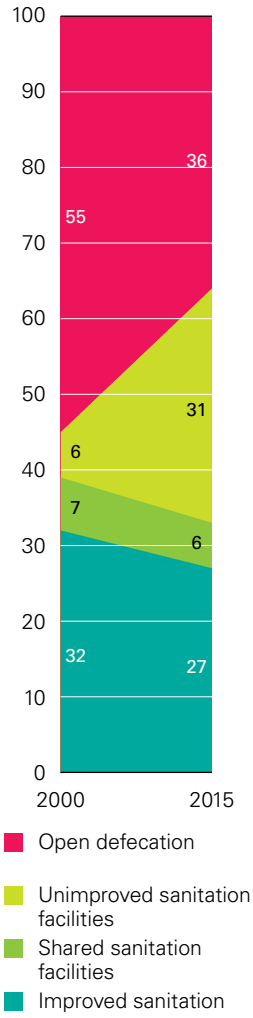
		2012	2015
Status and scale	CLTS date of introduction	2007	Not yet
	CLTS spread: % of country	100%	100%
	CLTS in urban areas	No	Yes
	CLTS coverage: major organizations	10	7
	OD population rural *(2010 and 2015, mill)*	0.27 m	0.28 m
	Villages triggered *(number)*	761	1,000
	ODF villages *(number)*	262	602
	Capacity developed *(trained facilitators)*	85	200
Enabling	CLTS in government policy	Yes	Yes
	CLTS targets in government plans	Draft	No
	CLTS financed by government	Indirect	No
	CLTS integrated with other approaches	May be	Yes
	CLTS sustainable monitoring	Yes	No
Effectiveness	ODF success rate	34%	60%

Scale of rural sanitation challenge

Category	2015 Rural sanitation coverage			2012 Population
	Per cent	Households	Population	
Open defecation	36%	51,603	283,818	269,400
Unimproved sanitation facilities	31%	44,436	244,399	295,500
Shared sanitation facilities	6%	8,601	47,303	50,400
Total without improved sanitation	**73%**	**104,640**	**575,520**	**615,300**

Source: 2015 JMP estimate; United Nations Population Division (2014) Annual Rural Population – 2015; 2010 UN Population Forecast.

JMP estimate: Rural sanitation



Rural: improved sanitation coverage

The JMP estimate suggests improved sanitation coverage in rural areas at 27 per cent in 2015. While this appears to be a decline since 2000 it is more of an adjustment between the proportion of improved and unimproved facilities during this period. Importantly, open defecation rates have fallen by a third, from 55-36 per cent in 2015.

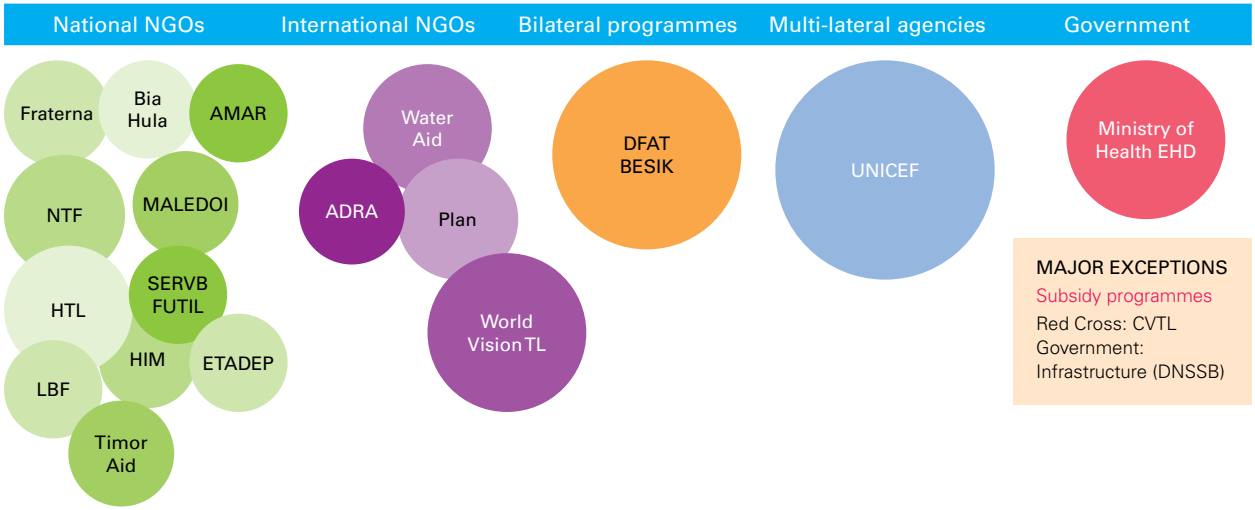
Where is CLTS implemented and by whom

CLTS status and geographic spread

Introduced by WaterAid in 2007. Since then, CLTS has spread to all 13 districts in Timor-Leste (100 per cent geographical spread), and to approximately 80-128 *sucos* (villages) out of 401 rural *sucos* (20-30 per cent).[20]

[20] Sector Planning Tool July 2015 records 80 *sucos*, while development partners separately estimated a total of 128 *sucos*.

CLTS institutional coverage



Since 2012 there has been a consolidation of local NGOs implementing CLTS with both local and international NGOs leaving the sector. UNICEF is implementing in six districts, the DFAT BESIK programme is in one district (Bobonaro), Plan International and WaterAid are implementing in two districts each, while World Vision is working in three districts, and ADRA has limited presence in two sub-districts in the Viqueque district. BESIK supports the secretariat for coordination of the Bobonaro district ODF plan, which is the only district to have a district-wide plan for achieving ODF. In Bobonaro out of five administrative posts (50 *sucos*) BESIK is taking care of three administrative posts (25 *sucos*), UNICEF one administrative post (18 *sucos*) and World Vision one administrative post (seven *sucos*). BESIK and UNICEF also provide support to the MoH to coordinate CLTS nationwide. The MoH stopped implementing in early 2015.

CLTS is being implemented in semi-urban settings such as district and sub-district headquarters but not in major urban areas such as the capital city Dili.

Major non-CLTS programmes

Cruz Vermelha de Timor-Leste (CVTL) is the national branch of the Red Cross, which receives substantial WASH finance through the international Red Cross network, and is an influential stakeholder in both the emergency relief and development sectors in Timor-Leste. CVTL has favoured a subsidy-based approach to sanitation improvement, and remains one of the key stakeholders not implementing CLTS. A recent review of its subsidy approach showed sanitation coverage initially of 85 per cent, with slippage to about 86 per cent of that, resulting in a final coverage estimated at 73 per cent. CVTL is working in several districts across the country and the subsidized approach is negatively impacting on districts and communities where CLTS is also being promoted.

World Vision Timor-Leste is new to CLTS and transitioning from a subsidized approach to a completely non-subsidized approach and is training staff to adapt to CLTS. In one of the three districts where it operates, Aileu, World Vision provides subsidies for concrete slabs to the village WASH committee who distributes them to most families, however this on a very small scale covering only a few villages.

The Ministry of Public Works' National Directorate for Basic Sanitation (DNSB) has in the past had funding for latrine subsidies to vulnerable households, however without a system in place for the distribution of these subsidies or agreed criteria for vulnerable households no subsidy latrines were built. DNSB had planned to support 86,000 vulnerable households, however this would have seriously undermined CLTS and caused high expectations for support in every community. Currently DNSB has no funding for vulnerable households but together with partners is developing systems to target subsidies through post-ODF incentives to move up the sanitation ladder, and SMART subsidies.

CLTS variations and practice

PAKSI

BESIK has supported the MoH in delivering a PAKSI programme that includes hand washing with soap, with a major HWWS campaign in 2012-2013. PAKSI (Participatory Community Action to Sanitation and Hygiene – In Tetun language) is a localized version of CLTS. PAKSI evolved in 2012 from the lessons of the early CLTS experiences in Timor-Leste; the phased sanitation approach in the National Basic Sanitation Policy; the success of the DNSA community action planning (CAP) approach to water supply development; and the decision that the MoH district offices should lead the process. The PAKSI approach is a participatory process for community-based ignition, planning and action to stop open defecation and wash hands with soap. PAKSI includes a form of CLTS modified to suit Timorese conditions and cultural sensitivities, notably by focusing on disgust rather than shame as the main trigger for behaviour change, and is a structured approach designed to be easier for field workers and communities to understand and support.

Schools WASH

CLTS is integrated with WASH in schools.

Nutrition

UNICEF/World Food Programme/MoH are leading an EU-funded nutrition project in three districts. UNICEF is implementing CLTS in all three districts (together with BESIK and World Vision in Bobonaro; alone in Ermera and together with Plan in Ainaro) and leading the integration of nutrition and CLTS. Partners are currently working out how to develop comprehensive behaviour change messages that include WASH and nutrition and are properly sequenced. DFAT may also trial an integrated nutrition and WASH approach in Manufahi. In Timor-Leste, where there is severe child malnutrition, sanitation partners are interested in integrating the two disciplines in a more systematic way and sanitarians and nutritionists using the same language.

Institutional triggering

In 2015 in Bobonaro district Kamal Kar facilitated an institutional triggering that succeeded in engaging the District Administrator to take the lead around engaging local government (Administrative Post, Suco, and Aldeia) in mobilizing communities to participate in PAKSI. A road map for ODF Bobonaro has been developed under the leadership of the administrator and BESIK; UNICEF and World Vision are supporting the plan on the ground.

CLTS scale

From current data sources (SIBS water and sanitation information system, and SPT Sector Planning Tool) it is difficult to calculate the number of CLTS triggered communities *(aldeia)*, but it is thought to be more than 1,000.

ODF success rate

Implementing partners in Timor-Leste estimate that 602 communities are ODF. Reaching ODF takes a community between two months and one year, with UNICEF reporting 4-9 months.

Indications are that CLTS is having a significant impact on sanitation access and also sustainability of ODF behaviour. An end-line survey of 55 communities (5,000 families) conducted by UNICEF in December 2014 found a slippage rate of 27 per cent (3-42 per cent reversion). 60 per cent these ODF *aldeias* (33 no.) had less than a 10 per cent reversion two to three years after ODF declaration. There had been a substantial decrease of open defecation by communities in project target areas and moderate improvement building permanent latrines to move up the sanitation ladder.

All *sucos* of four sub-districts (two each from Aileu and Ermera) were verified and declared ODF but there is a reversion of 3-10 per cent. Overall open defecation was reduced from 73 per cent to 9 per cent (Liquidoe, Aileu District) and 88 per cent to 3 per cent (Railaco, Emera Disrict).

District (Average)	Baseline KAP 2011 November	Endline KAP 2014 December
	OD practices by families	OD reduced to
Ermera	71%	4%
Aileu	30%	10%
Manatuto	64%	53%
Viqueque	70%	58%
Oecusse	66%	37%

In Alieu district CLTS has been the dominant approach in the municipality since 2010. In 2009, the sanitation coverage rate for the district was estimated to be 20 per cent, in 2015, the estimated coverage is at least 85 per cent, even with slippage taken into account.

Successful triggers include: disgust; privacy, convenience, desire for good health and the stigma of continuing open defecation. BESIK has found some success in triggering around adopting using a toilet as a new social norm where institutional triggering has been done i.e. Bobonaro.

CLTS capacity

Approximately 200 CLTS facilitators have been trained to date, including 65 who were trained by Kamal Kar in 2015 and of whom 15 were invited back to a more in-depth training in May 2015 to establish a PAKSI Quality Control/Support Team for PAKSI implementers in Bobonaro. Of all the trained facilitators nationwide, about 55 facilitators are still active, including 15 in WaterAid and 20 in UNICEF and five with Plan and its local NGO partners. Attrition is often due to NGO staff moving to a new unrelated job. A core group of 10-15 'super trainers' exists, who are highly competent trainers and CLTS facilitators.

CLTS scorecard

ENABLING ENVIRONMENT			
Policy CLTS in government policy		National Basic Sanitation Policy (2012)	Policy outcome is "an open defecation free environment" with ODF *sucos* being category 1 of 4 levels: • ODF *sucos* • Hygienic *sucos* (100 per cent latrine and handwashing coverage) • Litter free *sucos* (free of indiscriminate solid waste) • Foul water free *sucos* (free of wastewater run-off) The policy allows for household sanitation facilities to be subsidized where households are disadvantaged (according to criteria to be set by Ministry of Social Solidarity). ODF *sucos* are defined as having excreta-free open spaces, excreta-free drains, excreta-free water bodies, and excreta-free institutional buildings.
Strategy CLTS targets in government strategies or development plans		MoH Annual Plan	No national strategy with targets for achieving ODF communities. MoH's Annual Action Plan includes PAKSI but for institutional support only, with BESIK providing almost all the budget for the achievement of this annual plan. A draft National Strategic Sanitation Plan was prepared in 2012, which set targets for each of the four categories in the M&E framework of the National Basic Sanitation Policy. This draft is currently being revised.
Leadership CLTS led by government		Some leadership by MoH	MoH takes the lead, sets strategies and targets, and is responsible for monitoring and verification. However there is no budget for promoting CLTS. The sector receives considerable support from UNICEF and BESIK on strategy development, logistics, training, monitoring and verification. NGOs are implementing under contract to partner agencies.
Finance CLTS financed by government		No government financing at national or district level	No fund allocated from government budget at the national or district level. BESIK provides budget for sanitation to the MoH. MoH has committed to absorb salary costs for 10 Sanitarians in 2016. The National Health Institute has allocated funds to cover the training of PAKSI trainers in 2015.

ENABLING ENVIRONMENT *(continued)*			
Coordination Mechanisms for stakeholder coordination		Sanitation working group	CLTS issues are included in sanitation working group meetings with MoH, DNSB, funders (including BESIK and UNICEF) and NGOs.
IMPLEMENTATION AND SUSTAINABILITY			
Integration CLTS integrated with other approaches		Limited integration	Integrated with handwashing, school WASH and with district level triggering but on a limited scale.
Triggering Standardized facilitator training		Local Facilitation Guidebook Accredited training module	MoH PAKSI Facilitation Guidebook includes three modules: Pretriggering, Triggering, and Follow-up and is used by implementers. The National Health Institute (INS) has accredited a 6-day PAKSI Facilitation Training course and a 10-day Advanced PAKSI Facilitation Training course for a Quality Control Team. BESIK is helping INS and MoH to develop workplace-based assessments on the quality of facilitators and identify further training/mentoring needs.
Facilitator quality control		Project checks	Currently implementing partners are responsible for their own quality control through facilitator checks and feedback. Establishment of a PAKSI Quality Control team, which is trained to monitor the quality of PAKSI delivery and provide mentoring support based on identified needs is underway by MoH. With support from development partners (BESIK, UNICEF, WaterAid, Plan). The PAKSI Quality Control Team is composed of sanitation NGO and Government partners.
ODF Clear ODF criteria		National ODF Guidelines	National ODF guidelines prepared through MoH include: • All households have access to a toilet. • All family members (not including babies) use the toilet. • Water and soap near the toilet for HWWS (not an ODF criteria in the sanitation policy). • All schools have a working toilet. The guidelines lack clarity around the definition of family and household, and whether all households should have toilets or sharing is permitted. Interpretation of the criteria varies.
Verification protocol		No verification protocol	There is no harmonized and agreed criteria for ODF verification and declaration. District BESI team (district water, sanitation and hygiene (WASH) coordination committee) involving district level departments of the MoH, Ministry of Public Works (water and sanitation directorate) and MoE is responsible for verification. Local NGOs implementing CLTS facilitate the process and suco and *aldeia* leadership also participate. The certification of ODF is issued by the district public health office. However this system is not common for all implementing partners. There is no mechanism to withdraw ODF certification status and re-verify. Developing standard operating procedures for ODF verification and declaration for all sanitation partners is a priority for the MoH.
Post ODF support		No standard approach	There is no post-ODF support plan in place, but the need to have a plan as soon as possible is recognized. Implementers have different approaches from no follow-up to others such as WaterAid monitoring ODF villages with six monthly checks (village checks and meetings, some sample households) for two years after ODF. BESIK is working with the MoH, DNSB, and MSS to develop a system for advancing the sanitation improvement framework, to be piloted in Bobonaro. Following ODF achievement, ODF must be sustained for six months before the next level of achievement is considered.

IMPLEMENTATION AND SUSTAINABILITY *(continued)*			
Technical support Availability of products and services		Weak product availability and slow uptake of sanitation marketing	A very limited range of sanitation products is readily available. Efforts at sanitation marketing have been very slow or not worked so far due to over complexity, small scale, lack of buy-in from district authorities and weak enabling environment for triggering and CLTS. BESIK is working with DFAT's Market Development Facility, a private sector creation/support programme, to increase access to the sanitation supply at the municipal level and administrative post level. Progress with this is slow. Other efforts include World Vision's ecosan pilot in Aileu, small-scale sanitation marketing by local business groups (and local vendors. UNICEF has implemented a small-scale business group approach in three districts however it could not be scaled up due to the high costs of the latrine product (40 US$ per set) and transportation (30 US$ per set) for squatting slabs and rings for pit latrines.
MONITORING AND EVALUATION			
Monitoring Robust and regular monitoring of ODF achievements		1 SIBS: Rural Sanitation Information System 2 SPT: Sector Planning and Reporting Tool	No agreed national monitoring systems for ODF monitoring. ODF data are fed into SIBS (Rural water and sanitation information system), run by DNSA/BESIK, but this is not up to date. SIBS includes *aldeia* level monitoring, but field monitors lack training in ODF definitions and ODF is inaccurately reported. Input to a Sector Planning Tool includes annual partner activities and ODF. There have been some attempts to collect SIBS data through SMS (electronically), but they have not been successful. In project areas, implementing agencies manually collect data, and prepare and submit the monitoring report.
Post ODF monitoring of quality and sustainability		Very limited	Monitoring of ODF sustainability is limited to individual implementers. UNICEF's end-line survey report shows some communities relapsed to open defecation from ODF status but the reasons for slippage are yet to be identified.
Evaluations and knowledge sharing Evaluations, reviews and learning		Limited recent learning	Limited shared learning and evaluations on CLTS. • UNICEF KAP baseline 2011/end-line 2014 study in 55 *aldeias* highlights ODF sustainability (e.g. just 4 per cent slippage in two subdistricts in Emera). • CVTL 2014 learning study on sanitation reports that the subsidy method is better than CLTS because sanitation is more sustainable, however this is at household level and not ODF communities. The selection of communities was done by CVTL and independence may be compromized. • MoH wants to have an impact evaluation of CLTS in the near future, possibly using a recent Plan study methodology. The sector lacks a common strategic approach.
Information on costs and resources for CLTS		No standard costs	• There are no standard costs for reaching ODF in communities, although partners believe this could be a worthwhile pilot for the future in order to know the level of effort and cost to scale up. UNICEF estimates the cost of achieving ODF, including verification, is US$ 800-1,200 per *aldeia* (or community) of 60 families (i.e. about US$ 13-20 per family), based on NGO contracts. UNICEF overhead costs are not included. • MoH estimates approximately US$ 12,500/*suco* (4-5 *aldeais* per *suco*) to contract an NGO to implement PAKSI. This does not include the cost of sub-district Sanitarians.

Most significant changes since 2012

1 New types of triggering	Institutional triggering has been introduced to motivate district authorities and to increase awareness on sanitation issues. In Bobonaro this is showing positive signs. Separate triggering sessions with children have been tried and are showing influence on parents.
2 Improved facilitation skills	Facilitator skills have been improved through training, particularly focusing on pre and post triggering. Five batches of trainings to improve facilitations skills involving 200 facilitators have been held, with three of these trainings facilitated by Dr. Kamal Kar and his associates from CLTS Foundation.
3 Improved coordination	Improved coordination among CLTS implementing agencies. This has been achieved through implementation of five joint training of facilitators. Partners are also doing joint planning for achieving ODF in Bobonaro district, and this process has potential to be expanded to other districts.
4 Greater acceptance of CLTS	CLTS (PAKSI) is gaining acceptance and popularity among the district authorities and communities; e.g. communities and authorities have started using the term "*tae*" (meaning 'faeces' in the local language).

Lessons learned

1 Government leadership is needed to scale up	CLTS is still INGO and UNICEF-led, and government, especially MoH, is highly dependent on donors. Without Government's strong commitments, especially from the decision makers, it will be difficult to expand CLTS nationwide. There is a need for government to allocate dedicated budget for monitoring and follow-up of CLTS activities with adequate human resources in the Environmental Health Department (EHD) of MoH. Without a strong, committed and equipped EHD, CLTS cannot be led effectively by EHD.
2 Subsidies undermine CLTS	Household subsidy is still practised by CVTL which works in many communities across number of districts and undermines CLTS to some extent. The modality of subsidy by CVTL needs to be changed (it could be an incentive to move up the sanitation ladder after ODF).
3 Sector actors need common understandings and goals	There is no comprehensive common understanding or analysis of the rural sanitation sector yet and no common path forward. Implementing partners see parts of the problems and solutions but there is a need for everyone to join hands to remove the bottleneck and barriers in a synchronized manner. There is no costed strategy (or action plan/road map) for sanitation with a clear target of ODF for Timor-Leste by a target date. Agencies and partners are still talking about sanitation for all by 2030 (as per Government's Strategic Plan 2011-2030), however this target is very ambiguous and farsighted. An interim target of ODF Timor-Leste is needed much earlier than 2030 to drive action and resource allocation. All partners need to use the same approach.
4 Pre-triggering of government institutions can unlock doors	More effort is needed on institutional triggering as this has been neglected in the past. By engaging municipal administrators this connects through line responsibility down to *suco* chiefs and is a way of opening doors to lower levels of government. More work is needed on identifying and accessing the entry points to local government (sub-district and *suco* level) decision-making meetings and how CLTS can be introduced at the pre-triggering phase. From Bobonaro it was found that working with *suco* councils rather than just *suco* chiefs gives access to two women's representatives and a youth representative who can support sanitation in their communities more effectively than just relying on *aldeia* chiefs.

CLTS weaknesses and bottlenecks

1 Capacity of facilitators	Lack of skilled and committed facilitators is still a major problem.
2 Few CLTS implementers	Lack of partners due to funding uncertainty for CLTS activities. Only few international agencies (e.g. UNICEF, Plan and WaterAid) are committing to expanding CLTS in their project districts. There is no firm commitment from Government to fill the coverage gap (no funds set aside from Government for scaling-up CLTS activities).
3 Weak monitoring	Limited monitoring from the Government for CLTS activities implemented by international agencies (INGOS, UNICEF etc.). Lack of follow-up plan after ODF for supporting communities to sustain the behaviour. No overall reliable database for assessing progress and sustainability. There is a need to take stock of what has been achieved in districts since the start of CLTS to learn from successes and failures, and improve SIBS so that it can be better used as a tool for monitoring.
4 Mindset on subsidies	Some of the key DNSA staff (and other Government e.g. ministers/vice ministers) see CLTS toilets as inferior and that subsidies are needed with sanitation marketing. A change in mindset of government as well as some implementers is needed.
5 Lack of integrated approach	There is no integrated approach with all the elements in place needed to make CLTS work – e.g., strategy and targets, product availability, institutional buy-in, and Behaviour Change Communications. The enabling environment is not in place and no analysis has been done on what is required e.g. bottleneck analysis.
6 Weak information	The sector is lacking in joint analysis, reflection, and problem solving on CLTS. A common understanding of barriers and the way forward does not exist. The known enablers are not identified – why have some aldeias become ODF and stayed that way? The learning of successes is not being captured.

CLTS opportunities over the next 3-5 years

1 Integrating CLTS and nutrition	Timor-Leste has the highest under five stunting rate (50.2 per cent). The Government of Timor-Leste and some funding agencies (e.g. EU) are working together to improve its nutrition status. There is a window of opportunity to advocate a link between malnutrition, poor sanitation and hygiene (especially open defecation) and garner support for sanitation (CLTS) as a pre-requisite for improving the nutrition status among children. Donor agencies are doing this but have not been able to convince the Government to allocate funds for sanitation yet. There is a need for additional work in this area.
2 Institutional structure	Supportive institutional set-up. Government structures run all the way down to the *aldeia* level, with each level having an elected representative. If the national authority gives adequate support and direction, expanding CLTS should not be a major problem.
3 Small size of country	Timor-Leste is a small country, and all villages are accessible within a few hours travel from the district headquarters. This has advantages for the spread of information and materials which needs to be capitalized on.

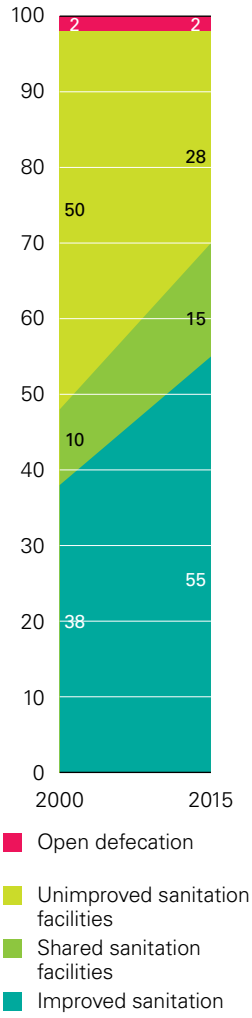
VANUATU

VANUATU: Country CLTS overview

CLTS summary

		2012	2015
Status and scale	CLTS date of introduction	Not yet	Not yet
	CLTS spread: % of country		
	CLTS in urban areas		
	CLTS coverage: major organizations		
	OD population rural *(2010 and 2015, mill)*	0.003 m	0.003 m
	Villages triggered *(number)*		
	ODF villages *(number)*		
	Capacity developed *(trained facilitators)*		
Enabling	CLTS in government policy	No	No
	CLTS targets in government plans	No	No
	CLTS financed by government	No	No
	CLTS integrated with other approaches	No	No
	CLTS sustainable monitoring	No	No
Effectiveness	ODF success rate		

JMP estimate: Rural sanitation



Scale of rural sanitation challenge

Category	2015 Rural sanitation coverage			2012 Population
	Per cent	Households	Population	
Open defecation	2%	796	3,899	3,560
Unimproved sanitation facilities	28%	11,139	54,583	51,600
Shared sanitation facilities	15%	5,968	29,241	26,700
Total without improved sanitation	**45%**	**17,903**	**87,723**	**81,860**

Source: 2015 JMP estimate; United Nations Population Division (2014) Annual Rural Population – 2015; 2012 UN Population Forecast.

Rural: improved sanitation coverage

The JMP estimate suggests a recent increase in improved sanitation coverage in rural areas of Vanuatu from a baseline of 32 per cent in 1995 to 38 per cent in 2010, and 55 per cent in 2015. Currently 43 per cent of the rural population use either shared sanitation facilities or unimproved facilities. The open defecation rate was estimated to be only 2 per cent, and is unchanged since the last review in 2012. This suggests that fewer than 800 rural households (3,900 people) do not use any form of sanitation facility.

Recent data suggest Vanuatu is expected to meet its MDG7 target for sanitation sometime in the 2016-2020 period, just missing the sanitation MDG in 2015.[21] The rural sanitation MDG will just be met, while for urban areas, access to improved sanitation has decreased in recent years.

Sanitation facilities were also damaged or destroyed following Cyclone Pam in 2015.

Where is CLTS implemented and by whom

CLTS status and geographic spread

CLTS has not been introduced into Vanuatu.

[21] ADB, *Key Indicators for Asia and the Pacific 2014*, p116 http://www.adb.org/sites/default/files/publication/43030/ki2014-mdg7.pdf

In 2013 UNICEF initiated possible twinning within the Pacific by sponsoring three participants from Vanuatu (UNICEF, MoH, and a rural training centre representative) to participate in CLTS training by Kamal Kar in the Solomon Islands. All participants were PHAST trainers and saw the potential of CLTS as an approach, however no national trainings have been held due to the limited applicability of CLTS to the sanitation situation in Vanuatu.

With very low rates of rural open defecation CLTS is not seen as a suitable approach for Vanuatu and the preferred focus is on upgrading from unimproved sanitation (including open pits and shared facilities) to improved sanitation by climbing the sanitation ladder. Other methods such as sanitation marketing and PHAST are considered more applicable.

Institutional setting

The MoH has responsibility for rural sanitation with support of the Department of Geology, Mines and Water Resources. Urban sanitation is the responsibility of municipal authorities.

The MoH's National Environmental Health Policy and Strategy 2012-2016 includes water, hygiene and sanitation as one of its core health prevention strategies, specifically aimed at MDG7 for increasing access to improved sanitation. The strategy has a goal of 80 per cent of the rural population having access to improved sanitation by 2016. The strategy to achieve this is by developing national sanitation standards (VIP, water seals, water tanks, compost toilets, and septic tanks), and improving sanitation facilities in communities, schools and health facilities. The Healthy Islands approach is mentioned as one possible way to achieve the strategy. Communication approaches include developing IEC materials on sanitation, training Environmental Health Officers on WASH and National Sanitation Standards, and introducing the sanitation standards to communities. Although there is now more focus on behaviour change, the current strategy lacks detail on how to implement this and MoH needs to develop a standardized module of what effective hygiene promotion and behaviour change communication entails in order to standardize the approach across the country.

Major exceptions

1 Subsidies

While there is greater recognition of the cost of latrine subsidy programmes in Pacific island states and their failure at sustaining improved sanitation (the majority of subsidized latrines fall into disuse and disrepair after only a few years), subsidized models are still taking place in forms of bags of cement, or other sanitation components.

Some NGOs and church organizations still subsidize sanitation in some form. For example the Anglican Church of Melanesia with support from ABM is working with churches in Vanuatu to deliver clean water and hygienic toilet facilities to people in rural areas. This WASH project includes installation of Ventilation Improved Pit toilets (or VIP toilets) in schools, parishes and communities. Staff from the Anglican Church of Melanesia are training local youth in VIP toilet installation.

Live and Learn has developed an approach that combines sanitation marketing with PHAST and some elements of CLTS, although this is being implemented on a limited scale.

VIET NAM

VIET NAM: Country CLTS overview

CLTS summary

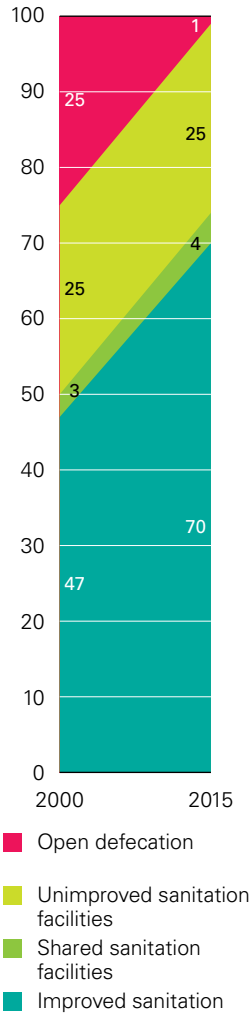
		2012	2015
Status and scale	CLTS date of introduction	2008	Not yet
	CLTS spread: % of country	29%	31%
	CLTS in urban areas	No	Yes
	CLTS coverage: major organizations	11	9
	OD population rural *(2010 and 2015, mill)*	3.7 m	0.6 m
	Villages triggered *(number)*	829	2,025
	ODF villages *(number)*	145	471
	Capacity developed *(trained facilitators)*	1,132	2,073
Enabling	CLTS in government policy	May be	Yes
	CLTS targets in government plans	No	Yes
	CLTS financed by government	May be	Yes
	CLTS integrated with other approaches	May be	Yes
	CLTS sustainable monitoring	No	Yes
Effectiveness	ODF success rate	17%	27%

Scale of rural sanitation challenge

Category	2015 Rural sanitation coverage			2012 Population
	Per cent	Households	Population	
Open defecation	1%	155,037	620,150	3,669,700
Unimproved sanitation facilities	25%	3,875,935	15,503,739	13,455,400
Shared sanitation facilities	4%	620,150	2,480,598	2,446,400
Total without improved sanitation	**30%**	**4,651,122**	**18,604,487**	**19,571,500**

Source: 2015 JMP estimate; United Nations Population Division (2014) Annual Rural Population – 2015; 2012 UN Population Forecast.

JMP estimate: Rural sanitation



Rural: improved sanitation coverage

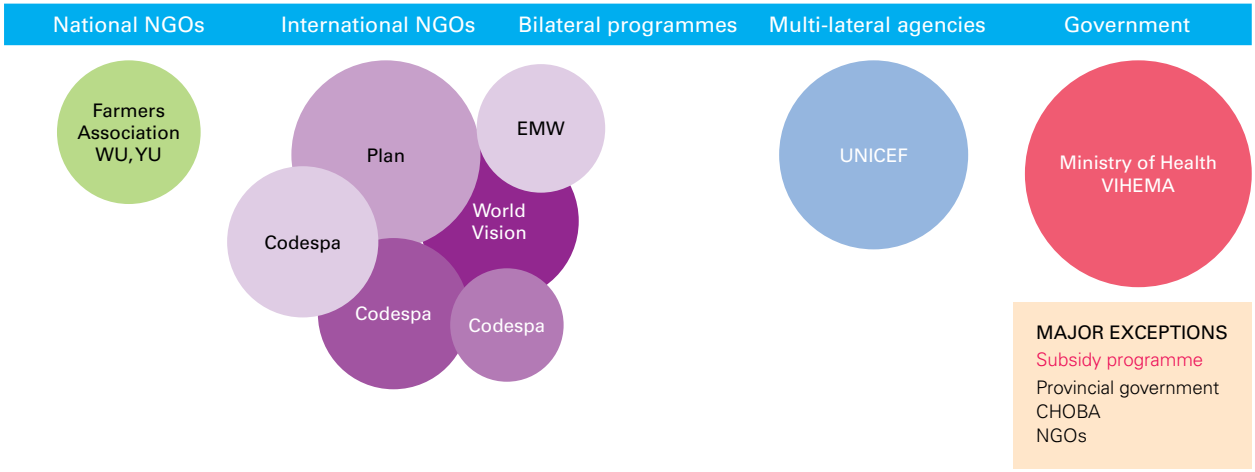
The JMP estimate suggests a rapid increase in improved sanitation coverage in rural areas from a baseline of 30 per cent in 1990 to 70 per cent in 2015. This is an impressive increase in improved sanitation coverage of 48 per cent in the last 15 years alone. According to the JMP open defecation has reduced from 43 per cent in 1990, to 25 per cent in 2000 and just 1 per cent in 2015. While there has been a significant decrease in open defecation this figure is somewhat misleading as it excludes fish pond latrines and other hanging latrines over rivers, which the Government of Viet Nam defines as unimproved latrines, rather than fixed point open defecation. From the JMP there are an estimated 155,000 rural households (620,000 people) who do not use sanitation facilities, but if fixed point open defecation is included then this number will be higher.

Where is CLTS implemented and by whom

CLTS status and geographic spread

Introduced by SNV in 2008. CLTS has since spread to 20 out of 64 provinces in Viet Nam (31 per cent nationally) in 2015, although in most provinces only selected districts are supported – representing about 15 per cent of the country. Selection of areas for implementation is based on high rates of open defecation, low rate of households with hygienic latrines and ethnic minority areas. With an upcoming World Bank/GOV Payments for Results loan programme – Scaling Up Rural Sanitation and Water Supply (SupRSWS) – support will increase through targeting of 19 of the country's poorest provinces located in the Northern Mountains and Central Highlands regions.

CLTS institutional coverage



The Vietnam Health and Environment Management Agency (VIHEMA) of the Ministry of Health is the lead agency for sanitation and a major implementer through seven UNICEF focus provinces and five Plan International supported provinces. VIHEMA provides training materials, low cost latrine designs, and guidelines for CLTS and sanitation marketing. Provincial Centres for Preventative Medicine support facilitator training in these provinces. World Vision is implementing CLTS in nine provinces, with Codespa and Child Fund also having a lead role. Child Fund has implemented CLTS in a total of 19 communes in two northern provinces since 2010. Church World Service (CWS) is implementing in three districts in Lai Chau and Thai Nguyen provinces. Several Viet Nam mass organizations such as Famers Association, Women's Union, Youth Union are also engaged in CLTS.

World Vision implements CLTS in peri-urban areas in Hung Yen province.

UNICEF has been instrumental in introducing CLTS within the provincial and national government systems through the DOH and MOH. This has largely helped CLTS as an official strategy for promoting sanitation. UNICEF has also introduced CLTS into the Government of Viet Nam's Rural Water Supply and Sanitation National Target Programs.

Major exceptions

Government

Over time, VIHEMA, as the practicing lead agency for sanitation is increasingly convinced the use of CLTS, SLTS and Sanitation Marketing is the way forward for sanitation promotion in Viet Nam. Previously subsidies were understood to be the way forward but the current understanding is on promoting more investment in community mobilization, follow up monitoring and leadership development. Some provinces are continuing to support subsidies for lowest income quintile households.

East Meets West (EMW) Community Hygiene Output Based Aid (CHOBA)

EMW uses CLTS as the approach to sanitation promotion but the CHOBA programme also encourages households to build improved household sanitation facilities and connect them with both approved local construction contractors and consumer lenders. Poor households are offered a consumer rebate (equivalent to 5-10 per cent of latrine cost) upon verification of a properly built and used toilet. Poor households must pre-finance the full latrine cost before receiving the rebate. Financial rewards are offered for the achievement of community-wide improved sanitation coverage benchmarks.

Church World Service:

CWS supports 30 per cent of the cost of latrine construction in Muong Te District in Lai Chau province. This is a very remote mountainous area in the northwest of Viet Nam, where many poor ethnic minority tribes live. Some communities have deeply entrenched traditional sanitation behaviours. In other districts CWS does not support any hardware costs.

CLTS variations and practice

CLTS is being integrated into:

Rural Water Supply and Sanitation Program National Target Program (NTP), National Patriotic Sanitation Movement; hand washing and sanitation marketing; and a Village Saving Loan programme of Plan International.

1 ChildFund: CLTS + PHAST

ChildFund is integrating CLTS with PHAST tools in order to provide knowledge about the relationship between hygiene and health as well as to enhance hand washing with soap practice and hygienic water usage. In order to raise the rate of households having hygienic latrines, activity will be combined with saving credits in the livelihood sector to improve economic conditions at the commune, with health sector to prevent malnutrition and water and environment sanitation related diseases. In addition, projects have conducted SLTS, CHAST, and activities advocating hand washing with soap at school.

2 SNV: Sustainable Sanitation and Hygiene for All (SSH4A)

SNV is implementing the SSH4A programme in five countries (Viet Nam, Lao PDR, Cambodia, Nepal and Bhutan). In Viet Nam, the SSH4A programme targets poor, ethnically diverse villages in the Northwest, using CLTS with additional components to provide information on sanitation options, behaviour change communication, increase access to low-cost sanitation goods and services, and improve WASH governance.

3 Plan International: Sanitation Marketing

Plan WASH combines CLTS triggering of villages to stop open defecation (OD) with the introduction of low cost options for sanitation (under Sanmark) to encourage people to make and use hygienic toilets (particularly pour flush toilets using concrete rings that can be made on-site using a mould from galvanized iron).

4 MoH and UNICEF: Community Approaches to Total Sanitation (CATS)

In Viet Nam, CATS is being implemented using interventions on CLTS, School Led Total Sanitation (SLTS), sanitation marketing and hand washing with soap. Supply chains and sanitation markets in the project areas are strengthened to meet and maintain the sanitation demand triggered by CLTS, and hand washing with soap is included to ensure that this critical faecal-oral disease transmission route is blocked.

CLTS capacity

Large numbers of CLTS facilitators have been trained in Viet Nam. Codespa reports that 700 CLTS facilitators have been trained under its programmes. The Ministry of Health and UNICEF have also supported the training of 900 CLTS facilitators, World Vision 250, Plan International 150, and ChildFund 73, making a total of 2,073 facilitators trained. Of these only 15 per cent are estimated to still be active.

CLTS scale

More than 2,020 villages have now been triggered using the CLTS approach, with the Ministry of Health efforts accounting for nearly 40 per cent of these triggered villages.

ODF success rate

CLTS is thought to be one of the most effective community mobilization models in sanitation promotion, and has resulted in a reduction of OD, and increased latrine coverage. Viet Nam's ODF success rate has improved from 17 per cent in 2012 to 27 per cent in 2015. The number of certified ODF villages reported is 120 for MOH; Plan International reported 188 including self declared villages without formal certification; 63 villages by Codespa, ChildFund 62, and World Vision has not yet conducted an assessment of the ODF villages. At least 468 villages are ODF which is just xx per cent of the villages triggered to date or between 15-69 per cent rate depending on the implementer. Time required to reach ODF is between six to 12 months depending on the location.

CLTS scorecard

ENABLING ENVIRONMENT			
Policy CLTS in government policy		1 National Target Program RWSS III Phase 2012-2015 Decision 366 2 Patriotic Sanitation Movement 3 VIHEMA (2013) National Guideline for Planning and Implementation on Rural Sanitation	1 CLTS included in the NTPIII's sanitation planning and implementation guidelines as an acceptable approach. Toilets are a household responsibility. "Focus on sanitation targets, particularly household latrines with priority to low-cost models and preferential credit to improve the access of the poor… Shift from IEC for awareness improvement to IEC for behavior changes". 2 The Patriotic Sanitation Movement being implemented in 30 provinces is designed to promote better sanitation in schools and the community and encourages communities to adopt hygienic habits and use toilets. 3 VIHEMA guidelines include "creation of collective demand for rural sanitation, such as community approaches (e.g. Community-Led Total Sanitation (CLTS)".
Strategy CLTS targets in government strategies or development plans		1 Resolution No. 05/NQ-CP dated 01/13/2014 2 Draft 5 year sanitation plan 2016-2020 3 Provincial plans	1 Resolution No 5 for promoting MDGs achievements, hygiene and sanitation targets. 2 The Government has a commitment for achieving 85 per cent of hygienic toilets by 2020, with the draft 5-year sanitation plan 2016-2020 including annual targets and roadmaps for ODF by 2025. The draft 5-year sanitation plan includes capacity building in sanitation for the health system. 3 CLTS is included in provincial sanitation plans in provinces with high rate of OD.
Leadership CLTS led by government		Ministry of Health	The Government, through the MoH – VIHEMA is taking full leadership of CLTS implementation at the national level, including developing guidelines, training etc. Centres for Preventative Medicine have responsibility at province level.
Finance CLTS financed by government		Limited government budget	Government provides a modest budget mainly for training and communication activities.
Coordination Mechanisms for stakeholder coordination		Sanitation Working Group	Annual review of CLTS included as part of sanitation working group under the leadership of VIHEMA and supported by UNICEF.
IMPLEMENTATION AND SUSTAINABILITY			
Integration CLTS integrated with other approaches		Integrated at programme and project level	• Rural National Target Program • National Patriotic Sanitation Movement • Hand washing • Sanitation marketing • Village Saving Loan programme (Plan International) • Integrated with PHAST tools to enhance hand washing with soap practice and hygienic water usage, saving credits in the livelihood sector, prevention of malnutrition and water and environment sanitation related diseases, SLTS (ChildFund)
Triggering Standardized facilitator training		MoH facilitator training	Standard CLTS training manual and supporting materials developed by MoH and used by implementers for training. The College of Agriculture and Rural Development is a centre for CLTS master training. A database of CLTS master trainers is maintained.
Facilitator quality control		Programme based	Method for facilitator quality dependent on implementing agencies. Quality is checked through on the job feedback, reflection and checklists by NGOs; with some monitoring and evaluation by provincial Centres for Preventive Medicine. No standard approach, or accreditation.

IMPLEMENTATION AND SUSTAINABILITY *(continued)*			
ODF Clear ODF criteria		Comprehensive ODF1 and ODF2 criteria developed by MoH and tested	Criteria developed by MOH and tested with stakeholders in seven provinces. Not yet nationally endorsed but criteria is comprehensive. Two stages: ODF1 includes all household members use latrines and safely dispose of children faeces, no traces of faeces in open places; at least 90 per cent households have latrines; 10 per cent households share latrines with others; 70 per cent of households have hand washing places with cleaning substance; community 'resolution on sanitation' to stop OD and use hygienic latrines; 'community monitoring group' established. ODF2 includes 90 per cent of households with hand washing and greater use of hygienic latrines. Criteria for commune and district ODF level 1 and 2 also established which includes WASH facilities in schools and health centres with a maintenance budget. ODF certification can be withdrawn at all levels if spot checks by health staff show violation of ODF criteria.
Verification protocol		MoH protocol developed and tested	Verification and certification protocol for village, commune and district level developed by MoH with technical assistance from UNICEF. Protocol has clear responsibilities and timeframes. Tested in seven provinces and being reviewed after feedback. Not yet nationally endorsed.
Post ODF support		Some post ODF reinforcement	Post ODF support includes on-going monitoring and in the MoH provinces, the ODF and latrine status is checked every six months. Follow-up contact occurs through later implementation of School-Led Total Sanitation and sanitation marketing in ODF villages. Post ODF follow-up is occurring but is not consistent across all implementers or systematically carried out.
Technical support Availability of products and services		Sanitation marketing	Most implementers introduce sanitation marketing through an informed choice of options to provide information for people. Some NGOs such as Plan International introduce sanitation marketing 6 months after triggering; others introduce immediately after triggering. Informed choice includes low cost technical options e.g. mould for concrete rings and toilet pan, sanitation marketing tools and guidelines. The poorest of the poor generally continued to face difficulties getting onto the sanitation ladder; better off move from pit latrine to pour flush. Product availability is the most difficult in northern mountainous areas.
MONITORING AND EVALUATION			
Monitoring Robust and regular monitoring of ODF achievements		Reporting protocols	Robust monitoring system developed at village, commune, district and province levels with reporting time frames. Management board of each level is responsible for planning, monitoring and synthesizing the plan for ODF verification and certification at their respective level. The monitoring plan is approved together with the implementation plan for ODF verification and certification. Village level monitoring and reporting each month. Provincial reporting to VIHEMA annually. The current national monitoring system focuses on HH latrine coverage only and there is no formal national system for tracking CLTS progress or performance. ODF monitoring will be introduced in the new guideline for 2015-2025. Manual recording with computerized data entry.
Post ODF monitoring of quality and sustainability		Draft guidelines for sustainability checks	MoH has guidelines for monitoring sustainability. Spot checks are carried out. The Qualitative Assessment of Sanitation study found HHs that used a latrine as a result of CLTS kept up this behaviour, if the latrine was in good repair, but sustainability proved a challenge where HHs primarily responded to CLTS by building simple pit and VIP latrines.

MONITORING AND EVALUATION *(continued)*			
Evaluations and knowledge sharing Evaluations, reviews and learning		Some reviews of CLTS	Viet Nam has conducted several reviews and evaluations on CLTS: • National review in 5 provinces 2011 (VIHEMA&UNICEF) • Regional review of CLTS in 2012 • National Qualitative Assessment study in 10 provinces including CLTS assessment 2013 (VIHEMA&WSP) • Provincial assessment in Quang Ngai 2013 (Plan International) Slippage not studied in detail but there is an understanding that some households built latrines but do not use them. Reasons are: ODF is not a social norm yet, weak leadership, lack of commitment, lack of water supply, temporary toilets, lack of regular follow-up. Reviews and assessments have been consulted and disseminated among relevant stakeholders at national and local levels.
Information on costs and resources for CLTS		Qualitative Assessment of Programmatic Approaches to Sanitation	Detailed costs per village are not available or benchmarked. The Qualitative Assessment of Programmatic Approaches to Sanitation in Viet Nam was conducted in 10 provinces by VIHEMA/WSP. The assessment shows that the cost of CLTS per commune – irrespective of commune size – varies widely from US$ 1,500-50,000.

Most significant changes since 2012

1 ODF verification and certification guidelines	Previously there was no official guide on what constitutes ODF and how to verify and certify when this milestone was reached. The introduction of ODF verification and certification guidelines has resulted in a commonly understood and clear definition of the ODF verification process. The guidelines comprehensively deal with faecal sludge management, as well as at commune level, bringing schools and health centres into the formalized certification process. The guidelines have been carefully developed and tested, with input from stakeholders.

Lessons learned

1 Government commitment needed for scaling up	CLTS is given more attention and support when the Government commits to becoming ODF by 2025 with a detailed plan and roadmap developed to reach this target, World Bank loan project for the scaling up of sanitation is upcoming and CLTS is mainstreamed into the poverty alleviation programmes.
2 Quality of triggering	The quality of facilitators impacts the quality and effectiveness of triggering sessions, with consistent quality follow-up needed to reach and sustain ODF. Implementing organizations do review facilitator performance at triggering and usually provide support and monitoring of facilitators but this is not systematic and varies between organization. Ensuring quality of follow up is a challenge.
3 Link with sanitation marketing	CLTS must be implemented together with sanitation marketing to address both supply support and demand creation. The availability of low-cost, socio-culturally appropriate latrine options using locally available materials has helped increase sanitation for a wider range of people with different levels of affordability and make CLTS more effective. Having markets available for sanitation products and services is important, as is involving masons early in the process.
4 Localize	Viet Nam's recent experience highlights the importance of using local language (especially for ethnic minority areas) for triggering and other communications. The involvement of opinion leaders/religious leaders within communities can shape attitudes and change behaviour, however the commitment of local leaders is a critical factor in sustaining behaviour change.
5 Cost efficiencies	The cost of implementing CLTS in a country the size of Viet Nam is expensive and the Government has little budget. Ways to minimize costs include: applying a district-wide approach to get economies of scale and increase ODF results; combining monitoring with other activities and village visits; optimizing facilitator training.

CLTS weaknesses and bottlenecks

1 Ability of poor	After triggering, some households do not build latrines, including entry level basic latrines, because they lack money. In some poor areas, the breadwinners of households work away from home, leaving only elderly people and children at home, making it difficult for poor households to physically dig pits and build latrines. There is little evidence of community initiatives to support the poorest members to build a latrine.
2 Weak capacity at village level	Village heads promote triggering, which means that the activeness of these people affects the triggering quality. Women's Union members at village level appear unenthusiastic and unskilled even though they have been trained frequently.
3 Poor follow-up at district level	Currently the district Government is tasked to provide management support to CTS implementation e.g. triggering, monitoring, and encouragement. However it is difficult for district staff to regularly provide support due to other commitments and distance to communities. The appointment of staff at the commune level to lead and monitor would increase efficiency of CLTS implementation.
4 Latrine solutions for challenging environments	There is still a gap in the availability of lowest cost latrine models that are suitable for hilly areas and the social and cultural conditions of some communes.

CLTS opportunities over the next 3-5 years

1 Government's commitment of ODF by 2025	Strong Government commitment to ODF by 2025, with a large loan programme from World Bank on scaling up sanitation with matching funds from the Government.
2 National ODF Guideline	National ODF Guidelines have been drafted, and when issued by MoH will become the standard for everyone to follow, especially guiding the responsibilities of local governments. The guidelines will also put emphasis on achieving and sustaining ODF rather than building toilets.
3 Low cost latrine options	Low cost latrine options are being developed by the MoH. Once issued they will provide official guidance on ranges of latrines including low cost hygienic latrines.

ANNEX 2: COUNTRY REVIEW TEAMS AND OTHER CONTRIBUTORS

List of the key stakeholders involved or consulted in the preparation of the country CLTS overviews.

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ANNEX 3: DATA FROM REGIONAL CLTS REVIEW

Table A3.1 Key indicators from country CLTS overviews (2012 and 2015)

COUNTRY	INTRO DATE	% SPREAD 2012	% SPREAD 2015	OD POPN 2012	OD POPN 2015	TRIGGERED 2012	TRIGGERED 2015	ODF 2012	ODF 2015	ODF SUCCESS 2012	ODF SUCCESS 2015
Cambodia	2004	48	76	8,132,400	7,457,002	1502	6160	608	1,494	40%	24%
China	2012	15	15	13,483,000	12,442160	0	50	0	31	0%	N/A
Indonesia	2005	97	100	38,322,880	34,303,67	7,325	24,955	1,279	4,419	17%	18%
Kiribati	2012	0	48	29,128	28,807	0	135	0	103	0%	76%
Lao PDR	2008	47	59	1,698,600	1,594,361	217	565	36	144	17%	25%
Mongolia	2011	0	24	272,200	220,663	10	N/A	1	0	10%	N/A
Myanmar	2010	12	29	2,546,000	2,141,715	224	531	12	63	5%	12%
Papua New Guinea	2008	95	86	1,079,800	863,107	477	666	21	144	1%	18%
The Philippines	2008	10	18	5,718,300	5,663,003	211	677	36	473	17%	70%
Solomon Islands	2012	10	44	143,700	299,624	2	50	0	0	0%	0%
Timor-Leste	2007	100	100	269,400	283,818	761	1,000	262	602	34%	60%
Viet Nam	2008	29	31	3,669,700	620,150	829	2,025	145	471	17%	27%

ANNEX 4: CASE STUDIES

1. Cambodia: Which comes first: CLTS or sanitation marketing?
2. Indonesia: CLTS in Indonesia's decentralized context: At what level is support most effective for scaling up sanitation?
3. Indonesia: Adapting CLTS for a major urban WASH programme in Indonesia
4. Kiribati: No golden solution – ODF is easy but sustainability it is hard in Kiribati's challenging environment
5. Myanmar: Myanmar – Doing the ODF two-step
6. Philippines: Closing the gap – Using CLTS to fast track sanitation for the poor in the Philippines
7. Philippines: CLTS in post emergency situations – Philippines
8. Solomon Islands: CLTS in urban areas: Informal settlements in the Solomon Islands
9. Viet Nam: Case study – Testing Viet Nam's ODF criteria and certification process

CAMBODIA

Cambodia: Which comes first: CLTS or sanitation marketing?

Is there a best way to integrate sanitation marketing with CLTS? Which should come first – sanitation marketing or CLTS? Cambodia has years of experience in implementing both sanitation marketing and CLTS. This case study looks closely at the different approaches used in Cambodia and draws conclusions on how CLTS and sanitation marketing best work together.

Defining sanitation marketing

According to the Water and Sanitation Program (WSP), sanitation marketing:

> "….is an approach that aims to increase demand for sanitation and to strengthen private sector capacity to supply sanitation products and services. The focus on the private sector and a view of households as consumers rather than beneficiaries is what sets sanitation marketing apart from conventional approaches to sanitation service provision."
>
> "Sanitation marketing focuses on the development of the sanitation market place, increasing demand for sanitation while simultaneously expanding market-based supply of sanitation products and services for low income households."

For Cambodia, this definition simplifies what is happening in practice. International NGO iDE and local NGO WaterSHED work with private businesses to develop production and sales capacity, in keeping with the WSP definition of sanitation marketing. However, there are variations to this approach: the World Toilet Organization (WTO) implements a franchise model where masons are supported and linked with a centralized production centre for the bulk production of slabs, lid covers, and chamber boxes; Plan International is building sanitation businesses with groups of young school drop outs; Live and Learn works with local communities through a mobilization approach rather than a private sector market-based approach. All of these approaches are called sanitation marketing in Cambodia.

As Petra Rautavuoma of SNV Cambodia says, "It's important to recognize that we use the same term – sanitation marketing – but what we do under the term can be quite different."

According to WSP: Sanitation marketing is about more than just training masons. It involves a more comprehensive demand and supply strengthening strategy drawing on social and commercial marketing, and behaviour change communication (BCC) approaches.

This case study uses the more comprehensive definition of sanitation marketing as an approach to increase access to household sanitation at scale.

To understand how CLTS and sanitation marketing are integrated in Cambodia, it is useful to look more closely at three different ways that CLTS and sanitation marketing could potentially occur:

1. Traditional CLTS
2. Sanitation Marketing
3. Hybrid CLTS-Sanitation Marketing

1. Traditional CLTS

The traditional CLTS approach is mostly carried out by Provincial Department of Rural Development (PDRD) with support from NGOs.

The approach follows four phases of engagement at the village level:

1) Pre-triggering – in the first month, meetings are held between implementers and local people to prepare a work plan, Participatory Village Assessments (PVA) to collect baseline data on households and sanitation are conducted, village chiefs are oriented to CLTS, and consultation occurs with the community.

2) Triggering – during triggering adults and children are triggered using standard CLTS tools. This is followed by the preparation of a community sanitation plan, identification of village volunteers to be behaviour change champions, and the election of a village focal point to work with PDRD until ODF is reached. At this point some households stop open defecation and use a latrine either by sharing with relatives, or building their own.
3) Post-triggering – this phase involves an initial follow-up visit by PDRD or an NGO one week after triggering, then monthly follow up visits. After three months, behaviour change and hygiene triggering occurs. Regular monitoring visits may continue until ODF is reached, which could be from six to 12 months after triggering.
4) Post ODF – when a village achieves ODF status, monthly follow-up monitoring is planned, however, in practice this usually falls to the community itself.

The opportunities for integration of sanitation marketing in the traditional CLTS model could occur in the first three months of the process: at pre-triggering, triggering and post-triggering phases. In practice there is no uniform approach, with NGOs and PDRD introducing sanitation marketing at various times or not at all.

Sanitation marketing is introduced in different ways. Some NGOs invite sanitation suppliers to promote their products at the initial triggering session. However, a community's exposure to CLTS triggering (and thus sanitation marketing) may be quite narrow depending on who attends the triggering session. With PDRD's limited resources, villages are only triggered once, which means that in larger villages as few as 25 per cent of households may be directly exposed to both demand triggering and sanitation supply information. The assumption is that exposed households will tell others about the need for sanitation and the available products, but this is not guaranteed.

Other NGOs invite sales agents from sanitation businesses to talk to groups of households during the BCC sessions, up to three months into the post-triggering phase.

Some CLTS implementers do not engage with sales agents or sanitation suppliers at all.

It would be wrong to think that villages selected for CLTS have had zero exposure to sanitation marketing. Sanitation marketing has been formally introduced in 15 out of the 25 provinces in Cambodia, but even outside of these provinces, some sanitation products and materials informally find their way to communes and villages.

It is therefore possible to make links between CLTS triggered villages and some type of sanitation supply, but under the traditional CLTS approach integration with sanitation marketing is ad hoc and unstructured. CLTS implementers, especially provincial governments, tend to treat sanitation marketing as the private sector's responsibility, and expect that the market will take care of itself. Traditional CLTS implementers often do not consciously make links with sanitation marketing. For example, the previous exposure of a village to sanitation marketing before CLTS triggering is not usually part of the information collected in participatory village assessments and other baseline data, but it could be.

Opportunities to link with sanitation suppliers in the district or province are missed because no one is thinking about this. A UNICEF officer recalls a field visit with PDRD:

> "In theory we all support collaboration with NGOs and PDRD and RHC to discuss who is doing what, but in practice no one is thinking broadly. For example, when travelling to a village for CLTS implementation in some provinces there is a big latrine producer along the road to the community but PDRD does not stop the car and talk to the producer to ask questions such as where do you sell it, how do you sell it".

Research by WaterSHED in CLTS and non-CLTS villages shows that initially sanitation coverage might be higher under CLTS, but people were building pit latrines "because someone told them to". Pit latrine use was not sustained. The study findings were that CLTS helps to prime demand, but to achieve sustained norms, the product matters. Consistent usage is linked to product satisfaction – people are more likely to use and maintain their preferred toilet type.

2. Sanitation marketing

Two NGOs, WaterSHED and iDE, have been involved in developing a scalable, replicable sanitation marketing approach in Cambodia since 2009. The initial development phase included market research and analysis to understand rural demand, consumer preferences and barriers, sanitation coverage, available technology, the rural supply chain, and national level barriers. After piloting sanitation marketing and product testing low cost sanitation models for 18 months, both NGOs have scaled up into 15 provinces. The near universal consumer preference for pour-flush latrines led to the development of an entry level pour-flush 'easy latrine' retailing for US$ 30-35.

Starting sanitation marketing in a new area involves going door to door and holding meetings to introduce the concept to suppliers, local authorities, village officials, commune councillors, and provincial officials. iDE and WaterSHED deliberately bring businesses, village chiefs and local authorities together and work hard to establish relationships and trust between them.

Once the relationship is established, work begins on giving practical support to latrine businesses. It is these businesses that are the key to unlocking the rural sanitation supply, thus developing their skills is critical. Businesses are supported to develop a business plan, and coached and trained in sanitation marketing aspects. Finally, attention is given to improving the product supply chain, based on up-to-date research about what consumers want.

Having available products is just one of the many elements in sanitation marketing, and it is not the most important. According to Lyn Mclennan from WaterSHED, "Marketing is key – how to market to rural consumers who have not thought about having a latrine before?".

Challenges for sanitation businesses

- Sanitation is only one part of the business
- Latrine sales are seasonal, with few sales in the wet season
- Labour is not stable – skilled staff leave and go on to other jobs
- Production costs are high at 65-75 per cent of the sale price of latrines
- No skills in managing sales agents
- Passive, lack confidence, skills and need ongoing training

One way to market is through village level sales events. These events are village gatherings that would typically involve displays, demonstrations and the promotion of latrine product options. In Cambodia, however, most of the time and attention in these sales events is given to sanitation demand creation rather than product promotion.

"For Cambodia our case is particular because there is no wide scale behaviour change/demand creation activity such as a Government programme. Our sales events are 90 per cent explaining why the product is important, 10 per cent about product information." Lyn Mclennan, WaterSHED.

Many elements of sanitation marketing or behaviour change in these sales events draw directly from CLTS tools and triggers. For example, the F-Diagram, hair in the water, faeces calculation, and the cost of latrines versus medical expenses are used effectively. This 'CLTS inspired approach' does not just focus on disgust but is tailored for the sales context and includes status, pride, privacy, convenience, and cost saving benefits as motivating factors. The difference with CLTS is that the tools are used to motivate individual household latrine ownership and drive sales of low cost latrine packages, rather than stop open defecation.

These 'CLTS-inspired' promotional events are facilitated by sales agents. In the case of iDE the sales agent is a full-time staff member of the NGO. A more 'hands off' approach is taken by WaterSHED, whereby the NGO's field staff facilitate and support sales agents, often community leaders commissioned by sanitation enterprises, to generate sales. Field staff also support latrine suppliers in their effort to create demand, and manage orders, payment, and delivery.

Sanitation marketing activities are occurring across 67 per cent of districts in Cambodia so it is inevitable that NGOs supporting sanitation marketing encounter CLTS implementation and subsidy approaches. WaterSHED develops agreements with all NGOs working on CLTS in the same geographical areas to try and improve the programming of sanitation marketing and CLTS. However, according to WaterSHED's experience, while it is possible to build synergy with CLTS efforts (more so than subsidy approaches)

agreements with NGOs have not always translated well into cooperation on the ground, and integration has not been smooth.

A random study of 36 villages in Kampong Speu province where WaterSHED implemented sanitation marketing found that sanitation coverage increased from 24.8 to 41.3 per cent between 2009 and 2012. Of the sample villages, 12 had been exposed to CLTS prior to the marketing intervention, and an additional nine were exposed to CLTS triggering over the project period. The results suggest that there is very little difference in percentage point increases in sanitation coverage between non-CLTS villages (16.1 per cent) and CLTS villages (16.9 per cent). CLTS is not a prerequisite for the early uptake of latrines through a market-based approach, but it may play a role in achieving 100 per cent access. The study further concluded that CLTS does appear to be associated with higher increases in villages with low and medium sanitation coverage at baseline. Sales agents or sales-commissioned village chiefs, who reside in the village appear to be more important drivers of change. Two factors that need to be considered from this data to understand the effectiveness of integration are: what was the quality CLTS facilitation and triggering? If this was poor then it may have affected sanitation demand, and to what extent was there real integration of the two approaches? Could the results have been better if there was close coordination and integration between NGOs implementing CLTS and sanitation marketers?

A difference from CLTS is that sanitation marketing practitioners talk about coverage rather than achieving ODF. This is because their focus is on hardware, and certain behaviours for achieving 100 per cent ODF, such as the disposal of infant faeces, are difficult to monitor. That does not stop WaterSHED working with PDRD to help them achieve their target of 100 per cent ODF communities. Despite this difference in measurement, WaterSHED has seen communities shift from 20 per cent coverage to high or 100 per cent sanitation coverage. A study by WSP found that sanitation marketing has contributed significantly to the sanitation increase in Cambodia over the past few years with nearly 270,000 latrines sold between 2009 and 2015 from partners alone. The latrines sold account for more than 55 per cent of number of pour-flush latrines during 2008-2013.

There are still significant challenges for sanitation businesses in Cambodia.

"Khmer business is passive. Most people sit in the hammock and wait for the business to come. To get them up out of that hammock is difficult – they say 'my business is going okay, I've got food on the table, my kids are going to school'. This is different to other countries where businessmen and women are tough." – Lyn Mclennan, WaterSHED.

"CLTS practitioners are in a perfect position to be saying "this village is getting it", we need to make sure there is a supplier and sales agent getting in to communities to meet the demand that has been generated."

3. Hybrid CLTS and sanitation marketing

A hybrid model of first building the sanitation market, then creating demand for sanitation is implemented by SNV, World Vision and Plan International. This approach has its roots in the WSP Sanitation Demand and Supply in Cambodia Study which found that people prefer good quality pour-flush toilets. A market usually provides these latrines, rather than households themselves, so if the market does not exist then this is an obvious bottleneck for households to get the toilets they want.

Underpinning this approach is the need for a 'handshake' between suppliers and consumers at the optimum time – so that when households have the desire and have decided to buy a toilet, there is a sanitation market ready to supply the toilet; and conversely once sanitation suppliers are ready to supply products they are brought to the community to connect with people who are generating the demand. This approach aims to create not just ODF communities but quality, sustainable sanitation.

For SNV, a district-wide approach to sanitation, rather than focusing on individual communities, is the key to effectively bringing sanitation marketing and CLTS together. Through its Suitable Sanitation and Hygiene for All (SSH4A) programme, SNV supports the capacity development of local government so they can lead and accelerate progress towards improved sanitation coverage. The SSH4A combines sanitation demand creation, sanitation supply chain strengthening, hygiene BCC, and WASH governance.

Before any work begins on sanitation marketing, SNV starts by supporting district and commune governments to assess the sanitation situation and open defecation rates in their areas. SNV helps

local governments understand the sanitation problem and address this as a total sanitation package. Governments develop their own sanitation and hygiene plan, make commitments to achieve 100 per cent ODF and set deadlines for becoming ODF. SNV facilitates the Government in answering the question of how to reach this target, and what are the different approaches needed to get there. CLTS can be one component of this package, but fixing up the supply chain gets attention first.

When assessing the supply chain in new villages and communes, SNV looks at:

1. if there is any partner doing sanitation marketing;
2. if there is any existing supply chain which is offering services and products; and
3. if it is necessary to build up a new sanitation market.

This sets the direction for how sanitation marketing will move forward within the local context. Supply chain development strategies for sanitation and hygiene aim to ensure that an increased range of options and services are available, products are less expensive and more responsive to what consumers want; the buying process is simplified; outreach is improved; information and marketing is available; and the right people and local enterprises are engaged with the potential to put into practice sustainable business models for reaching the target consumers.

How does CLTS fit in? CLTS is a key tool in triggering sanitation demand, but in this case CLTS is directly linked to the supply chain which was previously developed. Deliberate efforts are made to connect with sanitation marketing partners such as iDE or sanitation businesses in the area, who can introduce sales agents to the village to sell products after triggering. Sanitation marketing and CLTS are integrated and coordinated as part of a total sanitation package at the district level.

There is no benchmark for how long it takes a community to get to ODF but it can range from 6-12 months. The results speak for themselves. In 2012 the district of Banteay Meas had one of the lowest levels of sanitation coverage in Cambodia – with only 16 per cent of household having access to sanitation. By late 2014 over 80 per cent of households had access to, and used, toilets, with seven communes declaring ODF and 46,000 people living in ODF communes. The district has set a goal to be 100 per cent ODF in 2015 with eight more communes to be declared ODF.

Although the timeframe for reaching ODF status is the same as the traditional CLTS approach, the affected area for the hybrid approach is commune-wide rather than individual villages, and post ODF follow-up is strong. Support to the commune continues with post ODF follow-up to develop a plan to sustain ODF over time and address and strengthen key behaviours that are lagging such as handwashing.

"The commitment of the government and leadership are the crucial thing in creating ODF – all the other activities are supporting, but without these two, even if you had great CLTS implementation and a supply chain it is much more difficult to get the result." Petra Rautavuoma, SNV.

When the SSH4A began, over 90 per cent of ID Poor Households in the programme target district practiced open defecation and in several communes none of the poor households had access to sanitation. As SSH4A sanitation increased dramatically over the 18 months, access for poor households remained slow. To improve this some sanitation businesses in Banteay Meas district offered customers one to three months interest free credit which works well and allows many poor households to build toilets. SNV has also introduced a pro-poor sanitation fund which supports the poorest households (ID Poor 1 and 2) to access sanitation vouchers so they can then purchase sanitary toilets through suppliers at a discounted price. Each ID Poor Household has to sign an agreement with the village chief committing to construct the toilet within an agreed timeframe, as well as to use, clean and maintain the toilet.

When the SSH4A programme started only 2 per cent of the ID Poor Households in seven communes had an improved sanitary toilet. By the end of November 2014, 734 ID Poor Households had received the sanitation voucher (which is 3.5 per cent of the households in Banteay Meas district.) 65 per cent of the ID Poor Households in the seven communes now are using an improved sanitary toilet.

Lessons learned

What has been learned about the integration of sanitation marketing and CLTS in Cambodia?

For one, integration of CLTS and sanitation marketing is still limited in Cambodia which makes calculating the impact difficult. The different methods of integration range from informal integration of sanitation marketing into CLTS triggerings; using CLTS type tools during sanitation marketing; and a comprehensive planned integration.

The main conclusions are that:

- There is merit in trying to integrate the approaches in some way as CLTS provides the demand creation, and sanitation marketing the product and supply chain needed to deliver sanitation at scale.
- The deliberate integration to connect the two parts of sanitation marketing and CLTS is more effective for achieving 100 per cent ODF status and sustainable sanitation. Leaving integration to happen through natural market processes produces weak results.
- Integration requires coordination and communication between those involved in CLTS and sanitation marketing to optimize the timing of both approaches, particularly the readiness of the community to purchase toilets and the readiness of the market to meet demand.
- Programmes that integrate demand creation, supply strengthening and institutional support will require more resources and have higher costs than those that implement CLTS only or sanitation marketing only.[22]
- Other factors are important to the success of an integrated approach – e.g. quality of CLTS facilitation, engagement of local leaders and institutional arrangements.
- CLTS and supply chain development are not one-time activities but ongoing processes which need to be led by local government.

Sanitation marketing is an essential part of the sanitation equation for Cambodia. All sanitation practitioners seem to agree that when people get what they want (i.e pour-flush toilets) these toilets are more likely to be sustained than short term dry pit latrines. But this requires a market to supply the materials, products and services.

What next for Cambodia?

The opportunities to closely link CLTS with sanitation marketing are just being uncovered in Cambodia. Future steps that would help this integration are:

- Mapping of where sanitation marketing is occurring and where CLTS is being implemented.
- Gathering more evidence on sustainability of CLTS and sanitation marketing integration.
- Local government takes the front foot for collaborating at sales events and triggering events, with less hand holding by NGOs.
- Annual technical and progress reviews between practitioners on the links between sanitation marketing and CLTS.

Cambodia is thinking about an association of sanitation providers (similar to water associations in other countries) which could provide industry capacity building and collaboration to help sustain sanitation businesses.

Even at the highest levels Cambodia seems open to that idea and improving the integration of CLTS and sanitation marketing.

"I still think that it is not CLTS alone that is the solution – it has to be more integrated, a more holistic way of thinking to make it happen if you want to reach 100 per cent ODF" – Chreay Pom, Deputy Director, Ministry of Rural Development.

[22] WaterSHED estimates promotional costs of US$18-20 per toilet installed.

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INDONESIA

Indonesia: CLTS in Indonesia's decentralized context: At what level is support most effective for scaling up sanitation?

Many countries are going through some type of decentralization process, with responsibility for development issues, including sanitation, devolved to subnational governments. The challenge for development agencies is understanding how best to deploy limited resources to effectively increase access to sanitation and ensure it is sustained.

For Indonesia, the challenge is how to leverage money and resources at the right administrative level to scale up sanitation through CLTS to meet the country's ambitious sanitation targets. Recent experience from Government, UNICEF, Plan International and the World Bank's PAMSIMAS programme and the Water and Sanitation Program (WSP) provides some lessons on where and how to add value to decentralized Government structures to expand ODF status and sanitation access.

Background

CLTS is a Government programme in Indonesia

Rural sanitation in Indonesia has seen some remarkable progress in recent years. Following the introduction and success of the Community-Led Total Sanitation (CLTS) approach in 2005, the Government, under the leadership of the Ministry of Health, has developed the Community-based Total Sanitation and Hygiene Strategy (STBM), which takes the CLTS approach and complements it with hand washing with soap, hygiene, safe food and water treatment, safe wastewater management, and solid waste management at household level. At the same time, the Government is actively encouraging the private sector to deliver affordable sanitation products and services, with local sanitarians and health cadres taking a key role in behaviour change and demand creation. Since rolling out in 2008, STBM is now accepted as the standard approach for sanitation across Indonesia.

Sanitation remains a huge challenge

Despite decreasing open defecation from 40 per cent of the population in 1990 to 20 per cent in 2015 the remaining challenge is enormous simply because of the number of people in Indonesia. The 2015 JMP estimates of household access to sanitation, compiled by UNICEF and WHO, show that only 61 per cent of the 255 million population has access to improved sanitation, with 51 million people practicing open defecation, and a total of 100 million people having unimproved or no sanitation. Indonesia has the second largest number of people open defecating in the world, after India. Household survey sources such as the National Socio-Economic Survey (SUSENAS) and Basic Health Survey (RISKESDAS) clearly show that nearly all open defecation is by the poorest 40 per cent of Indonesian people.

The Government has recently revised its National Development Target of universal access to sanitation to be achieved by 2019. This is an ambitious target to achieve in a short time.

Who is responsible for achieving sanitation targets?

Following decentralization reforms in 2001, responsibility for sanitation services was handed from central to local city and district level. Central Government, including the national line ministries responsible for water and sanitation service provision, now focus on policy and strategy development, and oversight of implementation rather than direct control of service delivery. The Ministry of Public Works is the lead agency for providing water and sanitation infrastructure to urban and rural areas, while the Ministry of Health is responsible for behaviour change and setting standards for drinking water quality. BAPPENAS (Ministry of National Development Planning) is in charge of planning, setting sector targets and policy development, while the Ministry of Home Affairs is responsible for capacity building for local governments and their adherence to minimum service standards.

At the subnational level, districts and cities carry the authority to ensure service delivery, while provincial governments provide oversight and technical support to their respective cities and districts. For the STBM programme, local health offices and their sanitarian staff are responsible for carrying out the programme in their communities, with support from local government, local and international NGOs, as well as development partners.

To support the implementation of policies and strategies, and for the coordination of day-to-day activities, technical working groups for water and sanitation (*Pokja* AMPL) have been established both at national as

well as subnational levels. The national *Pokja* is headed by BAPPENAS and comprises of representatives of eight line ministries engaged in the sector, including the Ministries of Home Affairs, Health, Public Works, Finance, Environment, Education and National Bureau of Statistics. The national *Pokja* is also supported by various projects, NGOs, international agencies, donors, universities, etc. At the local level, the *Pokja* are comprised of the respective local government agencies responsible for water supply and sanitation. To date, *Pokja* have been established in all provinces, and in more than 500 district and city governments, though these function with varying levels of intensity.

Challenges

Large scale, fragmentation and variability

Implementing a national government programme in a country consisting of more than 17,000 islands with an ethnically diverse population of over 250 million – the fourth highest population in the world – is very challenging. Administratively the country is divided into 34 provinces, over 500 cities and districts, and more than 75,000 villages. There is a wide variation in the resources and capacity of each province. Several provinces are isolated from central Government and receive little support and attention. Conversely, under decentralization, provinces and districts operate autonomously and do not always pay attention to central Government directives. The national STBM programme is fragmented across Indonesia with many local departments involved in sanitation.

Weak coordination

When active and meeting regularly, *Pokjas* have proven to be a very effective forum to support and coordinate sector development and stimulate change at the district level (e.g. Nusa Tenggara Timur and East Java). However, the capacity to coordinate all WASH players and drive the STBM agenda depends on the province, and this is not uniform across the country. At the district level very few *Pokja* are effective.

Lack of institutional capacity

After the decentralization reforms, the flow of Government money changed from central to provincial level, to central to district level (effectively bypassing provinces), but with little support for service delivery. A critical challenge for the sector is for subnational government to develop the capacity to fulfil its devolved role in the planning, development and management of services; and for effective instruments to be in place to hold it accountable for doing so.

The central government is currently planning to release around US$ 100,000 in development funds annually to each village. In this arrangement the role of the district level is still unclear. Villages are likely to have even less capacity than districts to plan services, manage these funds and monitor the effectiveness of their use.

Lack of Government investment

The World Bank estimated that Indonesia needs to raise an estimated US$ 414 million per year in order to meet its rural sanitation targets for 2019.[23] About 43 per cent of these requirements are needed for replacing facilities at the end of their economic life. Despite much of the required financing expected to come from households (US$ 410 million), Government investment is still needed to create household demand for sanitation and to leverage household spending to meet the 2019 target.

STBM is clearly the national vehicle for driving household demand to achieve these targets, yet very little money and resources are allocated towards the programme. Indeed, STBM may be the victim of its own advocacy as it has advocated for no subsidies; unfortunately this has been interpreted by some in Government as meaning no money or resources are required without understanding that resources are needed to run the programme, not build toilets.

In many districts, district mayors (*bupati*[24]) are not putting money into the STBM programme due to lack of knowledge about the impacts of poor sanitation or the programme being a low priority.

Implementation strategy

[23] World Bank Water and Sanitation Program, 2014, Water Supply and Sanitation in Indonesia Service Delivery Assessment.

[24] Bupati are locally elected off.icials that run the district administration.

Targeting districts

Much of the past development partner and NGO support has been aimed at the district level. In UNICEF's programme of support to three provinces (Nusa Tenggara Timur (NTT), South Sulawesi and Papua), staff spend a lot of time advocating to selected district leaders to increase the priority and attention to STBM. The reasons are clear: a *bupati* that understands and supports increasing sanitation has the power to influence STBM implementation at subdistrict and village level by: issuing a regulation or decree to implement STBM at lower levels; allocating funds specifically for STBM; and following up with district administration that these funds are being used for the purpose and achieving results. These key actions signal to subdistricts and villages that sanitation is important and that the *bupati* has expectations on progress, and will pay attention to STBM being carried out.

An example of the effectiveness of the *bupati* is from Alor district in Nusa Tenggara Timor province. Although the *bupati* took some time to be convinced of STBM, when he became interested he implemented STBM in 15 villages that were subsequently declared ODF and then showcased these achievements to the remaining village heads, with a clear message that they too should implement STBM. Recently a further 30 villages have followed with ODF declarations.

The World Bank PAMSIMAS programme has also found that where districts are declared ODF there is a correlation between this, the strength of *bupati*, and their interest in sanitation. "If the *bupati* advocates for ODF and it becomes one of the programmes for the office of *bupati*, the budget and the regulation will be there and it will become the priority of the subdistrict and village government because of the strong push from the head of the district."

What does it take to influence *bupati* and increase sanitation? UNICEF has found that in Nusa Tenggara Timor, progress at district level is much better where there is a facilitator placed in the district to support the STBM process, including facilitating and advocating for a STBM budget at the district level, but also helping the sanitarian and health centre trigger and implement at village level. A district facilitator can use a limited amount of development agency or NGO implementation money, to leverage district budget and continue replication in other villages. Long term engagement is needed. Both Plan International and UNICEF are funding facilitators at district level for up to three years.

Experience from Nusa Tenggara Timor shows that districts do well if: (i) they have a good facilitator and process; (ii) if additional financial support is provided by an agency for leveraging purposes, (iii) local leaders are involved then they can positively influence budget allocation by the district government. To help institutionalize this successful approach, UNICEF, together with BAPPENAS, put together advocacy kits for *bupati*, using facts and infographics to help them understand the issue of poor sanitation and guide them in the steps they can take to change the situation, such as allocating budget towards STBM implementation; taking time to talk with the district administration and calling in the head of the district health office to ask about STBM progress; and issuing a decree.

By targeting district level implementation it is possible to achieve sanitation outcomes, but this approach requires time, resources, and skills in advocacy and facilitation, and is difficult to scale up quickly. With more than 500 districts and cities in Indonesia, getting to the required scale to reach universal sanitation is beyond the capacity of NGOs and development agencies. Papua province is a good measure of the STBM challenge: just nine out of 29 districts are implementing STBM (in just 25 out of 385 subdistricts) and 174 out of 3,538 villages.

Provincial level influence

A question to consider in scaling up is: how can the experience from district support flow upwards to the province level and then be used to spread implementation in other districts which have not been supported by external agencies?

UNICEF has found that there is efficiency in supporting provinces as well as districts to increase scale. Despite provinces having little direct responsibility for implementing sanitation, the provincial governor is still a powerful influencer of what happens at district level and lower, and which development agenda gets prioritization. For example in Nusa Tenggara Timor province, UNICEF has a full time coordinator at the provincial level and facilitators at selected districts. The coordinator works with the provincial *Pokja* to facilitate, develop skills, and guide planning processes to prioritize sanitation. If the provincial governor is convinced about the need for better sanitation, and issues a regulation to implement the STBM programme to achieve ODF villages, then this is a tool to communicate with local government to allocate their budget and implement the programme. The Governor's regulation in Nusa Tenggara Timor

was disseminated to all districts and they in turn created a similar regulation about STBM. This triggers the district government to provide budget for STBM which is then followed by budget allocation from the District Health Office and the health centre level. In Nusa Tenggara Timor, 20 out of 22 districts have a local regulation from the *bupati* on STBM.[25]

Provincial level support has other benefits too. Improving coordination at the provincial level through the *pokja* can also strengthen coordination at the district level. In a province such as Nusa Tenggara Timor, where there are number of agencies including the PAMSIMAS programme, Plan International, UNICEF, and others, the provincial *pokja* has a key role as a central point for capturing learning and sharing information as well coordination of efforts. If the provincial pokja is meeting regularly and coordinating, together with the governor's regulation on STBM this gives impetus to district *pokja* to meet and coordinate, and share information.

Another finding from Nusa Tenggara Timor is the influence of the provincial level in the planning cycle and getting financial commitment for STBM from districts. Those districts that have funding earmarked for STBM in their 2013-2018 medium term development plan can allocate budget for implementation, but without identified funding it is difficult to later allocate budget. The provincial *pokja* encourages districts to include budget in their multi-year plans for STBM, and for the remainder, the provincial *pokja* continues to advocate for those districts to review their development plan to include STBM and then allocate budget for it.

Provincial level influences can also be seen in Papua province where the local government receives special autonomy funds from the central Government in addition to its regular budget. The provincial governor has directed that 80 per cent of the special funds go to districts while 20 per cent is retained at provincial level. UNICEF's full time provincial coordinator was able to advocate that some of this special funding be allocated for sanitation activities, especially STBM. The outcome was a Governor decree, giving direction that a portion of the health funds allocated from the special autonomy budget to districts should be used for STBM implementation. The money is not enough for each district to automatically allocate funds for STBM so districts are encouraged to co-contribute.

The provincial government is also crucial in monitoring how budget is spent and the progress of activities. In Papua the province monitors district spending through annual provincial meetings. In this way, the province checks whether districts have allocated funds for STBM, and advises them to if they have not. The province particularly targets those districts that have been exposed to STBM awareness, but have not yet allocated any funds for it.

The province can also provide important technical support on STBM for districts. An example is Papua province, where all district health offices meet at the provincial level to review progress and achievements through an annual STBM network meeting. The province also allocates province health funds for the training of district staff as a way of spreading capacity. In 2013 the provincial health office trained representatives from nine districts not implementing STBM in Papua, and conducted training in a further two districts in 2014.

The World Bank Water and Sanitation Program now works with provinces to lead and implement the programme through districts.[26] Provincial level technical assistance includes: capacity building of local government at provincial level and some at district level (using the provincial budget); and supporting provinces to make strategic plans for effective STBM implementation at the district level. According to WSP, persistence is needed for the long process of developing a relationship, mentoring, advocacy, and providing data and information to aid decision making for provincial government staff, especially the health office. "Giving all the data, updating information, giving them fact sheets, makes the province really trust us to help them".

Subdistrict supervision

Another approach to scaling up is through intensive follow up at the subdistrict level. In Papua province,

[25] Except Kupang city, and Malata which is a new district without a *bupati*.

[26] Originally in 2008 WSP supported STBM in 29 districts.

Jayapura district has piloted an approach which builds the capacity of subdistrict staff and helps them implement in all 5-10 villages within each subdistrict. This involves a meeting at the subdistrict level with the sanitarian from the health centre and other members of subdistrict office staff to introduce the STBM concept and establish if there is interest to start implementation in a village.

Subdistrict staff and trained volunteers conduct triggering, with the subdistrict team continuing to follow up progress for four to six months after triggering. At this very localized level follow-up can be regular. In some villages sanitarians are following up daily, in others, weekly. The follow-up is not always guaranteed. In Biak a special facilitator is employed by a local NGO to follow up on a daily basis. The success of ODF is directly linked to intense follow-up.

UNICEF's involvement extends to the subdistrict level through the discussion of triggering results and a follow-up meeting (at subdistrict level) after three months to discuss the progress of each village. This strategy will be replicated by local government taking the place of UNICEF. The district has already contributed money for implementation, and in 2016 the budget will be increased further as new areas expand and district monitoring increases.

Sanitarians and village priorities

With new development funding being channeled directly to villages all over the country, and for places like Papua's where there is already special village funding, effective use of this money at the village level becomes critical while at the same time the capacity constraints are amplified. From Papua experience, the sanitarian is a key person to influence village priority for sanitation and the allocation of resources and funding for this purpose. In Papua only some villages have allocated funds for sanitation. This is because the sanitarians responsible for these villages have been trained in STBM methods. The five-day STBM training course for sanitarians includes a module on advocacy skills and how to influence village heads and subdistrict staff to use funds for STBM. There is a clear link with trained sanitarians and their ability to advocate and persuade the village head that sanitation is an important issue. The money that becomes 'available' is usually directed to building public toilets, or targeting support for the poorest families, or improving temporary dry pit latrines to more sustainable pour-flush types to meet STBM standards.

Full STBM

In Indonesia a lot of focus in the STBM approach is only on sanitation, with little attention to all five pillars of STBM. Plan International's experience shows that the model of multi-level support (provinces and districts) is effective when implementing the full STBM, including: ODF, handwashing with soap, solid waste, clean water, and wastewater disposal. In 2011 Plan implemented STBM in Grobogan district in 10 subdistricts, totalling approximately 153 villages. After two years all 153 villages were declared fully STBM and within four years the entire Grogoban district achieved full STBM on all five pillars. This was achieved through the placement of a Plan facilitator at the subdistrict level.

More recently, with a grant from Australia's DFAT, Plan International is supporting five districts in Nusa Tenggara Timur to become fully STBM. The approach has been adjusted to target district level implementation with support from the provincial level, and to deliberately leverage Government planning and financial support. Plan International has a project manager at the provincial level to work with local government and manage its five district facilitators. Importantly, Plan provides capacity building for Government and implementers in districts to do triggering. The facilitator in each district works to strengthen the *pokja*, especially for implementing a rolling plan, which sees Plan support decrease while district funding and involvement increases exponentially. In the first two pilot years, 150 villages were targeted but this expanded by a further 300 in the subsequent two years when Government took over. Plan funds the provincial project manager and district facilitators, and assists with monitoring, but the Government pays for and leads the implementation, whilst gaining the capacity to expand at scale.

Lessons learned

- **District interventions are difficult to scale quickly** – Development partners and NGOs have limited resources and cannot work in over 500 districts and cities, and even the largest NGOs are only working in a handful of districts. There is not enough capacity and resources to directly support all 34 provinces, so the leveraging of local government funds is critical.

- **More than money is needed** – To scale up STBM and achieve ODF it is not just money that is needed, equally important are: prioritization, regulation, and leadership on sanitation from all levels

and then to channel this around solid programming principles that have a strong evidence base (such as use of formative studies) and which are regularly monitored and reviewed.

- External agencies should support both province and district – It is not a case of external agencies supporting either/or provinces or districts, with experience showing that support is needed at both levels, and possibly at subdistrict level.

- Diverse capacity building required – External agency support is not simply required for implementing sanitation, but for building essential skills in advocacy for decision making, improved planning, coordination, budgeting and monitoring.

- A long-term engagement is essential – UNICEF, Plan and WSP are funding people in specific provinces and districts for a minimum of three years. This long term engagement is needed to build trust and effectively work with local governments.

- Sanitarians are a critical link – Sanitarians are the key to implementing STBM but there is a large deficit in people to do the work, the quality of sanitarians varies and not all of them have been properly trained. Sanitarians also need to be closely supervised to ensure reporting and follow up, so a higher level of support for implementation is very important to have in place.

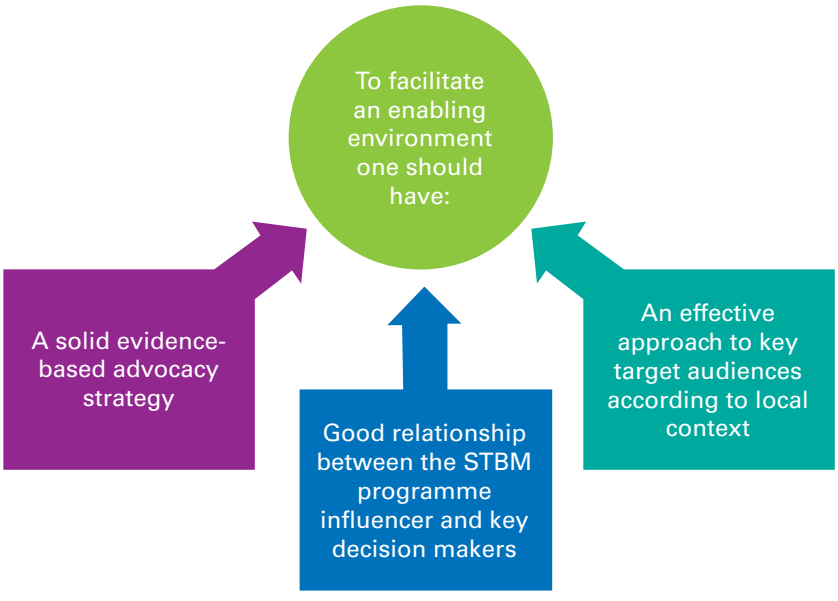
- Changing staff in local governments – It is common for there to be frequent staff turnovers or position changes at the local government level. For development partners this means having to restart training and capacity building processes again. While unavoidable, the situation can be helped through a long-term engagement.

- Start small with quality then scale – Rather than trying to implement STBM in entire districts or provinces it is better to start small in a limited area, and embed processes with Government commitment to expansion built in. In Indonesia the government mandate is to provide services for all, and sometimes this results in a tendency for the Government to spread resources too thinly to provide "something for everyone" rather than doing something well in one area and then growing from this.

- **Communities have a crucial role** – Experience from Aceh shows that villages that easily became ODF: did not expect outside assistance; had village leaders that were concerned and cooperative, and made it easy to contact them and midwives; could easily gather the community together; had the social capital of working together for a common good; and looked up to and followed the local leaders/ agents of change, i.e. religious leader.

Ingredients for a successful provincial level STBM enabling environment

What needs to happen



Monitoring strategies for scaling up STBM. The Ministry of Health's roadmap for sanitation is being finalized and Bappensas has a programme (PPSP) to help local governments plan for sanitation acceleration. One critical gap is the role of the Ministry of Health to oversee progress on scaling up, and how to push poor performing provinces so that every district and every province is brought up to the same level. Responsibilities for funding, supervision and monitoring between the central level Ministry of Health and provincial/district and subdistrict health need to be better defined and streamlined as part of this scalable model.

Increase in advocacy to drive prioritization of sanitation and ODF. Provincial sanitation targets focus on health and education, or on sanitation coverage but not specifically on the achievement of ODF. In Papua, for example, more could be achieved if the provincial governor is made aware of the connection between the one million people openly defecating in Papua as one of the main contributors to the high infant mortality rates and the poor nutritional status. At the central level, advocacy could increase political will. Indonesia is the second worst country after India in terms of access to sanitation, but it does not receive the national media attention and campaigns that India receives. Hence, UNICEF developed an online advocacy campaign to raise awareness within Indonesia on the serious sanitation challenges the country faces (see www.tinjutinja.com).

Targeting of the poorest and most vulnerable households. Concentrating on trying to get large populations to ODF status creates a tendency to sideline equity issues such as vulnerable people, women, people with disabilities, the elderly, children who may face accessibility issues and sources of financing for affordable sanitation. In Indonesia there is no formal support mechanism for low-income households on sanitation. There is potential to develop this through various means such as Government targeting, innovative financing, religious organization support and Corporate Social Responsibility.

Better knowledge of what it takes to scale up. Donors and NGOs need to have the costs and details of what it takes to scale up STBM as part of advocacy to *bupati*. In most cases information on costs, resources, and timing is not available, but this is exactly what district leaders want to know before committing their own staff and budget.

Indonesia: Adapting CLTS for a major urban WASH programme in Indonesia

Background

In 54 cities and districts within regions of North Sumatra, West Java-Banten-DKI Jakarta, Central Java, East Java and South Sulawesi-East Indonesia, CLTS is being used to trigger behaviour change as part of a comprehensive approach to improving urban sanitation. The Indonesia Urban Water, Sanitation and Hygiene (IUWASH) programme aims to not only stop open defecation but also improve on-site sanitation through a comprehensive approach to wastewater management. The IUWASH programme shows how CLTS triggering can be adapted for urban settings but also highlights some of the complex challenges for CLTS and sanitation in large cities.

Urban sanitation in Indonesia

Over half of Indonesia's 250 million people live in urban areas. In the absence of public investments, households have provided most of the sanitation infrastructure in place. The most recent 2015 JMP figures put Indonesia's urban improved sanitation (typically pour-flush toilets) at 72 per cent with 13 per cent open defecation. While open defecation is still significant, existing toilets are the main sanitation problem. With weak local government oversight and regulation, very few household toilets are built to standard and do not dispose of wastewater safely. Many toilets discharge into a *cubluk*, an unsealed tank or soak pit, also referred to locally as a *tangki septik*, or toilets discharge waste directly to drains and waterways without any treatment. The health and environmental impacts of this situation are equivalent to direct open defection.

The number of poorly operating household toilets is not known, but it is believed to be a huge number across Indonesia's urban areas. This number is not captured in official statistics because it is commonly thought that having a toilet solves the sanitation problem. In some cities, traditional open defecation such as public defecation over drains may be rare, but indirect open defecation is a hidden and very significant problem.

One example is the city of Tangerang in Banten province. With 3 million people and a very high coverage of household toilets, there would appear to be no open defecation problem. But a closer look at what happens to wastewater beyond the household toilet shows that most toilets are connected to four inch pipes at the back of the house which directly discharge waste into gutters, drains and canals. The effect is the same as open defecation as faecal waste is not being collected and safely treated.

The challenge is getting the community and local governments to see that wastewater management is a problem and needs to be prioritized. As a way to overcome this challenge, the IUWASH programme is using CLTS tools to trigger demand for both improved on-site sanitation and demand for better city sanitation management.

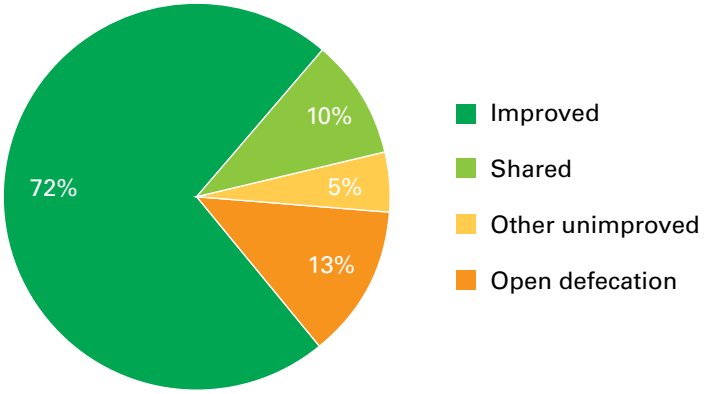
IUWASH approach

IUWASH is a five year (2011-2016) water supply and sanitation development programme funded by the US Agency for International Development (USAID). IUWASH's sanitation component aims to create access to improved sanitation facilities and services for 250,000 people (50,000 families).

IUWASH's approach recognizes the complexity of urban sanitation and the need for an interaction between demand creation, sanitation options (supply), and city management of sanitation services to achieve effective and sustainable sanitation.

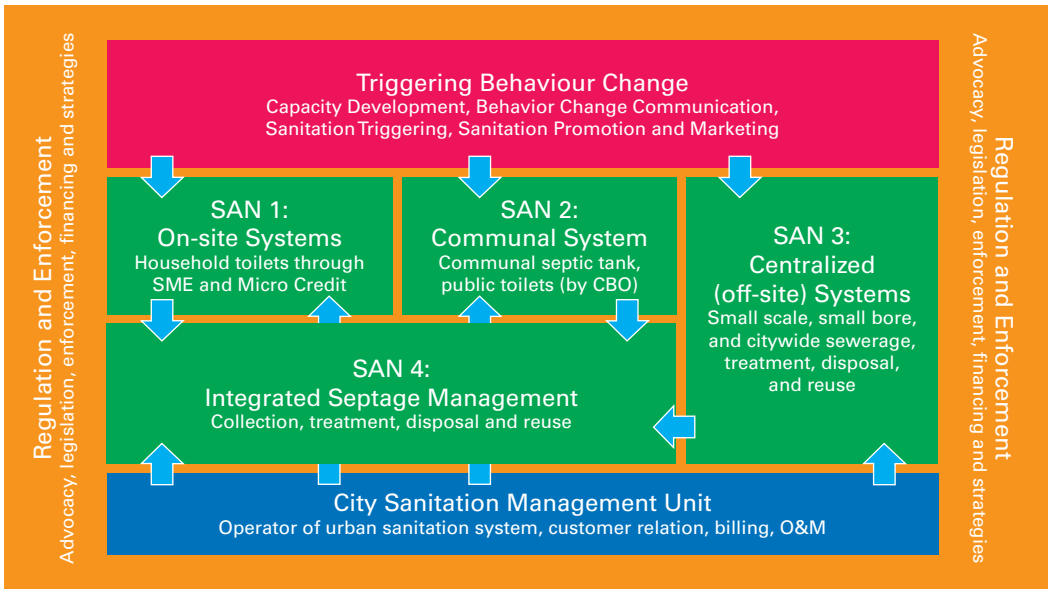
To support sanitation sector sustainability IUWASH implements a series of structured activities: promotion of behaviour change communication (BCC) for triggering community demand, support for the development of enabling regulations at the local government level, identification of sources of finance for the improvement of household sanitation, and institutional strengthening through the establishment and capacity building of city Sanitation Management Units. These activities fit together in an urban wastewater framework (Figure 1).

Figure 1: Urban sanitation coverage in Indonesia



Source: JMP Update 2015.

Figure 2: IUWASH Urban Wastewater Management Framework



Triggering behaviour change

The objective of demand triggering in conjunction with sanitation promotion and marketing is the elimination of open defecation and other inappropriate sanitation practice by improving individual sanitation facilities (usually septic tanks) or the opportunity for connecting to an off-site reticulation system.

IUWASH is supporting community demand triggering through CLTS or as it is known in Indonesia, Community-Based Total Sanitation programme or STBM approach. STBM is a national programme by the Ministry of Health that addresses sanitation, health and hygiene in five programmatic 'pillars': open defecation free (ODF) communities, hand washing with soap at critical moments, household water treatment and safe storage of water and food, solid waste management and liquid waste management. The programme advocates a subsidy-free approach to sanitation, and the sanitation objective of STBM (Pillar 1) is to attain an open defecation free status at the community level.

The Ministry of Health and local Department of Health and community health cadre already have responsibility for promoting clean and hygienic behaviour, and take on the role and responsibility for triggering and sanitation and hygiene promotion, with IUWASH staff working closely with them to support the process.

The community 'triggering' process in IUWASH is based on the STBM programme and involves:

- social mapping by the community to create a map of the neighbourhood, and identify specific groups and their hygiene and sanitation practices;
- transect walk – discussion about conditions and how they feel, what they might do to improve them, photograph, interview people along the way;
- structured focus group discussions after social mapping and the transect walk to discuss the findings;
- introduction of the F diagram to identify how disease is spread and ways to protect the community from contamination;
- community exchange visits usually to another community that is more advanced in the sanitation improvement process to find out how the improvement was managed; and
- other meetings to discussion the sanitation situation and options.

Urban CLTS triggering may involve a transect walk which seems abbreviated compared to a rural transect walk to an open defecation site, but it is no less powerful. The 30 minute transect walk involves visiting small alleys to see the poor sanitation situation behind houses and to see where toilet waste discharges. Signs of open defecation may be rare but visitors will experience raw waste discharging from houses, foul smelling and often stagnant black water in drains and canals, and sometimes rats. A small number of people may take part in the transect walk, but triggering is still effective because the community is facilitated to see and understand the sanitation issue. The presence of the head of the village *(keluarahan)* usually results in a quick decision to do something about the poor sanitation situation. The village head can be motivated to improve the situation out of pride in their community and concern that the name of the village will be associated with poor sanitation.

The use of mobile phone technology is a modern feature of urban CLTS triggering. The community is encouraged to take pictures with their mobile phones during the transect walk as a way to record the baseline sanitation situation and to capture examples of good sanitation practice. The photos can be used as a talking point for those who are not able to be at the front of the transect walk line to hear the discussion, or even for use in meetings when the sanitation problems are discussed with those who could not attend the transect walk.

Household visits

Because urban residents often have busy schedules or need to work at night and not have the opportunity to participate in triggering, community level meetings or other activities, IUWASH conducts follow-up household visits to promote sanitation. Small two to three person promotional teams visit households and discuss willingness and ability to improve sanitation, including: concerns and barriers to improvement; technical options; benefits of improved sanitation and hygiene; costs and contributions; importance of everyone participating; economic benefits e.g. lower health costs, less time lost due to sickness.

After demand creation

Triggering helps the community understand that open defecation is a bad practice, but on its own this is not enough to successfully change behaviour. The next step is to empower a community to fund or use other financing options to build proper toilets or improve their current ones. Access to finance is critical for low-income households who are unable to afford the cost of a simple toilet (approximately Rp 1.2 million or US$ 120). IUWASH has been working with microfinance organizations to provide loans for low-income families, as well as establishing revolving funds in combination with technical training on healthy toilet construction for low-income households, and microcredit systems with trained masons. To ensure microfinance and microcredit systems are robust and suitable for different markets, IUWASH provides capacity building to different financial providers, from banks through to cooperatives and small sanitation contractors.

The technical aspects of sanitation are an essential part of urban CLTS triggering in Indonesia. In fact the location to be triggered will vary depending on the feasible technical solution. Unlike rural villages where the whole village is triggered, in urban areas for communal or networked systems only those affected might be triggered, but for household systems, triggering of the whole community is needed. Triggering

includes detailed discussions with communities about septic tank technology and operation. IUWASH works with masons and sanitation entrepreneurs to improve toilet and septic tank construction that adheres to the Ministry of Public Works' sanitation standards.

Challenges and lessons learned

The following are some challenges and lessons learned on how and why the STBM approach needs to be adapted for the urban context.

Densely populated urban areas limit technical choices. Urban areas are much more densely populated than rural areas. As such, basic, non-septic latrines or pour-flush pit latrines are not appropriate. Not only is there no space to rebuild pit latrines when they are full, but they are not effective at creating a barrier to disease transmission because people live close by and there is potential for the pollution of groundwater, which many households depend on for their basic water supply. In urban areas the household sanitation ladder is less relevant but collective septage management becomes very important. Sanitation entrepreneurs need to be brought into the triggering process to support the more complex technical solutions in urban settings.

Community engagement needs to be flexible and fast. It is difficult to organize events and activities in urban areas in which all community members can participate. Therefore, the times of meetings need to be flexible, or multiple meetings are needed to align with particular schedules. For example, if husbands (as key decision makers) are working away from home, then meetings need to be scheduled when they are present. Because residents do not have much time, CLTS triggering processes need to be short and simple learning exercises.

Facilitators need advanced technical knowledge and communication skills. A facilitator needs to understand the sanitation situation and how sanitation facilities fit into a holistic sanitation system, e.g. how households can empty their septic tanks when full, and how much this would cost. Facilitators can expect to be asked these questions by the community, thus they need to be ready with answers. Facilitators must have a broad knowledge of how and who to coordinate with (agencies/field/community leaders); costs and how to access finance; construction; maintenance requirements and where to get technical support; need for sludge removal and how to access this; and relevant regulations on sanitation. This skill set is different to that required of rural CLTS facilitators.

Neighbourhood pride is an effective motivator. Using shame as a trigger in urban Indonesia is not effective. A better approach is to build on neighbourhood pride and self-esteem, religious values, and positive role models of others who are of a similar social standing in the community and have good sanitation. Facilitators must speak in a delicate way so that people see the problem for themselves; using shame can result in residents rejecting the facilitator as an untrustworthy outsider.

Community cohesion is weaker in urban areas. Members of rural communities are often more willing to work together to achieve a common goal, while members of urban communities may not have the time or willingness to work together. It is also generally more difficult to enforce community-level rules (such as a ban on, or sanctions against, open defecation) in urban areas. Strong local leadership, follow-up household visits and other community engagement helps improve cohesion.

Different financial challenges to household affordability. Although urban incomes may be higher than rural ones, poor and low-income households often have very limited resources (such as land or basic building materials) and find that investing in any improvement to their home or community is very hard because of more urgent day-to-day obligations. Also, as non-septic latrines are not allowed in urban areas, the investment cost by families in appropriate sanitation systems is much higher. Providing access to microfinance is a critical element in changing behaviour.

Renters are reluctant to invest. Many urban households do not own their home. They are renters or staying in their community on a temporary basis, and consequently are reluctant to invest in improving someone else's property.

Environmental regulations need to be enforced. Because of their complexity and the increased interaction among people, urban environments naturally require more formal regulations and a more strict enforcement of those regulations. Indonesia requires that all human waste is collected, disposed of and treated properly. Such regulations need to be respected and enforced.

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KIRIBATI

Kiribati: No golden solution – ODF is easy but sustainability is hard in Kiribati's challenging environment

The Central Pacific nation of Kiribati, comprises 33 low lying coral atolls stretching along the equator. With lagoons and white-sand beaches, the country's 103,000 people appear to live in paradise. But Kiribati has one of the highest rates of infant mortality in the Pacific region, at 47 deaths per 1,000 live births.[27] This shocking statistic is mainly due to diarrhoeal disease, caused by inadequate access to clean water and appropriate sanitation.

The majority of the population of Kiribati lives in the Gilbert Group of 16 atolls in the west of the country. The Gilbert Group includes the so-called Outer Islands, and the capital, South Tarawa. Nearly half of Kiribati's population lives in the urban capital of South Tarawa.

Due to poor sanitation many children die from preventable diseases before their first birthday. For this reason there is always a special celebration when a child turns one year old. (Photo: P Dutton)

Open defecation rates in Kiribati are some of the highest in the Pacific sub-region. According to the UNICEF/WHO Joint Monitoring Programme data in 2015 just 40 per cent of the population of Kiribati has access to improved sanitation, with 36 per cent defecating in the open.[28] In rural areas and the outer islands the rates are even higher – open defecation is practiced by nearly half of the rural population (49 per cent) and by more than 70 per cent in some outer islands.[29]

CLTS was only introduced in Kiribati in 2013 by UNICEF and the Ministry of Public Works and Utilities (MPWU) through the EU-funded KIRIWATSAN 1 Project, but in a short space of time it has rapidly changed behaviour and reduced open defecation on Kiribati's Outer Islands.[30] Early efforts at adopting the approach were boosted by a visit from Kamal Kar in 2013, during which training and demonstration triggerings were held in North Tarawa. Very quickly the 13 villages on this island became ODF and on 11 May 2013 North Tarawa was declared the first ODF island; not just in Kiribati but in the entire Pacific region. Previously about 64 per cent of its 6,000 people used the beaches and mangroves for defecation. The success of the CLTS approach in North Tarawa led the President to set the goal of an "Open Defecation-Free Kiribati by 2015".

Following the success in North Tarawa, the MPWU and UNICEF planned to roll out CLTS to all 139 villages throughout the 16 Outer Islands, and included in the KIRIWATSAN Phase 1 Project, complemented with funding from the Government of Kiribati. One year later, over 70 communities on six

[27] Ministry of Health, 2012, *Health Service Delivery Profile Kiribati 2012*.

[28] UNICEF and WHO Water and Sanitation Joint Monitoring Program, 2015 *Progress on Sanitation and Drinking Water – 2015 update and MDG assessment*.

[29] *Outer islands profiles, KIRIWATSAN-1 Project, January 2013*.

[30] The Ministry of Public Works and Utilities is implementing the EU-KIRIWATSAN project with technical support from UNICEF and funding from the European Union.

Outer Islands had declared themselves to be free of open defecation. By October 2014 the number had increased to 90 villages on 10 outer islands with the involvement of a total of 30,054 people representing 84 per cent of the triggered population and 29 per cent of the total population of Kiribati.

Pit digging. (Photo: B Tiim)

The shift from open defecation to ODF communities, has driven a large household latrine building effort. Pit latrines and pour-flush toilets with concrete slabs and pedestals are popular. Island councils even subsidized the cost of a concrete slab for pour-flush toilets as encouragement for island residents to improve sanitation and stop open defecation. Under the KIRIWATSAN Phase 1 Project, chainsaws were purchased for each island so these can be used to sustainably cut down coconut trees to make platforms and slabs. Molds are also available on islands and pedestals can be made locally, which is critical for success and sustainability of remote Outer Islands that lack even the most basic supply chain.

Using sustainable local materials for slabs and pit lining. (Photos: B Tiim)

This speed and scale of achievement is impressive. Part of this is due to a high level of commitment from the President of Kiribati and Cabinet, who promoted CLTS as the main approach for increasing sanitation coverage in line with the National Sanitation Policy.[31]

The massive mobilization to Outer Islands to launch the ODF campaign was due to efforts of people on the ground. UNICEF's WASH Community Development Officer Beia Tiim has organized and cultivated a Core Technical Group of 73 people from the Ministry of Health, MPWU, Ministry of Environment, Ministry of Internal Affairs, Women's Federation, and other organizations to lead the CLTS roll out. Beia trained the core technical group, together with Kamal Kar, in CLTS facilitation skills. They are now community

[31] Monitoring Report: Water and Sanitation in Kiribati Outer Islands – Phase I, Delegation of the European Union for the Pacific, (December 2013).

champions who go to the Outer Islands and work with Island Councils on triggering and changing sanitation and handwashing behaviours.[32] The strength of this cross-sectoral facilitation team has been a cornerstone of the successful triggerings on Outer Islands.

If open defecation is being eliminated and people are using toilets, then where is the problem?

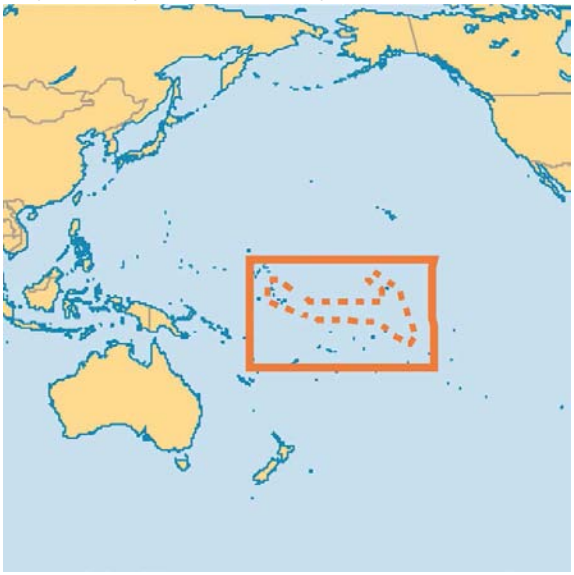
Kiribati has unique challenging physical and social environments which significantly affect achievement and sustainability of ODF status.

For one, open defecation in the ocean or on the beach is a deeply entrenched social norm on all Outer Islands. In the village lifestyle, open defecation is not only socially acceptable but it is a social activity.

There are also the issues of distance and remoteness. The country is made up of 33 small islands and coral atolls spread out across a distance greater than the width of India. Simply getting the Core Technical Group to the Outer Islands is a major challenge due to their remoteness, infrequent boat and flight schedules and the cost and time required to visit these islands. Continuous monitoring, follow-up and verification are critical to sustaining behaviour change and ODF status, however this is not easy to do in Kiribati. As a result, a key lesson learned has been that building capacity for CLTS facilitation and follow-up on each Outer Island through the Island Council, Medical Assistant and staff, is critical to sustainability.

Figure 4: Map showing the location of Kiribati

The most serious challenge is posed by the relationship between sanitation and drinking water. The



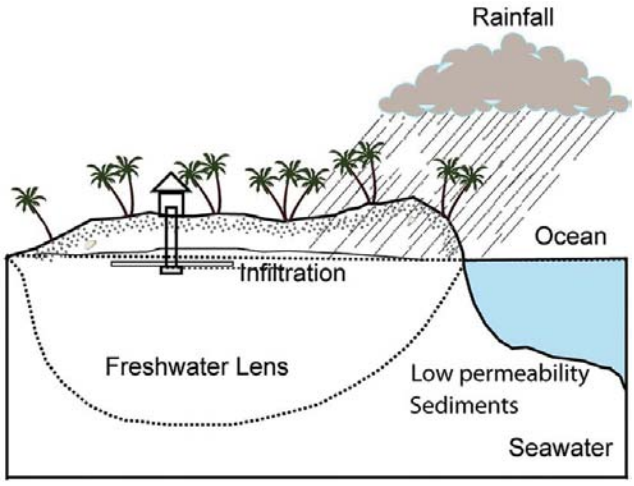
usual logic in CLTS is that stopping open defecation helps protect drinking water sources, but in Kiribati stopping open defection by building and using toilets can actually harm drinking water sources. Many people living in coral atolls rely on shallow groundwater reserves, referred to as freshwater lenses, to provide drinking water. These lenses are very fragile and with porous coral soils, pollutants from human waste and other sources easily enter the groundwater lens, threatening public health.

Kiribati's environmental constraint turns conventional logic on 'improved' and 'unimproved' sanitation options on its head, as improved facilities such as pour-flush and flush latrines harm people's health as much as unimproved options like pit latrines.

Figure 5: Model of a freshwater lens

[32] Handwashing is integrated into CLTS triggerings through family training, handwashing demonstrations, and messaging. ODF criteria include the presence of a handwashing station.

Source: http://www.epa.gov/climatechange/impacts-adaptation/islands.html



As the demand is created throughout Kiribati for households to build their own toilets, it becomes critical to develop a supply chain that gives people safe sanitation options that will not contaminate their drinking water. There are few sanitation options to protect these groundwater lenses, and suitable technical options are not low cost. Neither of the current sanitation options – pit latrines and pour-flush toilets – protect the ground water, even though they have stopped open defecation. Households prefer simple pit latrines because they are cheap and can be built quickly, but these can do more harm to public health than the original practice of open defecation if they contaminate a freshwater lens that people depend on for drinking water. Flush toilets are inappropriate for Outer Islands since they require scarce water for flushing and costly septic tanks are prone to leaking.

To raise awareness of the impacts of sanitation on water supply, the New Zealand-funded Kiribati WASH In Schools Project is introducing WASH safety planning to be used with CLTS triggering techniques. WASH Safety Planning, similar to water safety planning, is an approach that schools and their communities can use to identify the risks to their health from WASH practices, and take steps to reduce their risk. Participatory mapping during CLTS triggering can be an entry point for identifying and discussing health risks not only from open defecation, but also from poorly built latrines, pigs, and household waste. Through this risk mapping process, the community identifies the risks and threats to water supply and is 'triggered' to modify what it does, in particular where people defecate.

The KIRIWATSAN 1 Project provides guidance to island communities on latrine construction – for example where to build toilets to protect the ground water table, safe distances of latrines from wells, and identification of coastal areas suitable for building toilets where there is much less risk of polluting ground water. Once people understand the risks to groundwater they accept the loss of convenience in having toilets away from where they live.

Through the CLTS process and WASH safety planning, people are realizing the importance of maintaining water quality and protecting water supplies. Reinforcement from Island Councils is important, but is most effective where there is Sanitarian Aid to advise communities on toilet locations and enforces Island Council by-laws on sanitation; and where there is a very active mayor. Currently, most Island Councils do not have Sanitarian Aid.

Raising awareness of the risks of pit latrines and pour-flush toilets has had an unintended consequence. The people who built toilets in the early stages of CLTS in Kiribati have since learnt that they are contributing to ground water pollution. Many stopped using their toilets and reverted to open defecation, but they do this covertly by hiding in the bushes.

Although the extent is not yet measured, the wrong sanitation solution has caused slippage in ODF achievements. In Kiribati there are few right choices for sanitation. According to Marc Overmars from UNICEF, dry latrines are the only option but finding a technology that is affordable, and acceptable to communities' demands and preferences is problematic. There is an interest in composting toilets as a solution, especially from the Ministry of Environment, Land and Agricultural Development which sees that there could be ways of using sanitation technology to improve agriculture through composting. Another extreme solution suggested by some is for sparsely-populated villages on Outer Islands to have

designated open defecation 'safe' areas, but this is not being seriously considered just yet.

A search is on for the most suitable technology, yet everyone agrees that there is no perfect technology and a balance needs to be found between cost, environmental protection and user preferences. Currently there is a coalition of partners working on developing suitable sanitation options – New Zealand's Ministry of Foreign Affairs and Trade (MFAT), Australia's Department of Foreign Affairs and Trade (DFAT), Asian Development Bank, NGOs, and research partners New Zealand Institute of Environmental Science and Research – are all looking at technical options which are acceptable, feasible, affordable, and use locally available products.

The researchers want to avoid past mistakes. Trials of composting toilets in Kiribati's Kirimati Island 20 years ago were largely unacceptable to the community, as the approach was primarily a technology-driven solution without considering community preferences or taboos around handling waste. Unless there is in-depth community engagement and decision-making, together with WASH safety planning, the communities cannot grasp why they have to use composting toilets.

The coordinator for KIRIWTSAN Phase 2, Pauline Komolong, is also looking to Kiribati's Pacific neighbours in Tuvalu for inspiration. A composting toilet project there was successful at gaining public acceptance and there could be lessons learned to help Kiribati's problem. Under KIRIWATSAN Phase 2, implemented by the Secretariat of the Pacific Community, two demonstration toilets of the Tuvalu design will be provided in each community. While the composting toilet designs used by KIRIWATSAN 2 are environmentally acceptable, they are financially out of reach for households on Outer Islands.

Another approach is to change the behaviour of the younger generation first. Under the Kiribati WASH in

To solve Kiribati's sanitation dilemma, community engagement is key (Photo: B Tiim)

Schools Project, UNICEF and its partners will trial composting toilets in schools on four Outer Islands in 2015. The premise is that children can easily adapt to new behaviours, and that schools are a catalyst for change and a suitable place to trial new technologies. If the trial proved successful it can be rolled out to other schools in the Outer Islands and increase exposure to new technology on a wide scale.

"Solving the issue of water and sanitation in Kiribati is one of the most difficult issues in the world. There are no golden solutions, only compromises" according to Marc Overmars from UNICEF. There may not be a golden solution but it is clear that a range of solutions need to be developed collectively by Government, development partners, NGOs, researchers, Island Councils, and most importantly, the communities themselves. A stepwise approach is needed, which includes a strong enabling environment and partnerships, and cost-appropriate solutions in the context of WASH risk plans. CLTS will continue to play a key role in community mobilization and behaviour change, but achieving sustainable and healthy ODF communities in Kiribati is a continuing process.

MYANMAR

Myanmar: Myanmar – Doing the ODF two-step

UNICEF and the Department of Public Health in Myanmar, are experimenting with increasing the sustainability of ODF through a two-stage certification process. The idea is to have a warranty or probationary period of 12 months, during which time an ODF village is supported and monitored to keep its ODF status. However, the village also risks losing its hard won ODF status if it is not careful.

Myanmar's ODF criteria

In Myanmar the ODF criteria includes:

1. No evidence of open defecation in the whole village.
2. Every latrine has a proper lid over the latrine pan and a cover on the ventilation pipe of the pit to prevent flies.
3. Children's faeces are disposed in the latrine pit or properly covered.
4. Everyone must wash their hands with soap or other soap substitutes such as ash or sand after using the toilet, as indicated by presence of soap and water at the latrine.

The community should also prepare a strategy for sustaining the 100 per cent ODF status and an action plan to carry this out, such as how it will mobilize and support the community to continue using latrines and reduce the number of shared latrines.

In many countries, getting to this ODF point is achievement enough, and follow-up beyond 100 per cent ODF status is left to Government health staff, with little in the way of formal monitoring and rectification of any slippage.

Building in a post ODF process

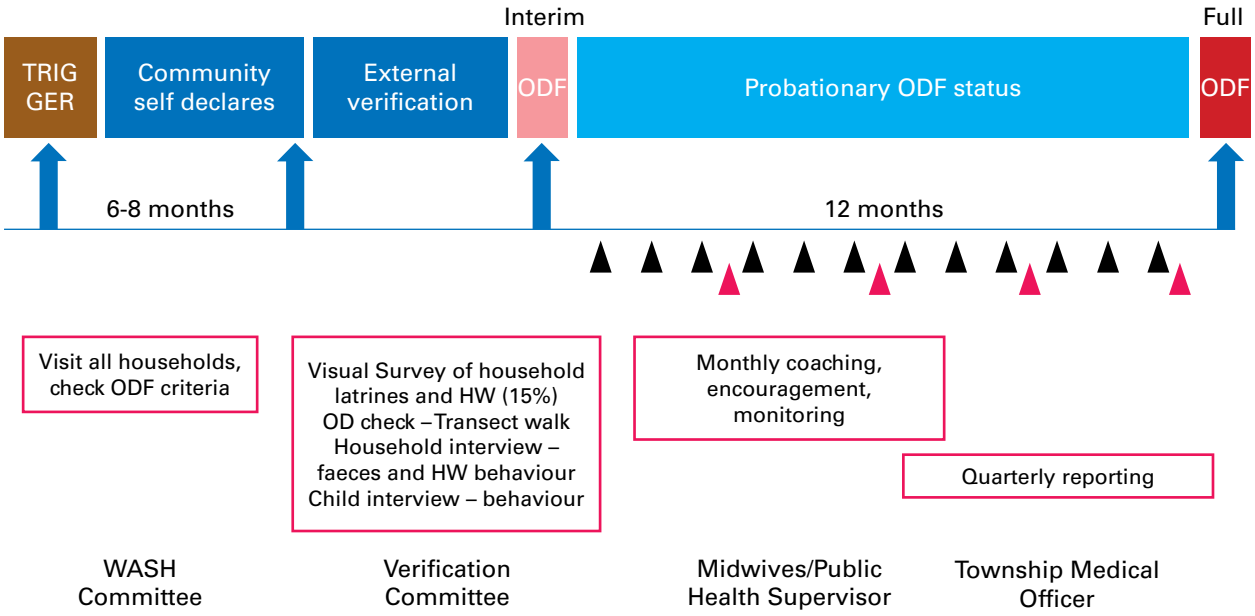
Myanmar is trialling a process that shows promise for strengthening ODF sustainability, by closer monitoring during the post ODF period and then rewarding the community for sustaining the status. The theory is that a community can be supported and encouraged to adopt and continue positive sanitation and hygiene practices through this additional step.

The timeline of the ODF process involves:

1. Village self declares ODF. Approximately six to eight months after triggering, if a community believes it has reached ODF status, members of the village WASH committee check against the ODF criteria by visiting all the households. When they are satisfied the criteria is met the committee contacts the township (district) health office and requests an official independent verification.
2. External verification. An external verification team checks the compliance of the village with the ODF criteria. Members of the verification team include: representatives from the Department of Public Health (Central Health Education Bureau, and Environmental Sanitation Division) in collaboration with the state/regional health education bureau, township medical officers, basic health staff, other local governmental officials who are already trained as CLTS facilitators, and natural leaders from nearby villages. The verification protocol involves sampling 15 per cent of households, carrying out physical checks of latrines, interviewing households, and a transect walk through the village.
3. Interim ODF certification. If the village complies with the verification protocol then an interim ODF status is awarded. This involves ODF declared villages attending a special ceremony at the Township Medical office, which is also attended by the township authority, parliamentarians, township education officer, basic health staff, CLTS triggered (but not yet ODF) villages and other ODF villages. This ceremony is an opportunity for the sharing of lessons learned by ODF villages and non-ODF villages, encouragement from the Town Medical Officer to non-ODF villages to become ODF, and for ODF declared villages to maintain their ODF status. ODF villages also receive large signs that they can display in their villages. ODF status is probationary for one year, during which time it can be revoked if slippage occurs. For national monitoring purposes, villages are officially counted as being ODF at this point.

4. Probationary ODF status. As part of their regular monthly visits to villages, Public Health Supervisors and midwives include ODF follow-up. They encourage the community to continue using latrines and maintaining other behaviours, build new latrines for those who are using shared latrines and avoid reversion to open defecation. The maintenance of the ODF status is monitored and recorded on a quarterly basis by the township authority and township medical officer. If they find non-conformance with ODF requirements then the community status is revoked. A full award of ODF is granted after maintaining ODF status for one year.
5. Full ODF certification. After one year of sustaining ODF, a village is certified as achieving full ODF status.

Figure 1: Myanmar's post ODF process



Key issues

- This process is yet to be adopted by Government and is only being trialled. In fact CLTS is not yet part of the Government's approach to increasing sanitation and there are no authorized guidelines on CLTS and ODF.
- Implementers find that village ODF acknowledgement ceremonies should be held as soon as the villages are declared ODF to keep community enthusiasm high. However, this requires strong planning and coordination by township officers to ensure timing is suitable for ceremonies for batches of ODF villages.
- As yet, no village has implemented CLTS long enough to get to the full ODF status after the 12 month probationary period.
- The process has not been developed and described in detail beyond the probationary period. For example, exactly how the full interim ODF status is verified and awarded is yet to be finalized, as is the monitoring system for full ODF villages.
- Regular follow-up by basic health staff is still weak because staff are overloaded with many tasks. Implementers also do not have funds to conduct continuous monitoring after villages achieve ODF.

The trial of this approach will continue to be monitored by CLTS implementers and may soon find its way into the Government's official CLTS approach.

One question remains – what happens after full ODF status is achieved? Indications so far are that once a community reaches ODF status that using a latrine becomes a social norm for villagers, and close monitoring is not necessary. The key challenges are to move households away from using unsanitary latrines to sanitary latrines, and to improve the sustainability of latrines in flood prone and sandy soil areas where toilets are not durable and need to be frequently replaced. In these conditions, better technical solutions and sanitation marketing could improve sustainability.

THE PHILIPPINES

Philippines: Closing the gap – Using CLTS to fast track sanitation for the poor in the Philippines

The sanitation problem

Access to improved sanitation in the Philippines has been increasing in rural areas since 1990, from 46 to 71 per cent in 2015, but open defecation is still around 10 per cent.[33] It is predominantly poor families that are disproportionally without access to sanitation. This is starting to change in the Philippines through WASH integration in the core programmes of the Department of Social Welfare and Development (DSWD) that directly target low-income households.

The target group

With support from The World Bank Global Water Practice Water and Sanitation Program (WSP), DSWD is piloting CLTS and sanitation for 80,000 households through the Pantawid Pamilyang Pilipino Program. Pantawid Pamilya is a social protection programme from the national government that invests in the health and education of poor households with children aged 0-18 years old and/or pregnant women. The Program supports the policy of the state to promote social justice, raise the standard of living and improve quality of life for all.

Patterned after the conditional cash transfer scheme implemented in other developing countries, the Pantawid Pamilya provides cash grants to beneficiaries, provided that they comply with the set of conditions required by the programme. These include conditions such as pregnant women attending pre- and post-natal check-ups, school enrolment and attendance, health check-ups, and attending monthly parent counselling sessions. The Pantawid Pamilya also invests in human capital to overcome future poverty and break the intergenerational poverty cycle. On average, 55 per cent of the 2.3 million households registered in this programme do not have access to an improved toilet.

At first DSWD seemed an unlikely promoter of sanitation but WASH is a priority of the Department and is included as a measure in its Social Welfare and Development Indicators (SWDI).[34] Access of families in the Program to sanitary toilet facilities is regularly monitored. In 2014, DSWD realized that it was not making effective progress at increasing access to household sanitation, with results from the SWDI showing that 584,373 households still had no access to any toilet facilities. The Philippines' 2013 review of scaling up rural sanitation also identified the Pantawid Program as a possible way for increasing access to sanitation for the poor.

The main avenue for promotion of sanitation is through the Family Development Sessions. These are monthly meetings between DSWD staff and 20-30 household grantees of the Pantawid Program. Attendance at these regular one to two hour meetings at the *barangay* or village level is a condition of receiving the DSWD cash grant. The topics covered aim to expand the knowledge and skills of parents, and help them appreciate and comply with the health and education conditionalities of the programme. The sessions also aim to strengthen family life and increase parent involvement in community development efforts.

Sanitation and health have always been a topic in the Family Development Sessions, but usually involved telling parents to look after their children and not let them defecate around the house.

> "Previously we were not focused on proper hygiene. Children go everywhere and don't mind what germs they touch, so we would just say to parents, look after your children, keep them clean, protect your children… CLTS is more effective. I wish this project started earlier". – Jehan Lacandazo, Pantawid Program, Babatngon municiplality, Leyte province)

What the pilot changed

The pilot has strengthened the sanitation module of the Family Development Session by modifying the content covered and making the style of delivery more participatory and engaging.

[33] JMP (2015) Progress on Drinking Water and Sanitation, 2015 Update. World Health Organization and UNICEF.

[34] *Social Welfare and Development Indicators (SWDI)* is an assessment tool that describes the socio-economic conditions in a family and measures its level of functioning in terms of utilizing available internal and external resources to improve their quality of life.

Integrated into the enhanced Family Development Session now is:

- The concept and urgency to stop open defecation;
- The CLTS approach, in particular triggering using shock, shame and disgust to: build awareness on the negative implications of open defecation, as well as its repercussions on health, especially on children; and create demand for improved sanitation facilities;
- Behaviour Change Communications (BCC), in particular a flipchart discussion or engagement session to: (1) stress the unlimited benefits of having a toilet, and (2) to get commitment of Pantawid grantees to build their own toilet; and
- Promotion and offering of low cost or alternative designs of hygienic toilets.

These changes are integrated into more than one Family Development Session, with triggering done first, then one month later at the next session, the BCC and latrine model options are introduced.

In addition to revising the content of the Family Development Session, a facilitator's guide and BCC materials were produced, DSWD staff trained, the concept pilot-tested, progress evaluated and learning shared.

The *Unli Asenso Pag May* Inidoro (roughly translated means 'there is unlimited progress when one has a hygienic toilet') Flipchart: Handheld and Large Format.

Results are showing promise

Beneficiaries of the Pantawid Program realize that open defecation causes health problems, and importantly, has cost implications in terms of medical expenses. Their strong reactions to discovering that they are 'eating faeces' include crying, and vomiting.

Within hours and days of triggering in Babatngon municipality in Leyte province, beneficiaries ceased open defecation, began covering their faeces, sharing latrines with others, or using public facilities. Some beneficiaries started to dig pits and build toilets. In another pilot in Quezon province, within four months of the new approach in 10 demonstration municipalities, 3,298 beneficiary households have ceased open defecation. According to DSWD staff, this is far more effective than the previous approach.

A Rapid Assessment in early 2015 was commissioned by WSP in the provinces of Negros Occidental and Quezon to determine the initial outcomes of the integration of sanitation into the Pantawid Program. Results have shown strong evidence on the impact of the enhanced Family Development Session process:

Health Awareness – Most of the grantees exposed to the enhanced Family Development Session demonstrated a high degree of awareness on healthy water and hygiene practices. They were able to associate unsanitary practices and unsafe water with prevalent diseases in their locality, i.e. amoebiasis, diarrhoea, and helminthes. This awareness translated into increased household water treatment and improved solid waste disposal practices.

Sanitation Facility Adoption – Households triggered through the Family Development Session adopted sanitation at rates of 17 to 29 per cent, depending on the municipality. The decision to build toilets was driven mostly by social and emotional drivers, including: the protection of children and teenage daughters, convenience and comfort, pride, health, and cleanliness.

Financing – Grantees have employed various means to finance the construction of toilet facilities including: setting aside a small portion of the Pantawid cash grant; accumulating savings from income sources; and obtaining loans from relatives, employers, and hardware stores. Other grantees were recipients of traditional Local Government Unit subsidies for toilet bowls or construction materials.

Links with other DSWD Programs

DSWD recognizes that the Pantawid Program alone cannot transform households out of poverty. In 2014 DSWD developed a new framework to integrate DSWD's three big programmes, namely the Sustainable Livelihood Program,[35] the Kalahi-CIDSS-National Community Driven Development Program,[36] and the Pantawid Pamilya. DSWD has "convergence" officers at municipal, provincial and regional levels to operationalize how these programmes can be brought together to enhance their effectiveness.

For sanitation, the links with other programmes provide a way for poor households in the Pantawid Program to gain skills, tools, money, and community support to end open defecation and build toilets. Through the Sustainable Livelihood Program, Pantawid beneficiaries can access:

- skills training in the areas of masonry, plumbing and carpentry;
- cash for work programmes which provide 11 days of work including on toilet building projects; and
- loan funds of 10,000 pesos for self-employment assistance. This is an opportunity for masons to pool funds and manufacture latrines for other beneficiaries or sell to the local government.

PILOT

4 Regions

11 Provinces

31 Municipalities

891 Barangay

80,210 Households

For the Kalahi-CIDSS programme, WASH projects (including sanitation) are one of the choices on the menu of community projects that can be funded by the programme. The programme follows a defined project cycle that promotes strong stakeholder participation starting with the identification and selection of community sub-projects.

Challenges

A very different approach

One of the biggest challenges has been the acceptance of CLTS by DSWD facilitators who are used to a different style of engagement.

[35] *Sustainable Livelihood Program (SLP)* is a community-based capacity building programme that seeks to improve the programme participants' socio-economic status. It is implemented through the Community Driven Enterprise Development approach, which equips programme participants to actively contribute to production and labour markets by looking at available resources and accessible markets.

[36] *Kapit-Bisig Laban sa Kahirapan-Comprehensive and Integrated Delivery of Social Services-National Community-Driven Development Program (KC-NCDDP),* is the expansion into a national scale of operations of the community-driven development (CDD) approach, a globally recognized strategy for achieving service delivery, poverty reduction, and good governance outcomes. These are realized by helping communities identify challenges in their locality, and making informed decisions on a range of locally identified options for development.

"At first I experienced some difficulties in doing CLTS. The normal Family Development Session is a very different approach – you have to be very nice, very approachable. In CLTS you have to be strong, you have to make people realize they should have a latrine. If you cannot be effective as a facilitator you cannot touch their lives, their emotions, their knowledge, and then you cannot change the way they think…. After two or three times it started to come naturally." – Christina Lim, Pantawid Program, Macalelon, Quezon province.

Pantawid Program staff themselves initially experienced shock, shame and disgust doing the CLTS triggering in open defecation areas, but are now getting used to dealing with *'tae'* (faeces). Their own improved awareness of the transmission of disease through flies and faeces has spread to their personal lives and families and also to their colleagues in other programmes.

The participatory style of CLTS triggering has also influenced some staff in the way they conduct other Family Development Sessions. Open forums with discussion and sharing of solutions are more common because of learning from the CLTS style.

Maintaining relationships with beneficiaries

When the piloting of CLTS was first discussed, a major apprehension of DSWD senior staff was the possibility of alienating people in disadvantaged situations and damaging long-standing relationships with beneficiaries. Pantawid staff build up rapport with beneficiaries over one or two years of regular contact, but the different approach of CLTS was initially confrontational; DSWD feared that the approach would break these relationships and triggering would require sensitive handling. CLTS triggering has in fact brought back community pride and a consensus to stop open defecation. The process has proven effective through the use of humour – community participants laugh about the topic and shaming is subtle. Some facilitators feel the need to further protect the feelings of beneficiaries, by explaining the necessity of going through the CLTS triggering process and the importance of sanitation that needs to be addressed to reduce the effects of poor sanitation and malnutrition on children. After CLTS triggering, staff go back to the community for monitoring, and for other Family Development Sessions, so for some facilitators this session closure is needed.

Can the poor really afford toilets?

The Pantawid Program grant does not provide cash or credit for latrine construction. The small monthly grant (a maximum of 2,000 pesos or US$ 44 per month) is for immediate needs such as education and food. Access to money to build a latrine, especially a septic tank toilet in high water table areas, is a challenge for beneficiaries, particularly the 30 per cent of beneficiaries who are at poverty level. A household with any available savings is faced with competing priorities of whether to pay off long-standing debt, set aside funds for special occasions or emergencies, or build a toilet. The capacity to purchase the necessary materials to build toilets remains an ongoing challenge, however some creative approaches are being used to work around this:

- Savings of beneficiaries – from the Pantawid grant money and from informal work some beneficiaries are able to save small amounts of money towards a latrine. Usually this is through practicing daily savings of 1 or 2 pesos (US$ 2-4 cents) which is put aside in a coconut shell or a piece of bamboo, and quarantined from regular household spending.
- Loans – some beneficiaries with a capacity to repay, borrow money from friends and neighbours.
- Community support – during the Family Development Session beneficiaries are encouraged to help and support each other. For example, if one beneficiary is not able to dig a pit they can call on other parent group members to help.
- Grants from local government – Very poor beneficiary households without capacity to build a toilet, such as a solo mother with many children, or an elderly couple, are helped by DSWD to link them to the local government unit for financial assistance with materials. Young, able-bodied beneficiaries are expected to self build.
- Smart subsidies – The DSWD may negotiate a bulk price at a hardware provider, thus reducing the materials' cost; or the local government may be persuaded to provide a truck for the transport of materials to beneficiary homes, saving on transport costs.

This Pantawid beneficiary gave up smoking and used the money to save for a latrine.

- Sustainable Livelihoods Program – Through this DSWD programme beneficiaries can be trained as masons, earn short-term wages and potentially be organized as a local enterprise supplying sanitary products and services to their community.
- Kalahi-CIDSS Program – Priority for *barangay* sanitation is identified during the community participatory process of this DSWD programme. However, due to limited resources, sanitation may drop off the priority list presented at the Municipal Inter-Barangay Forum if other *barangays* have more pressing issues.

Making coordination work is hard work

Internal coordination between DSWD programmes and externally with other agencies, such as the Department of Health, is a constant challenge, and requires special effort, particularly at the municipal level.

DSWD programmes have different implementation schedules, especially the community driven development cycle of the Kalahi-CIDSS and the monthly parents meetings of the Pantawid Program. Optimally, CLTS triggering should occur just before the first *barangay* assembly of the Kalahi-CIDSS in which the need for the construction of toilets to be funded as a subproject for Kalahi-CIDSS is identified. If the schedule does not align then the need for the construction of toilets for triggered beneficiaries does not get picked up.

To improve timing and sequencing, DSWD programmes share their work schedules through Municipal Action Team meetings. During these meetings core DSWD programme representatives discuss plans and activities for the next days, weeks, and months. Local priorities and needs are identified and agreement reached on who is doing what and when. For example, if Kalahi-CIDSS is planning to conduct *barangay* assemblies in July, then Pantawid staff arrange their schedule to trigger beneficiaries in June.

Coordination with outside agencies is more challenging, but there is a forum at the municipal level for this to occur. Municipal Inter Agency Coordination meetings are held monthly with all agencies and the local government. This is an opportunity to discuss local issues with partner agencies, and update each other on progress, and needs. However, a challenge is that DSWD staff rely on the attendance and availability of partner agencies for that coordination to occur. Other ways of coordinating with outside agencies are through personal contact and building relationships. For example, Pantawid staff work closely with nurses to coordinate health checks with triggering on the same day; or invite rural sanitary inspectors to attend triggering and other events.

Support of political leaders essential for scaling up

Support of the Municipal Local Chief Executive or mayor can make a huge difference to the speed and uptake of CLTS for both Pantawid and non-Pantawid households and achieving Zero Open Defecation (ZOD) communities. When mayors are very open and supportive to improving sanitation, progress can be rapid and comprehensive. In the Lucban municipality in Quezon province, DSWD staff have been able to push the local government to embrace the WASH programme for the whole municipality, with everyone triggered. This has resulted in only a small number of people without a toilet facility and the prospect of achieving ZOD within reach in 2015.

Although Lucban municipality has a male mayor, DSWD staff say that it is often female mayors who are most supportive of achieving ZOD.

Many other mayors are indifferent and do not prioritize sanitation as an issue in their community, especially those that have won awards for a clean environment. Often it falls on DSWD staff to lobby the mayor to take care of other non-Pantawid households and prioritize sanitation and ZOD.[37] This involves many presentations at the municipal level to sell the idea, highlight needs and achievements, and then regular follow-up visits and consultations with feedback to mayors on the progress. Staff generate a little competition by comparing progress between municipalities. The strategy to win over local leaders is demanding on DSWD staff time. Staff are both daunted and optimistic about the prospect of an election in 2016 – it will mean repeating the consultation process for new local leaders, but it provides an opportunity for a fresh start and a chance to get local leaders on board early.

Land is not always available

WSP's rapid assessment found that a number of grantees were landless and not permitted to build permanent structures on the land they were living on by the landowner. In Typhoon Yolanda (Haiyan)-affected areas many people live in temporary or transitional housing and are awaiting relocation to permanent housing or live in informal settlements. Even in these areas landlords often do not agree to the construction of latrines on their land. Some beneficiaries in Yolanda-affected areas are holding off building a toilet until they are relocated, but they are currently digging and covering faeces. In Babatngon, solving the problem of open defecation was discussed at a *barangay* council meeting where it was resolved by an offer to donate land to build community toilets.

This is just a pilot isn't it?

The potential of DSWD to contribute to the national goals for ZOD is not yet fully appreciated by the DoH or integrated into the National Strategic Sanitation Plan. The pilot is seen as a separate activity from the efforts of the DoH. This may change in time with more evidence and consultations on how the two departments can work together strategically and practically. There is also an on-going initiative among national agencies, including DSWD and DoH, to establish the National Inter-Agency Committee for Rural Sanitation to coordinate and jointly implement WASH initiatives.

Criteria for pilot site selection

REGIONAL
The top four regions with the highest incidence of households without access to sanitary toilet facilities and safe water.

MUNICIPAL
Areas where three DSWD programmes are integrated
30 per cent or greater incidence of households without access to toilet facilities
25 per cent or greater incidence of households without access to safe water
Improving the level of well-being of 2.3 million Pantawid Pamilya participants

[37] The Municipal Health Officer of DoH is expected to trigger non-Pantiwid beneficiaries.

What works:

- WASH is already a priority for DSWD in its programmes. The integration of the three core DSWD programmes means the opportunity for sanitation is being optimized through the DSWD's convergence.
- Focusing integration at the municipal level and strengthening staff is where the action is. The Municipal Action Team monthly meetings provide a formal mechanism for essential coordination.
- CLTS has a captive audience. It is compulsory for Pantawid beneficiaries to attend Family Development Sessions where they are exposed to CLTS triggering.
- CLTS' simple and experiential triggering approach is very suitable for beneficiaries, many of whom who have no schooling.
- Many of DSWD's municipal staff are young professionals with backgrounds in social welfare, teaching, and nursing. They are energetic and independent, but as with all department staff, are motivated to deliver results due to employment on one-year performance based contracts.
- Close regular monitoring by DSWD means that the effectiveness of CLTS in stopping open defecation is obvious. This information is an important tool to demonstrate results to municipal mayors.
- A DSWD Guidance Note clearly outlines how the integration of the three programmes works at all levels.

Lessons learned:

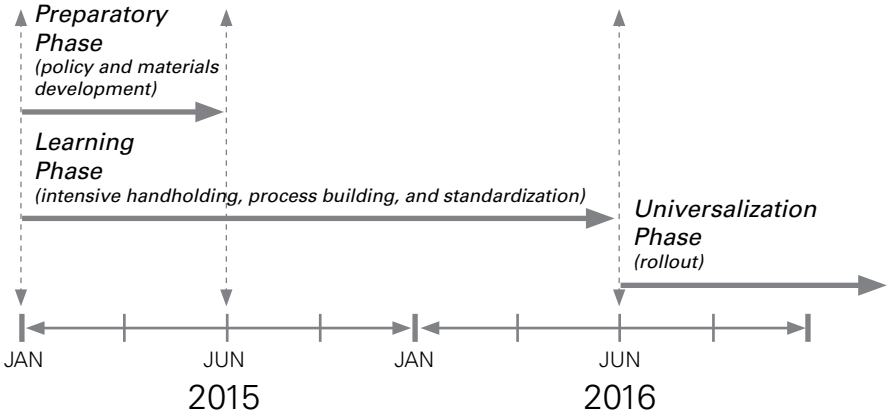
- Non-traditional advocates of sanitation promotion and CLTS triggering can be as effective as traditional ones. DSWD has proved it can increase sanitation access, despite only recently becoming an advocate.
- CLTS is a new approach with which DSWD staff take time to become familiar.
- Coordinating and integrating three different programmes requires a concentrated effort and clear operationalization of what integration means in practical terms.
- Staff support and training is essential at all levels of the Department, from the national level through to implementing staff at the municipal levels.
- Advocacy to local government, especially mayors, is critical to the success of community sanitation.

"The biggest learning from Quezon is that we cannot do things alone. It has to be a collaborative and coordinated effort, and the dedication to achieve something." – Marilyn Barrameda, Provincial Link, DSWD Quezon province

Future outlook

The WASH integration in DSWD's convergence pilots is only at an early stage and although initial results are promising it will not be rolled out to other provinces, municipalities and *barangays* until June 2016. The next step will be to reflect on the learning so far and strengthen the approach.

Areas for further consideration include: consistent guidelines on funding of sanitation; advocacy processes and approaches; sanitation marketing; sanitation inclusivity; and involving people with a disability.



Philippines: CLTS in post emergency situations – Philippines

How can CLTS fit within a post emergency situation when people and Government are recovering from widespread devastation and disruption? Experience from the Philippines following Typhoon Haiyan in 2013 shows that it is possible when part of a larger strategy to address sustainable sanitation.

Background to the emergency

Around 2 a.m. on 8 November 2013, Typhoon Haiyan (or Yolanda as it is known locally) made landfall in the Philippines. It was one of the most powerful and destructive typhoons ever recorded, with winds travelling at hundreds of kilometres per hour and a massive 5-6 metre storm surge that swept through low-lying coastal communities.

The Philippines is no stranger to tropical cyclones or typhoons, with 20 entering the country's Area of Responsibility each year and of these usually six to nine make landfall. Despite storm warnings and preparedness, Typhoon Yolanda resulted in more than 6,000 people killed, and houses, schools and health centres flattened. Some 14.1 million people were affected. Over 4.1 million people were displaced, including 1.7 million children. Those hardest hit were on coastal and inland areas of Biliran Island, Eastern Samar, Leyte, Northern Cebu, Metro Cebu, Samar, and Southern Leyte. Tacloban city, in Leyte province had 90 per cent of its buildings destroyed or damaged. Before the typhoon hit, these communities were among the most vulnerable in the Philippines with 40 per cent of children living in poverty.[38]

The Government of the Philippines mounted an immediate response to deliver life-saving relief, with assistance from the United Nations. UNICEF's Emergency Procedures for a Level 3 emergency were triggered and the cluster system of coordination, co-led by the Government and United Nation agencies, was also immediately made operational. An Inter-Agency Strategic Response Plan (SRP) was developed and run from November 2013 to November 2014.

As co-lead for the WASH cluster, UNICEF coordinated national efforts for disaster relief relating to water supply, sanitation and hygiene and related efforts to transition to development. In an emergency the initial response is to meet immediate lifesaving and medium term WASH needs for the most affected people. For sanitation this involved UNICEF engaging in or contracting humanitarian NGOs to construct emergency latrines in affected areas, and provide and operate portable toilets in camps reaching 310,000 people by the end of the SRP in November 2014. After life saving needs were met, UNICEF supported the development of a longer-term government-led holistic recovery and sustainable sanitation strategy in the Yolanda-affected area covering three regions (6, 7 and 8), six provinces, 47 municipalities, 874 *barangays* or villages and with the aim of reaching a total of 1 million people.

The strategy to address sanitation in Yolanda-affected areas

The Philippines WASH Cluster, including the Departments of Health (DoH) of affected regions, developed a Sanitation Strategy for Early Recovery in Yolanda-affected areas based on the rural sanitation strategy concept that existed prior to Yolanda. The Phased Approach to Total Sanitation (PhATS) is designed to help the national government achieve the goals of the Philippines Sustainable Sanitation Roadmap and the National Sustainable Sanitation Plan. These goals include that all *barangays* (villages) be declared Open Defecation Free by 2022, and all Local Government Units (LGUs) have their own local sustainable sanitation plans and budgets in place under the Investment Plan for Health by 2022.

PhATS builds on these national objectives to create an open defecation free environment with the safe disposal of liquid and solid wastes through a phased and holistic approach. PhATS combines the interrelated pillars of demand creation, with supply side interventions, and improvements in the enabling environment.

[38] UNICEF (2014), *One Year After Typhoon Haiyan, Philippines – Progress Report.*

Figure 1: PhATS holistic approach

The *enabling environment* pillar aims to develop the capacity of LGUs and governance at the regional and provincial level, including DoH and Department of Education, to understand, own and trigger PhATS. This pillar specifically aims to: improve WASH policy and planning, strengthen decision-making, increase accountability and transparency of processes and duty bearers, effectively allocate budget for sanitation, improve sector coordination, and increase monitoring capacity. Comprehensive governance training and engagement is provided to achieve this. The enabling environment also includes generating knowledge and information to improve performance.

The *community demand creation* pillar is divided into three main stages: pre-triggering, triggering and post-triggering. These stages aim to: identify expectations, generate the accountability of *barangays* through the participatory development of action plans and the discussion of sustainability, and trigger community members to recognize the need to change hygiene and sanitation behaviours, particularly stopping open defecation and achieving Zero Open Defecation (ZOD)[39] *barangays*. A range of approaches to sanitation and hygiene demand creation at community and household levels is acceptable, including tools such as Community-Led Total Sanitation (CLTS). School *demand creation* aims to develop children as messengers of change at home and school by targeting at least one school in each *barangay* for cash transfers, with capacity development for the Department of Education.

The *supply* pillar aims to strengthen local supply chains for sanitation and hygiene goods and services, encourage sanitation marketing, and develop the regulatory, monitoring and support functions of the local government. This pillar also includes the development of financing mechanisms for household credit, and working capital loans to local sanitation producers and service providers. Support is provided to partners to develop at least one decentralized wastewater treatment system, which can be used as a model for replication.

Phased approach

The PhATS implementation strategy is designed to overcome weaknesses of conventional sanitation interventions that just focus on building facilities or completing behaviour change activities, without planning for follow-up activities, or improvement of facilities and practices over time.

PhATS also takes account of the heightened needs and limited human resource capacities that exist within the first three to six months of a large scale emergency response and breaks down the early

[39] Zero Open Defecation (ZOD) is the local term for Open Defecation Free (ODF).

recovery process into several phases. Each of these phases requires the achievement and independent verification of defined and measurable outcomes, before graduation to the next phase (or Grade). The key entry point is achieving ZOD status using a common framework.

Figure 2: PhATS implementation phases

For a *barangay* to achieve ZOD status (G1) it must have excreta-free open spaces, drains and bodies of water, 100 per cent use of hygienic toilets (up to 20 people per toilet), and safe child excreta disposal.

The WASH Cluster agreed that the G1 process should also include some minimum activities to address behaviour change, build capacity within the LGUs, and share learning between the different stakeholders and partners. These include: use of demand creation tools; involvement of school and day care centre WASH stakeholders in the community processes; minimum health and hygiene promotion; *barangay* baseline sanitation survey; *barangay* sanitation plan for ZOD achievement; *barangay* sanitation committee; *barangay* health worker training; a ZOD verification and certification process; and knowledge management activities.

Once the *barangay* is open defecation free, it self-declares ZOD status and requests verification by the municipal Sanitary Inspector and Provincial Health Office representative, resulting in the *barangay* being awarded ZOD certification. Following an agreed official monitoring procedure, the Sanitary Inspector follows up on the status of ZOD and reports back to assure sustainability of results.

A difference with the phased approach of the Rural Sanitation Strategy being implemented in other parts of the country and the Yolanda Recovery is that the subsidy of sanitation hardware is permitted. This is because of the devastating and economically challenging conditions created by the typhoon, particularly for very poor households without toilets prior to Yolanda.

No specific demand creation approaches or tools are prescribed to reach ZOD, but NGOs and LGUs are encouraged to draw from a toolbox of demand creation approaches and tools, and training in key approaches like CLTS are also made available. How NGOs and LGUs apply demand creation tools is flexible; allowing for innovation, and application of their own capacities and experiences from elsewhere in the Philippines and the region. Efforts are made to monitor, evaluate and share best practices across partners, as a way to spur the evidence-based improvement of approaches.

The phased approach is supported by incentives (both financial and non-financial) that encourage and reward the achievement of each grade. Partners are taught on how to apply subsidies and incentives, and while the subsidy amount is generally fixed,[40] partners have the flexibility of when and how to apply subsidies.

[40] The value of subsidies was fixed at PS 6,000, with higher subsidies only allowed in low water table areas.

Progress and results

The Philippines had experience in CLTS implementation prior to Typhoon Yolanda. UNICEF, World Bank WSP and Plan International each had its specific implementation approach, but at a very limited scale. According to a 2013 report on scaling up rural sanitation, there were only around 50 ODF communities, and fewer than 250 *barangays* triggered after five years of CLTS implementation (in a country with 42,000 *barangays*).[41]

As of May 2015, more than 400 *barangays* or nearly half of all 874 *barangays* in 47 municipalities across the Yolanda-affected area have been verified as ZOD at G1 level.[42]

How did these disaster-affected areas get to ZOD in just 18 months after Typhoon Yolanda?

After the initial emergency response following Typhoon Yolanda people moved back to their homes and communities much faster than expected. This provided an opportunity to use existing systems and build on research and past thinking from the previous years of CLTS implementation in the Philippines. The idea was to test experience on whether it was possible to do a participatory demand-led approach within the context of an emergency in the Philippines.

One of the biggest challenges to implementing CLTS in the post emergency situation has been changing the mindset of emergency implementers to a developmental approach. Immediately after the emergency UNICEF made humanitarian response Partnership Cooperation Agreements (PCAs or contracts) with 12 international NGOs which ran until August 2014. The PCAs did not have targets for ZOD or even mention CLTS or demand-led approaches as they were standardized humanitarian PCAs targeting life saving needs. Most of the staff from NGOs working on the Yolanda response had never been exposed to the ZOD concept or done CLTS before, however, they were used to supplying latrines in emergency situations.

The idea of CLTS and ZOD was slow to take hold. During a WASH cluster meeting, at the end of November 2013 UNICEF began discussing open defecation free communities as an outcome (consistent with national policy) rather than just supplying sanitation. In the beginning this elicited a strong negative reaction from the emergency group, with some NGOs simply saying they do not do CLTS. UNICEF's dialogue with humanitarian NGOs continued through early 2014, eventually an informal commitment was agreed that all of the 12 NGOs should try to get at least two *barangays* to ZOD in the Yolanda-affected area. NGOs committed to this goal, despite no contract requirement to do so, and began using demand creation and social mobilization in their approaches. To support this, UNICEF provided condensed two-day demand creation training for all humanitarian PCA partners in April 2014.

The thinking behind the target was that if the 12 NGOs committed and started with a small doable target, then they could do one *barangay*, then two and possibly many more. It turns out that this is exactly what happened. By the end of the strategic response plan (end November 2014) 84 *barangays* had achieved ZOD – more than three times the expected 24.

Supporting Government to accelerate progress

The Government has a critical role to play in supporting and sustaining sanitation beyond the recovery phase. Consultation took place with DoH's in all affected provinces to get feedback on how to move forward from the emergency response to development.

In order to shift to large scale development, UNICEF knew that work had to start immediately on governance and the ability of local governments and sanitary inspectors to understand what demand creation was. Under a separate interim PCA agreement (from April 2014), the NGO A Single Drop for Safe Water developed a training module and began providing five-day training sessions in demand creation and other training in governance (including how to develop a WASH plan) for mayors and key players in LGUs.

At same time in June 2014 UNICEF developed partnership agreements with 40 LGUs where UNICEF funded targeting of sanitation improvements using direct cash transfers through Government systems to test and strengthen the governmental funding flow. Although seen as risky by some, direct cash

[41] Robinson, A. (2013), *Development of a multi-stakeholder implementation strategy for scaling up rural sanitation - Final report*, UNICEF.

[42] PhATS Newsletter Volume 1 Issue 2 May 2015.

transfers channelled funds and expenditure using Government procedures and mechanisms, helped build capacity at different levels and make the Government central to decision making about how money was spent. Achieving ZOD *barangays* was written into the contracts with the LGUs, and with training from UNICEF on governance, demand creation and technical aspects it was then up to each LGU to use their own mechanisms to get their *barangays* to ZOD. This supports a long-term development approach where in the future the Government could use its own funds to implement a Government programme and even hire NGOs.

Almost all direct cash transfer PCAs were completed in June 2015, and while a detailed analysis is yet to be undertaken, the results have been mostly positive. Using expenditure as an indicator of success, a number of LGUs have spent all their funding and are able to use other funding streams within the bureaucracy of the municipality to reach higher sanitation goals. Some municipalities have allocated additional funding for WASH into their annual investment plans, while some have developed WASH plans which clearly tackle ODF in their communities.

Since September/October 2014 the UNICEF team started shifting to the next level of governance and began working with Provincial Health Officers and the DoH at regional level to scale up.

Formalizing NGO commitments to ZOD

As the end of the humanitarian PCAs loomed in August 2014, UNICEF was keen to push towards development and build on the ZOD achievements made informally by humanitarian NGOs. Following comprehensive discussions with Government in all provinces, UNICEF teams, and with humanitarian partners on how to take the early recovery phase into a development programme, new standardized development PCAs were devised. The PCAs covered 874 *barangays*, and included ZOD targets embedded in a standardized approach which all PCA partners had to follow. The development PCAs encompass 12 NGOs (many from the emergency phase) and run from September 2014 until November 2015 with a possible three month extension.

One NGO's perspective

An example of one of the Yolanda NGOs that has fully taken on board the PhATS approach is Samaritan's Purse. Although not one of the original humanitarian NGOs contracted by UNICEF, a major component of Samaritan's Purse's Typhoon Yolanda relief strategy was a large-scale sanitation project, which saw 11,700 household latrines (with septic tanks) constructed across two municipalities in Region 8. This involved the supply of free materials in different stages, contracting skilled masons, with households contributing labour. Since then Samaritan's Purse has moved away from subsidized approaches, and is facilitating demand creation, linking with micro finance organizations, strengthening the supply chain through developing technical skills and business acumen of local entrepreneurs, and sanitation marketing promotion, as well as supporting the design of septage treatment facilities.

In terms of demand creation, Samaritan's Purse follows the general process of pre-triggering to post-triggering process. However, it has found that in the post emergency situation there are some people in the community who were waiting for handouts from international NGOs. To overcome this it is made clear at the outset that there is no special handout according to Beverlely Holares, one of the Hygiene Promoters. "We make it clear from the very beginning that we are now in a recovery phase. We tell them we are visitors in their place and we have nothing to give, and we are here to talk to them, ask how they are doing, about their situation. We set the environment, and set proper expectations."

Samaritan's Purse has found that the speed of reaching ZOD from triggering is increased significantly when two people from each *barangay* are appointed as PhATS advocates. These people are involved from the beginning and receive training for three days in all the CLTS and PhATS processes, and activities. Most PhATS advocates are *barangay* officials or *barangay* health workers. During triggering PhATS advocates take an active role and participate as environment setter, lead facilitator, core facilitator, or process recorder. The results from Basey municipality[43] highlight this effect – the time from *barangay* triggering to submitting a letter for verification of ZOD is just two to six weeks.

Lessons learned

[43] Basey municipality has 52 *barangay*.

Why has the PhATS approach worked after such a devastating emergency? What are the lessons learned?

- **Do not conduct CLTS during the height of the emergency.** In the critical emergency phase CLTS is not a suitable approach to sanitation; an immediate life saving response is needed for six to eight weeks, possibly up to 12 weeks after the emergency event. During this time it is not possible to talk about community mobilization as no one is open to the idea. The appropriate sanitation response is to construct emergency latrines in communities and emergency centres.
- **Shift to development as soon as possible.** There is a huge opportunity immediately after an emergency to take the energy, initiative and openness of people and Government to shift into a large-scale development programme which innovates and tests ideas. The transition to a development phase should be made as soon as possible after the emergency peak period.
- **A large budget.** Having a large budget available as a result of the emergency allows for both experimentation/innovation and scale. Before Yolanda, UNICEF WASH pilot projects included CLTS in *barangays*, but the total development programme budget was extremely limited (less than US$ 4 million per year). Yolanda had US$ 40 million WASH programmatic funding (not including staff) – US$ 20 million which was for humanitarian work and a further US$ 20 million for development.
- **Consult regularly with partners.** Changing mindsets and introducing new approaches requires a lot of ongoing discussion and joined learning. Monthly PCA partner meetings were held to share experiences and allow for learning on PhATS step by step over time by people from humanitarian backgrounds. Joint development of the large scale development programme with PCA partners and government required ongoing discussions. This process, especially feedback and involvement from Government should begin as soon as possible.
- **Have flexible PCAs.** UNICEF provided the strategy, training, and tools for PhATS and achieving ZOD communities. Although the development PCA was standardized between NGOs, it did not prescribe in detail what approach NGOs were to take and what they had to do on a daily basis, but only that there were targets for achieving ODF. This kept ownership of the process with NGOs and allowed for innovation in the way they set about reaching their goal.
- **Build on existing approaches and existing policy.** Whether CLTS can be applied in a post emergency situation depends on the policies existing within the country for a development programme at that moment. PhATS builds on the existing policy and directives of the DoH in achieving ZOD communities. CLTS had also started to be used in a conflict area in Mindanao with positive experiences. The same three-phase sanitation development framework outlined for the rural sanitation implementation strategy was applicable for PhATS for Yolanda Recovery but with some adaptation for context and integration with the successful strategic approaches utilized by humanitarian actors working on the early response and recovery.
- **Build capacity of government as soon as practical.** From the outset there was a focus on governance and training the different entities at government levels about PhATS. This training can start early, even just six months after the emergency. Although this sounds early, in the Philippines six months after an emergency typhoon is six months before the next one. For Government, typhoons are part of a continuous annual cycle and do not present any particular barrier to improving capacity.
- **Get national level endorsement.** DoH was hesitant about the phased approach to total sanitation, but the emergency gave the impetus to try the approach, and DoH was willing to support it in affected areas. A very detailed Mid Term Review process, which was joined by national level DoH, showed how the national policy on sanitation fitted into the PhATS, and that PhATS provided a methodology to operationalize the national policy. This led to DoH staff confirming that the approach did support the Philippines' sanitation policy.
- **Institutionalize ZOD criteria and verification process.** Institutionalizing the ZOD criteria ensures standardization of measurement, as well as local government buy-in. In the Philippines it is usually essential to have municipal or regional ownership and endorsement of a programme to get anything achieved. However, because of the emergency context, the PhATS concept and ZOD monitoring system was jointly discussed and agreed with all provinces, and able to be implemented without formal approval. Later UNICEF helped to retrospectively formalize PhATS and ZOD through a memorandum issued G1 and G2 certification in Region 8 building on existing national guidelines. UNICEF is now working with Region 6 on the verification process.
- **Employ knowledge management to share experiences.** UNICEF made a special effort to develop tools and systematically document what was being done in order to share learning between PCA

partners. This is being done through a contracted NGO to consolidate NGO experiences, and a senior sanitation specialist to document technical findings from the field.

What has been learnt about what could be done better?

- The understanding and application of **subsidies, rewards and incentives** by NGOs could be improved. The approach has been an open one, with NGOs choosing whether they offer subsidies and rewards before or after ZOD. However, better targeting of the very poor is needed and more thought about when it is best to support them.
- **Overall lessons need to be drawn** from the many different approaches to achieving ZOD employed by NGOs and LGUs. A second implementation cycle should take these lessons into account and apply them within a tighter implementation framework.
- NGO staff and Government would have benefitted from more **quantity and depth of training**, however the capacity for people to take up new learning after an emergency is an issue. NGO staff turnover was also a challenge for capacity development.
- Strengthening **advocacy** and greater use of **media** campaigns to reinforce the overall messaging of PhATS and to increase dissemination of the approach.

Next steps for sanitation in the Yolanda affected area and nationally

Perhaps the most promising outcome from the Yolanda experience is the institutionalization of ZOD within local government systems. Governance work aimed to secure additional allocations into the WASH budget line at the local government level and there are signs that budget allocation is increasing. With skilled NGOs available, it is hoped that NGOs will one day be engaged by LGUs using their own resources to achieve ZOD of all *barangays*.

In the meantime UNICEF is continuing to build on partnerships with Government entities to strengthen Government units at provincial and municipal levels, with the aim of expanding the roll out of PhATS with the objective to declare additional *barangays* ODF. UNICEF is also providing funding to DoH and Provincial Health Offices to establish a much needed national monitoring system for tracking and analysing ZOD achievement and sustainability, with Region 8 selected as a pilot to develop the monitoring system. This pilot could very well serve as a springboard for DoH in establishing and systematizing a ZOD information and monitoring system at the national level.

SOLOMON ISLANDS

Solomon Islands: CLTS in urban areas: Informal settlements in the Solomon Islands

Across Melanesian cities, WSP estimates that between 20 and 45 per cent of the urban population lives in informal settlements with poor access to WASH services.[44] These are unplanned residential areas that have developed outside of the formal urban planning rules of a city, often in physically marginal or peri-urban areas, with uncertain or illegal land tenure, minimal or no services such as water and sanitation, and a lack of recognition by formal governments. In Honiara, the capital of the Solomon Islands, at least 35 per cent of people live in settlements.[45]

World Vision is implementing a programme to improve WASH services in five informal settlements around Honiara in order to improve the health and safety of residents. The settlements vary dramatically in their physical environment, size, land tenure, social cohesion, and cultural practices. Each settlement is home to between 800 and 4,000 people and they are well-connected by transport to the city, with many people working in the urban cash economy. World Vision has complementary programmes in each of the settlements focused on promoting youth employment and reducing gender-based violence. Each settlement has a Community Facilitator and an Assistant Facilitator employed by World Vision to work across programmes. The Assistant Facilitators are from the settlements.

Prior to CLTS, the sanitation conditions were either basic unsanitary pit latrines which were self built without any technical expertise and are shared between multiple households; or open defecation in bushes, creeks, or the ocean.

One of the objectives of World Vision's programme is to pilot CLTS methodologies and contextualize CLTS for Honiara. Paul Amao, Project Coordinator for World Vision's Honiara Urban WASH Program says: "It is not a matter of transplanting rural CLTS into an urban setting". To increase the success of their programme, World Vision has modified CLTS approaches and messages depending on the context of each settlement.

Compared to rural villages, it is more difficult to get participation in CLTS triggering events because residents are often working in Honiara and spend long periods of the day away from home. World Vision has learned that the best time to conduct CLTS triggering is in the afternoon or later part of the day when more people are back in the settlements.

It is much harder to implement CLTS in urban settlements that are a melting pot of people from different ethnic groups living together. World Vision has found greater success with CLTS in peri-urban areas where there is a single ethnic group, similar to a rural community. To overcome the lack of unity, World Vision works with church and natural leaders, and helps set up and empower WASH Action Groups or Committees in each settlement. Usually five men and five women are in the Group, although this varies by settlement. The members are selected after community CLTS triggering, based on their interest and availability.

The function of the WASH Action Group is to mobilize the community and facilitate action to improve the WASH situation in the settlement. These WASH Action Groups motivate and monitor community progress, working with World Vision to develop and implement monthly action plans to tackle the problem. One challenge is that attendance, especially by women, is inconsistent due to other commitments and duties. Another challenge is that in urban settings, members of the WASH Action Group sometimes expect or demand cash stipends or compensation for their participation.

In dense urban areas, simply covering faeces is not a suitable sanitation solution. Having a toilet is important for privacy, convenience, women's safety, and health benefits. Even though there is access to a sanitation supply chain outside of the settlements, the cost is a barrier to residents on low and often irregular incomes. Even local bush materials such as palms, and recycled materials must all be purchased outside the settlement and transported to the community at a cost.

[44] World Bank-WSP, 2015, *Delivering Water and Sanitation to Melanesian Informal Settlements: Solomon Islands, Fiji, Vanuatu, Papua New Guinea.*
[45] ibid.

World Vision is helping settlers gain access to toilet products by linking with the Honiara City Council. Honiara City Council has been manufacturing low cost, improved sanitation products for more than 18 years and selling these to the public at a small loss. Toilets are made of concrete with a fiberglass water seal, but the toilets are heavy and bulky, so it is very difficult and expensive for an average person to buy a toilet and transport it back to their home. Households prefer raised toilets, but these are very expensive at SBD 600 (US$ 75) each. Squat toilets are much cheaper, at SBD 120 (US$ 15) each.[46]

On behalf of settlements, World Vision places combined orders of slabs and construction materials with the City Council and then supports the cost of transportation of the order to the five Honiara settlements. The size of the order depends on each community, with an average order around two to four slabs. Without this support, residents in peri-urban settlements like Burns Creek would have to pay an additional SBD 200-300 (US$ 25-38) to get their toilets home. The community also receives training in how to make slabs and cement risers using molds. World Vision has assisted some areas by providing access to free construction materials, like used tires that could be used for lining pits. By facilitating orders for materials and toilets through the City Council, World Vision is helping to maintain the low cost sanitation market.

Past subsidy approaches to sanitation still result in residents expecting some form of hand out, even in urban settlement areas. Overcoming this thinking is a challenge for World Vision. During triggering, in response to community anger about a lack of subsidies, World Vision carefully explains the CLTS approach. The NGO does not subsidize toilet construction, except for households with special needs, and the cost of transport for bulk orders. Still, in urban areas with a long history of subsidized projects and residents working in the cash economy, there is a persistent perception by some that World Vision should provide construction materials for free and stipends for WASH Action Committee members.

Another challenge is land tenure and physical space for on-site sanitation. Most informal settlers lack land tenure, instead receiving provisional permits.

The settlements were originally triggered during a visit by Kamal Kar of the CLTS Foundation to Honiara in March 2013. Progress has varied in each settlement depending on the specific context of each. For instance, in the relatively homogeneous settlement of Lord Howe, social cohesion is high, but cramped living quarters, insecure land tenure, and strong cultural practices of defecating in the sea retained from the residents' home island means that open defecation persists. In response, World Vision's programme initially focuses on hygiene while appropriate sanitation solutions are sought. In the settlement of Wind Valley, a sub-set of the larger White River settlement, there is moderate social cohesion as most people are from the same place, and there is sufficient space for people to construct their own on-site sanitation facilities. Because of this, Wind Valley is making better progress towards their ODF status, and prepared for an ODF declaration date of September 2015.

Sanitation behaviour is very slow to change and the elimination of open defecation and the upgrading of sanitation is difficult to influence. Settlers who have come from rural areas may be the slowest to give up defecating in the open.

[46] ibid.

Latrine slabs for sale at the Honiara City Council

White River Settlement – New latrine

White River Settlement – Collecting rainwater for flushing and handwashing.

VIET NAM

Viet Nam: Case study – Testing Viet Nam's ODF criteria and certification process

Viet Nam has given a lot of thought to its ODF certification system. The Ministry of Health and other sector partners, with technical assistance from UNICEF, have developed comprehensive guidelines on the criteria for ODF, and the protocol for verification and certification.

Many countries have established criteria for reaching ODF only at the village level; Viet Nam's ODF monitoring system is multi-level and includes detailed procedures for ODF villages, as well as aggregated ODF verification at the commune and district levels.

The guidelines were developed by reviewing and learning from several other countries outside of the region, namely Ethiopia, Ghana, Nigeria, Sierra Leone, and Uganda. These other countries were reviewed for how they have developed their ODF criteria, and the content of their guidelines. Viet Nam's draft guidelines were then tested in seven provinces where UNICEF is supporting the Ministry of Health's Vietnam Health Environment Management Agency (VIHEMA) to implement CLTS through provincial Centres for Preventive Medicine. The guidelines have been reviewed following this practical application.

What does it mean to be ODF in Viet Nam?

For a *village*, the ODF criteria means a village has achieved the most basic changes of stopping open defecation and promoting handwashing. Fish pond latrines and overhanging toilets, buckets and barrels are all excluded from the guideline's definition of a latrine and are considered as open defecation.

For a *commune* to be certified as ODF, all the villages and hamlets within its jurisdiction should have already been certified as ODF; along with all main school branches and health centres having functional and used WASH facilities.

The criteria for *district* ODF is that all the villages and hamlets within the district stop open defecation and have handwashing in place. In addition, all the schools and health centres within the district have functional WASH facilities that are in use.

The criteria for each administrative level is shown in Figure 1.

Figure 1: ODF criteria at village, commune and district levels

Village ODF	Commune ODF	District ODF
• The entire village stops open defecation, every family and its members use latrines. • Faeces of infants/children are disposed into latrines. • At least 90% of households have latrines; and the remaining 10% of households share latrines with others. • No trace of faeces found in the village. • At least 75% of households have an improved pit latrine. • At least 70% of households have handwashing places with a cleansing agent (soap or a soap substitute). • Village establishes 'community monitoring volunteers'. • The community has rules and regulations against open defection behaviour.	• All villages and hamlets in the commune achieved **Village ODF**. • The commune has volunteers representing each of its villages in a 'commune monitoring group' to assist the head of the commune and the Commune People's Committee to promote and monitor sanitation and hygiene. • 100% of health centres and schools (main school branches) in the commune have access to water, hygienic latrines and handwashing facilities that use a cleansing agent.	• The entire district stops open defecation. • All villages and hamlets in all communes have achieved Village ODF. • All communes in the district have achieved Commune ODF. • 100% of health stations, district health centres and schools (main school branches) in the district have access to water, hygienic latrines and handwashing areas with cleansers.

Village verification and certification process

What the guidelines embed in the verification process is clear responsibilities for who does what, and also a strict but realistic time frame for action. For example, when a village meets the criteria specified, the leaders in the village self-declare and send an appraisal request (including completed checklists) to the Commune People's Committee (CPC) for the village to be independently verified. The CPC reviews the claim of the village within a week. After a satisfactory review of the village's ODF claim, the commune authorities request the district authorities to verify the village for ODF certification.

Every district authority sets up an appraisal team of five to seven people – including representatives from the district health centre, commune health station, CPC, village leaders, and village health and mass organization representatives. The appraisal is made on all households in the village, with village ODF status awarded as follows: (1) recognized; (2) recognized with certain items to be completed; or (3) unrecognized. The district authority organizes appraisal within 15 working days of request and sends their report to the village and commune authorities with their recommendation, with a copy to the Provincial People's Committee (PPC).

If successful, a village is awarded ODF status within one month from the appraisal. The ODF recognition certificate is then issued by the District People's Committee (DPC).

ODF award ceremonies are a serious part of the certification process. According to the ODF Guidelines: "The ceremony should be solemn, meaningful, effective and economical to express residents' pride in their achievements, raise awareness and commitment of local people to maintain the ODF status and effectively manage environmental sanitation, and personal hygiene to improve public health." Groups of villages may be granted their ODF certificates at one time to accelerate the process, especially combining cultural or festival activities or other important events. The ceremonies are an opportunity for recognition by commune and district level government and other organizations, but the attendance of representatives from the PPC and/or Provincial Health Centre give the event gravity. The ceremony often includes speeches and presentations, arts performances, games and competitions, but most importantly they feature a public declaration of commitment from village residents to uphold the ODF status.

Commune and district verification

Commune and district verification is done on a sample basis. Where the *commune* claims to have achieved ODF status, at least 15 per cent of total villages in the commune are randomly selected to undergo re-verification. Out of the selected villages for re-appraisal, the verification team will randomly select a sample of 10 per cent of the total households. The WASH status is also verified for 100 per cent of main school branches and health centres. Similarly, a sample of 15 per cent of the communes will be drawn from which to verify district level ODF.

Both the commune and district level verification processes have clear lines of responsibility and time frames for the execution of the checks and certification.

Sustaining ODF

Due to resource constraints it is difficult for district authorities, under guidance of the provincial authorities, to frequently verify the 'sustainability of ODF' at *village* level. It therefore falls to the CPC to maintain the status by enforcing a 'commune and village resolution' and by using a set of volunteers/ leaders, who may serve as the members of the 'community monitoring group' to continually promote sanitation and hygiene.

The long-term continuation of village and commune ODF status is checked. This task falls to the DPC which conducts a review after three years. For district level sustainability of an ODF status, the PPC checks ODF after five years of certification. In either case the ODF certificate may be withdrawn if commune and village authorities fail to maintain the ODF status.

How well have the guidelines worked?

The pilot of Viet Nam's ODF guidelines has provided valuable testing of how guidelines on paper are practically implemented in the field. Several provincial Departments of Health are using the verification and certification process, and NGOs such as ChildFund and Plan International are also using the guidelines, with more sector partners interested to join the process.

Initially, Viet Nam's draft guidelines had two levels of ODF – ODF1 and ODF2 depending on the level of coverage of hygienic latrines and other criteria – but this was complex and the initial focus is on getting the basics right.

The latest guidelines have been refined with further consultation with VIHEMA/Ministry of Health and other sector partners in Viet Nam's sanitation working group.

One feature of the guidelines which supports their implementation, is the recognition of the ancillary support needed for an ODF verification system. Other countries have good processes but sometimes overlook the responsibilities or budget to carry out the processes. In Viet Nam, steering committees or working groups under Ministry of Health and chaired by VIHEMA, at province, commune and district level and are responsible for overseeing the verification processes. The steering committees are provided with documents and instructions to implement appraisal and the recognition of ODF communities. These steering committees ensure there are skills, responsibilities and budget for all ODF certification, including training, planning, scheduling, transport, stationery, communication, and mass media – all the practical items needed to support ODF certification.

What's next?

Following the testing of the guidelines in seven provinces over one year, the guidelines have been revised with input from the practicing provinces, NGOs, the World Bank Water and Sanitation Program, and UNICEF. Now the guidelines need to be finalized by partners, authorized by Government, and then utilized by all.

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