APPLICATION OF TOTAL SANITATION AND SANITATION MARKETING (TSSM) APPROACHES TO USAID

FINAL

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CONTENTS

Contents i
Acknowledgements iii
Acronyms v
Executive Summary vii

1. Introduction 1
   1.1 Rationale/Background 1
   1.2 Scope 2
   1.3 Methodology 2
   1.4 Report Organization 3
2. TSSM – What Is It? 5
   2.1 What Is TSSM? 5
   2.2 Summary of International Experience of Development Partners 7
3. TSSM Experiences in USAID Focus Countries 13
   3.1 Introduction 13
   3.2 Methodology 14
   3.3 Analysis of Findings 15
4. Application of TSSM in Rural, Small Town, and Peri-Urban Context 17
   4.1 Application of Total Sanitation (TS) in Rural Context 17
      4.1.1 Introduction 17
      4.1.2 How has Total Sanitation (TS) Worked in Rural Areas? 18
      4.1.3 Challenges of TS Approaches 22
   4.2 Application of TS Approaches in a Peri-urban Context 25
      4.2.1 Introduction 25
      4.2.2 Kalyani Municipality Case Study 26
      4.2.3 Challenges of TS Approaches in Peri-urban Settings 27
   4.3 Sanitation Marketing (SM) in Rural and Peri-urban Context 28
      4.3.1 Challenges of Sanitation Marketing (SM) 30

4.4 How has TSSM Worked? 31
4.4.1 Introduction 31
4.4.2 Case Studies of TSSM (Implementation Models) 31
4.4.3 Challenges of TSSM 35
5. Making TSSM Work 37
5.1 Introduction 37
5.2 Institutional Framework 37
5.3 Staffing and Management Requirements 41
5.4 Training 42
5.5 Costs 45
5.6 Financing 49
5.6.1 Subsidies and Incentives 50
6. Recommendations 53
6.1 TSSM Approach 53
6.2 Global Partnerships 54
6.2.1 BMGF/WSP Partnership 54
6.2.2 Water Supply and Sanitation Collaborative Council (WSSCC) 54
6.2.3 Department for International Development (DFID) 55
6.2.4 United Nations Children's Fund (UNICEF) 56
6.2.5 Recommended Role for USAID 56
Annex 1 - Database
Annex 2 - Resources
Annex 3 - Bibliography

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ACRONYMS

ASEH	Accelerating Sustainable Environmental Health
BCC	Behavior Change Communication
BMGF	Bill and Melinda Gates Foundation
BPL	Below Poverty Line
CATS	Community Approach for Total Sanitation
CLTBC	Community-Led Total Behavior Change
CLHI	Community-Led Health Initiative
CLTS	Community-Led Total Sanitation
DFID	Department for International Development of the British Government
GoI	Government of India
GSF	Global Sanitation Fund
HP	Himachal Pradesh
HE	Hygiene Education
HHW	Honorary Health Worker
HIP	Hygiene Improvement Project
IHHL	Individual Household Latrines
JMP	Joint Monitoring Program for water supply and sanitation
KUSP	Kolkata Urban Services for the Poor
MCH	Maternal and Child Health
MDG	Millennium Development Goal
NGO	Non Governmental Organization
NGP	Nirmal Gram Pruscar (ODF Award ceremony India)
NSWG	National Sanitation Working Group
MP	Madhya Pradesh

OD	Open Defecation
ODF	Open Defecation Free
PHAST	Participatory Hygiene and Sanitation Transformation
Plan	Plan International
SA	Supporting Agency
SM	Sanitation Marketing
SO	Support Organization
SSHE	School Sanitation and Hygiene Education
TRG	Training Resources Group
TS	Total Sanitation
TSC	Total Sanitation Campaign
TSSM	Total Sanitation and Sanitation Marketing
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
ULB	Urban Local Body
UST	Unnayan Shahojogy Team
VERC	Village Education Resources Centre
WASH	Water and Sanitation for Heath
WHO	World Health Organization
WSP	World Bank/Water and Sanitation Program
WSSCC	Water Supply and Sanitation Collaborative Council

EXECUTIVE SUMMARY

Background

The importance of sanitation is indisputable. Good sanitation is a major stepping stone for good health and could help save the lives of over 1.5 million children that die annually from diarrhoeal diseases as a result of poor sanitation. A staggering 2.6 billion people are still without access to improved sanitation with the majority in South and East Asia and sub-Saharan Africa. Sanitation, unlike water supply, is in less demand and often requires a push to increase demand and uptake. This situation is exacerbated by insufficient investments in sanitation by various countries and donor agencies.

The world is set to miss the Millennium Development Goal (MDG) target for sanitation by 2015 if drastic measures are not taken to improve access—particularly in South and East Asia and sub-Saharan Africa. Since less than five years remain to halve the proportion of people without access to improved sanitation, new approaches are required to achieve coverage at scale. Although the majority of people without improved sanitation live in rural areas, urban population growth provides increasing challenges and undermines the progress made so far.

The majority of the sanitation programs/projects have been mainly supply driven, often with full direct household subsidy, and with little or no community participation. Toilet technologies were pre-determined with little understanding of user preferences. This has led to millions of dollars of investments in sanitation not yielding the desired results, as many of the facilities provided were unused or used for other activities. Evidence has shown that demand generation approaches that are user-led, integrate user preferences, and build on user's motivations have been more successful in ending open defecation and increasing uptake of sanitation. Total Sanitation and Sanitation Marketing (TSSM) approaches have the potential to increase access at scale.

To respond to this challenge, the United States Agency for International Development (USAID) requested a review of the experience with Total Sanitation and Sanitation Marketing (TSSM) approaches and their application to the USAID context. USAID sees the potential in using these approaches to achieve coverage at scale. This document describes the above approaches, assesses their application to rural and urban areas, provides guidance on what it takes to make them successful, and offers recommendations to USAID.

What is Total Sanitation and Sanitation Marketing (TSSM)?

TSSM is a combination of the following approaches that are community led:

- *Community-Led Total Sanitation (CLTS)*

  CLTS is an approach that uses participatory methodologies to raise awareness of the problem of open defecation and trigger collective community effort to end open defecation. CLTS was first developed in Bangladesh in 1999, and has since been introduced and/or adapted in over 30 countries. It consists of four major steps (*pre-triggering, triggering, post-triggering and scaling up*), and uses participatory techniques to assist community members in analyzing their sanitation situations and taking collective steps to make improvements. Some of the benefits of CLTS

include the absence of direct household subsidy; focus on stopping open defecation; use of a bottom-up approach where communities take the lead as an entity rather than on individual household basis; household choice in building a toilet; and opportunity for a community to work together and build on their capacity for other development needs.

- *Sanitation Marketing (SM)*

  SM uses commercial marketing principles to increase demand and facilitate supply of improved sanitation thereby increasing uptake. SM endeavors to establish a sustainable supply mechanism to make it easier for users to gain access to improved sanitation products and services. It is suitable for most places from small rural communities to large urban settlements. Other benefits of SM include its ability to establish mechanisms to help to eliminate the barriers faced by households in acquiring improved sanitation and its use of user sanitation preferences as the basis for developing products and communication plans. The success of sanitation marketing lies in understanding the target market and getting the marketing mix (4 Ps) right – ***Product; Price; Place; and Promotion.*** There are usually about five steps to sanitation marketing - ***formative research; intervention design*** *(communication strategy and products attributes);* ***pre-testing and refinement; promotion*** *(product, price and place); and* ***monitoring.***

TSSM combines CLTS and SM. TSSM provides an opportunity for SM to complement CLTS in areas where it is thought to be weak, and vice versa. TSSM implementation includes two parts: 1) preparatory activities (training of facilitators for CLTS; pre-testing and refining of communication materials and products, and training of masons; and 2) sanitation mapping and triggering; the launch and reinforcement event; and point of sale launch.

Experience to Date

The majority of the existing experiences are programs that focus on CLTS with only a few that also include SM. The report includes an annex which includes an inventory of TSSM activities supported by USAID and international partners in USAID priority countries.

CLTS has been supported and implemented at scale mainly in rural areas by development agencies that include UNICEF, WSP, DFID, USAID, WaterAid and Plan International. Although CLTS has been adapted and called different names in some countries, the key principles remain the same. The differences in the CLTS adaptation are generally related to subsidies to poor households and incentives for Open Defecation Free (ODF) communities. The success factors for CLTS include training effectiveness and facilitators' skills; institutional framework for implementation (local government or NGOs); funding; and monitoring and reporting.

There are many case examples of successful CLTS programs in rural areas including, among others, UNICEF's program in Mozambique, WaterAid in Bangladesh, Plan International in a number of countries, and USAID/Hygiene Improvement Project (HIP) in Ethiopia. The only documented successful case example of an at scale urban CLTS activity is the Kalyani Municipality program in India under the DFID supported Kolkata Urban Services for the Poor project.

SM is a relatively new approach, although social marketing has been used in the health sector for the promotion of condoms, pre-treated bed nets, oral rehydration products, and water treatment products. There are few case studies of large-scale sanitation marketing programs/projects. The preparatory phases of SM (*formative research* and *development of communication plans*) are usually contracted out to private specialized agencies and the training of masons is conducted by NGOs.

TSSM is being piloted at scale by the World Bank/Water and Sanitation Program (WSP) in Tanzania, Indonesia (East Java) and the Indian states of Madhya Pradesh and Himachal Pradesh as part of the Global Scaling Up Sanitation project funded by the Gates Foundation. WSP plays a supporting role to government to conduct formative research, provide technical assistance, generate evidence-based learning, and capacity building. The report includes summary descriptions of these activities.

Challenges in Implementing TSSM

Key challenges in implementing TSSM include the following:

- Funding – especially for the initial set up of CLTS and SM – can be more expensive than expected, although much less expensive during implementation. Evidence-based advocacy has been found to be effective in convincing governments to fund TSSM.
- Subsidizing household sanitation is no longer advisable, but the question still remains how poor and landless households can afford to build toilets without support.
- Land tenure issues in some rural areas, particularly in South Asia, and in peri-urban settlements presents a challenge for stopping open defecation and building toilets.
- All the evidence is not yet in about the effectiveness of TSSM. While the results of the WSP activities appear to be promising, a final evaluation is expected to provide powerful evidence of how well it has worked.
- The TSSM approach combines two approaches and as a result requires specialized skills from a range of implementers at various levels.

Making TSSM Work

The TSSM approach has immense potential as it combines aspects of CLTS (proven to be successful at ending open defecation at scale) and SM. Lessons from the various total sanitation and TSSM projects/programs have highlighted important factors to consider when planning a large-scale program.

- *Institutional framework.* Large-scale CLTS, SM or TSSM programs require the government to take the lead. Central government must play an enabling role through the development of policies and plans and provision of resources. Local governments are the focal point for implementation and work through sub-district and community levels of government. Although NGOs have successfully implemented CLTS, their operational scale is limited.
- *Staffing and management requirements.* These include a national program coordination unit (that could be provided by a USAID implementing partner) that is staffed by a national coordinator, specialists in CLTS and sanitation marketing; a monitoring and evaluation specialist; and field coordinators for district level activities. In addition to central level coordination, the host government will be required

to provide regional support, often through a sanitation task force consisting of staff from the departments of water, health, education, and rural development. At the district level, local government will provide a cross-departmental team to support TSSM.

- *Training.* TSSM at scale can only be implemented through a cascading training approach. This requires training master trainers that then train district level CLTS trainers who in turn train a cadre of facilitators to trigger communities and train local government staff to plan, implement, and monitor TSSM activities in their districts. SM involves the training of masons either by master masons or by education or technology institutions as well as development of communications materials.
- *Financing.* This is often shared between national and local government, donors, and households. Households bear the highest percentage of the total cost, as they fund their sanitation facilities. Governments often fund sanitation/hygiene promotion; monitoring/evaluation; incentives for community achievements; and subsidies for poor households and institutional sanitation facilities. Donors fund advocacy, technical assistance, capacity building, and knowledge management. The 'no subsidy' approach of CLTS (for the majority of household facilities) is still subject to debate. Incentives, which are utilized to recognize ODF communities, seem to be more widely accepted as long as it is transparent, sustainable, and funded and led by the government.

The cost factors for CLTS include subcontracts to supporting agencies, subcontracts to implementing NGOs, advocacy and orientation meetings, training of trainers and facilitators, capacity building of local government, and provision of incentives. The report provides illustrative example of CLTS costs from Mozambique. The cost factors and estimates for SM vary by country and size of population but include formative research; supply chain assessment; development of communication plans; media placement; training and accreditation of masons; linkages with financial institutions to provide credit for households and masons; and orientation and capacity building meetings on the use of communication materials.

Recommendations

The report offers specific recommendations to USAID. These recommendations are divided into two categories - TSSM Approach and global partnerships. Some of the key recommendations include the following:

<u>TSSM Approach</u>

- Develop programs based on a combined TSSM approach rather than CLTS or SM alone. These two approaches, used in complement to each other, are quite powerful.
- Focus on rural areas first since that is where most of the experience is to date.
- Adopt the WSP TSSM approach to scaling up, which is to work through government and make local governments the linchpin of implementation.
- Include policy advocacy and development as an explicit objective of country level TSSM activities.
- Provide incentives but not subsidies.

Global Partnerships

Global partners that were contacted all expressed great interest in increased USAID involvement in rural sanitation at the global level. Recommendations include the following:

- Become active in global mechanisms focused on improving access to sanitation in rural areas.
- Use centrally-funded USAID mechanisms to provided targeted support to further refine the TSSM approach. WSP, UNICEF, and WSSCC would welcome USAID involvement.
- Replicate TSSM, especially using the WSP model, at the country level. This could be in partnership with another donor in a given country or a stand alone USAID-funded effort.
- Provide targeted technical assistance to country programs being implemented by such partners as WSP and UNICEF, such as the Hygiene Improvement Project (HIP) did in Ethiopia.

1. INTRODUCTION

1.1 RATIONALE/BACKGROUND

The importance of sanitation is undisputable. Good sanitation is a major stepping stone for good health and could help save the lives of over 1.5 million children that die annually from diarrhoeal diseases as a result of poor sanitation. Sanitation is fundamental to human dignity—particularly for women. In schools, good sanitation increases attendance by adolescent girls. Although sanitation has begun to gain more recognition, a staggering 2.6 billion people are still without access to improved sanitation. The majority of those without improved sanitation are in South and East Asia and sub-Saharan Africa. Sanitation, unlike water supply, is in less demand and often requires a push to increase demand and uptake.

This situation is exacerbated by insufficient investments in sanitation by various countries and donor agencies. In the past few years, sanitation has begun to gain recognition in the international scene with 2008 being declared the International Year of Sanitation. This has contributed to raising the profile of sanitation both within countries with poor coverage and on the international level. However, the WHO and UNICEF Joint Monitoring Program (JMP) on Water Supply and Sanitation has indicated that the world is set to miss the Millennium Development Goal (MDG) target for sanitation by 2015 if drastic measures are not taken to improve access, particularly in South and East Asia and sub-Saharan Africa (WHO and UNICEF 2010). Bearing in mind that the world has less than five years to meet the MDG goal and halve the proportion of people without access to improved sanitation, new approaches are required to achieve coverage at scale. The urban/rural disparities in sanitation coverage also call for context specific approaches. Although the majority of people without improved sanitation live in rural areas, urban population growth provides increasing challenges and undermines the progress made so far.

In the past, sanitation provision has been mainly supply driven, often with full direct household subsidy and with little or no community participation. Toilet technologies were decided upon and designed by engineers with little understanding of user preferences. This has led to millions of dollars of investments in sanitation not yielding the desired results, as many of the facilities provided were unused or used for other activities. Evidence has shown that demand generation approaches that are user-led have been more successful in ending open defecation and increasing uptake of sanitation facilities at scale, particularly in settlements with a sense of community. Other approaches with the ability to increase access at scale are those that integrate user preferences and build on user motivations.

The new approaches that are proving to have the potential to increase access at scale are called Community Led Total Sanitation (CLTS), Sanitation Marketing (SM), and a combination of the two known as Total Sanitation and Sanitation Marketing (TSSM).

CLTS, which has been used mostly in rural areas, was first introduced in 1999 in Bangladesh and proved very successful in ending open defecation and increasing the use of toilets at scale. Since then, it has been introduced to other places, including sub-Saharan Africa, with similar levels of success. The impact CLTS has had within a short time of introduction has led to increased interest in this approach. Moreover, its nature of being community-led, often with no direct subsidy, makes it even more attractive to many governments and donors because of the reduced cost.

SM on the other hand, uses marketing principles to increase the demand and uptake of improved sanitation. It begins by studying user preferences, motivations, and barriers to acquiring improved sanitation. The sanitation marketing approach endeavors to establish a sustainable supply mechanism to make it easier for users to gain access to improved sanitation. It is particularly useful in small towns and urban settlements.

The third approach, TSSM, which combines aspects of CLTS and SM, is being implemented by the World Bank Water and Sanitation Program with funding from the Bill and Melinda Gates Foundation (BMGF) in rural areas. The approach has the potential to also increase the uptake of improved sanitation in small towns and peri- urban settlements.

The United States Agency for International Development (USAID) is interested in learning about the successful implementation of the above approaches, including those carried out by the World Bank/Water and Sanitation Program (WSP), USAID implementing partners, and other donors. Like others in the international community, USAID sees the potential in using these approaches to achieve coverage at scale. USAID requested an assessment of the experience in CLTS, SM, and TSSM to inform future work in various countries including its Maternal and Child Health (MCH) focus countries.

1.2 Scope

This document aims to summarize the body of knowledge around TSSM approaches, which USAID missions and others could then use in developing sanitation programs at scale. It is intended to increase the understanding of total sanitation and sanitation marketing approaches. The utilization of CLTS and Sanitation Marketing together and separately in MCH priority countries has significant potential for increasing coverage levels. Specifically, it includes:

- Inventory of USAID, other donor and NGO efforts in total sanitation and/or sanitation marketing in the MCH focus countries.
- Identification of development partners that USAID might collaborate with within the focus countries.
- Description of the costs associated with total sanitation and sanitation marketing programs – either through examples of existing activities for which there are available data and/or the characterization of the types of resources needed for a successful program.
- Analysis of the application of total sanitation and sanitation marketing approaches in rural areas, small towns and peri-urban areas of MCH priority countries with the understanding that almost all of the experience is in rural areas. For example, is there potential to use total sanitation approaches to stop open defecation or end the use of "flying toilets" in peri-urban settings?
- Recommendations to USAID on next steps to adopt or adapt the TSSM approach in its MCH focus countries.

1.3 Methodology

The team for this activity was put together by CDM and consists of three members from Training Resources Group (TRG); Water, Engineering and Development Centre, Loughborough University, UK; and CDM. This activity was initiated with a team planning meeting held in Washington DC from 14 – 15

July 2010. Detailed discussions were held with two USAID staff members to understand USAID's perspectives, the nature of the outputs expected from the activity, and the target audience. The meeting with the USAID team helped to refine the methodology for the activity, including the types of literature to review and contact persons for various organisations. One key message that came out of the discussion is that the final document will be targeting USAID program managers with varying levels of responsibility for programming sanitation activities.

Following the discussion with USAID staff, the team conducted a mapping of organizations to seek information from and the contacts that the team members have for these organizations. The team planning meeting included a meeting with WSP at their World Bank office to discuss their work on TSSM in Tanzania, India and Indonesia funded by the Gates Foundation. The meeting was also used as an opportunity to discuss WSP's sanitation work in the MCH countries, the cost factors associated with TSSM in their projects with the Gates Foundation, and the application of total sanitation approaches in small town and peri-urban areas. Discussions were also held with the AED team that managed USAID's Hygiene Improvement Project (HIP), and ARD to discuss their CLTS and sanitation marketing experiences.

The timeline, report outline, and contents were drafted and agreed upon. A presentation of the work plan with proposed methodology, roles and responsibilities, and report contents was made to USAID.

1.4 Report Organization

The report is organized in the following sections:

- This report begins with an *Executive Summary* outlining key findings of the experiences of implementing total sanitation and sanitation marketing approaches in the MCH countries and the application to small town and peri-urban setting.
- *Chapter 1* is this introduction.
- *Chapter 2* describes total sanitation and sanitation marketing approaches. It begins with the benefits of TSSM approaches and basic description of CLTS and Sanitation Marketing. International experiences of implementing total sanitation and sanitation marketing by key development partners are also described.
- *Chapter 3* elaborates the inventory of TSSM in 17 USAID focus countries. It contains the summary of inventory of TSSM attached in the appendix. The focus countries for which information was available include Afghanistan, Angola, Bangladesh, DR Congo, Ethiopia, Ghana, Haiti, Indonesia, Kenya, Liberia, Madagascar, Senegal, Southern Sudan, Timor-Leste, Uganda, Tanzania and Zambia.
- *Chapter 4* is an analysis of the implementation of TSSM approaches in rural areas and the potential application in small towns and peri-urban areas. It contains a detailed analysis of TSSM in rural areas, the adaptations that have been made, and the requirements and the limitations for scaling up. Case studies of TSSM application in rural areas are also included.

- *Chapter 5* discusses important issues necessary for success of total sanitation and sanitation marketing approaches. This chapter describes the factors necessary for making TSSM work and includes the institutional framework, costs, financing/subsidies, training, and management/staffing requirements.
- *Chapter 6* provides recommendations for adopting or adapting total sanitation approaches and sanitation marketing in USAID focus countries including suggestions for collaborating with partners.
- *Annexes* include: Annex 1 – Database, an inventory of total sanitation approaches and sanitation marketing; Annex 2 – Resources for CLTS and SM; and Annex 3 - an annotated bibliography.

2. TSSM – WHAT IS IT?

2.1 WHAT IS TSSM?

TSSM–Total Sanitation and Sanitation Marketing–is a new approach that combines Community-Led Total Sanitation approaches (CLTS) and Sanitation Marketing (SM). This section briefly describes the two approaches individually and explores ways in which they complement each other. The benefits of combining CLTS and SM into TSSM are also discussed.

CLTS (Community-Led Total Sanitation) is an approach that uses participatory methodologies to raise awareness of the problem of open defecation and trigger collective community effort to end open defecation. CLTS was first developed in Bangladesh in 1999, and since then it has been introduced and/or adapted to over 30 countries with the majority of them in sub-Saharan Africa. It consists of four major steps (*pre-triggering, triggering, post-triggering* and *scaling up*), and uses participatory techniques to assist community members in analyzing their sanitation situations and taking collective steps to make improvements. (For more information, consult the CLTS handbook, available at http://www.communityledtotalsanitation.org/resource/handbook-community-led-total-sanitation. CLTS has proven to be effective in stopping open defecation and encouraging the use of sanitation facilities on a large scale, particularly in rural areas and, in a few cases, has also been successfully applied in urban settings.

The benefits of the CLTS approach are as follows:

- It focuses on ***'stopping open defecation'*** and adopts a bottom-up approach to improving sanitation conditions by helping rural communities to analyze their sanitation situation and take collective action to end open defecation.
- It works on a no subsidy basis and households pay for building their own toilets using affordable or locally available construction materials. The majority of the subsidised sanitation projects are unable to achieve large scale use of toilets or an end to open defecation.
- The CLTS approach is the only one so far that has demonstrated the potential to end open defecation and increase uptake and use of toilets at scale in rural areas.
- CLTS targets the entire community rather than individuals and triggers a collective action to end open defecation. The benefits of sanitation are enhanced when an entire community modifies their practices by ending open defecation.
- CLTS pushes for communities to declare themselves **ODF** (***Open Defecation Free*****)**, thereby creating competitive spirit within a community and with other communities.
- The CLTS approach gives households the option to build the toilet of their choice and does not insist on a particular technology.

SM (Sanitation Marketing) is the use of marketing principles to generate demand and facilitate supply of improved sanitation thereby increasing uptake. The application of marketing principles to sanitation promotion is a fairly new approach although social marketing has been used successfully in a range of health related products such as insecticide treated bed nets, condoms for HIV/AIDS prevention

programs, and household water treatment products. The focus of sanitation marketing is on generating demand and strengthening the supply of improved household sanitation products. The success of SM lies in understanding the target market and getting the marketing mix (4 Ps) right –***Product, Price, Place, and Promotion.*** "Product" refers to the physical product, service or practice that provides a solution to a problem that consumers perceive. "Price" generally refers to establishing a price for the product that is feasible and affordable, but that also is sufficient to confer the perception of quality to the product and dignity to the consumer. "Place" describes the way that the product reaches the consumer, which may refer to the distribution system and channels of communication. The final P, "promotion" consists of the integrated use of advertising, public relations, promotions, media advocacy, personal selling and entertainment vehicles to create and sustain demand for the product.

SM is suitable for most places from small rural communities to large urban settlements. There are usually about five steps to sanitation marketing – ***formative research; intervention design*** *(communication strategy and products attributes);* ***pre-testing and refinement; promotion*** *(product, price and place);* ***and monitoring.***

The benefits of SM include the following:

- Can be used in all types of settlements including small to large rural communities, small towns, and peri-urban centres.
- Focus on both demand generation and improving the supply of sanitation goods and services.
- Mechanisms are put in place to help eliminate the barriers faced by households in acquiring improved sanitation. These include one-stop shops for sanitation (products, information about builders, and credit facilities).
- Based on an understanding of user perceptions as well as current and future preferences for improved sanitation.
- Enables facilitators to work with users to identify attributes of desired sanitation facilities, thereby ensuring that information on the supply of suitable toilet options are made available to users.

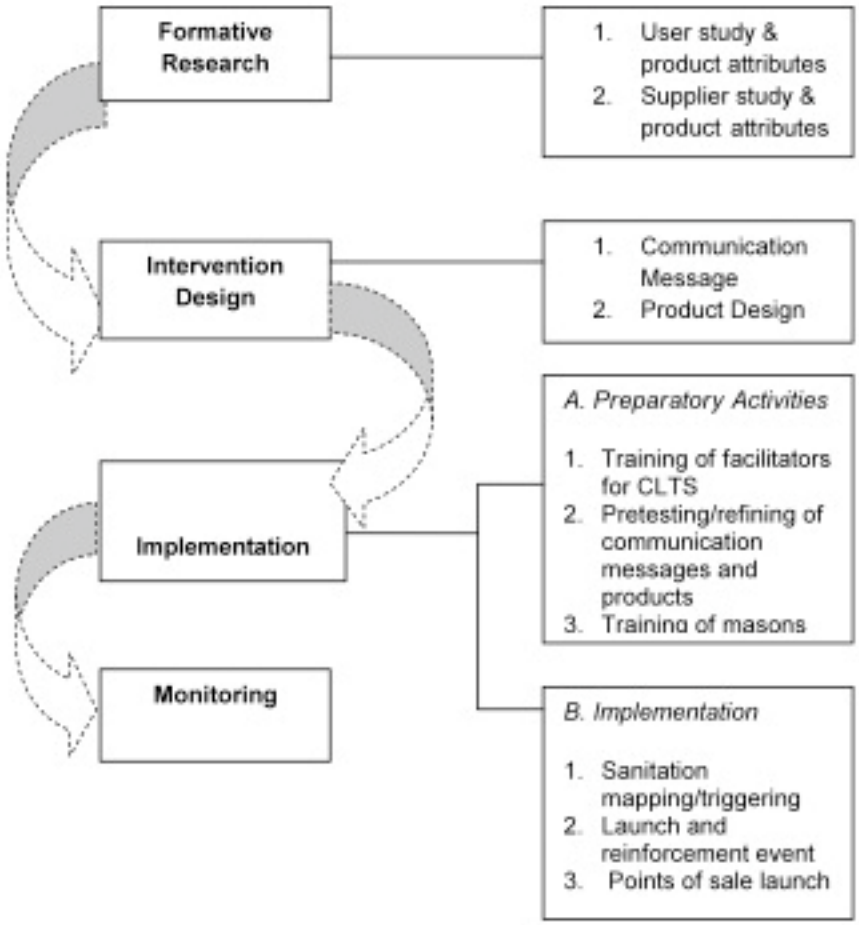


FIGURE 1: COMPONENTS OF A TSSM APPROACH

- Communication campaigns are developed and used to reinforce user motivations to acquire improved sanitation.
- Enables the development of a standardized branded advertising/promotion and behaviour change communication which can be used over time until the desired changes are achieved.

TSSM (Total Sanitation and Sanitation Marketing) provides an opportunity for SM to complement CLTS in areas where it is thought to be weak and vice –versa. For example, CLTS focuses on stopping open defecation with minimal emphasis on the supply of improved toilet options. On the other hand, CLTS can trigger immediate collective action to stop open defecation, while sanitation marketing can complement this by reinforcing behaviour change communication and strengthening the supply of improved sanitation products. TSSM is a new approach that is currently being piloted by WSP in Tanzania, Indonesia (East Java), and Indian states of Madhya Pradesh (MP) and Himachal Pradesh (HP). The TSSM approach combines steps of SM and CLTS, but not necessarily in a rigid order. Figure 1 on the previous page shows the components of TSSM, which are flexible and can be adapted to specific situations.

2.2 Summary of International Experience of Development Partners

Total sanitation approaches have been implemented on a large scale mainly in rural areas by various development agencies such as Plan International, WaterAid, UNICEF and WSP. Governments of various countries such as Ethiopia, Bangladesh, Nepal and others have adopted CLTS as part of their national strategy for rural sanitation and have scaled up its implementation. CLTS has also been applied in emergency situations, including in Afghanistan by the development consultancy ARD with funding from USAID. A detailed inventory of total sanitation and sanitation marketing experiences in USAID focus countries is presented in Annex 1 - Database and is summarized in Chapter 3.

Plan International's Experiences

Plan International (Plan) has scaled up the implementation of CLTS in many of its country programs and has also introduced SM in its CLTS activities. Plan has compiled an inventory of its global CLTS, SM and Hygiene Education (HE) programming. Through an internal survey, Plan summarizes that they are currently implementing CLTS programs in 22 countries, including 8 of USAID's focus countries (Bangladesh, Ethiopia, Indonesia, Kenya; Tanzania, Timor-Leste, Uganda and Zambia). Their programs in those 22 countries have a target population of over 12.7 million people and Plan is funding these programs with just over $12.6 million. They have reached 1,257 ODF verified communities and plan to reach 3,595 ODF communities by the time these programs are completed. Furthermore, as a result of their CLTS programming, Plan reports that there are more than 397,000 families with improved sanitation to date. Plan also notes that they have SM programs in 15 countries, including 7 in USAID's focus countries, and have trained more than 170 local entrepreneurs to date. The details of Plan's programs in the USAID focus countries are outlined in the table in Annex 2 - Resources.

WaterAid Experiences

CLTS began with a WaterAid partner in Bangladesh called Village Education Resources Centre (VERC) and has now been extended to most of their other country programs. The experiences in this report will be focused on three countries:

- Bangladesh where WaterAid has its largest project implemented through 22 local partners (12 rural and 10 urban)
- Nigeria
- Nepal

An evaluation of the CLTS approach was conducted in the above three countries in 2009. WaterAid used CLTS as an entry point to achieve ODF status, which they then built on for further hygiene improvement including school and community toilets and water supply improvements. A WaterAid report in 2009 indicated that the time taken to achieve ODF status varies from 22 days to 54 months with an average of 19 months. This average was reduced significantly to 3-6 months under the the Department for International Development of the British Government (DFID)-funded ASEH Project (Collin 2009). This reduction in time was not attributed to any specific factors, but similar experiences in the UNICEF Mozambique project, toilet coverage varied between 60% and 95% with an average of 73% although there was a strong indication that about 27% of those without toilets were sharing with others.

The toilets built were mainly pour-flush into a direct or off set pit with the majority having a water seal. The majority of the households built their toilets for less than $1.50 although there were some that spent $7.00 and others up to $14. The majority of the households also built their latrines without subsidies. The WaterAid experience of implementing CLTS in Bangladesh is particularly instructive as it is the longest running CLTS country.

An evaluation conducted in 2009 indicated that two-fifths of the respondents had experienced a full pit and half of them emptied their pits while the others relocated to another spot. A quarter of the respondents repaired their toilets and new members of the communities were sharing or built their own toilets.

UNICEF Experiences

UNICEF has introduced CLTS in its various country programs with promising results. UNICEF works with government and non-government agencies as partners in the implementation of CLTS. UNICEF has played major roles in either facilitating the introduction of CLTS into various countries or supporting its scaling up. UNICEF works mainly with governments and implements CLTS often in partnership with NGOs.

In Mozambique, for example, CLTS was introduced in October 2008 with the training of facilitators. By the end of December 2008 173 communities had been triggered, resulting in 34 communities being declared ODF. Over 50,000 latrines were built and are in use across the entire triggered communities, with over 200,000 gaining access to sanitation. By the end of 2009, 693 communities had been triggered, 151 had achieved ODF status, and over 154,000 latrines (10% improved) were built without subsidy. A detailed cost analysis of establishing CLTS in Mozambique is shown in Chapter 5, Table 13.

Similarly, in Ethiopia and Zambia, tremendous successes were achieved using CLTS. In Zambia CLTS was introduced in late 2007. By 2009 14,500 toilets were built and 402 villages had achieved ODF status. The

common theme across the board was that the latrines were built by households with no direct subsidy; CLTS communities were often triggered by local NGOs and mainly in rural areas.

Water and Sanitation Program (WSP) Experiences

The WSP has been implementing a Global Scaling Up Rural Sanitation Project funded by the Gates Foundation in the following three countries: Indonesia, India (States of Madhya Pradesh and Himachal Pradesh) and Tanzania. The project has used total sanitation approaches and sanitation marketing since 2007 with emphasis on scale, impact and sustainability. It is currently the only such project where total sanitation approaches are combined with sanitation marketing. WSP places emphasis on creating an enabling environment to create the conditions for scale up. This means policy dialogue with national government officials and building the capacity of local government to plan and implement TSSM activities in their jurisdictions.

In Indonesia, WSP works with 29 district governments in rural communities in East Java to increase access to improved latrines. In Tanzania, WSP works with 10 district governments to improve sanitation in rural areas with planned expansion to small towns. In the Indian state of Himachal Pradesh (HP), WSP works with 12 district governments and in the state of Madhya Pradesh (MP) with 20 district governments. WSP supports governments (often in partnerships) with capacity building; evidence based advocacy; evidence based learning; formative research; policy reform support; results based performance monitoring; sharing knowledge with partners; and technical assistance. Table 1 gives an overview of the targets set for the project and the results that has been achieved up to 31st December 2009.

TABLE 1: TARGETS AND RESULTS FOR THE WSP GLOBAL SCALING UP SANITATION PROJECT

Objectives	Country	End of Project Target	Results (until 31 Dec 2009)
Access to Improved Sanitation (No. of People)	Indonesia	1.4million	615,000
	India - HP	800,000	3 million
	India – MP	1.5 million	2.6 million
	Tanzania	750,000	205,060
	Global	4.45 million	6.52 million
Number of ODF Communities	Indonesia	870	779
	India - HP	400	1,791
	India – MP	600	1,396
	Tanzania	957	0
	Global	2,827	3,966

Source: Perez et al (2009)

In addition to the above targets, Indonesia and Tanzania also set targets for the communities that received promotional events and the number of communities triggered for ODF. In Indonesia, 86% of the 2,700 targets for promotional events in communities and 100% of the targets set for triggering of ODF had been achieved by the end of 2009. In Tanzania, 13% of the 1,496 targets for promotional events and 12% of the targets set for triggering of ODF had been achieved. The wide differences in the results, particularly between India and Tanzania, could be attributed to the number of the years the programs have been running. The Total Sanitation Campaign (TSC) program in India was initiated in 1999 and some States introduced CLTS into their program as early as 2000, and others such as Madhya Pradesh only began in late 2007. The TSSM program in Tanzania was only launched in 2008, which could be one of the reasons for the large disparity with India. Other reasons given for not achieving the set targets are the administrative limitations of the Ministry of Water in timely disbursements of funds to local governments and the weakness of the master trainers-thus affecting the strength of potential facilitators.

WSP's new five year business plan focuses on five areas, one of which is rural sanitation using TSSM. Plans call for expansion of TSSM into 10-12 new countries.

USAID/HIP experiences

USAID is implementing TSSM approaches through its partners under the recently completed Hygiene Improvement Project (HIP). Ethiopia was one of HIP's "at scale" countries where it worked in collaboration with WSP to help guide the implementation of the National Hygiene and Sanitation Strategy of the government of Ethiopia. HIP supported and built the capacity in the Amhara region to achieve total sanitation by 2012 through fostering Community Led Total Behaviour Change and Hygiene and Sanitation in four districts. To support the action plan agenda developed by a group of key stakeholders, HIP developed a set of "small do-able" hygiene practices. HIP, in partnership with WSP and the Amhara Region Health Bureau, developed a step-by-step process guide and resource materials and built the capacity of health extension workers, community volunteers, development agents, and other outreach workers to ignite change. A detailed list of resources developed by HIP in Ethiopia is available in Annex 2 - Resources.

In Uganda, HIP worked with Plan International (Plan) in Tororo to develop tools for planning SM at the district level. HIP worked closely with local leaders to test and implement the SM approach. SM was initiated through the National Sanitation Working Group (NSWG) to gain from partner knowledge and facilitate scaling up. HIP, in partnership with Plan developed various SM tools which are included in Annex 2 - Resources. In Madagascar, HIP worked with the central government to implement CLTS and SM but the project was interrupted by the 2009 coup.

Significant progress has been reported in Afghanistan from the USAID-funded project implemented by ARD in partnership with local NGOs. The project uses an incentive-based CLTS approach where ODF communities were rewarded with an improved water supply source. The target is to facilitate access to latrines for 250,000 people – equivalent to 50,000 latrines built and in use.

DFID Experiences

The Department for International Development (DFID) of the British government has funded several sanitation improvement programs, some of which adopted the total sanitation approach. DFID supported the government of Kalyani Municipality under the Kolkata Urban Services for the Poor (KUSP) project to implement CLTS. Kalyani is one of the few examples of implementing CLTS in urban areas and the only known municipality to be declared ODF. This program is discussed in more detail in Chapter 4. DFID also funded WaterAid Ethiopia to implement the Accelerating Sustainable Environmental Health (ASEH) program, which aimed to reach 5.3 million rural people and 0.5 million urban at a total approximated cost of $23.25 million.

3. TSSM Experiences in USAID Focus Countries

3.1 Introduction

The inventory in this chapter summarizes TSSM activities in 17 of the USAID focus countries, a list provided by USAID. The inventory was compiled with the aid of information gathered from partners. These partners include: Plan International, Oxfam, UNICEF, WaterAid, Water Engineering and Development Centre (WEDC), WSP, World Vision, and USAID. In addition to these major players, a number of other organizations were found to be active in some type of TSSM programming in the 17 focus countries, including, but not limited to: AAR-Japan; AECID-Spain; AusAid; CARE; Caritas; Carter Center; DFID-UK; FINIDA-Finland; NORAD-Norway; PACT; Red Cross; Simavi-Netherland; SNV-Netherlands Development Organization; Tearfund; UNDP; VITA; and a host of national, regional, and local NGOs.

A summary of the major organizations found to be active in TSSM programming in the 17 focus countries is presented in Table 2 below.

TABLE 2: SUMMARY OF ORGANIZATIONS INVOLVED IN TS AND/OR SM PROJECTS IN USAID FOCUS COUNTRIES

USAID Focus Countries	Organizations Implementing CLTS, SM or TSSM-type programming							
	Oxfam	PLAN	UNICEF	USAID	Water Aid	World Bank WSP	World Vision	Others
1. Afghanistan			✓	✓				✓ (Tear Fund)
2. Angola			✓	✓				✓
3. Bangladesh		✓	✓		✓	✓	✓	✓
4. Democratic Republic of Congo								
5. Ethiopia		✓	✓	✓	✓	✓		✓
6. Ghana			✓	✓	✓			
7. Haiti	✓		✓					
8. Indonesia		✓	✓			✓		
9. Kenya	✓	✓	✓			✓		✓

TABLE 2: SUMMARY OF ORGANIZATIONS INVOLVED IN TS AND/OR SM PROJECTS IN USAID FOCUS COUNTRIES

USAID Focus Countries	Organizations Implementing CLTS, SM or TSSM-type programming							
	Oxfam	PLAN	UNICEF	USAID	Water Aid	World Bank WSP	World Vision	Others
10. Liberia			✓	✓				
11. Madagascar			✓	✓	✓			
12. Senegal			✓	✓		✓		✓
13. Southern Sudan			✓					✓ (Tear Fund)
14. Timor-Leste	✓	✓	✓	✓	✓			✓
15. Uganda		✓	✓	✓	✓	✓		
16. United Republic of Tanzania		✓				✓		✓
17. Zambia		✓	✓			✓		✓

Key:

No info found	✓ Details included in the inventory obtained from correspondence or interview	✓ Details included in the inventory obtained from literature	✓ Organization reported to be involved in some type of TS activities

3.2 METHODOLOGY

Information used to compile the inventory was obtained from representatives of the various organizations and, in particular, the Water and Sanitation for Health (WASH) officer for the country of interest through emails or telephone interviews. Some of the program information was also obtained through literature searches. Respondents were asked to characterize the program work as CLTS, SM, or TSSM and to describe the scale of activities, including the target population and project costs or funding amounts. Other characteristics that were requested of the respondents included the project/program location (rural, small town, or peri-urban); comments on the government support and/or participation at various levels of government; the facilitators and/or community health workers involved; and any unique aspects to the program, unusual challenges, or lessons learned.

Other sources of relevant information included documents and reports on the CLTS website (http://www.communityledtotalsanitation.org) as well as organizations' individual websites. For example, the World Bank's WSP has compiled and published numerous detailed reports describing much of their

work, including their project's work in India, Indonesia, and Tanzania. All of these reports are available on their website (http://www.wsp.org).

The data collected is presented in the inventory of TS experiences in USAID focus countries, Annex 1-Database. The inventory is not exhaustive nor does it include all TS activities in any given country. Although respondents were very generous with their time and responses, data collection was limited by the timeframe and scope of this study. Furthermore, not all respondents answered all questions and information obtained from the literature did not necessarily address the specific questions asked in this study.

3.3 Analysis of Findings

The total sanitation (TS) approaches reported by the respondents are primarily CLTS with variations in the titles and scope. In some countries, such as Mozambique, it was initially called Community Approach for Total Sanitation (CATS). In the Amhara region of Ethiopia, it is known as CLTBC (Community Led Total Behavior Change in hygiene and sanitation). But CLTS remains the most widely reported total sanitation approach.

Key findings include the following:

- *Combining Total Sanitation (TS) and Sanitation Marketing (SM).* Some organizations reported both TS and SM activities respectively in a country program and others reported that they were implementing the combined TSSM approach in their programs. Of the reported projects and programs compiled in the inventory, the total population targeted using TS approaches in the 17 focus countries exceed 87 million. The majority of the respondents emphasized that TS designed to achieve ODF status in the communities is the starting point for a more comprehensive TS programming. SM is not as widely implemented as CLTS. The majority of the projects/programs that reported SM appear to be focused primarily on supply mechanisms for hardware, including the training of masons. Other than the WSP projects funded by the Gates Foundation in Tanzania, India, and Indonesia there are few examples of countries where SM is being implemented at scale and in combination with CLTS.
- *Cost.* Program cost information was neither widely available nor consistent. However, Plan's inventory of its CLTS activities in 22 countries, including several countries that have scaled-up their programming, indicated an extremely low average program funding cost of about $1 for each person in the target population. Others reported program costs between $2 and more than $100 for each person in the target population. The higher costs appear to be in pilot projects where it typically costs significantly more than in scaled-up programs. It is noteworthy that WSP's TSSM approach eschews the pilot approach and is aimed at scale from the beginning.
- *Pilot projects approach.* A program typically starts as a pilot project in a few communities with or without the participation of the district government. Some of the projects later develop to cover an entire district in partnership with the local government before achieving ministry-level support and scaling up to a regional or national level.
- *Rural focus.* The majority of the programs were focused in rural settings, with the exception of SM activities that were also targeted to peri-urban audiences. There are also some reported

CLTS activities in Bangladesh and Indonesia that target peri-urban populations with the biggest success recorded in India. There were very few reported cases of implementing TS approaches or SM in small towns. One explanation for this could be that the definition of small varies across countries and amongst development agencies and NGOs. It is possible that what is considered a small town in one country may be regarded as rural or even urban in other countries.

- *Government facilitators.* The level of government support or participation is difficult to quantify and many respondents did not respond to these questions. However, it was commonly noted that government participation and institutional support at all levels was critical; in fact it was often considered a key factor for scaling up and for long-term sustainability.
- *CLTS facilitators.* The responses to questions about the facilitators and/or community health workers were varied. Several programs used government health workers or community promoters who participated in the program in addition to their other regular work load. Many programs used school teachers as facilitators for school programs and others used local facilitators from NGOs who were supported by program funding. Other programs relied on 'natural' leaders in the community and volunteers or some combination of the above. Natural leaders are those members of the community that have a natural ability to lead and motivate people but may not necessarily have a formal designation as a community leader.
- *Lessons learned.* In response to the requests for lessons learned and challenges, several respondents noted that national and/or regional governments are incorporating CLTS methodology as part of their official policy (such as in Afghanistan, Bangladesh, Ethiopia, Indonesia, and Timor-Leste). Local governments are playing a major role in the scaling up of CLTS with central and state government facilitating the process by providing the enabling environment.
- *Use of subsidies.* The majority of the CLTS programs report that they follow "no-subsidy" guidelines. However, several programs are exploring or implementing micro-financing or hardware loans, and others use a new improved drinking water source as an incentive. Respondents from countries that are experiencing, or recently experienced, active conflict noted that they are dealing with specific challenges related to the issue of subsidies.
- *Policy impact.* The total sanitation concepts have been so influential that several national and/or regional governments are in the process of or have already included CLTS methodology as a major component of their national policy. These countries include Afghanistan, Angola, Bangladesh, Ethiopia, Indonesia, Timor-Leste, Zambia and Mozambique. In Ethiopia, the government is even taking over some of the programs that UNICEF started. WSP views policy advocacy as one of its essential roles and has used the results of TSSM activities to promote policy changes in rural sanitation. WSP staff participate actively in national policy forums including inter-agency coordination committees. WSP also organizes site visits to ODF communities for policy makers.

The inventory of TS, SM and TSSM activities indicate that there are many programs that are implementing these approaches and with varying degrees of success. These programs create opportunities for lessons learned and can be built on to develop and implement large programs using the TS approach alone or in combination with SM. The inventory provides strong evidence to support the assumptions that TSSM are approaches that can potentially be used to scale up access to sanitation.

4. Application of TSSM in Rural, Small Town, and Peri-Urban Context

This chapter discusses the application of Total Sanitation (TS) approaches and Sanitation Marketing (SM) in various contexts. Since its introduction in late 1999 in Bangladesh, CLTS and its adaptations has become the approach of choice for ending Open Defecation (OD) and encouraging the use of latrines. Sections 4.1 to 4.3 below present a detailed analysis of the application of TSSM approaches in the rural, small town, and peri-urban contexts.

4.1 Application of Total Sanitation (TS) in Rural Context

4.1.1 Introduction

CLTS is the most popular TS approach currently in use for promoting the adoption of safe defecation practices. CLTS has been adapted and is known by different names in some countries. The titles notwithstanding, the principles are similar, which is to target the entire community rather than individual households to become open defecation free (ODF).

CLTS has proved very successful for igniting change even in communities where OD was the general practice. It uses shame and disgust to trigger action amongst communities to stop OD and to build and use latrines without direct subsidy. It has worked particularly well in small rural communities, which can be attributed to the level of involvement that is required by the entire community at the triggering stage. There are four major steps to CLTS as described earlier in Section 2.1, but the corresponding activities in each step can be adapted for various situations. For more details see the Mozambique case study on http://www.communityledtotalsanitation.org/topics/africa.

TS approaches have the following aspects in common:

- Targeting of the entire community rather than individual households; stopping open defecation is one of the key objectives;
- Skilled human resources at all levels;
- Training at all levels;
- Government buy in and leadership for scaling up;
- Greater involvement of the local government and community leaders; and,
- Clearly defined institutional framework to facilitate support for scaling and sustainability.

The above similarities notwithstanding, there are also some differences amongst the TS approaches used in various countries. These include: the use of subsidy and incentives; focusing entirely on defecation practices or including other hygiene practices; use of government institutional networks or NGOs; and definition of improved latrines. Some of these similarities and differences in the way in which TS has worked are discussed below.

4.1.2 How has Total Sanitation (TS) Worked in Rural Areas?

Training

In the majority of the countries where CLTS is implemented, training is used as an entry point. The success of CLTS is dependent on the skills of the facilitator; therefore training is a very important aspect of CLTS. The facilitators require skills for motivation and igniting change and also for data collection and follow-up. The training sessions are usually organized by either a development agency such as UNICEF or WSP, NGOs, or government. The training is usually organized in-country, but sometimes participants also attend training organized outside of their own country. Attending training outside of the country is often an incentive, particularly for government staff, but also provides an opportunity for exchange of ideas and strategies for making CLTS work in their country.

The participants in the training sessions are usually a combination of government (national and provincial levels), NGOs, and international agencies staff (such as UNICEF). The majority of the participants have either been exposed to, or are conversant with, the use of participatory tools which are central to CLTS. It is expected that those that have been trained will then return to train CLTS facilitators at the district level to prepare them to introduce CLTS in the community. CLTS training usually includes a few days classroom discussion followed by field practice. Many countries have not developed specific training curricula and they use the CLTS handbook as a guide.

In many countries, especially in projects implemented by Plan and UNICEF, the initial training of trainers was facilitated by Dr. Kamal Kar, the originator of the CLTS approach. Further trainings were then scaled up by those that were trained. The approach used varies from place to place. For example, in India, under the WSP TSSM project, private consultancy firms are contracted by the government to conduct training and monitor and evaluate communities for ODF. In Mozambique, the government works with UNICEF to scale up training of district level facilitators, which includes government, NGO staff, and natural leaders. In Tanzania, WSP works with local government but NGOs and consultancy firms are contracted to conduct the training.

Box 1: Training in the CLBTC Program in Amhara Region, Ethiopia

In Ethiopia, development agencies such as WSP, UNICEF and USAID/HIP support the Amhara Regional government to build the capacity of district government staff. The district administration, with the support of their trained staff, is in turn required to train and support the Health Extension Workers, Development Agents and local NGOs that work at the community level in line with the government health extension program. The two main objectives of the training for the HEWS, Das and local NGOs are to equip them with the necessary skills to be able to ignite community total behavior change and to collect data. Several training manuals have been developed in by the Amhara National Regional Bureau of Health in partnership with WSP and USAID/HIP Project. For details see www.hip.watsan.net.

Although many countries have adopted CLTS and other TS approaches as part of their national strategy for sanitation, a good example of a national training framework to support large scale national programs has not yet been developed (WSP is currently working on developing this national training framework). The majority of the countries still rely on development agencies and NGO staff to conduct training at various levels. The success of CLTS is not just dependent on facilitation skills, but scaling up also depends on monitoring and supporting facilitators that work at the community level.

Implementation

The scope of TS approaches differs across countries. In the majority of the countries where CLTS is used, the scope is limited to defecation practices with the objective of communities becoming ODF. In a few countries, such as Ethiopia (CLTBC) and Bangladesh (Dishari), the scope of TS programs and projects goes beyond defecation practices to include other hygiene behaviors (see Box 2 at right). Typically TS sanitation approaches begin with small pilot projects by NGOs or development agencies such as UNICEF in a few communities. The approach is only scaled up into a district, province, and then to a national program when there are verifiable results to advocate for scaling up. In countries where TS approaches such as CLTS have not been adopted as part of the government program, progress is slow and expensive. This is currently the case in many countries where various NGOs are implementing CLTS and achieving some success but on a small scale. However, it is important to note that TS approaches, especially CLTS, are widely accepted amongst the NGO sector and development agencies as the way forward for improving defecation practices at scale.

BOX 2: SCOPE OF TS PROGRAM IN ETHIOPIA AND BANGLADESH

Ethiopia (Amhara Region HEP)

- Hand washing with soap or cleaning agent
- Safe disposal of feces
- Safe handling and treatment of household drinking water

Bangladesh Dishari Project

- Access to potable water
- Individual or shared sanitary larine
- Hand washing with soap or cleaning agent
- Use of footwear in latrines
- Safe disposal of solid waste

Institutional framework for the implementation of CLTS

The more successful CLTS experiences appear to be in countries where government has adopted TS approaches as part of their national sanitation program and are scaling up implementation with the support of development partners and NGOs. Scaling up of CLTS and other TS approaches requires an established and wide spread institutional framework, which only governments have. In order to explore the various institutional frameworks in relation to TS approaches, a few country case studies have been reviewed and presented below. These include countries where TS approaches have become the main component of a national sanitation program and some where implementation is still NGO- and development agency- driven.

- ***India Case Study***. Prior to the introduction of CLTS, the Government of India (GoI) launched a Total Sanitation Campaign program (TSC) in 1999 with the aim of eradication of OD by the end of 2010 (see Box 3 at right). The four components of TSC are: *Individual Household Latrines (IHHL); School Sanitation and Hygiene Education (SSHE); Community sanitary complexes; and Anganwadi (day-care centre) latrines.* The program revised its guideline in 2004 by adopting CLTS as the main approach. The TSC program is

BOX 3: COMPONENTS OF TSC

- Individual Household Latrines (IHHL)
- School Sanitation and Hygiene Education (SSHE)
- Community sanitary complexes (for landless households)
- Anganwadi (day-care centre) child-friendly latrines.

the largest TS program in the world in terms of its target population, budget, and funding. It is entirely government-led with support from some donor programs, such as the WSP TSSM project in the states of MP and HP, where WSP works to influence the way in which the TSC program is implemented. India is probably the only country where a high percentage of investment for rural sanitation comes from the government; more than all the donors put together.

TSC is managed at the central level by the Department of Drinking Water Supply in the Ministry of Rural Development. At the State level it is either managed by the Department of Drinking Water Supply or the Department of Rural Development. At the District level the program is managed by the District Administrator, and by the Block Administrator at the block level. Below the block level are the Gram Panchayats who are in charge of 5-10 communities, each headed by a Sarpanch. The guidelines allow the District Administrator to use a network of staff from the various departments for community motivation and monitoring. The actual triggering of change in the communities is carried out by either the trained Sarpanch, the 'natural leader', or NGOs contracted by the district government. In theory, there should be a sanitation task force from the district level down to the block level, but in practice this varies across states.

The district government receives direct funding from the central government to implement TSC rather than through the state government, which is the usual funding route. The aim is to reduce bureaucracy and facilitate easier program implementation. The existence of many private consultancy firms and local NGOs in India means that the government can play a facilitating role and contract the consultancy firms and NGOs to implement the program. The TSC program allows for a household incentive or subsidy to be given to those below poverty line (BPL), depending on the model of toilet chosen. This can vary from the government subsidizing 80% of the costs of Model 1 toilets Rs1500 ($33) and 60% for toilets that costs between Rs.1500 – Rs.2000 ($44). Some states offer direct household subsidies in the beginning (e.g. Madhya Pradesh) and others as an incentive for ODF (Himachal Pradesh). There is also a central government award system to recognize ODF communities and it comes with a cash prize. This has created healthy competition to achieve the highest number of ODF communities amongst district administrators, block administrators, and communities.

- ***Bangladesh Case Study***. CLTS started as a small initiative by WaterAid and its local NGO partner VERC and developed into a national program in 2003 after a national baseline survey revealed that only 35% of households used hygienic latrines. A national sanitation program was launched in Bangladesh in late 2003 with the target of 'Sanitation for all by 2010'. It closely follows the India model of subsidy and incentives, but for ODF Unions (a grouping of on average 10 villages). Initially the program was primarily NGO-driven, making it more difficult and slow to scale up and accelerate progress. The results were achieved within a short period and attracted the interest of government. Discussions began on how to scale up the program.

  Development agencies, including international NGOs, argued that local government is important for scaling up the TS program, thus the launch of Dishari in 2004. Dishari was launched with support from WSP in partnership with Plan Bangladesh, WaterAid and Dhaka Ahsania Mission. The goal was to improve the quality of life of people living in poverty in terms of access to sanitation through increased capacity of the district governments (Ahmed undated). The

emphasis of the Dishari program was to strengthen the capacity of local government institutions to plan, implement, and monitor TS approaches for all by 2010. Sanitation has been taken as an entry point at the local government level.

The cost of scaling up access to latrines was considerably low, as community members bear over 90% of the cost (see Box 4 below). In a study of WaterAid-supported total sanitation programs in Bangladesh, it was found that the cost of achieving ODF in a community ranges from $829 with one NGO to $724 with a second NGO partner. Over 73% of the costs in the first NGO were WaterAid-supported; 4% local government/UNICEF contribution; and 24% community contributions. In the second NGO, 70% of the costs were WaterAid-supported; 4% were community contribution and 27% local government/UNICEF. A detailed analysis of the cost factors for achieving ODF per community in Bangladesh compiled by WaterAid Bangladesh is outlined in section 5.5.

BOX 4: TOTAL SANITATION PROGRAM IN BANGLADESH

- 20% of local development funds rechanneled to sanitation.
- 75% of the BPL subsidy is for latrines construction; 25% for promotion activities.
- Funding system is reversed when a Union achieves ODF.
- Of the 219,000 new latrines built in 5 sub-districts, 90% were funded by households; 9% by union councils; 1% by NGOs.
- Total investment estimated at $952,000, (91% by Hhs; 7% govt. subsidy; 2% NGOs).
- An indication that 1.1million people invested about $866,000, about $4 per household for a latrine.

Source: Ahmed (undated)

- ***Mozambique Case Study***. Mozambique is an example of a country where government is in the process of adopting CLTS as a key part of the sanitation component in the recently launched National Rural Water Supply and Sanitation Program (PRONASAR). The project described here is the UNICEF One Million Initiative Project funded by the Dutch government. The project's main objective is to provide safe water supply and sanitation for 1 million people in 3 provinces (6 districts in each). The project is implemented with the National Department of Rural Water Supply at the national level. Local NGOs were contracted to implement sanitation and hygiene promotion, and community mobilization. Due to the slow progress made in sanitation improvements using the Participatory Hygiene and Sanitation Transformation (PHAST) approach, UNICEF introduced CATS which uses the CLTS methodology but has incentives for ODF communities.

  Similar to other countries, CATS was introduced with the training of resource persons, a combination of UNICEF, national government, and two supervisors from each of the partner NGOs. A pilot project was initiated in November 2008 and by the end December 2008, 173 communities across the 3 provinces had been triggered for ODF using the CLTS approach. An evaluation of the initial pilot project showed that over 49,000 latrines had been constructed by households without subsidies benefiting over 249,000 people. Of the communities assessed, 34 were declared ODF. The Provincial Department of Water, with support from UNICEF, contracts NGOs to implement CATS at the community level after receiving training from UNICEF.

The limited amount of time it took to achieve results using CLTS without subsidy generated huge interest amongst various levels of government, NGOs, and other development agencies. In 2009, the number of communities triggered went up to 693 with 151 verified as ODF; this number is expected to rise to 480 ODF communities by the end of 2010. Based on the success of the One Million Initiative Project, other programs such as the recently concluded ADB-funded ASNANI project in Nampula Province also introduced CLTS towards the last three months of the project. Over 4,000 household latrines were built with no subsidy, which is more than the latrines built with subsidized slabs during the life cycle of the project. World Vision also implemented CLTS during a minor emergency flooding in 2010 with good results; an indication that CLTS could also work in emergency situations.

The Mozambique government plans to scale up CLTS to another 3 provinces under PRONASAR in addition to the remaining districts in the three provinces of the One Million Initiative project. Emphasis has shifted to building the capacity of district government institutions to be able to support the scaling up. It will also provide an entry point for inter-departmental collaboration for community development activities. The One Million Initiative Project provides an indication of CLTS costing and is discussed Chapter 5.

All of the above case studies demonstrate that CLTS is an attractive approach for TS and must be supported by the government to scale up. It offers governments an opportunity to spend less and still achieve big results; thereby increasing their status amongst the people. In addition to government support, scaling up also requires well established institutional structures, particularly at the district/local government level.

4.1.3 Challenges of TS Approaches

CLTS and other TS approaches have proven to be a successful method for collective sanitation improvement. Although TS approaches are being implemented in many countries, the majority are still small scale with slow progress. The limitations to scaling TS approaches can be grouped into five main categories:

- Funding
- Subsidy/incentives
- Institutional issues
- Sustainability (technology, upgrading, cost, maintenance)
- Socio-cultural

<u>Funding</u>

The important cost factors that can limit the scaling up of CLTS are as follows:

- *Training*. The success of any TS program depends on the quality of training received at the national level down to mobilizers at the community level. This cost is considerable if a TS program is to be scaled up nationally. For example, it costs UNICEF in Mozambique an estimated $16,000 to send 5 people, including national government staff, to be trained as trainers outside of the country. It then costs another $95,000 to train 74 trainers at the onset. This will equate to about $1,300 per trainer,

excluding the costs for training community mobilizers and leaders. The costs mentioned above cover airfares and hotel accommodation (overseas training); per diems; consultants fees; logistics for hands-on training, etc.

- *Exchange visits*. This is important for advocacy, particularly for top government officials including ministers that can make the decision to scale up TS approaches to a national program. These often involve funds for airfares, lodging and accommodation, allowances, and transportation.
- *Community mobilization/triggering*: A key aspect of TS approaches is the community mobilization and triggering for collective behaviour change. The CLTS approach not only requires good facilitation skills, but also the necessary logistics to support this. Facilitators would need adequate transportation to get to the rural communities and also the right type of food and water for the triggering.
- *Staff costs.* Even where government institutions' staff are used in a national program there may still be the need to offer them some incentives, as they may be required to work longer hours and take on extra workload. In cases where government subcontracts to NGOs to carry out community mobilization, staff must be hired. In a national program, there may be the need to recruit a program director or an advisor either locally or internationally.
- *Monitoring/evaluation*. The main objective of TS approaches is for communities to become ODF. This requires monitoring and evaluation of communities that have declared themselves ODF, particularly if there is an award ceremony where they are recognized. An example of the cost to evaluate 159 communities in 2008 by UNICEF in Mozambique was estimated at $31,000; excluding salaries of UNICEF, WSP, NGOs and government staff that were involved in the evaluation. It was estimated that it will cost about $330,000 using the same method to evaluate 360 communities.

Subsidy/Incentives

The use of subsidy and incentives in TS programs has always, and will remain, a debate amongst development agencies, NGOs, governments and academics. TS puritans argue that subsidy and incentives should never be used if communities are to sustain their ODF status. Some argue that subsidy transformed to incentives should be given only when a community achieves ODF status. However, there will always be the question of how the very poor and vulnerable households will ever be able to afford to build their own latrines, particularly with the AIDS pandemic that has resulted in many child-headed homes in sub-Saharan Africa.

Because governments in many countries cannot afford subsidies, non-monetary incentives, such as a recognition ceremony for reaching ODF status, can still serve to motivate communities. In Mozambique, UNICEF started offering a range of modest monetary incentives including hygiene kits for households; a borehole with handpump; and bicycles for community leaders for every ODF community. Incentives are also offered to local governments including, a mobile phone for the head of the administrative posts with the highest number of ODF communities and a photocopying machine for district administrator with the highest number of ODF communities. All of theses incentives, including the organization of an award ceremony, came to an estimated total of over $500,000 for 34 communities. As discussed earlier, the Indian government is the one government

> *Quote from a woman during triggering:*
>
> "I did not realize that flies can also perch on rich men's food and water!!!"

that has sustained and funded both subsidies for families below the poverty line and community incentives for reaching ODF status.

Institutional Issues

One of the key factors to scaling up TS programs is the institutional framework needed for a large scale program. It is now widely accepted that NGOs are not capable of scaling up TS programs, and that government alone has the capacity to establish the institutional infrastructure to do so through local government. Local government institutions are the only ones that have the potential to serve as a vehicle for scaling up sanitation since, by definition, they cover the entire country. Yet some local governments may not have the capacity and sufficient number of staff required for scaling up.

Another challenge is that in many countries there is no clear institutional home for rural sanitation. This creates a challenge for coordination and management at the provincial/state/regional and central government levels.

Sustainability (technology, upgrading, cost, maintenance)

TS approaches thrive on the philosophy that they are community-led and people- centered, which also means that the decision on the type of latrine built is left up to the household. The majority of the latrines that have been built as a result of TS approaches have mainly been traditional latrines, which often do not meet the JMP criteria for improved latrines. Some of these latrines are considered temporal on the assumption that the households will upgrade to an improved latrine at some point. However, many households cannot afford to upgrade to an 'improved' latrine, which can vary in costs from $5 in some countries to more than $200 in others. The soil types also determine the type, cost, and sustainability of a latrine. Unstable soil conditions would require reinforcement without which the latrine will collapse.

Technology plays an important role in the sustainability of ODF. In a recent study by WaterAid in three countries it was found that poor families that could not afford to rebuild collapsed latrines have now resorted to sharing with their neighbours. In other countries, some households went back to open defecation.

Critics have also pointed out that one major limitation of the TS approach is that it does not provide latrine options after a community has been triggered. They argue that communities need guidance when making decisions on the type of latrines to build.

Socio-cultural

Socio-cultural challenges are related to issues of land ownership and equity in relation to sanitation. Landless families commonly found in Asia are unable to build their own latrines. In India, for example, the government made provisions in its TSC program to provide communal latrines for landless families. This approach is often not possible in many other countries where the government cannot afford the costs.

Another important socio-cultural factor that can limit the scaling up of TS is the caste system, which is prevalent in Asia. In communities where there is a mix of different castes, it is common to find that the

part of the community with the higher castes are ODF, while the part with the lowest caste still practice OD.

4.2 Application of TS Approaches in a Peri-urban Context

4.2.1 Introduction

There is no universal definition of small towns and they can vary from country-to-country. A small town in India, for example, might be considered a city in an African country. The big debate about what actually is small town has meant that population size cannot be used as the main criteria. This therefore implies that sanitation promotion approaches cannot be defined specifically for small towns. Considering that the definition of a small town is country specific, it would be more effective to look at the individual characteristics of a settlement and use that as the basis for deciding the most appropriate approach. On the other hand, in settlements with similar population but with the characteristics of rural settings, it will be more effective to use sanitation promotion approaches that have worked for rural settings such as CLTS. In settlements with urban characteristics, SM or TSSM can be applied as appropriate. Based on the lack of a general definition of small towns across countries and the fact that approaches in small towns will likely follow either the approach used in rural areas or urban areas, this report has not covered the applicability of TSSM in small towns. This is on the assumption that managers can make decisions based on their individual situation or the most appropriate approach to use.

The use of total sanitation approaches in an urban context is relatively new with few case studies of large scale programs. One of the key principles of TS is that it community-led and people-centered. Peri-urban settlements are often densely populated with little or no sense of community. It is therefore more complicated to get the great majority of the residents to participate in the triggering sessions. Table 3, on the following page, presents a summary of countries that have reported the use of CLTS and other TS approaches in peri-urban settlements. This section also reviews a case study of a large scale TS program in a peri-urban settlement. A more detailed inventory is outlined in Annex 1- Database.

TABLE 3: OVERVIEW OF TS APPROACHES IN PERI-URBAN SETTLEMENTS

Country	Organization	Target population	Comments
Bangladesh	WaterAid with 22 partners funded by DFID UNICEF SHEWA-B (funded by DFID)	500,000 Not indicated	
Cairo (Cairo South)	Plan Egypt	Not indicated	Used TS approach to mobilize the population of Cairo South for waste management & cleaner living surroundings.
India	Kalyani municipality (funded by DFID)	10,000	• All 52 slums in the municipality have been

TABLE 3: OVERVIEW OF TS APPROACHES IN PERI-URBAN SETTLEMENTS

Country	Organization	Target population	Comments
(Kolkata)			declared ODF. • The known ODF municipality using CLTS.
Indonesia	UNICEF with Care International & Mercy Corp.	70,000	
Kenya	Plan International		Commenced piloting CLTS in the Mathare 10 peri-urban settlement.
Mauritania	UNICEF	32,000	8 neighbourhoods in Rosso have been declared ODF.

4.2.2 Kalyani Municipality Case Study

Background

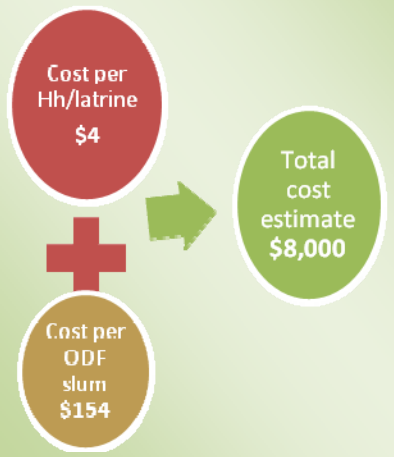
Kalyani municipality, with a total population of 85,000, is located 48 km north of Kolkata in India. Prior to the introduction of CLTS the government had spent over Rs.35 million ($789,000) building toilets for slum dwellers. The Kolkata Urban Services for the Poor (KUSP), a DFID-funded program aimed at increasing services for 21.5 million slum dwellers, also built free toilets in the initial phase of the project. OD practices continued even with the amount spent on building free toilets by the government and donor agencies.In late 2005, the concept of CLTS was introduced to the KUSP and Kalyani was one of the municipalities that made the decision to stop all subsidies for latrine construction, pilot CLTS in 5 slums, and establish an incentive in the form of development programs for slums that achieve ODF status. Although the approach adopted CLTS processes, CLHI (Community-Led Health Initiative) actually had a broader scope that included solid waste disposal and other public health issues. CLTS was, however, used as an entry point for tackling the huge problem of open defecation.

Implementation of CLHI

- *Training.* Honorary Health Workers (HHWs), community and natural leaders, and interested youths were trained in CLTS. The initial pilot took place in 15 slums and a further training on CLTS was organized for natural leaders that emerged from slums where CLTS had been successful.
- *Monitoring.* There was regular follow-up and linkages of CLTS slum communities by the municipality. Private vendors were encouraged to stock more latrine construction accessories. There were periodic meetings in slum communities with ward councillors and municipal officers at the municipality level. Monitoring was done at different levels from the slum community to the municipal boardroom.

- *Latrine design.* Although there were no specifications on the types of latrines to build, slum dwellers were introduced to the attributes of a sanitary toilet, which included non-visibility of excreta, no foul smell, and no access to insects and animals.
- *Incentives.* Solar street lamps were installed in the first slum that became ODF and all ODF slums were prioritized for other development work. Natural leaders were taken for an exchange visit to the Bombay slums.
- *Results.* Progress was initially slow but within 6 months, 5 slums were declared ODF with the emergence of a considerable number of natural leaders. Many innovative toilet designs also emerged. The program was scaled up to all the 52 slums in early 2006 and all were declared ODF by November 2008.

BOX 5: COST ESTIMATE FOR CLTS IN KALYANI MUNICIPALITY



- *Institutional support.* Kalyani Municipality, particularly the Board of Councillors; Head of the Urban Local Body (ULB) who was the CLTS Chairman; Chief of Health of the ULB (Team Leader); natural leaders that emerged during the initial implementation; and strong political will from Kalyani municipality contributed to the success. DFID also engaged Dr. Kamal Kar to advise the Municipality.

4.2.3 Challenges of TS Approaches in Peri-urban Settings

- *Population density.* Peri-urban settlements are often occupied by people from all parts of the country with no visible community ties. Population density is usually high and the majority fall into low-income groups. Due to the lack of community cohesiveness and the fact that many people are daily income earners, it can be difficult for a large number of people to attend the triggering sessions.
- *Land tenure.* Land tenure and ownership in the majority of peri-urban settlements is complex and there is a large population of tenants or transients who are often unwilling to pay for toilets.
- *Space.* Space availability limits the options even where slums dwellers have been triggered. It can be difficult to build individual latrines, which is often the first choice of households.
- *Infrastructure.* The lack of space and the nature of many peri-urban settlements can make it difficult to build a lower cost toilet. It may be necessary to line the pits to make the toilets more durable. The lack of space also means that households cannot shift their toilet and full pits must be emptied. The limitation is that the majority of the peri-urban settlements lack the necessary infrastructural support from the municipality to support the maintenance of toilets.
- *Miscellaneous factors.* Other limiting factors include the provision of sanitation facilities in public places and the involvement of street kids and homeless people.

4.3 SANITATION MARKETING (SM) IN RURAL AND PERI-URBAN CONTEXT

SM is a relatively new concept for sanitation promotion. Unlike CLTS, SM is more complex to implement and requires skills that are often not available in the WASH sector. A key component of SM, whether in a rural or urban setting, is the initial formative research which becomes the basis for designing the marketing strategy. Some of the benefits of SM include the following:

- Covers both the demand and supply side of sanitation and can complement TS approaches by facilitating the household decision-making process for latrine choice.
- Can be implemented in rural, small town, and peri-urban settings.
- Is people-centered, but does not necessarily require large number of people to participate in community motivation activities. People in urban settlements tend to be daily income earners with limited time to spend in meetings, hence the suitability of SM for peri-urban settings.
- Aims at establishing or developing a robust supply system for sanitation by involving the private sector.
- Places emphasis on developing private and informal sector participation by providing sanitation services from latrine installation to emptying and disposal.
- Uses marketing techniques to sell improved sanitation to users based on the identified motivations, not just for health reasons.

Considering the above benefits, there are few case studies of large scale SM programs. The majority of the examples of SM are small scale projects that seem to focus only on the supply side, specifically the training of masons. Table 4 provides an overview of the MCH focus countries where SM is being implemented. The only large scale SM program is the WSP/Gates Foundation TSSM program in Tanzania and East Java in Indonesia as part of the TSSM project discussed in Section 4.4.

TABLE 4: OVERVIEW OF SM PROJECTS

Country	Context	Organization	Activities
Afghanistan	Rural	UNICEF/ NGOs and Government	• Project implementation just beginning.
Bangladesh	Rural	Plan (2005 – 2008)	• Implemented training for the production of quality latrine components. • Provided mould set for latrine components. • Created a revolving fund.
Ethiopia	Rural	Plan (2011 – 2014)	• Studying mechanisms and facilitating establishment of community-managed SM centers using revolving funds.
Indonesia	Rural	Plan	• Local artisans have received training to improve their skills to create a safe-low-cost-toilet.

TABLE 4: OVERVIEW OF SM PROJECTS

Country	Context	Organization	Activities
		(2008 -2014)	• 20 local entrepreneurs trained. • Capacity of 2 local hardware sellers developed.
	Rural	Plan Netherlands (2009 – 2011) (2013 – 2014)	• Identifying and training artisans to manufacture affordable sanitation technology options. • Improving access of sanitation businesses and masons to financing. • Promoting marketing of various sanitation technologies to enable communities access them. • Engaging communities in their efforts to climb the sanitation ladder. • Working closely with various partner/stakeholders in ensuring supply of sanitation technology options.
Kenya	Peri-urban	WSP	• Service provider capacity developed and strengthened to help water sector boards adopt and implement TSSM methodology. • Adding SM component to CTLS work carried out by others.
Madagascar	Peri-urban	WaterAid (DFID- funded) 2003 – 2004	• Conducted formative research. • Developed and pre-tested promotion materials. • Trained masons and mobilizers. • Organized an event to launch improved latrines. • Facilitated masons to establish a latrine information center.
Senegal	Rural	USAID	• Increased the supply of sanitation goods and services through capacity building of small and medium sized enterprises.
Tanzania	Rural	Plan Australia (2008 – 2010)	• Created 5 SM groups producing and selling sanitation accessories. • Developed various technological options, including the selling of plastic pour-flush pans. • Developed marketing material, including sign boards and information leaflets. • 12 local entrepreneurs trained. • Capacity of 8 local hardware sellers developed

TABLE 4: OVERVIEW OF SM PROJECTS

Country	Context	Organization	Activities
Timor-Leste	Rural	Plan (2007 – 2010)	• Produced 200 training manuals and 200 catalogues. • 14 local entrepreneurs trained. • Capacity of 89 hardware sellers developed.
Uganda		USAID/HIP	• Conducted in-depth consumer and supply assessments. • Developed training manuals for masons. • Developed latrine catalogue. • Developed a SM manual for managers.

4.3.1 Challenges of Sanitation Marketing (SM)

Cost

- The two main components of SM are generating demand and increasing the supply of sanitation goods and services. Developing these two components requires detailed user and supply studies which can be expensive in relation to what the sector is used to spending on sanitation promotion. For example, WSP estimates that it costs between $75,000 to $300,000 to conduct formative research for demand and supply. In Ghana, for example, market research agencies charge between $500 to $1,000 per focus group discussion.
- The cost of developing and pre-testing a communication strategy and materials is also high at $75,000 to $300,000 depending on the country.

Skills Requirements

- SM is based on the principles of commercial marketing which requires that the 4Ps (Product, Price, Place, Promotion) are covered appropriately. An SM initiative is usually initiated by in-depth consumer and supply assessments. The 4 P's discussed on page 6 are then based on this research. These are skills that do not often exist within the government, NGO, or development agencies and, as a result, need to be brought in from the commercial sector. Obtaining the necessary skills in the commercial sector can be problematic since they often do not have a good understanding of the complexities of rural sanitation.

Methodology

- The methodology for SM, unlike CLTS, is not simple and easy to use by community mobilizers and people with minimal or no education.
- There are no clear, simple, and tested guidelines or manual on how to implement or scale up a SM program. However, the USAID/HIP project in Uganda developed a manual for managers (www.hip.watsan.net/page/4388), and WSP is in the process of developing a SM guide.

Multiple Implementers

- SM requires input from various implementers such as research firms; communications and marketing firms; sanitation consultants with knowledge about marketing social goods; government (municipalities, utilities, or local governments); NGOs to support training of masons; masons; and pit emptying service providers.
- Coordinating and managing these different stakeholders can be a challenge for development agencies, NGOs and government.

Result

- Unlike CLTS, the results of SM are not as immediate. It takes a while to conduct the initial study and complete all the initial preparatory work. Because CLTS can produce tangible results in a short period, government and even NGOs may begin to lose patience and confidence with the program.

Lack of Good Case Studies

- The lack of good examples of large scale SM currently makes it difficult replicate in other areas.

BOX 6: COMPONENTS OF THE WSP GLOBAL SCALING UP SANITATION PROJECT

1. *Demand.* Creating community-based and household level demand to stop OD and move up the sanitation ladder.

2. *Supply.* Working with the local private sector to improve quality and increase the range of sanitation products/facilities.

3. *Learning.* Ensure that responsive knowledge products are developed and shared with other programs in order to encourage knowledge uptake and replication.

4. *Monitoring & Evaluation*

4.4 How has TSSM Worked?

4.4.1 Introduction

As discussed, TSSM is a relatively new approach initiated by WSP in the *Global Scaling Up Sanitation Project* in partnership with The Bill and Melinda Gates Foundation. The way in which CLTS and SM are combined varies in countries. The processes for TSSM are outlined in Figure 1 (found in Section 2.1) with activities consisting of market research; planning the marketing mix (Production, Price, Place, Promotion); triggering collective behaviour change; promotion events; and monitoring.

Three case studies from the project implementing TSSM on a large scale are discussed below. The project has four main components; *Demand; Supply; Learning;* and *Monitoring & Evaluation* (see box 6). WSP plays a supporting role to government to conduct formative research, provide technical assistance, generate evidence-based learning, and capacity building.

4.4.2 Case Studies of TSSM (Implementation Models)

The Global Scaling Up of Sanitation Project that uses TSSM approaches began implementation in 2006 and is scheduled to end in 2011 in all three countries – India, Indonesia and Tanzania. A presentation made by WSP at the 2010 World Water Week at Stockholm indicated that over 8 million people have gained access to sanitation (a mixture of improved and traditional toilets) with over 5,500 communities declared ODF. Other objectives that have been achieved so far include increased local government

capacity to manage and sustain large scale rural sanitation programs; stronger national government enabling environments; and increased evidence-based learning for the sanitation sector.

East Java Indonesia

East Java, Indonesia has an estimated population of 37.4 million with the majority (88%) living in the rural areas, with sanitation coverage of 69.8% and 54.9% for urban and rural areas respectively (SUSENA 2006 in Devine and Paynter, 2010). The program aims to facilitate access to improved sanitation for 1.4 million people; creating 870 ODF communities and training 174 facilitators. The Indonesia implementation model was based on the SaniFOAM Behavior Change Framework[1] that included demand and supply research at the onset of the program. The findings from the research were used to develop tools and materials for implementation. The target for East Java was to reach 29 districts with a combination of CLTS and SM.

A formative research and supply assessment was conducted in six sample districts in East Java by a team of consultants hired by WSP. The study used qualitative methodology including 7 focus groups and 50 key informant interviews with local residents, provincial/district health officials, community leaders, suppliers, manufacturers and installers of latrine equipment. The findings identified indicators influencing growth of latrine markets in Indonesia as being related to demand, supply, and enabling environment (see Figure 2). It also revealed misconceptions amongst providers and in the community about what constituted a safe toilet.

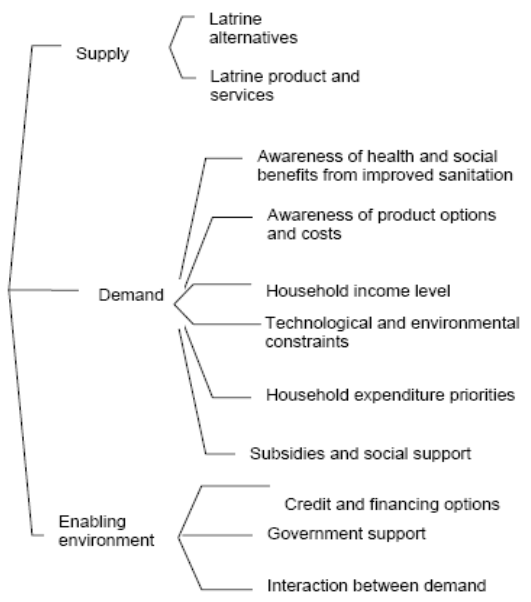


FIGURE 2: INDICATORS INFLUENCING GROWTH OF LATRINE MARKETS IN INDONESIA.

CLTS was used to trigger collective behaviour change from open defecation to more hygienic processes. In order to further reach those with unimproved toilets and those still practicing OD, the TSSM program developed an integrated communication campaign to reinforce the new social norm created through CLTS; right the misconceptions; and use the drivers for improved sanitation identified during the research.

The campaign, with the aid of a character called 'Lik Leke', features an 8-minute video drama, radio commercials, and a series of posters. After receiving orientation and prototypes of the communications tools, districts are able to fund the campaign, either fully or partially, through their budgets. In other words, CLTS, in combination with behavior change communication (BCC) was used to target people that practiced OD and those with unimproved or shared toilets. SM is then used to motivate

[1] For details of the SaniFOAM framework, see http://www.wsp.org/wsp/node/86

people to move up the ladder of improved sanitation from pit latrine to flush latrines. The results to date in Indonesia are outlined in table 5 below.

TABLE 5: RESULTS OF TSMM PROGRAM IN INDONESIA

Number of people that gained access to improved sanitation.	740,000
Number of communities triggered in 29 districts.	3,000
Percentage of districts triggered with district support.	70%
Number of ODF communities.	1,300
Number of masons and suppliers trained.	1,700
Level of funding leveraged from local governments in 2009.	Up to 40%
Other results: • One-stop sanitation shops for latrines. • SMS-based self monitoring and verification system. • Good governance indicators now include provision of sanitation services. • National CLTS strategy issued by the Ministry of Health. • Medium-term development goals (2010-2014) includes target to achieve ODF in Indonesia by 2014. • East Java districts contributed $470,000 in 2009 and extended CLTS to over 2,300 communities.	

Source: Weitz (2010)

Good progress has also been made in the *'learning'* component of the project. A number of knowledge products have been produced from the TSSM program in East Java. The program has a monitoring manual, which has been recently complemented by a modified TSSM monitoring system based on mobile text messaging. The new monitoring system, where data gathered at community level is sent via mobile phones on a monthly basis, has been piloted in one district.

Tanzania

The United Republic of Tanzania has an estimated population of 42.5 million, of which 75% live in the rural areas. The JMP 2010 update indicated that only 24% of the population uses improved latrines, 63% use unimproved or shared latrines, and 13% practice open defecation (WHO and UNICEF 2010). This indicates that over 24.5 million people that live in the rural areas use some form of unimproved sanitation. Although the country has high latrine coverage, diarrhoeal diseases rates are still high. Tanzania's national poverty reduction strategy 'MKIKUTA' adopted a national strategy with the target of achieving 95% sanitation coverage by 2010.

The TSSM program covers 10 districts with the following targets: access to improved latrines for 750,000; triggering CLTS in 1,440 communities; training 540 masons; and sanitation messages received by over one million households. A market research assessment was conducted in 2008 by PricewaterhouseCoopers consisting of a consumer/household research and sanitation market assessment. 1,000 households and 161 sanitation providers were interviewed and 85 shops were visited for the study. Findings from the study confirmed the high latrine coverage but indicated 70% out of the 79% using latrines have unimproved facilities and that acquiring an improved latrine ranked low on the

household list of priorities. Some of the major drivers for improving sanitation include shame, privacy and safety. Findings from the supply market assessment indicated that providers were small individuals with other sources of income supplemented by sanitation provision. They also identified a low demand for improved sanitation products and services associated with low income households. The major obstacles to developing the sanitation business include the lack of capital and accessibility of materials. (Detailed report available at: http://www.wsp.org/wsp/sites/wsp.org/files/publications/TZ_TSSM_Research_Report.pdf .)

BOX 7: ROLE OF NATIONAL AND LOCAL GOVERNMENT IN TSSM

National

- Allocate funding
- Monitor progress
- Set standards of latrines
- Define approaches
- Provide technical assistance
- Fund and implement mass media
- Fund and implement national community events

Local

- Monitoring implementation
- Fund training of masons
- Fund training of community facilitators
- Supervision

Source: Devine & Paynter (2010)

The findings from the research were used to design the intervention for the TSSM program. At the onset, 60 master trainers were trained in triggering CLTS in each of the 10 districts and were then expected to train about 350 ward extension workers as community facilitators. CLTS was used to trigger collective behaviour change from OD to more hygienic practices. In order to further move people up the ladder from unimproved and shared latrines, to improve sanitation (from pit latrine with slab up to a combination bathroom/toilet), SM and BCC were used. A communication strategy was developed targeting heads of households and making them believe "*in their hearts that an improved latrine and stopping OD is essential to their status and aspiration to be modern*". Consumer contact promotion events were organized at the various wards. To improve the supply and reduce the barriers to acquiring an improved latrine, a cheap slab priced at $5 is being promoted, masons are trained, and point-of-sale and sanitation committees have been established and branded. The national and local governments play leading roles in their various capacities (See Box 7 below). The results achieved so far in the TSSM program in Tanzania include:

- CLTS triggered in 188 communities
- 200,000 people with improved sanitation
- 75,000 people reached by promotion events
- 10 district governments contributing $40,000 each

Himachal Pradesh (HP) and Madhya Pradesh (MP), India

India is slightly different from the other two WSP TSSM programs in that the central government had already been implementing a national Total Sanitation Campaign for a number of years. The TSSM program in the Indian States of Himachal Pradesh (HP) and Madhya Pradesh (MP) is intended to effectively influence the way in which the national TSC campaign is implemented by capacity building, technical support, and advocacy work.

In HP, the project is working in 12 districts where the TSSM approach has been adopted within the TSC program. The district officials have also been engaged in training of the local government to ensure that

results achieved at the community level are monitored, verified, and sustained. About 500 master trainers have been trained across the state with the support of WSP and they have in turn trained over 7,000 motivators at the community level across the state. In order to support TSC in districts that have been not performing well, the team in HP adapted the TSSM-Indonesia model of contracting an advertising agent to develop BCC. The materials include TV commercials, poetry, scripts for folk arts, a children's game, and wall murals with the aim of reinforcing and sustaining the new social norm of ODF.

In MP, the TSSM project has gained significant interest from 20 of the 50 districts. These districts have adopted CLTS as the core strategy for stopping OD and generating demand and uptake of improved latrines. In order to facilitate the shift of state emphasis on large scale toilet construction, the TSSM project has continued advocacy at different levels to promote behavior change through CLTS and sustained usage of toilets. The results achieved so far are outlined earlier in Table 1.

TABLE 6 (ON THE FOLLOWING PAGE) IS A SUMMARY OF SOME KEY KNOWLEDGE PRODUCTS DEVELOPED BY WSP TO DATE.TABLE 6: KNOWLEDGE PRODUCTS FROM COMPONENT 4 OF THE WSP GLOBAL SCALING UP SANITATION PROJECT

Country	Product
Indonesia	• Informed choice catalogue of improved sanitation options • Mason training program and curriculum • Total Sanitation and Sanitation Marketing in Indonesia: "Learning at Scale" Field Note • Monitoring Information Flow Learning Note (in draft)
India (HP and MP)	• Benchmarking District Performance on Rural Sanitation Learning Note • Scaling Up Rural Sanitation: Best Practices (Draft) • ODF Verification Field Note (Draft) • Sanitation and Health (Draft) • District Approaches to ODF (Draft)
Tanzania	Yet to produce formal knowledge products.

4.4.3 CHALLENGES OF TSSM

TSSM is a new approach that combines two approaches that have only been tried and tested together for a short while.

Some of the limitations of scaling up the TSSM approach include the following:

- All the evidence is not yet in about the effectiveness of TSSM. While the results of the WSP activities appear to be promising, a final evaluation is expected to provide powerful evidence as to how well it has worked.

- There is a relative lack of experience in large scale SM projects.
- The TSSM approach combines two approaches, and as a result, requires separate skills at various levels in order for its implementation to be successful.
- While local governments are the centerpiece of TSSM, many are weak overall and lack capacity to carry out their role.
- Total sanitation approaches require motivators with good triggering skills for CLTS and a local government with skills to supervise, monitor, verify, and sustain the results. SM on the other hand requires skills that are often available in the commercial private sector but are costly and neither the local, nor the central governments, have experience working with them.
- The TSSM approach has higher up front implementation costs which many governments and the development sector are not used to funding. Though the up front costs of CLTS (training, triggering, and monitoring) and SM (formative research and developing communication packages) can be seen as high, they can potentially cover many more people than other approaches. The questions are: *How do we convince governments to make these investments? Can they afford it? Will they have the necessary skills to monitor and supervise the SM component of the TSSM approach?*

The methodology of TSSM is still evolving. WSP will be documenting their lessons learned in 2011-12.

5. MAKING TSSM WORK

5.1 INTRODUCTION

TSSM has the potential to stop OD and encourage the uptake and use of latrines on a large scale. Total sanitation approaches such as CLTS have been successfully scaled up in many countries, particularly in rural areas. Experience from the WSP Global Scaling Up Sanitation project indicates that the combination of CLTS and SM has even greater impact and with the additional advantage of building sustainable supply mechanisms for improved sanitation.

Lessons from the various total sanitation and TSSM projects/programs have highlighted important factors when planning for a large scale program. These important factors outlined in Figure 3 (below) are discussed in the remainder of this chapter.

FIGURE 3: FACTORS TO CONSIDER WHEN PLANNING FOR TSSM PROGRAMS

While these factors are likely to be applicable in small towns and peri-urban contexts, the focus in this chapter is on rural areas since that is where the preponderance of experience to date lies.

5.2 INSTITUTIONAL FRAMEWORK

Large scale CLTS, SM, or TSSM programs would require an established institutional framework with networks at the central, provincial, district, sub-district, and community levels. Although NGOs have successfully implemented CLTS, their operational scale is

BOX 8: 3-TIER LOCAL GOVERNMENT STRUCTURE

India: Districts, Blocks, Villages

Indonesia: Districts, Sub-districts, Villages

Tanzania: Districts; Wards, Villages

Mozambique: Districts, Administrative Posts, Villages.

often limited–even the larger NGOs. The institutional framework required to support a large scale program must have an established structure at the central, provincial/regional/state, district, sub-district, and community levels. This therefore highlights the importance of working with governments in various countries, as government institutions have the only established structure that will remain, even when the project/program ends. Each level of government has an important role to play but the local government has the most critical role. However, government institutions cannot scale up TSSM alone and would require the support of development agencies, NGOs, and the private and informal sector.

Models of institutional frameworks that have been used in the implementation of TSSM as a combined program or CLTS on its own have identified various roles for the different levels of governments. Table 7 outlines case studies from four countries where TSSM and CLTS are being implemented at scale.

TABLE 7: COMPARISON OF ORGANIZATIONAL MODELS IN INDIA, INDONESIA, TANZANIA, AND MOZAMBIQUE

	India	Tanzania	Indonesia	Mozambique
National level coordination	Ministry of Rural Development, Department of Drinking Water and Sanitation	Ministry of Health and Ministry of Water and Irrigation	Ministry of Health	Ministry of Public Works & Housing, National Department of Water
State or regional coordination	Unit at the state level supervises resource agencies and provides guidance to districts	None	Regional committee coordinates, provides technical guidance, M&E	Department of Public Works and Housing
Resource agencies (RA)	Two national NGOs provide training, monitoring, and reporting	Two national NGOs provide training, monitoring, and reporting	Specialized regional, private sector consulting firms provide training, and assist with planning and monitoring	6 NGOs support the districts through training, monitoring and reporting
Districts	Primary implementation unit	Primary implementation unit	Primary implementation unit	Primary implementation unit
Local support organizations (SO)	Implement TSSM at block level	None	None	Implement CLTS at the community level
Sub-districts (blocks or wards)	Monitor local SOs and report to districts	Triggering, reporting	Trains facilitators, monitors	Monitor SOs
Villages	Village committee	Village committee	Village committee monitors	Village committee and natural leaders

Adapted from: Rosensweig and Kopitopoulous (2010)

A recent study by Rosensweig and Kopitopoulous (2010) identified the roles and functions of local government in the implementation of TSSM as: *strategy and planning; advocacy and promotion; capacity building; supervision; monitoring and evaluation/reporting; regulation;* and *coordination.* Three organizational models from the Global Scaling Up Project using TSSM in Indonesia, India, and Tanzania and one for a CLTS program in Mozambique all have identified the important role of the local government. In all four countries local government consists of a three-tier structure. This indicates that similar structures are in existence across many countries and are important for scaling up CLTS and TSSM programs.

The organizational models outlined below (Figures 4-7) highlight what has worked in these four countries and also gives an indication of the staffing requirements and the role of development agencies, such as WSP and UNICEF, for a large scale program. The first three organizational models were abstracted from Rosensweig and Kopitopoulous (2010). It is important to note that in all four models there is a development agency (WSP or UNICEF) that plays the lead supporting role for the program at the national level.

India

In India, the TSC program, which began before the TSSM program, is embedded into the local government structure. The management model for TSSM consists of supporting the existing structures and their effort to implement TSC.

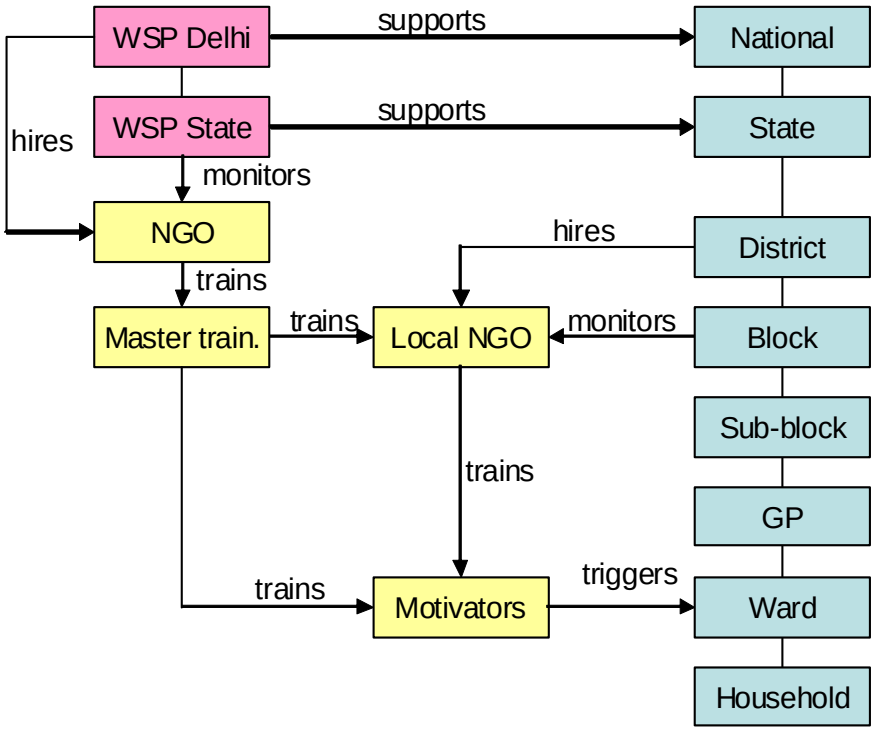


FIGURE 4: TSSM ORGANIZATIONAL MODEL IN INDIA

Indonesia

In Indonesia, the local government is again the primary implementation body with the central government acting as facilitators through strategy formulation, capacity building, and provision of incentives.

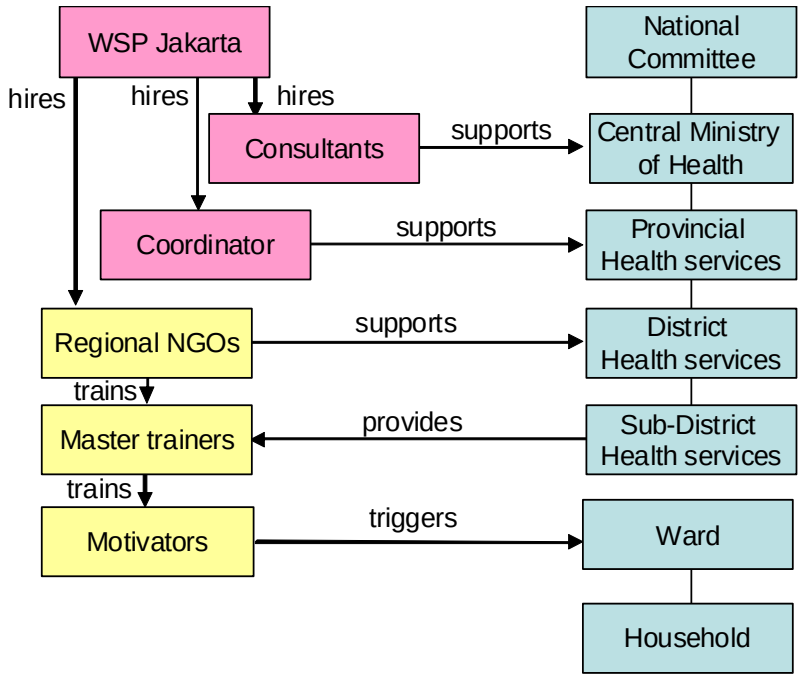


FIGURE 5: TSSM ORGANIZATIONAL MODEL IN INDONESIA

Tanzania

The local government is also the primary implementing body supported by WSP and other local NGOs.

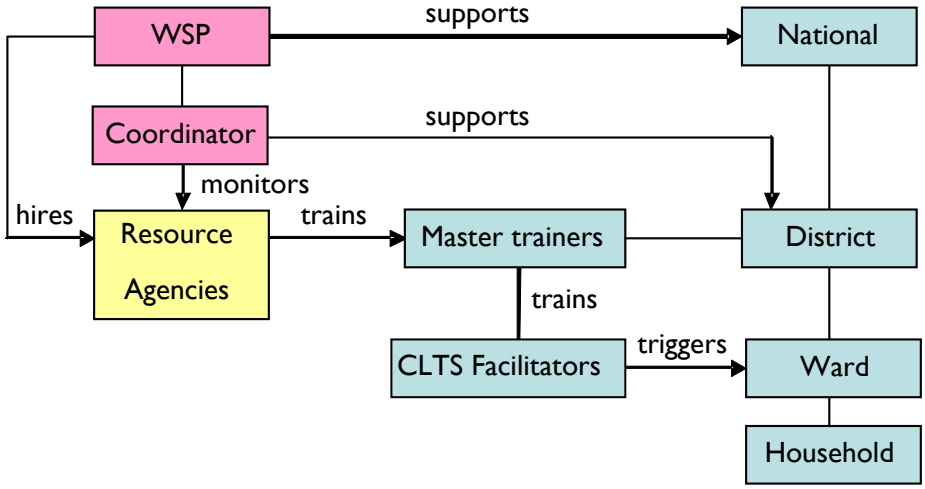


FIGURE 6: TSSM ORGANIZATIONAL MODEL IN TANZANIA

Mozambique

In Mozambique, the management of the CLTS program lies with the district that contracts local NGOs to train and support CLTS animators. The local government supervises the NGOs and monitors and reports the progress of the CLTS program to the province. The National Water Department acts as facilitators developing guidelines, training NGO trainers, and conducting verification of ODF communities.

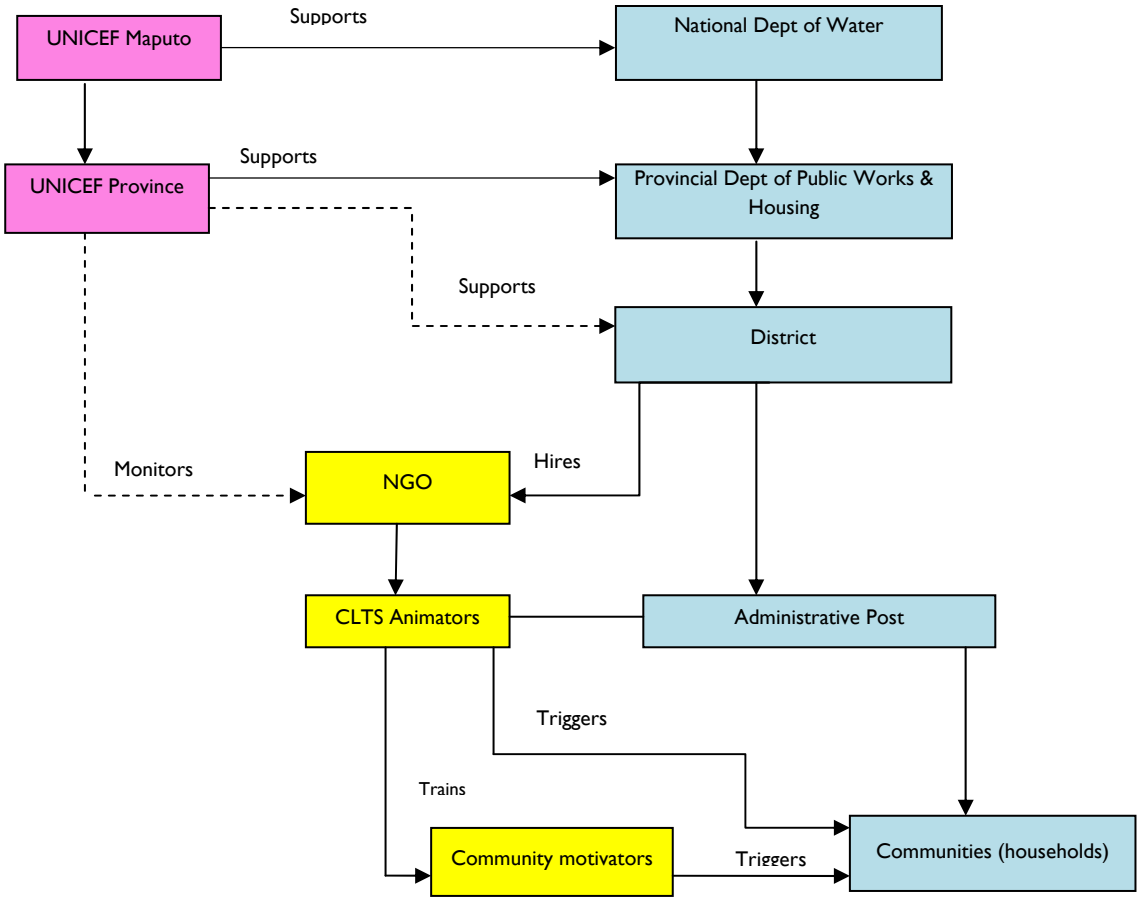


Figure 7: TSSM Organizational Model for Mozambique

5.3 Staffing and Management Requirements

Following from the institutional models outlined in the previous section, the staffing and management requirements for large scale CLTS or TSSM program can be summarized as follows:

<u>*National Level: National Coordination Unit*</u>

- National Department of Water and Sanitation – national program coordination headed by a *coordinator or director* and supported by *a Hygiene and/or Sanitation Specialist.*
- Supporting Agency (SA) – Development agencies such as UNICEF, WSP, or USAID (through an implementing partner) support the central government unit to design, plan and scale up TSSM.

The staffing requirements include: *i) Project Director/Coordinator ii) Sanitation Specialist, iii) Hygiene Specialists; iv) Sanitation Marketing Specialist;* and *v) Knowledge and Information Management Specialist.*

Provincial/State/Regional Level: Provincial Coordination and Support Unit

- TSSM could be managed by the regional/provincial government department of water and headed by a coordinator. However, since the lack of clarity regarding roles and responsibilities for sanitation is often even more pronounced at the provincial level, it may be worth advocating for the establishment of a regional sanitation task force consisting of staff from the *departments of water and sanitation*; *health*; *education,* and *rural development*.
- Supporting agency - a *Regional Coordinator or Consultant* in every region where the TSSM/CLTS program is being implemented. The Regional Coordinator/Consultant will work with the regional government to advocate for scaling up, fund allocation, and to supervise and coordinate TSSM at the districts.

District Level and Below

- The primary responsibility for the planning and implementation of CLTS or TSSM lies with the district government. The district administrator is the most appropriate person to lead the district team with support from the water, health, education, and rural development officers.
- The district government, with the support of the developing agency team, can contract with *NGOs* to conduct training, triggering, and monitoring and reporting progress, as is the case in India.
- At the sub-district level, the program should be led by the administrator supported by the health extension workers. They work at the community level to trigger CLTS and monitor progress.

5.4 TRAINING

Training needs for CLTS

The training needs vary across the levels of government. The higher levels will require program development, planning, and coordination skills while the local government levels will require skills in planning, implementation, monitoring, and reporting. The success of CLTS is dependent on the effectiveness of the triggering, monitoring, and reporting of progress. In order to ensure sustainability within the country there is a need to have skilled resource persons/trainers at the various levels of government. Table 8 (below) summarizes the training requirements at the various levels for CLTS.

- *National master trainers* At the national level, a national training team that supports the scaling up of CLTS across the provinces is essential.
- *Provincial master trainers*. They should be based in the provinces for ease of training of the districts under their jurisdiction. They will also be responsible for supervising and monitoring the quality of training delivered by the district trainers, such as NGOs.

- *District trainers/supervisors*: These include NGOs that are responsible for training sub-district CLTS facilitators and community animators. It is important that they are extensively trained, supervised and monitored, as the success of triggering CLTS at the community level partly depends on the quality of their training skills.
- *Sub-district facilitators:* These include CLTS facilitators; community animators; and natural and community leaders, including health extension workers. This group has the primary responsibility of triggering CLTS in the communities.

TABLE 8: TRAINING NEEDS FOR A CLTS PROGRAM

Levels	Who Could Benefit?	What is Covered?	ResourcePersons
National	• Staff from the national coordination unit • Staff from the Ministry of Health • Supporting agency central team **National master trainers**	• Overview of the CLTS methodology • Training skills • Program planning and coordination • Exchange visits in-country or in the region	• International CLTS consultant • Program planning and coordination specialist
Provincial	• Staff of the provincial/state coordination unit • Supporting agency provincial staff/consultant • NGO hygiene promotion and community mobilization managers **Regional master trainers**	• CLTS methodology • Training skills • Program planning and coordination • Supervisory skills	• International CLTS consultant • Program planning and coordination specialist • National master trainers
District	• Staff of the local government CLTS team including health, education, sanitation, and water supply • NGOs **District trainers / supervisors**	• CLTS methodology • CLTS triggering skills • Monitoring and reporting skills	• CLTS specialist • National and regional master trainers
Sub-district	• Health extension workers • Community and natural leaders • Community animators • NGOs' sub-district facilitators **CLTS facilitators**	• CLTS methodology • CLTS triggering skills • Follow-up visits, monitoring and reporting skills	• District trainers

Training needs for SM

Sanitation marketing (SM) unlike CLTS does not require as much training for the different levels of government. This is due to the type of activities in SM, which are often contracted out to specialized agencies. The majority of the training requirements for SM are concentrated on developing the supply of improved sanitation facilities and related services.

As part of the planning process for SM, an orientation meeting should be held at the national level for the TSSM coordination unit team and provincial coordination team. This should be facilitated by a SM specialist to create an understanding within the teams of the SM approach, activities involved, and agreement on who should carry out these activities. The orientation meeting can also be used to plan and discuss the details of the process for SM and the roles of the various government institutions and the supporting agency.

Table 9 (below) summarizes the training needs for SM and who should be targeted.

TABLE 9: TRAINING NEEDS FOR A SM PROGRAM

Levels	Who Could Benefit?	What is Covered?	Resource Persons
National	• Staff of the national coordination unit • Staff from the Ministry of Health • Supporting agency central team	• Overview of the SM approach • Processes and activities for SM	• SM specialist
Provincial	• Staff of the provincial coordination unit • Supporting agency provincial staff/consultant • NGO hygiene promotion and community mobilization managers	• Overview of the SM approach • Processes and activities for SM • Facilitate media placement in government broadcasting stations	• SM specialist
District	• Staff of the local government CLTS team including health, education; sanitation, and water supply • NGOs • Suppliers of sanitation hardware and building materials	• Overview of SM approach • Masons accreditation programs • Orientation for formative research • Orientation meeting/capacity building for local government CLTS on using communication tools • Orientation meetings sanitation providers and suppliers • Training of masons	• SM specialist • Research agency • Advertising and marketing specialist • Supporting agency provincial staff or consultant

TABLE 9: TRAINING NEEDS FOR A SM PROGRAM

Levels	Who Could Benefit?	What is Covered?	Resource Persons
Sub-district	• Health extension workers • Community leaders, animators • Masons	• Orientation meeting / capacity building for local government CLTS on using communication tools • Training of masons	• District trainers and supervisors • Supporting agency provincial staff or consultant

5.5 COSTS

It was not possible to obtain the exact costing for setting up a large scale CLTS, SM, or TSSM program in the rural, small-town, and peri-urban areas. However, it is possible to provide the cost factors that need to be taken into account. These factors include institutional, partner agency, staffing, training, advocacy, and other costs related specifically to SM. The cost factors for TSSM, and some illustrative costs, are summarized in Tables 10 and 11 (below). The costs factors outlined in this table are those that will be borne directly by the funding agency. A breakdown of cost for achieving ODF per community in Bangladesh is summarized in Table 12 and a more detailed cost estimate for setting up CLTS in Mozambique is summarized in Table 13.

TABLE 10: COST FACTORS FOR CLTS

Activity	Illustrative Cost Range	Comments
Subcontracts to supporting agencies	Varies	• These are costs related to supporting agencies (e.g. UNICEF, USAID and WSP) that can manage and coordinate the program on behalf of the donor. • This will also include staffing costs for project director, sanitation/hygiene specialists, SM coordinator, and knowledge/information management specialist. • There may also be costs for head office support.
Subcontracts to implementation agencies (NGOs)	Varies	• These are costs for NGOs that will provide training services, facilitate CLTS, and support districts with monitoring and reporting.
Advocacy and orientation meetings	Varies	• These are meetings and advocacy seminars that are organized at the various stages of the program to create awareness within the various levels of government.
Training of trainers	Varies (was $153,000 in Mozambique)	• The illustrative training costs from Mozambique include cost of training national master trainers externally and the cost of training of 74 people internally.

TABLE 10: COST FACTORS FOR CLTS

Activity	Illustrative Cost Range	Comments
Other capacity building activities such as monitoring and reporting	Varies	• Training on the various monitoring and reporting methods.
Incentives	Varies	• Debatable, but where used can be partly funded by the donor agency and the government. • They include household incentives such as hygiene kits and community incentives such as a safe water point.

TABLE 11: COST FACTORS FOR SM

Activity	Illustrative Cost Range	Comments
Formative research (demand and supply study)	Varies $75,000 - $300,000	• Varies by country and size of population studied.
Supply chain assessment	Varies	
Development of communication plans (concept design; pre-testing, production of master materials, some production)	Varies $75,000 - $300,000	• Varies by country, depends on the type of media used (radio versus TV, street theatre, etc.).
Media placement	Varies	• This can be partly funded by government.
Training of masons	Varies	
Accreditation program for masons	Varies (costs about $100,000 annually in Indonesia)	• Where it exists, the cost varies.
Establishing linkages with credit and savings groups to ease financial constraints to households and suppliers	Varies	• Depends on the country and level of local savings and credit facilities that exists. • May also require situation analysis, which is an additional cost to ascertain type and activities of credit groups.
Advocacy and orientation meetings to create awareness, and gain government buy-in.		• This will include initial orientation meetings on SM for national and provincial governments.

TABLE 11: COST FACTORS FOR SM

Activity	Illustrative Cost Range	Comments
Orientation and capacity building meetings at the local government levels on the use of communication materials and tools.		
Sanitation marketing coordinator	Varies	• Depends on whether it is an international or national position.

TABLE 12: ESTIMATED COSTS OF ACHIEVING ODF PER COMMUNITY (US$ 2008)

	VERC	UST
Program costs (training & support)		
• Local NGO support & overheads	369	282
• WaterAid national support	152	152
Software (Hygiene/IEC)	33	52
Software (CLTS, raining & follow up)	56	20
Hardware	0	0
Total WaterAid	**610**	**506**
Local government/UNICEF contribution	31	31
Household contributions	200	200
Total	**829**	**724**

Cost Effectiveness of WaterAid Investments in Study Communities		
Cost per household	7	6
Cost per latrine	12	42

Source: Collin (2009) (see www.wateraid.org/publications for details).

The UNICEF managed One Million Initiative Project in Mozambique introduced CLTS in 2008. The illustrative costs for setting up CLTS in the 3 provinces are outlined in Table 13 (below). The costs outlined were all funded directly from the project budget funded by the Government of the Netherlands. Note that this does not include UNICEF staff costs that are funded through the project.

TABLE 13: ESTIMATED COSTS OF SETTING UP CLTS IN MOZAMBIQUE

Activity	Cost Estimates (USD$)					
	Per Activity	Per Triggered Comm. (173)	Per ODF Comm. (34)	Per Household in ODF Comm.	Per Latrine in CLTS Comm.	Per Beneficiary in CLTS Comm.
Training cost (Zambia and in-country)	109,917	635	3,233	20.37	2.21	0.44
Triggering Cost	17,496	101	515	3.24	0.35	0.07
Marketing	8,832	51	260	1.64	0.18	0.04
Evaluation	31,170	180	917	5.78	0.63	0.13
Subtotal Costs (minus awards ceremony and incentives)	***167,415***	***968***	***4,924***	***31.03***	***3.36***	***0.67***
Award Ceremony	42,817		1,259	7.93	0.86	0.17
Incentive (best performing district)	12,000		353	2.22	0.24	0.05
Incentive (best performing administrative posts)	2,400		71	0.44	0.05	0.01
Incentives (leaders of ODF communities)	6,800		200	1.26	0.14	0.03
Incentives (ODF communities)	340,000		10,000	63.01	6.82	1.36
Incentive (households in ODF communities)	107,920		3,174	20.00	2.17	0.43
Subtotal Costs (awards ceremony and incentives)	***511,937***		***15,057***	***94.87***	***10.28***	***2.06***
Total costs (plus awards ceremonys a all incentives)	**679,352**	**968**	**19,981**	**125.90**	**13.64**	**2.73**

5.6 FINANCING

Financing of a TSSM program is often shared between national and local government, donors, and households. In some cases, particularly at the beginning of the project, donors may fund the initial phase until enough results are obtained to get governments buy in. Households bear the highest percentage of the total cost, as they have to fund their sanitation facilities. This is what makes TSSM the most effective approach to scaling up sanitation in rural areas. Analysis of the three countries that are implementing TSMM under the Global Scaling Up Sanitation Program shows that the financing is being shared between the governments, households and donors (see Figure 7 below).

FIGURE 7: FINANCIAL STRATEGY FOR WSP/GATES FOUNDATION TSSM PROGRAMS (SOURCE: PEREZ, 2010)

Analysis of public and private investments in rural sanitation across three TSSM countries from January 2007 to June 2010 indicates that national and local governments have contributed over $33 million; households over $47 million; and WSP technical assistance $6 million.

Community Fundraising Initiatives for Sanitation

A story of Khadeja, a woman from Omarpur Union of Chirirbandar sub-district in Bangladesh. She motivated women in the 25 households in her community to stop OD and to build and use latrines. The majority of the households could not afford to build latrines so Khadeja established an association up of 14 women and they each contributed part of their daily rice portion to the association's rice bank. Records of contributions were kept and the rice was sold when it reached a reasonable quantity. A lottery was organized to select the association member that would benefit from latrine construction each time the rice stock was sold.

The UNICEF managed One Million Initiative Project in Mozambique, with the objective of ensuring access to safe water and sanitation for one million people in rural areas in 18 districts, has a total cost of $45 million dollars. The total budget for the sanitation component is $5.2 million of which the government contributes 10% of the total cost. In the Mozambique experience, donor contributions are higher than that of the government. It is of interest to note that the majority of the funding for sanitation, which was earmarked for household latrine construction before CLTS was introduced, is now being re-allocated to creating the conditions for scaling up of CLTS. This is a result of households building their own facilities, thereby freeing up funding for program implementation such as sanitation and hygiene promotion.

FIGURE 8: FINANCIAL STRATEGY FOR ONE MILLION INITIATIVE PROJECT IN MOZAMBIQUE

5.6.1 Subsidies and Incentives

The issue of direct household subsidy is debatable within the sector and across countries. TSSM approaches do not support subsidies even for the poorest household. Some people argue that there are households that can never afford to build their facilities without subsidies. Targeting subsidies to the most vulnerable is a complex issue and it often ends up with the more affluent getting the support. This is one of the biggest challenges of the TSC program in India where households that are BPL are targeted for subsidy. Subsidising household latrines can be very expensive, and most times has proven to be ineffective. In countries where subsidies are applicable, it is usually funded by the government. Experiences from various countries that are implementing CLTS in rural areas indicate that communities have ways of helping one another obtain access to a latrine when a collective decision is made to stop OD. They sometimes come up with their own internal funding mechanism to help each other build latrines.

In some situations, particularly where communal or family shared toilets are the only option, subsidies could be considered. In peri-urban settlements for example where space is an issue and many houses are occupied by tenants, subsidising the construction of sanitary complexes that combine showers and laundry rooms have been successful. Here the residents contribute labor and establish a maintenance schedule for the complex while donors and governments pay for the materials for the structures. In some countries where there are landless families, even in rural areas, subsidies have also been used to help them to construct family shared latrines.

Incentives

Incentives are becoming a common feature of the TSSM approach, although it is not part of the CLTS principle. Incentives can be non-monetary award ceremonies to recognize leaders of ODF communities and sub-district and district administrators. Incentives have helped to scale up CLTS as many communities and leaders want to be recognized and respected by other communities and the government. It has helped to sustain ODF status in many communities. In some places, incentives come with prizes including cash prizes, infrastructure, and even household prizes. In India, incentives include cash awards for ODF communities funded by the government. In Mozambique, as part of the incentives funded by donors, ODF communities are prioritized for new water points; their leaders get a bicycle;

and the households get a hygiene kit (bucket, soap, mirror, water purifier). The issue of incentives is also debatable, but has been more effective than subsidies as they are given as recognition for good results and rather than to produce results. A study in Mozambique indicated that although people knew about the incentives prior to CLTS, the collective decision to end OD was attributed to the triggering rather than the incentives.

6. RECOMMENDATIONS

TS and SM have shown potential as cost effective approaches for scaling up access to improved sanitation, especially in rural areas. Case studies from USAID focus countries indicate that total sanitation approaches such as TSSM and CLTS alone are being scaled up in a number of countries. There is evidence to suggest that SM can also be used in peri-urban settings where there are challenges with implementing CLTS. The combination of CLTS and SM (TSSM) can have even greater impact than implementing the two approaches separately.

The recommendations below are based on the analysis of the TS, SM, and TSSM experiences documented in this report. The recommendations are intended to guide USAID and various country programs when planning for sanitation projects/programs.

6.1 TSSM APPROACH

Prioritize Focus

- A clear decision should be made on whether to begin with TS approaches alone or to plan for a combined TSSM program. Based on the experiences and lessons learned to date from the WSP activities, the recommendation is to begin with TSSM because of the complementary nature of TS and SM.
- The majority of the successful large scale CLTS programs have been in rural areas rather than small towns or peri-urban settlements. It is recommended that country programs should first consider rural sanitation programs and, if successful, build on the success to expand to larger and more complex settlements.

Focus on Government

- Partnership is important and necessary when scaling up TSSM. Partners can play various roles including management, implementation, or facilitation. The lead and central partner in scaling up TSSM is the government, particularly local governments. It is recommended that USAID country teams adopt the WSP TSSM approach in building local government capacity to support, coordinate, and manage TSSM.

Importance of Policy

- Policy advocacy and development is an essential component of scaling up TSSM. TSSM activities at the country level should include a policy component. In WSP's programs in Indonesia, India, and Mozambique, this is a function of WSP staff. Each country program should have an explicit strategy for engaging policy makers. This might include presentation of the evidence, visits to TSSM sites, study tours to other countries, and support in developing rural sanitation policies.

Funding

- *Subsidies.* USAID should not provide funds for direct household subsidies but rather focus on supporting the software components of TSSM. These include management, training of trainers and facilitator, monitoring and evaluation, advocacy activities at various levels of government,

and some of the logistics for triggering. In relation to SM, USAID could pay for formative research, development of communication materials, training of masons, and training of community extension workers on the use of communication materials.

- *Incentives*. The debate on whether incentives should be part of a TS program will continue but the decision should be left for the various country governments. The recommendation is that USAID provide incentives but leave the design of these incentive programs to the governments of the various countries.

6.2 GLOBAL PARTNERSHIPS

The study team contacted several key international partners to identify ways in which USAID might collaborate with them. This section summarizes those discussions.

6.2.1 BMGF/WSP PARTNERSHIP

At the global level, the BMGF and the World Bank Water and Sanitation Program (WSP) have played leadership roles and have been catalysts for TSSM. Both organizations were contacted to determine how USAID might collaborate with them in the next three to five years. Based on those discussions, a number of potential roles emerged for USAID and its implementing partners. In order to frame the recommendations, it is first important to note the following:

- BMFG will provide WSP with two years of bridge funding through 2012. The focus during this period will be ongoing support to the four existing project sites in Himachal Pradesh and Madhya Pradesh in India, East Java in Indonesia, and Tanzania. In addition, Ethiopia will be added to the list of WSP-supported countries. WSP will also complete the impact evaluation and assess the results of the experience to date. With this evidence in hand, BMGF will then determine its future strategy in rural sanitation. BMFG believes that TSSM is still a work in progress and that more time is needed before the results can be assessed and a complete model packaged and rolled out.
- WSP has made a major commitment to rural sanitation in its five year business plan. As one of its five core areas of emphasis, WSP will seek to develop TSSM activities at scale in 10-12 new countries. Possible countries include Mozambique, Rwanda, Senegal, Uganda, Cambodia, Laos, Philippines, Bangladesh, Pakistan, Bolivia, Honduras, Nicaragua, and Peru.
- BMFG is interested in finding the right global mechanism to support rural sanitation. One of BMFG's priorities is to establish this framework for global cooperation.
- Both WSP and BMFG stress that their interest is in identifying donors that are interested in an approach whose goal is rural sanitation at scale and which emphasizes the development of a supportive policy framework and strengthening of the enabling environment with a focus on local governments as the primary vehicle for scaling up.

6.2.2 WATER SUPPLY AND SANITATION COLLABORATIVE COUNCIL (WSSCC)

WSSCC is supportive of CLTS and sanitation marketing approaches and a key focus of its work is spreading lessons learned as they develop. WSSCC's Global Sanitation Fund (GSF) is active in 17 countries. The GSF promotes hygienic behaviors and motivates households to build and use a toilet in

such a way that they will never return to OD and unhygienic behavior. The programs are at various stages of development; some are up and running (Madagascar, Senegal and Nepal); some are in the procurement stage; and others are still in the early stages of developing a program. The existing programs contain aspects of CLTS, SM, and hygiene education. WSSCC has indicated that they are committed to building on these approaches adapted to local contexts. GSF aims to build on the TSSM approach being implemented by WSP and also on the USAID HIP model in its program in Ethiopia.

WSSCC welcomes collaboration with USAID at the global and national level and have suggested the following:

GSF potential areas for collaboration

- Contribution to WSSCC's global pooled fund for the GSF programs.
- Parallel finance to an Executing Agency to build the national program – at the beginning, after the mid-point evaluation, or to extend the GSF program once the first five years are complete.
- Pooling resources and providing small grants to sub-grantees to enhance the process. USAID missions could work to support or fill capacity gaps that have been identified such as developing the private sector's ability to meet demand, or the capacity of local government to deliver hygiene messages and sustain ODF achievements.
- Participating in a collaborative effort to align programs (e.g. by adopting a similar mix of techniques, a no subsidy approach, sharing CLTS training events, planning at scale etc.)

Overall WSSCC Collaboration

- Sharing and learning regionally to support the sector working at scale. For example, in July WSP initiated, and WSSCC facilitated, an East Africa Learning Exchange. This brought together UNICEF, WaterAid, PLAN, PATH, WSP and WSSCC.
- Working collaboratively on the evidence and advocacy links between these approaches and the impacts of improved sanitation with the health sector in order to increase investments in preventive health.

For ongoing collaboration with USAID, WSSCC suggested the following:

- USAID country offices link with the Program Coordinating Mechanism in each country. Some may already be involved in the National WASH Coalition, and the Coordinating Mechanism is typically an extension of this or some other existing coordination group.
- USAID missions maintain contact with the relevant GSF Program Officer responsible for that country. WSSCC regularly share information on their websites, via publications and at workshops, trainings, and conferences.

6.2.3 Department for International Development (DFID)

DFID would value USAID's engagement on global leadership especially the Sanitation and Water for All initiative. This initiative addresses political leadership for sanitation as well as knowledge and best practices globally. DFID's main country activities in sanitation are in Ethiopia, DRC, Sierra Leona, and Nigeria. As a funder of WSP, DFID would also welcome USAID support to WSP. Recommendations on collaboration with WSP are discussed above.

6.2.4 United Nations Children's Fund (UNICEF)

UNICEF continues to align its sanitation programs towards the goal of eliminating open defecation through interventions rooted in community demand and focused on behavior and social change. A major part of this focus is the expansion of pilot and scaled up CATS programs in 49 countries. As a result of this emphasis, a growing number of people are now living in ODF communities. Many projects are moving beyond the pilot stage and in some CATS is becoming the national standard. For example, Niger has adopted a CATS model as its operational strategy for sanitation and in Timor Leste the national sanitation policy is being revised to incorporate CLTS. In an increasing number of countries, governments have embraced CLTS as a way to rapidly scale up progress. UNICEF has also focused on building capacity for CATS programming. In comparison to total sanitation, sanitation marketing initiatives need greater attention, especially in Africa.

UNICEF would welcome USAID technical and financial support to strengthen and expand sanitation programs to take them to scale. Areas where collaboration would be especially welcome included enhancing the enabling environment for TSSM, building national and local capacity, carrying out formative research and the development of sanitation marketing initiatives, and developing appropriate indicators of progress.

UNICEF highlighted the following three areas as potential areas of collaboration.

- Strengthen documentation and learning to improve the effectiveness of existing sanitation programming. This would include assessments and analysis at the country level and qualitative learning around such issues as strategic planning, scalability, capacity needs, program delivery, and community uptake.

- Focus on capacity building and experience exchange. This would include capacity assessments, development of capacity development plans, the institutionalization of training including collaboration with government training institutions and professional associations, and establishing a community of practice for sanitation practitioners.

- Develop innovations and model approaches at scale. Such approaches could include a specific focus on sanitation marketing, establishing public private partnerships, and the development of financial models.

At the global level, support to the Sanitation and Water for All initiative is a priority for UNICEF.

6.2.5 Recommended Role for USAID

Based on these discussions with potential global partners, a number of potential roles emerged that USAID might consider. These roles can be framed at the global, central project, and country levels.

<u>Global</u>

- *Become active in global mechanisms*. USAID could become a player in the global community interested in rural sanitation. BMFG and WSP would welcome a more active role in global mechanisms and

collaborative efforts to address some of the big questions facing TSSM. BMFG believes that as the evidence comes in there will be the need for advocacy for TSSM to build an international movement. BMFG suggested setting up a regular coordination meeting with USAID. WSSCC would welcome USAID involvement in GSF and UNICEF and DIFD in the Sanitation and Water for All initiative.

Centrally-funded Activities

- *Support targeted efforts to further refine the TSSM approach.* Through centrally funded mechanisms, USAID could provide targeted support to further develop the TSSM approach. Specific ideas suggested by WSP include developing a model of formative research at the household level to determine the kind of sanitation facilities; conducting a value chain analysis of sanitation supplies that goes beyond what masons require; developing a model for working with advertising firms to develop public campaigns for rural sanitation; and developing a real time performance monitoring system to foster continuous improvement, including the use of technology such as cell phones. UNICEF cited similar areas in which USAID assistance would be welcome. The key point is that there are methodological issues that would benefit from USAID involvement and would be a way for USAID to contribute to the development of the TSSM methodology.

Country

- *Replicate TSSM at the country level.* While it is important to take note of the BMFG's point that the evidence is not all in yet, both WSP and BMFG also feel that is not a reason not to replicate TSSM now at the country level. The USAID model of using contracts and cooperative agreements is well suited to replication of TSSM at the country level. The implementing partner would in effect play the same role as WSP does in managing the country activity. Key TSSM resources including training materials and guidance documents are already developed that can be used by a USAID implementing partner. The key in this recommendation is to not have a narrow project mentality, but to design the activities to strengthen the enabling environment to support TSSM at scale. USAID/Washington and its implementing partners could create templates such as model statements of works that USAID missions could use to create bidding documents for TSSM awards.
- *Collaborate with WSP and GSF programs in the same country.* USAID could award a contract or grant to work alongside WSP or the GSF at the country level with USAID being responsible for a set number of districts. This might be of interest in countries that are the focus for USAID, WSP, or the GSF. This approach would require a high degree of collaboration. USAID might fund an additional 10 or 20 districts, for example, in an existing country like Tanzania or this could be in a new TSSM country.
- *Provide targeted TA to country programs.* A central mechanism could provide TA in a TSSM country supported by WSP, UNICEF, or a GSF supported country much like HIP did in Ethiopia.

In summary, the moment is right for increased USAID involvement at any of these levels. It is a priority of WSP, BMFG, DFID, UNICEF, and WSSCC to increase involvement of other donors in TSSM and all would welcome USAID's engagement.

Annex 1 – Database

Annex I - Database

Inventory of Total Sanitation Experience in USAID Focus Countries

	Country	Type of Sanitation Activities			Scale of Activities		Project Location			Government support/participation (little-to-none, tentative, significant)			Facilitators / Community Health Workers		Organization(s)	Notes and Comments
		CLTS	SM	TSSM	Target Population	Project Costs	Rural	Small Town	Peri-urban	National	District	Local	Paid or Unpaid	#/#		
1	Afghanistan	✓	✓		1,400,000	not available	✓			significant	not known	not known	unpaid CDC's (22,000), CHW's (17,000) and teachers (156,000)		UNICEF with local NGOs + 124 gov't staff	1. Project implementation is just beginning. 2. The new Afghan National Rural Water, Sanitation and Hygiene Policy includes CTLS as the national approach and methodology.
		✓			22,500	$1.5 - 2 M / yr	✓			supportive	supportive	supportive	paid thru local NGO and gov't		USAID (2010 - 2012) with local NGOs	1. There are specific challenges working in active conflict areas 2. Program will also explore micro loans and savings products. 3. Gender issues are challenging in Afghanistan.
		✓			2 Districts	not available	✓			not known	not known	not known			TearFund (2008 - present) with local & regional NGOs	1. 10 communities declared ODF by 2010
2	Angola	✓			4 provinces 760,000	$1,000,000	✓		✓ next phase	National Policy is in preparation			govt workers and volunteers	1 nurse : 600 1 mobilizer : 1,500 1 water sector : 500	UNICEF (2008-2011) with USAID, Spanish Govt, EU and national partners	1. Some incentives are provided to volunteer facilitators/mobilizers (such as bicycles and backpacks) 2. No subsidies for latrine building 3. Need greater coordination and involvement at provincial level for scale-up. 4. 8,000 latrines built in pilot province - coverage up to 95% so far.
3	Bangladesh	✓	✓		1,626,920 - CLTS 1,300,000 - SM	$1,245,147 - CLTS	✓								PLAN (FY2002-2010) - CLTS PLAN (FY2005-2008) - SM	*CLTS* - 1. 49 Union Parishads received awards from the government 2. Significantly reduced rate of diarrheal disease 3. Trained 6,854 Union Parishad members, 13,230 natural leaders, 3,528 rural engineers, and 7,450 children 4. 640 ODF verified communities, 320,068 families with improved sanitation *SM* - 1. Implemented training for the production of quality latrine components 2. Provided mold set for latrine components 3. Created a revolving fund
		✓			30,000,000	not available	✓		✓				9,191 community health promoters		UNICEF - SHEWA-B (2003 - 2011) with DFID	1. 355,000 new latrines built 2. number of people defecating in the open has halved since 2003
		✓			5,300,000 - rural 500,000 - urban	$724 to $829 per community	✓		✓	significant	significant	significant			WaterAid (2003-2009) with DFID and 22 partner organizations	1. 12 clusters declared ODF 2. 73% average reported latrine coverage, 37% sharing toilets 3. Partial hardware subsidies for the poorest 7% 4. Self-reported monitoring, tendency to over-report 5. CLTS is recognized in national policy 6. After 5 years, there appears to be sustained behaviour changes.
							unknown								WSP	1. Help government develop and implement integrated strategies and policies to ensure improved sanitation and hygiene practices 2. Support improving performance monitoring and evaluation systems on water and sanitation
		✓			1,200 villages	$840,000 ($7 per household)	✓					limited			NGO Forum with 635 local NGOs (as reported by WSP)	1.Supply-driven approach resulted in rapid increases in toilet coverage but little evidence regular usage

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		CLTS	SM	TSSM	Target Population	Project Costs	Rural	Small Town	Peri-urban	National	District	Local	Paid or Unpaid	#/#		
4	Democratic Republic of Congo	No Total Sanitation programming identified in DCR. Since 2006 Government runs the *Village Assaini* and the *Ecole Assaini* programs.														1. UNICEF has not started a CLTS program in DRC because of the government's strong sanitation program *Village et Ecole Assainis*. The government's program is extensive and includes some subsidies. 2. In 2009, the government reports that 288,000 people gained access to sanitation.
5	Ethiopia	✓	✓		1,291,437	$882,367 - CLTS $20,000 - SM	✓								PLAN UK, PLAN Netherlands, PLAN Australia (2007-2011) & UNICEF - CLTS PLAN (2011 - 2014) - SM	*CLTS* - 1. Decreased incidence of diarrhea 2. Government has accepted CLTS as a national approach for sanitation development and has established National Hygiene and Sanitation Task Force to harmonize and coordinate activities 3. Plan to extend ODF to 1.2 million people in the next 4.5 years 4. 13 ODF verified communities, 14,661 families with improved sanitation *SM* - 1. Studying mechanisms and facilitating establishment of community-managed sanitation marketing centers using revolving funds
		✓			6,000,000	Budget for all WASH activities (includign emergency funding) is $20 M per year	✓			National Strategy		significant	gov't health workers supported by volunteers	1 health worker: 5,000 people	UNICEF (2006 - 2011)	1. Health extension network include 35,000 workers who approx. 1/2 of their tasks are WASH related, including emphasis on hygiene and handwashing 2. Preliminary scale-up includes about 4,500 villages triggered with almost 2,000 verified ODF. Approx. 3,200,000 people with improved saniation 3. Government is successfully taking over several programs. 4. Attempting to bring in sanitation marketing by training local artisans.
		✓			20,000,000	not available	✓			significant	significant	significant	Part of the gov'ts health extension program + *per diem* for training, etc	approx. 1 : 500 families	USAID HIP (2006 - 2010) with UNICEF, FINIDA, Carter Center and local NGOs	1. Program included emphasis on behavior change, hand washing and sanitation, including "small doable actions" and "learning by doing" 2. CLTS is part of the National Hygiene and Sanitation Strategy - Program possible because of commitment at all levels. 3. 26% drop in open defecation, 4 million people reached ODF status 4. Although there was a tremendous drop in open defecation, only 30% of the newly-constructed latrines met international standards. 5. Systematic Capacity Building at all levels is key for success.
				✓ planned	2,400,000	$3,000,000 for 2 years	✓								WSP - program is just starting	Starting work in 8 districts in 4 regions
		✓			52 villages and 24 schools	not available	✓						250 gov't staff	unknown	SNV (2008) with 6 local institutions, 7 NGOs and 250 gov't staff	1. Strong facilitators are crucial 2. Participation of outsiders at the launch and follow-up is essential 3. Gov't recognition is required to sustain the process
		✓			14,084,702	not available	✓			unknown	significant	significant	Volunteer health promoters		Regional Health Bureau (2003-2006) (as reported by WSP)	1. On-site sanitation increased from 13% to 77 % in 2 years 2. Zero-subsidy approach

Annex I - Database

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		CLTS	SM	TSSM	Target Population	Project Costs	Rural	Small Town	Peri-urban	National	District	Local	Paid or Unpaid	#/#		
6	Ghana	✓			6,656	$180,000	✓			not known	not known	tentative	paid (per diem)	2 mobilizers / 2 villages	USAID - WAWI (2010) with UNICEF (planning support) RuralAid (local NGO)	Subsidies to schools when communities reach their sanitation goals - subsidies include latrines and provision of potable water (boreholes and water catchments) at 5 schools.
7	Haiti			✓ pilot	3 communities	not available	✓			signed MOU & providing training	unknown	unknown	unknown	unknown	UNICEF (with PLAN, Oxfam and UNDP)	Currently in preliminary planning phase - Ministry provides coordination and agrees to conduct training and pilots
8	Indonesia	✓	✓		1,100,000 - CLTS 1,020,000 - SM	$3,200,000 - CLTS $3,010,000 - SM	✓			significant					PLAN (FY2008-2014), AusAID, Simavi-Netherlands - CLTS PLAN (FY2008-2014), AusAID, Simavi-Netherlands - SM	*CLTS* - 1. Indonesian Ministry of Health has promulgated as National Strategy the five-pillared CLTS methodology. 2. 100 ODF verified communities, 2,000 families with improved sanitation *SM* - 1. Local artisan is normally being used by the community in the village 2. Local artisan has received capacity building to improve their skills to create safe-low-cost toilet 3. 20 local entrepreneurs trained; 2 local hardware sellers
		✓	✓ starting next phase		320,000 rural & small town 70,000 urban	$25,000,000	✓	✓	✓		20 of 28 district gov'ts support		gov't health workers		UNICEF (2006 - 2010) (also with Care Int'l, MercyCorps)	1. 194 (180 planned) villages participating - 2. Established 6 WATSAN provincial groups, 27 district working groups and 5 municipal working groups 2. 18,245 new latrines constructed, over 25,449 latrines being used 4. Program includes incentives for improved access to water 5. Program requires continuous learning of gov't counterparts at all levels.
				✓	1,400,000	$2,494,000 ($86,000 per district)	✓					local gov'ts allocated $650,000 to reach addt'l 2,641 communities	Core group of paid facilitators		WSP (2007-2010) with 29 district gov'ts in East Java	1.779 ODF Communities (as reported Aug 2009) 2. Improved sanitation for 433,000 people 3. Helping government adapt sanitation designs for areas with challenging environments and plans to implement them as part of city-wide sanitation strategies under National Sanitation Acceleration Development Program

Annex I - Database

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		CLTS	SM	TSSM	Target Population	Project Costs	Rural	Small Town	Peri-urban	National	District	Local	Paid or Unpaid	#/#		
9	Kenya	✓	✓		1,000,000 - CLTS 1,600,000 - SM	$38,000 - CLTS $630,000 - SM	✓								PLAN (FY2007-2010) - CLTS PLAN Netherlands (FY2009-2011; FY2013-2014) - SM	*CLTS* - 1. Involved 50+ trained, qualified and passionate CLTS trainers/facilitators in the CLTS roll out activities 2. 100 ODF verified communities; 10,000 families with improved sanitation 3. Identifying and training of artisans to manufacture affordable sanitation technology options 4. Engaging with private sector partners and artisans with a view to enabling that latter access finances for their activities 5. Promoting marketing of various sanitation technologies to enable communities access them 6. Engaging communities in their efforts to climb the sanitation ladder *SM* - 1. Working closely with various partner/stakeholders in ensuring supply of sanitation technology options
		✓ 1st phase	✓ next phases	✓ target	2500 villages	$500,000 1st phase	✓			significant			currently unpaid, may change	20-100 households each	UNICEF (2010-2015), with PLAN and others	1. Volunteer health workers get remunerated when their village achieved ODF (3rd party verification), followed up by sanitation marketing in a future phase heading toward a TSSM program. 2. CLTS program includes three phases in multiple provinces.
			✓		not available	not available	✓		✓						WSP	1. Service provider capacity developed and strengthened to help water sector boards adopt and implement TSSM methodology 2. Adding SM component to CTLS work carried out by others
		✓			37	not available	unknown				Selected schools		Gov't school teachers		SNV (2008)	Schools building latrines (1 per 25 girls & 1 per 35 boys) Incentives provided to schools
10	Liberia	✓			60 communities	not available	✓								UNICEF (2009 - present)	1. Three ODF verified communities to date. 2. Developing a large group of NGOs working on CLTS programs.
11	Madagascar	✓	✓		88 villages - CLTS 6,420,000 - SM	$4,000,000 ($1M per year)	✓	✓	✓				Volunteers	varies	USAID HIP (2009-2010)	1. Programming and government collaboration interrupted by the 2009 coup. 2. Program includes loans to purchase slabs. 3. Reduction from 31% to 23% who practice open defecation 4. 40 ODF Villages
		✓			multiple districts	not available	✓								UNICEF	

Annex I - Database

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		CLTS	SM	TSSM	Target Population	Project Costs	Rural	Small Town	Peri-urban	National	District	Local	Paid or Unpaid	#/#		
12	Senegal	✓			60 communities	not available	✓								UNICEF (2009 - present)	1. Five communities verfied ODF to date. 2. GSF $5M fund available for NGOs for demand-driven, community-led sanitation processes.
		✓	✓		6 villages (CLTS pilot), 108 villages (CTLS planned)	not available	✓								USAID	*CLTS* - 1. Pilot in Tambacunda region, planned to scale up to 108 villages in 3 regions. *SM* - 1. Increase the supply of sanitation goods and services through capacity building of small and medium sized enterprises.
		✓			336,039	$42,678,671 plus $3,722,434 household contribution			✓	significant					World Bank and Government of Senegal (2002-2008)	1. Attempt to scale up CLTS - PAQPUD program in peri-urban Dakar 2. Raised profile of on-site sanitation in peri-urban communities in and around Dakar 3. High subsidies (50 - 75%), approach is costly and not scalable
		Large scale handwashing program			not available	not available	✓								WSP	1. Large Scale HWWS project - Goal to change HWWS behaviour of 1.5 million mothers and children. 2. Improve capacity of government and private sector to integrate handwashing programs
13	Southern Sudan	✓			700	not available	✓								Tearfund (2009)	1. 32 families started building latrines, only 1 completed
14	Timor-Leste	✓	✓		3,000	$40,000 CLTS $6,000 SM	✓								Plan Australia (2008-2010)	*CLTS* - 1. One ODF verified community, 1,500 families with improved sanitation *SM* - 1. Created 5 sanitation marketing groups producing and selling sanitation accessories 2. Advocacies to influence national sanitation policy development through evidence-based research 3. Developed various technological options, including the selling of plastic pour-flush pans 4. Developed marketing material, including sign boards and information leaflets 6. 12 local entrepreneurs trained, 8 local hardware sellers
				✓	3,600	$112,000	✓			significant	tentative	varies	gov't health workers	1: 1,000	UNICEF (2009-2011) with local NGOs	1. 1st grouping of 4 communities (440 households) was declared ODF (Aug 2010) 2. ODF communities are prioritized for water supply projects 3. Gov't wants to include more subsidies and there are mixed messages from top officials
		✓			30,000	not yet evaluated	✓			significant	varies	varies	gov't health workers plus unpaid volunteers plus local NGO	1 per community	USAID (DWASH)	1. 1st ODF community in 2010 2. Ministry of Health and Ministry of Infrastructure sometimes work at odds. 3. No subsidies. 4. Unpaid community health volunteers are not motivated without some type of compensation.
		✓			5 villages	not available	✓			unknown	unknown	unknown	unknown		WaterAid	1. Subsidies for drinking water possible after ODF verification 2. All 5 villages achieved ODF status in 42 days, but after 1 year regular latrine usage was estimated as low as 50%.

Annex I - Database

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	Country	Type of Sanitation Activities			Scale of Activities		Project Location			Government support/participation (little-to-none, tentative, significant)			Facilitators / Community Health Workers		Organization(s)	Notes and Comments
		CLTS	SM	TSSM	Target Population	Project Costs	Rural	Small Town	Peri-urban	National	District	Local	Paid or Unpaid	#/#		
15	Uganda	✓	✓		896,309 - CLTS 148,903 - SM	$2,226,463 - CLTS $126,000 - SM	✓								PLAN (FY2007-2010)	*CLTS* - 1. Recorded reduction of diarrhea episodes in both children and adults and subsequent reductions in medical bills 2. Improved household sanitation and handwashing practice, as well as self esteem of communities 4. Carried out 112 community dialogues, conducted 336 village health team trainings, and triggered 84 villages 5. 54 ODF verified communities; 5,376 families with improved sanitation *SM* - 1. Produced 200 training manuals and 200 catalogues 2. Trained 17 health assistants 3. 14 local entrepreneurs trained ; 89 hardware sellers
		✓			not available	not available	✓			significant	significant but varies		district governmental staff		UNICEF (through 2011)	1. CLTS has started in 2 districts: 6 ODF verified villages with 5,400 people. 2. Program includes National Programming focused on training & facilitation manuals, guidelines and advocacy. 2. Working with UWASNET (Uganda Water & Sanitation NGO Network). 3. At the district leve, supporting 7 districts and capacity of village health team and local leaders. 4. Post-conflict challenges include local expectations of subsidies.
			✓		not available	not available									USAID HIP (2004-2009)	1. Developed guidance and tools for program development. 2. Developed masons training manual and catalogue of affordable latrine options. 3. Developed Assessment Reports and Marketing Strategies.
				✓	30 of 64 districts	not available	✓								WSP - program in early stages	1. TSSM Pilot 2. Strengthen government capacity to plan, monitor deliver and sustain TSSM approach (advocacy)
16	United Republic of Tanzania	✓	✓		592,143 - CLTS 1,230,143 - SM	$47,217 - CLTS	✓								PLAN (FY 2008 - ongoing) - CLTS PLAN (FY 2007-2010) - SM	1. Constructed 20,790 new latrines 2. Employed strategies such as local learning and training activities to partners and communities, capacitating district authorities and local NGO to institutionalize CLTS in their districts, and engaging and empowering youth 3. 19 ODF verified communities
		✓	✓	✓	750,000 (by 2011) or 1,300,000 (by 2013)	$ 2.7M (10 districts) ; $ 1.6 M (addt'l 11 districts)	✓	✓ next phase			significant				WSP with 10 district governments (1st phase 2007 - 2011) and adding 11 more districts in 2nd phase	1. Target to reach 2,900 communities 2. Refresher training required for community facilitators 3. Goal to change HWWS behaviour of 1.2 million mothers and children

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		CLTS	SM	TSSM	Target Population	Project Costs	Rural	Small Town	Peri-urban	National	District	Local	Paid or Unpaid	#/#		
17	Zambia	✓			480,000	$1,110,000	✓								PLAN (FY 2009-ongoing), with NORAD, EU	1. Reduced incidence of diarrhea 2. Trained 150 community CLTS promoters (with 350 more planned) and 50 district professionals 3. Triggered 100 villages (with 480 more planned) 4. Formed and trained 4 district CLTS task forces 5. Plan to build capacity of Environmental Health Technicians under Ministry of Health to roll out, monitor and sustain the CLTS process 6. 44 ODF verified communities; 3,520 families with improved sanitation
		✓			4,536 or 12-villages (pilot) & 517 villages (scale-up)	not available	✓	✓	✓	significant		significant	unpaid		UNICEF (2007 -	1. After 3 months, 9 of 12 villages verified ODF. After 12 months, 402 of 517 villages are ODF. 2. Upon scale-up, sanitation coverage increased from 38% to 93% in triggered area. 3. Over 14,500 toilets constructed with no hardware subsidy. 4. Spearheaded by one community leader, the first region was recently verified ODF.
			✓		not available	not available			✓						WSP	Developed policies, guidelines and models for sanitation service delivery to urban poor.
		APPROX. TOTAL CTLS			90,115,315											

Notes & Abbreviations:
CDC - Community Development Council
CHW - Community Health Worker

Annex 2 – Resources

ANNEX 2 - RESOURCES

Resource documents for total sanitation and sanitation marketing

India-based resources (TSC program)

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