11 Community Led Total Sanitation Approach: Some personal field experiences from Bangladesh

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Abstract

Community Led Total Sanitation (CLTS) is a participatory approach to hygiene. Developed in Bangladesh in late 2000. It has inspired people to carry out their own appraisals and ensure total sanitation of the community. The approach has successfully engaged all sorts of people, including children, to work collectively for total sanitation. The early success and rapid spread of CLTS has occurred without much research into its processes.

The most significant outcomes of CLTS are:

- *People can buy cheap latrines, which means they can install them immediately using their own resources.*
- *Government Organization (GO)- Non-Government Organization (NGO) coordination has brought momentum to the issue.*
- *There has been mutual support for installing latrines at community level.*
- *Spontaneous leaders have emerged as part of the process to mobilize the people.*
- *Rural Sanitation Engineers have developed among the community; they provide technical support on the installation of latrines.*
- *Use of safe water has increased significantly though water remains scarce in some areas during the dry season and floods.*

Community initiatives and outside support have significantly reduced open defecation, despite a lack of subsidy for domestic latrines. However, some people still practise open defecation. This is mostly because they did not repair latrines after they collapsed, or failed for a long time to share other latrines.

Some NGOs are providing and subsidising tube wells to the community at public places, including educational institutions and growth centres. Local government is using 20% of the Annual Development Programme (ADP) fund for the total sanitation programme.

Management of solid domestic waste and better hygiene practice are the two major components of CLTS that require more in-depth attention and follow-up by the spontaneous leaders and the implementing organisations. Change in practice from open defecation to the use of hygienic latrines and other hygienic practices will take time and requires strong commitment from all stakeholders.

Regular monitoring and follow-up by the community and NGO staff are necessary for the sustainability of the CLTS approach. The general assumption is that once people are accustomed to using latrines and safe water, they will not opt for open defecation.

We have identified the following issues as effective and essential to scale up this approach:

- *proper ignition*
- *systematic facilitation support*
- *active community participation*
- *affordable options for latrines and tube wells*
- *easy access to raw materials*
- *coordination with local government and other organisations*
- *regular follow-up.*

Background

Community Led Total Sanitation (CLTS) is a participatory approach to sanitation developed in Bangladesh in late 2000. It is a general public health prevention programme which aims to reduce the incidence of human illness and disease from a wide range of activities. It follows the philosophy of Participatory Reflection and Action which has spread to other countries such as India, Pakistan, Indonesia and Cambodia. The nature of its approach, spread and potential has caught the attention of others.

The CLTS approach relies on creating a demand for the elimination of open defecation (and hence for toilets). It is not an external project where toilets are chosen and built for communities. The first step is to raise awareness of the risk of open defecation and to reinforce a natural sense of ‘disgust’ about this practice.

Facilitators encourage communities to carry out their own appraisal and analysis of community sanitation. This generally leads them to recognise the volume of human waste they generate. They realise how the practice of open defecation results in environmental degradation, which directly affects health and quality of life.

Over the years, NGOs and community-based organisations have committed to increase and

improve support to expand CLTS services to many villages in Bangladesh. CLTS is thought to have been spread to well over 2,000 *paras* (hamlets) in the country. This figure shows that the approach is on track to meet the Millennium Development Goal (MDG) target in sanitation by 2010. This MDG called for access to safe drinking water and basic sanitation for all. Advocates of CLTS see the potential for a movement with exponential spread, bringing multiple gains for all who live in the communities. CLTS is also used as an entry point for broader livelihood activities.

The early success and rapid spread of CLTS has occurred without much research into its processes or the conditions under which it works. Until now, only a few studies have been comprehensively conducted to get a better understanding of the decentralised sanitation system in Bangladesh. Various non-governmental agencies have conducted some limited studies in isolation.

Experiences gained from the field

Experiences presented below are based completely on the field experience of the author. In no way is this an outcome of any study or research.

Access to latrines

The proportion of latrines built during pre-CLTS period varied between villages. Very few household members in the villages used another household's latrine. Poor people lacked land to build their own latrine. Some villages are very small and densely populated.

CLTS process

The ignition process of CLTS at community level is similar in each village. The first task is to awaken the community to the bad effect of open defecation. Facilitators then work with people to put in place a process to overcome these problems. The activities in this process are described below.

Awareness building

Awareness building starts with an informal gathering of people in the village known as an "*ignition session*". The whole community participates in the discussion. Flow charts, prepared by the participants, show the bad effects of open defecation. The examples might include faeces travelling from the ground to people's mouths via flies, or water being polluted by faeces. Related issues, such as calculating the amount of faeces deposited per day or per year in the community, are also discussed in the session.

Community mobilisation

After becoming aware of the sanitation issues, people develop their own action plan on how they will stop open defecation. They are encouraged to start with the resources they already have and are motivated to see how they can share these resources. People wishing to install latrines are encouraged to start with affordable ones so they are not burdened by high costs. NGOs also mobilize children, students, school teachers, *imams* (religious leaders), and Union Parishad (UP) members to encourage people to install latrines. According to an NGO field staff member, "*Let the people start with a cheap latrine first. They will go for improved quality when they become accustomed to using the latrine.*"

Access to resources

The development of an action plan helps people identify and procure resources from within and outside the community. To begin with, they come forward with the resources (both cash and in kind)

of the family. They also find resources from Union Parishad (local government). UP spends 20% of the ADP fund for the local level sanitation programme.[1] Some NGOs also provide training and technical support to install various types of low-cost latrines, giving poor people an easier start (VERC, 2005).

Many small entrepreneurs come forward to produce latrines and sell spare parts of tube well close to the community. This growing business means people do not have to buy latrines from a distant market place with high transportation costs. A number of small businesses in sanitation seem to have started as a direct result of the community mobilisation/awareness programme.

Several NGOs provide support to extremely poor people through their programmes[2]. Some provide support for installing latrines and tube wells to educational and religious institutions and growth centres.

Changing behaviour: rates of open defecation

Previously, defecation in the open field or in the bush was common among the rural people of Bangladesh. A few rich and educated families had latrines some decades ago, but these were not sanitary. Defecation in the open was a big problem for women as they cannot go out to do this during the daytime. They had to go either very early in the morning or wait until night. More recently, the destruction of bush land and new settlements have reduced the scope for open defecation. In rural areas, roadsides or river/canal banks are now used for defecation. Children defecate anywhere they like and mothers do not bother to put the faeces in a safe place. The faeces become covered with flies, attracts chickens and infect the water supply. As a result, diarrhoea has become a common disease in rural areas.

The level of open defecation has reduced significantly, although it continues in some villages. It is hard to discover who was responsible, as the faeces are found by the side of road, in the periphery of the villages and on common ground. After more detailed discussion, some households have admitted to open defecation.

Changing trend

Over the years, the Bangladesh government has distributed sanitary latrine sets to people free of charge. They were distributed through UP as part of the national sanitation programme. As described earlier, 20% of the Annual Development Plan (ADP) fund is allocated each year for sanitation improvement in each Union. Some NGOs have also distributed latrines to their members. However, in most cases the latrine sets were used to feed cattle, to keep chickens or to wash clothes on the slab. Many people had even broken the water seal, believing it obstructed stool flow. Although all the installed latrines were in use, some of them were not maintained well.

But the main reason for not using the latrines was lack of awareness. Through NGO staff raising awareness of the consequences of open defecation, the community now gives equal importance to

[1] This is easy for certain areas as some of the organisation is directly involved with the Union Parishad and the various committees and taskforces developed by the government programme.

[2] BRAC (Building Resources Across Communities) under the CFPR (Challenging the Frontiers of Poverty Reduction) programme and CCDB (Christian Commission for Development in Bangladesh) as part of the health programme.

constructing houses for shelter and latrines for defecation. The construction of latrines has become an indispensable part of their life.

There are still some people who opt for open defecation. The reasons people gave were the failure to repair latrines due to poverty, or the inability to share them. Some said the latrine was damaged by flood, and that there were not any available in the working fields, markets or public places. Other reasons given were children not being able to sit on the pan as the foot rests were too far apart, and being afraid of latrines as they are dark and confined, especially at night.

Options for different types

Before the introduction of modern sanitary latrines, people had to use water-sealed ring-slab latrines. These are costly for poor people. VERC has introduced over 30 different types of sanitary latrine, most of which are within the financial reach of poorer people. The cheapest latrine costs only Tk 50 (US$ 0.50). In addition, raw materials for the construction of latrines are available in the rural areas. As a result, people can easily make latrines within few hours by using local materials, such as earthen pots, bamboo mats, jute straw and plastic pan and sheet.

Household latrines

The materials used in household latrines vary from place to place. The super-structure also varies; it may be made from jute sticks, bamboo or cement. The pit lining materials differ too, from unlined to bamboo, polythene or concrete. The cost varies, but is mostly around Tk 150 – 400 (although costs have been found to range from Tk 50 to 15,000).

Procurement

People in rural areas have easy access to cheap latrine materials. They do not wait for the government to supply free latrines. Easy technology also encourages poor people to install latrines at their home. NGOs such as BRAC, CCDB, CARITAS and World Vision provide water-sealed latrine sets to poorer people. Some NGOs also extend credit support for installing latrines, with minimal or no interest. Others provide support to primary schools and markets, with tube wells, latrines and urinals.

People learned from others how to install their latrine, or were helped by neighbours who had already installed theirs. Rural Sanitation Engineers[3] received training from the NGOs on installing different types of latrine and supporting people with their own installations.

Maintenance

In some villages latrines had collapsed following heavy rain, and people could not afford to repair them. The "*monga*" seasonal poverty was evident in some areas during the investigation. However, we observed that some of the latrines were upgraded with improved design. This shows the high motivation of the community, who now feel that the latrine should be hygienic and usable for all family members.

Coping with disaster

Poor people who can afford latrines still find it difficult to safeguard them, especially during the rainy season and floods. During floods, most areas are submerged by water, resulting in problems of

[3] Members of the community who have received training from NGOs on the installation of different types of latrines are known as Rural Sanitation Engineers.

defecation. Awareness programmes run by local NGOs motivated people about the benefit of using latrines, and as a result they reconstruct latrines and houses simultaneously during the post-flood period. People living in riverside areas face frequent problems due to river erosion and loss of land. As a result they migrate to other safe places where they need to construct new houses. Once there, they construct a latrine alongside their new houses. Field experiences support the view that rural people have already developed skills for reconstructing a latrine within the shortest possible time.

Access to safe water

The common sources of water are tube well, river, canal and pond. People use these sources for taking baths, washing household goods and bathing cattle. The situation has now improved – with a few exceptions, people are using tube well water for drinking only.

Access to safe water under total sanitation is another big concern for rural people. People face more difficulties in places with a low underground water table. They used to use pond, river or canal water for all purposes; subsequently, they have used well water for drinking. Due to the effect of media campaigns and the awareness building programme, people are becoming aware of the importance of using safe water.

Past practices

Some women said local belief was that rice and *dal* (pulses) should be cooked with pond or river water to maintain quality. They said pond, river, canal or well water were the common sources for drinking water, as they did not have access to tube wells in the past. People did not clean their water pot before collecting water, and did not always cover stored water.

Present sources

People who have received health education do not use unsafe water, so the most common source of water has become the tube well. In many villages people said they were using tube well water for all purposes, including drinking. Scarcity of pond and well water during the dry season, as well as pollution of water due to flooding, were the reasons given for not using these sources. The installation cost of a hand pump in high water table areas is about Tk 500, which seems very cheap. But the cost of constructing a platform is very high – about Tk 1,500. Because of this, people opt for installing a tube well, but do not make a platform. As a result, used water trickles down alongside the tube well pipe, polluting the underground water.

Seasonal disaster and scarcity of water

Water is scarce in areas where the underground water table is low. During the dry season it gets lower, and people cannot lift water using hand pumps. They have to depend on the deep tube well – the *tara pump*. Respondents said that installing these pumps is a costly process; the cost ranges from Tk 15,000 to 25,000, which the poor cannot afford. Government and NGOs have now set up *tara pumps* in public places, for use by all the community.

Hygiene practices

Hygiene is an integral part of the total sanitation process. NGOs have managed to raise awareness among rural people of common hygiene practices. In the past, open defecation in bare feet was common among the rural poor. People working in

agricultural fields did not wear slippers or shoes; they did not even use soap or ash after defecation. An effect of the awareness campaign is that people are now following some hygienic practices. Among those reported are:

- using slippers in the latrine
- using soap/ash after defecation
- cutting fingernails
- covering food and water
- washing hands before preparing food and eating.

Respondents said that it was common practice to keep a soap or ash pot inside the latrine. Reasons given for not washing hands were the high cost of soap, soap being taken away by a crow, soap not being available while working in the field, and a lack of water. Reasons given for not using slippers in the latrine were lack of knowledge, inability to purchase slippers and not being in the habit of wearing slippers.

In rural areas, people have made water channels for the easy flow of waste water from the tube well, which is stored in a pit. They generally dump cow dung in a particular place to use as manure in the field or to use as fuel. After NGO intervention, some people have begun dumping household waste in a pit. But the rate of such practices is not significant. When asked about their sources of knowledge on hygiene practices, people mentioned NGOs, government health departments, doctors and the media.

Social capital and spontaneous leaders

Social support

The CLTS program has strengthened the social bond between people of all occupations. During the early discussion sessions held by NGOs, people were asked to consider the amount of faeces accumulated in the area, and the flow of faeces from the ground to people's mouths. Rich people said they would not be safe if their neighbours used open latrines or defecated in open places. So, mainly to keep themselves safe from disease, they helped their poorer neighbours to install latrines. In some areas rich people provided a range of free materials to the poor, such as bamboo, slab and rings. Some gave land to poor neighbours to set up latrines, and some distributed short-term loans.

The formation of children's groups has created scope for their early involvement in the total sanitation process. The general assumption is that these children will never opt for open defecation.

Rise of spontaneous leadership

The ignition process and social mobilisation has compelled some enthusiastic people to offer voluntarily help to the community. They have given advice, helped people to procure materials for the installation of latrines and tube wells, and offered voluntary physical labour. They are known as "*shavab neta*", or spontaneous leaders. By profession they are day labourers, students, teachers, small businessmen, housewives or farmers. CLTS has created scope for many poor people in rural areas to develop leadership in the overall community development process. Comments from the spontaneous leaders show their enthusiasm and commitment:

- We have to come forward to ensure proper sanitation of the community.
- We have the potential to work for ourselves. We will not be dependent on government and NGOs.

- We will look for our own resources to overcome the problem.
- We are now providing support to our relatives and friends in other areas.
- We will make the people aware of sanitation and support them to mobilize their own resources.
- We will keep contact and coordinate with the UP to achieve our objectives.

Collective efforts of GO and NGO

The CLTS programme has established links between the government and NGOs working on health and hygiene. The government's target of 100% sanitation by 2010 gave an opportunity for the NGOs to work in collaboration with the government. Taskforces developed at different levels have become active, and people from various segments of society participate. People now are more aware of the proportion of the ADP budget allocated for the sanitation programme at Union level.

CLTS has made the UP sub-committees accountable for the use of the funds allocated for a programme. Duplication and overlapping of activities on sanitation programmes by the government and NGOs have reduced significantly in the study area.

Impact of CLTS programme

People used to think that the government should ensure better sanitation for the community at any cost. They also felt that the government should supply latrines and tube wells. After the intervention of the CLTS programme, they now realise that they need to share responsibility with the government to ensure total sanitation.

There have been some changes in the programme implementation policies. The implementing organisations have stopped providing subsidies for latrines. The local UP has also become careful in selecting people for the free distribution of latrines. NGOs are now putting more emphasis on software-based training, motivation and the awareness programme, rather than on distributing latrines. As a result, people's dependency on NGOs and UP for hardware has reduced substantially.

Recent experience shows that people have benefited from CLTS programmes in almost all the intervention areas. Poor people are less likely to suffer from diarrhoea, which means treatment costs have reduced significantly. This has resulted in more working days, which means increased income. People have also been motivated to start sanitation businesses; they are now producing low-cost latrine materials and selling these in the local market.

Sustainability

Sustainability of the CLTS approach largely depends on the proper ignition, monitoring and follow-up activities of the community and NGOs. Once poor people are accustomed to using latrines and safe water, the general assumption is that they will not opt for open defecation. The availability of quality materials at an affordable price for the poor is a prerequisite for the sustainability of CLTS.

To ensure sustainability, implementing organisations need to think about providing child-friendly latrines and to create options for people living in disaster-prone areas. An alternative source of safe water is essential for people living in the

low water table areas. People living in flood-prone areas suffer from a scarcity of safe water and places for defecation during floods. Organisations should give proper attention to the issues facing these areas.

Scaling up

Over the years, NGOs working on CLTS have gradually expanded their working areas, taking into account the total sanitation approach. A range of issues have been identified which are found to be effective and essential for scaling up this approach:

- proper ignition
- systematic facilitation support
- active community participation
- affordable options for latrines and tube wells
- easy access to raw materials
- coordination with local government and other organisations
- regular follow-up.

References
VERC (2005) *Compendium of latrine models in use in the community*