

IFRC, Swiss Red Cross and French Red Cross

Community Led Total Sanitation (CLTS) in the red cross / red crescent movement

Discussion paper

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GLOSSARY

CHAST	Children Hygiene and Sanitation Transformation
CLTS	Community Led Total Sanitation
CRC	Cambodian Red Cross
HH	Household
IDS	Institute of Development Studies
IFRC	The International Federation of Red Cross and Red Crescent
M&E	Monitoring & Evaluation
MDG	Millennium Development Goals
MRD	Ministry of Rural Development
NGO	Non Governmental Organization
NS	National Society
O&M	Operation & Maintenance
OD	Open defecation
ODF	Open defecation free
PDRD	Provincial Department of Rural Development
PHAST	Participatory Hygiene and Sanitation Transformation
PNS	Partner National Society
P&V	Principles & Values
RC/RC	Red Cross / Red Crescent
RCV	Red Cross Volunteer
SARAR	Self-esteem, Associative strength, Resourcefulness, Action planning and Responsibility
UNDP	United Nations Development Fund
WatSan	Water and Sanitation
WHO	World Health Organization
WSP	Water and Sanitation Programme

SOME DEFINITIONS

Champion: Those personalities who emerge from the CLTS process (implementation, institutionalization, scaling up, etc) at any level (community, local authority, central government, etc.) that influence positively in the process and whose contribution is widely recognized by all parties.

Community consultant: Natural leaders in CLTS are those activist or enthusiast members of the community who emerge and take lead during CLTS process. Some natural leaders become community consultants, trigger and provide encouragement and support to other neighboring communities, often through exchange visits.

Open Defecation Free (ODF): Open defecation means defecating in the open and leaving the faeces exposed. Open defecation free means that there are not faeces openly exposed to the air. In CLTS context, ODF refers to the entire community, not to a single household.

Sanitation ladder: Starting with a basic level of service, the sanitation ladder presents increasingly higher levels of service options, each with higher complexity, cost and O&M needs.

Smart subsidy: This term is used for different modalities of subsidies (microfinance schemes, post achievement awards, community revolving funds, etc) that are introduced by the project only after up-front demand creation.

Triggering: A critical step in CLTS is what it is commonly called the ‘triggering’ meeting or session. Triggering activities looks at stimulating a collective sense of disgust among community members as they confront the facts about open defecation and its negative impacts on their community.

BACKGROUND

In the recent years, CLTS (Community led total sanitation) has become widely promoted and implemented by several NGOs (Plan International) and sponsored by relevant donors (UNICEF) in Asia, Africa and Latin America. IFRC WatSan delegates have been increasingly questioned by many RC/RC partners about the significance and efficacy of the CLTS methodology and requested advice from the IFRC WatSan Unit in Geneva on the adaptation / utilization of this new methodology in RC/RC WatSan programmes.

An initial discussion on CLTS was held in the IFRC WatSan global meeting in Dakar (June 09). At that stage, key WatSan stakeholders within the red cross / red crescent showed initial concerns and resistance to a methodology that may be perceived as extremely radical in its format and/or not technically sound. However, the WatSan group agreed to conduct a further investigation on this new approach and its principles, and assess its potential relevance for RC/RC WatSan programmes. The main output of this research would be at evaluating whether CLTS should be integrated into existing PHAST activities, seeking opportunities for CLTS to complement the RC/RC standard PHAST approach.

It was decided to conduct a mission to Cambodia, since this is the only example where the red cross / red crescent is effectively involved in CLTS implementation. The visit to Cambodia also offered the opportunity to participate in a regional workshop organized by the core group of agencies (core CLTS 'champions' such as IDS Sussex, WSP-Wold Bank, UNICEF and Plan International) that are promoting CLTS worldwide. The main output of the field mission is this concept note, drafted in conjunction with Cambodian RC and those PNS (French RC and Swiss RC) who presently support the CLTS implementation in Cambodia, in order to collectively identify the way forward for the future.

The scope of the discussion paper on CLTS addresses the four following questions:

1. What is CLTS? Is it very different from PHAST?
2. Is there any example of CLTS implementation within the RC/RC Movement? Is it positive?
3. Is CLTS a relevant methodology for the red cross / red crescent?
4. Can CLTS be integrated in present RC/RC WatSan programming? If yes, which are the critical elements that should be taken on?

EXECUTIVE SUMMARY

PHAST shares the same participatory learning principles as CLTS, which aim at gaining self-esteem, believing in people's ability to solve basic problems with their own resources. PHAST and CLTS also have in common the technical scope in their original conception, since both have been designed to focus on sanitation issues in rural communities. However, PHAST in Red Cross / Red Crescent has been successful in integrating other elements, such as water supply and hygiene promotion.

Main distinctions between these two methodologies can be found mainly in five areas, in relation to the drive forces for change (natural disgust vs. health benefit), collective responsibility (community focus vs. household focus), subsidies (against-subsidies vs. pro-subsidies), technical solutions (community-led vs. engineer-supported) and sustainability (one-off event vs. long term process).

The only examples of CLTS implementation within the red cross / red crescent movement are the projects implemented by the Cambodian Red Cross in Takeo and Oddar Meanchey Provinces. The CLTS approach as applied in Cambodia is a positive example of local adaptation. The CLTS module applied in Cambodia contains the necessary adjustment to suit the local context: 'shame' is replaced with 'shock', PHAST tools are combined with CLTS triggering and post-triggering steps, external technical advice for latrine construction is provided, and social pressure is sensitively undertaken. Additional details in Annex 2.

Although the purist CLTS approach does not seem an appropriate approach for Red Cross / Red Crescent, certain technical aspects of the methodology may be positively incorporated in traditional Watsan RC/RC programmes. From the example of local CLTS adaptation in Cambodia, one can assume that a 'softer' CLTS version seems to work satisfactorily in conjunction with another hygiene / sanitation promotional approaches such as PHAST and that a 'softer' CLTS approach can be applied with good results. Three elements differentiate the 'softer' CLTS from the traditional approach, described as follows:

Shock: In Red Cross context, utilising the feeling of 'shame' may seem culturally insensitive and not respectful of communities. The local adaptation of the original CLTS principles to a 'softer' style would require, in the context of Red Cross / Red Crescent, taking up 'natural disgust' or 'shock' as the driven force vs. shame. This approach is therefore more focused on the sense of self-respect that emerges from the shock caused by natural disgust, hence more suitable for Red Cross / Red Crescent context.

Subsidy approach: There are deep concerns on the ability of CLTS in reaching the poor segments of the society, since affordability and access to low cost toilets seems to be serious constraints in many countries. The Red Cross / Red Crescent should not adhere to the principle of non-subsidies, but should be aware of the challenges and actually, willing to explore the concept of 'smart subsidy'.

External technical advice: Serious concerns have been raised on CLTS since the quality of the toilets achieved by non-subsidized projects is highly variable and they often do not meet the standard of 'adequate' and 'hygienic'. The Red Cross / Red Crescent should provide external technical support to the communities.

Integration with PHAST: CLTS triggering activities can act as a good entry point at the community to gain the momentum and ignition from where PHAST can be added on. Different models of intervention can be applied as follows:

- 1) CLTS followed by the complete traditional PHAST 7 steps cycle.
- 2) CLTS followed by a shortened version of PHAST (Cambodian model; see Annex 2).
- 3) PHAST cycle with integration of specific triggering activities along the cycle, merging both methodologies.

FINDINGS AND DISCUSSION

1. What is CLTS? Is it very different from PHAST?

Successive evaluations of sanitation programmes in Bangladesh in the late nineties have shown that the subsidy approach in the sanitation sector had built-in elements which prevented total community sanitation. WaterAid, and its local counterpart, decided in 1999 to explore a radically different approach, without any subsidy, and strictly based on participatory facilitation to catalyse community self-help.

These experiences were documented in 2003 under the paper 'Subsidy or self respect? Participatory Total Community Sanitation in Bangladesh' (by Kamal Kar, 2003). Other manuals and handbooks have recently followed this paper, spreading the word on this new approach and gaining increasingly the attention of many agencies and donors, due mainly to reasons: 1) the success in generating open defecation free villages within very short period of time (weeks or months), and 2) the complete rejection of subsidies attached to the programmes. Up-to-date, the CLTS website (www.communityledtotalsanitation.org) lists 30 countries where CLTS programmes are present: 15 in Africa, 14 in Asia and 1 in Latin America.

Community-led total sanitation (CLTS) involves facilitating a process to inspire and empower rural communities to stop open defecation and to build and use latrines, without offering external subsidies to purchase hardware such as pans and pipes. CLTS is defined in the original handbook as an integrated approach to achieve and sustain an open defecation free (ODF) status. This entails the facilitation of the community's analysis of their sanitation profile, their practices of defecation and the consequences, leading to collective action to become ODF.

CLTS is undertaken in three steps: 1) pre-triggering or preparatory phase; 2) triggering and 3) post-triggering (See details in Annex 1). The most crucial step in the process is step 2 – triggering - when community members analyse their own sanitation profile, including the extent of open defecation and the spread of faecal-oral contamination that detrimentally affects every one of them. The CLTS approach ignites a strong sense of disgust and shame among the community. They collectively realise the terrible impact of open defecation: that they quite literally will be ingesting one another's 'shit' as long as open defecation continues.

At a first glance, CLTS might seem to be rather different from PHAST. In order to facilitate the discussion, CLTS and PHAST are compared in five areas in this paper, emphasizing those issues that distinct both approaches: 1) motivation for change; 2) collective responsibility; 3) technical solutions; 4) subsidies and 5) sustainability.

i. Motivation for change:

CLTS methodology begins with a transect walk (also called the 'walk of shame') through the village. This walk aims at gathering the group around some places where people generally defecate openly. The community villagers often feel very embarrassed to visit these dirty spots with the dignified outsiders. At the defecation site, the facilitator mixes up some fresh faeces with water and offer to the villagers for drinking, who naturally refuse. With those techniques, CLTS methodology seeks this initial embarrassment as the main motivation to give way to a strong desire to stop open defecation and also as the ignition factor for the villagers to take immediate action.

Although the calculation of health cost derived from sanitation-related diseases in undertaken under CLTS, the most important element is not the knowledge of health hazards, but the **feeling of disgust, sense of un-cleanliness, dirt and impurity**. The underlying universal assumption is that no human being can stay unmoved once they have learnt that they are ingesting other people's faeces.

While CLTS creates momentum by igniting the emotional feeling of disgust, PHAST builds on cognitive motivations. The main strategy of **PHAST** is helping people to rationally perceive the **risk of getting sick** due to poor sanitation conditions and hygiene practices. Through the cycle, PHAST members discuss the contamination chain and interiorise the connection between those poor conditions and practices and the diseases affecting the community (often prevalence of diarrhoeal diseases is ranked highly in the community). In some forums, CLTS is called ‘the emotional’ PHAST.

PHAST has been criticized in the last recent years because it has been implemented focusing in the **transfer of knowledge**, assuming that once people know the risk of getting sick they feel motivated for change. However, experience has shown that the main motivation for using a toilet at household level are: 1) sign of status & for convenience and 2) in response to disgust & shame. Presently, it is recommended, within RC Movement, to implement PHAST taking into account social, cultural and traditional norms in the community that might be additional motivations for behavioural change.

In that sense, CLTS has been proven to be a powerful tool for stimulating community members to adhere to new sanitation practices, with particular focus on control of excreta or ‘toilet use’. Besides stimulating explicitly the feeling of disgust, CLTS seems to have the ability to encourage the community to accept this new practice as a social norm, establishing internal regulation mechanisms for social control and local adaptation.

An important aspect of CLTS is in fact ‘**social control**’ or ‘**local regulation**’. Those households that, after being triggered, are not adhering to ODF status might be consequently controlled and pressured by their own neighbours since one single household openly defecating can pose a serious health threat to the entire community. An example of community vigilance is the use of stickers to label those HH practicing OD. Often the CLTS action plan includes self-organized ‘processions’ for **raising awareness**. Children, in particular, can play a crucial role by chanting slogans to stop open defecation. Mothers are encouraged to advise their peers and educate their children to stop defecating in open areas. Religious and natural leaders are involved in disseminating publicly key messages against open defecation.

In the purist CLTS approach, ‘**peer pressure**’ and ‘**shaming**’ may come together into action. After the initial moment of shock, CLTS true believers encourage the use of shaming practices in order to force hesitant households to adhere ODF practices. Examples of shaming practices are: children patrolling fields whistling and flagging as they spot offenders, sticking flags with offender’s name to mark the leftovers, placing a map in a central location ticking off those households that have not toilet, etc.

In PHAST, the 7 steps cycle does not include any promotional activity, so the elements of pressure are often planned separately and undertaken by RC/RC volunteers. Those activities integrated in a parallel manner and strictly related to ‘peer education’ or ‘peer advice’, with no elements of shame whatsoever. A common complementary activity to RC/RC PHAST programmes is hygiene promotion in schools. In Somalia for example, an adaptation of PHAST to schools (**CHAST**) has been developed and widely promoted in the country.

ii. **Collective responsibility:**

In CLTS the key for action is **communal responsibility**. The CLTS approach focuses on the collective action rather than on individual behaviour. Families who do own and use a toilet discover that they are just as prone to faecal oral contamination due to the actions of those who do not own or do not use a latrine. Everyone in the community, regardless their sanitation status, is involved in the action, since open defecation affects all in the community. CLTS stands against counting household latrines but assessing with rigorous standards the number of communities that truly achieve ODF status.

In PHAST, this sense of communal action exists, but there is the tendency to involve only those who are lacking facilities at home, so often the most wealthy segments of the community are kept away of

the discussion. CLTS has shown that the better-off group can eventually mobilise resources and support the poorest families in developing their toilets, although this option seems to work only in those communities where solid networks of solidarity among the community members are already established prior to CLTS intervention.

iii. Technical solutions:

As a result of CLTS and PHAST processes, the community often decides to create a committee and agree on an action plan. In CLTS, the members of the committee vow to complete the construction of their homemade latrines within a week and they take the responsibility for persuading 10–12 households in their neighbourhoods to do the same. Every **family** is encouraged to develop their own **action plan** (actually all households in the community are listed by the committee identifying their present sanitation status).

According to the purist CLTS version, community members must have the **freedom to innovate** and experiment choosing their toilet models based on their capacity. Technical support from outside should be kept to a minimum. Each household should gradually move up along the sanitation ladder based on their capacity, so there is not a ‘blue print’ solution for the entire community but tailored responses for every family. The sceptics question the quality of those local technical designs and the risk that poor basic toilets pose for the environment and human health. In reality, most of the NGOs implementing CLTS provide technical support to their target communities far beyond the recommendations in the CLTS handbook.

In the red cross / red crescent, through PHAST approach, the selection of technical options should be made as well by the community but preferably with external technical support and guidance. The **hardware engineer** attached to the project often provides advice to the community when selecting the latrine design. This external advice becomes critical in complex scenarios where environmental issues need to be taken into account (high ground water table areas, unstable soils, congested urban areas with space limitations, etc.) so the selection of an appropriate design is guaranteed.

Within the red cross / red crescent, the engineer is encouraged to follow a **demand responsive approach**, informing to the community about a wide range of technical choices from which the community can discuss, analyse and agree upon according to their technical, financial and organizational capacities.

Their choice is made based on their fully understanding of pros and cons of each technical option. In PHAST, there is a specific tool (‘**sanitation options**’ in step 4) that helps the villagers to describe the sanitation situation in the community and discover the improvements that might be made step by step. During the construction phase, the red cross / red crescent promotes community based latrine construction and integration of local artisans and local suppliers in order to effectively utilize local skills and materials.

iv. Subsidies:

CLTS strictly rejects individual household hardware subsidies and it encourages local innovation and production with **no injection of external support** whatsoever, promoting linkages between the community and local traders and relying on social solidarity.

As a result of CLTS approach, thousands of low cost latrines (dry simple pit latrines; cost of 0 – 2 USD) have been constructed by villagers in countries of Asia and Africa. The experience in some countries, like Cambodia, has shown that for maintaining simple pit latrines, or further **moving up in the sanitation ladder** towards more durable, safe and hygienic toilets, access to affordable, low / middle (2 – 20 USD) range cost options reveals as a critical issue. Unfortunately, CLTS seems to be efficient in raising awareness and creating demand but in some scenarios, unable to fulfil the

expectations of those villagers among the poorest who witness how their latrine collapse after every rainy season and cannot afford a more durable solution.

A study conducted in 4 regions of Bangladesh, concluded that, although all families targeted by CLTS made significant upward movement in sanitation ladder, the **hardcore poor families** were slow movers, reporting economic hardships and landlessness as the main reasons behind the slow movement towards more costly and improved option up in the latrine ladder.

In the red cross / red crescent and red crescent movement, sanitation programmes are often attached to an external **hardware subsidy**. When implementing traditional PHAST, it is in fact, recommended as general practice to attach a subsidised hardware element and start implementing basic construction activities targeting vulnerable groups as soon as the community has agreed on the basic designs and management aspects.

In CLTS it is expected that emerging donors in the community will support the poorer and weaker groups, initiating a process of **social solidarity** within the community. This approach works well in those communities where values of cohesions, solidarity and mutual aid are effectively conveyed. On the contrary, social solidarity poses an enormous challenge in those scenarios where community members come from different backgrounds and do not share same experiences, identities and values. CLTS has been criticised in the sense of presenting a 'naïve' or idealised notion of community.

v. **Sustainability:**

Triggering activities, as described in the handbook, are often undertaken as a **one-off event**. Lessons learnt from CLTS projects in Cambodia have shown that, after triggering, only an average of 30 - 40% of household in the community fully break off open defecation practices. Even in those successful examples, where a village reaches ODF status, a high percentage of households shortly abandon their simple pit latrines (often during raining season), reverting to OD practices. CLTS experts agree that **'follow up'** and 'support' reveal as critical aspects in terms of ensuring sustainable CLTS interventions.

PHAST in Red Cross is implemented following a **cascading system**, from training of volunteers within the National Society down to the facilitating PHAST sessions in the communities for a period of up to one year. After this vertical cascade, from NS to community, a horizontal cascade is set up in the community. An example of horizontal cascading is the concept **'model homes'**, applied by Uganda RC in conjunction with PHAST.

The PHAST volunteers, after completing the traditional PHAST cycle with their community groups, follow up and support the community members who are actually working on their homes to turn them into 'model homes'. A model home is a home with all the basic sanitary facilities and is practising at least basic hygienic behaviours (*Washing hands at critical times, boiling water for drinking and consistent use of toilet*). The PHAST community group members are often heads of households or/and influential people who are evenly located throughout the entire village so that their actions and behaviours are felt and emulated in all sections of the village. This model has been seen as a good practice in terms of ensuring sustainable and durable action in the community beyond the project's life.

CLTS is claimed to be a starting point for adhering to new hygiene practices and progress up in the sanitation ladder. But who is responsible for following up those indicators and verify progress in the ladder beyond the project life? Present CLTS model seems to lack the answers. In PHAST, two steps, step 6 & 7, are clearly focused in creating those M&E mechanisms within the community so self-evaluation can continue after the completion of the project. However, even with these two steps clearly incorporated to the methodology, experience has indicated that this is one of the most greyish areas in any Watsan programme.

Is it PHAST very different from CLTS?

PHAST, as CLTS, in its origins was designed to **focus on sanitation issues** in rural communities. Over the last years, part of the PHAST adaptation in Red Cross / Red Crescent consisted in integrating other elements, such as water supply and hygiene promotion, by adjusting some of the PHAST tools to other practices (water use and hygiene practices at household level for example), hence a more integrated approach can be applied to the RC/RC WatSan programming. It is expected that CLTS in the next coming years will take on different elements so agencies do not feel tempted to implement parallel methodologies for water, sanitation and hygiene promotion components.

During the research process, a high number of interviewees referred to PHAST as a ‘top-down’ process, ‘formal education tool’, etc. PHAST, as initially developed in 1998 by WHO, UNDP and World Bank, generated a great expectation and many agencies incorporated its approach to their WatSan programmes. Over the years, PHAST methodology has been extensively altered and/or misunderstood, resulting often in a **formal and rigid training process**, suffering the loss of ‘community sense’ and having a slight impact at community level. However, it should be noted that PHAST is actually derived from **SARAR methodology**, which builds on people’s innate ability to address and resolve their problems. If properly conducted, PHAST shares the same **participatory learning principles** than CLTS, which aim at gaining **self-esteem**, believing in people’s ability to understand that what they can do with their own resources is, in many cases, enough to make a significant improvement to their health.

After several reviews of PHAST programmes in the last years, Red Cross has been able to identify weaknesses and gaps within PHAST methodology. **Critical challenges** identified by the 2009 review are:

- 1) recruitment of competent PHAST master trainers and retention of volunteers,
- 2) difficulties in translating training into action at community level on the long run,
- 3) linking software component to the engineering aspects of the project, including O&M,
- 4) hygiene promotion activities based exclusively on the theory of health benefit for behaviour change and
- 5) monitoring the impact of those activities on the ground.

CLTS, in fact, presently shares some of those challenges, since CLTS and PHAST stay in fact very close to each other, except in the five areas discussed above. Introduction of CLTS may represent an opportunity for the WatSan sector to come back to the initial participatory principles that were supposed to drive PHAST process and, somehow, have been lost along the way.

2. Is there any example of CLTS implementation within RC Movement? Is it positive?

The only examples of CLTS implementation within the red cross / red crescent and red crescent movement are the projects implemented by the **Cambodian Red Cross** in Takeo and Oddar Meanchey Provinces.

The CLTS approach in Cambodia is being promoted in the country by the Department of Rural Health Care and MRD (Ministry of Rural Development) as one of the several strategies to increase access to and sustain sanitation, particularly in the rural areas. As of the end of 2009, more than 600 villages in 12 provinces were covered by the CLTS approach. CLTS is being promoted and backed up by many sector stakeholders and it is likely to be adopted in the national sanitation policy in the near future.

The CLTS approach as applied in Cambodia is a positive example of local adaptation. After piloting CLTS in two provinces in 2004, MRD developed a complete module in Khmer language for CLTS based on the original guidelines but with the necessary adjustment to suit the local context: ‘shame’ is replaced with ‘shock’, PHAST tools were combined with CLTS triggering and post-triggering steps,

external technical advice for latrine construction is provided, and social pressure is sensitively undertaken (the approach put less emphasis in collective shaming practices and it gives more attention to peer education processes).

This ‘softer’ approach has been adopted by the Cambodian RC (see Annex 2 & 3 for details) in partnership with the Swiss RC in Takeo Province and the French RC in Oddar Meanchey Province. An integrated PHAST / CLTS approach has been used, mobilising the community through CLTS activities and using PHAST activities as promoting tools to reinforce positive hygiene habits. The CLTS / PHAST cycle, facilitated by the provincial CRC branch, is completed in about 7 months, and followed by monitoring activities undertaken by RC volunteers in the communities.

CLTS in Takeo Province: Short story on *Beng Village* experience.

Beng Village, with a total of 283 households, was initially triggered in 2007 as part of the CLTS project of Cambodia RC in Takeo province, supported by Swiss RC. Prior to the triggering session, the sanitation coverage in the village was 7%, even less than the average percentage for the province (13.5%). After the triggering activity, the sanitation coverage increased rapidly and spontaneously, without any external subsidy or technical advice, up to 67%, reverting to 47% later on, according to the last assessment conducted in the village in 2009.

Pit simple dry latrines was the common technical choice among the villagers, differing in the design and materials used (wooden, bamboo, palm leaves, etc.). The team could observe that most of them are presently kept in fairly good state but the design seems to be **vulnerable during the rainy season** (major problems are pits getting collapsed after heavy rain and due to sandy, unstable soil conditions). In that scenario, some villagers keep rebuilding their latrines after the rains, including CRC volunteers, setting an admirable example to the community. Others, scarcely motivated, **revert rapidly to previous OD practices**. In this last group, however, there are some examples of people who being unable/unwilling to rebuild their latrines, have opted for other **alternatives to OD**, such as ‘cat method’ (‘chi-koo’) or sharing the latrine with relatives/neighbours; indicating a certain level of success in regard to individual behaviour change.

Some of the members in the community, who still have their pit latrines functioning, were asked by the team, whether they would plan to upgrade the latrine. Most of those members pointed at the issue of **affordability** as the main obstacle to move up the sanitation ladder. There seems to be a great gap between the simple pit latrine (0-2 USD) and the next available technical option, which is a pour flush latrine, of around 200 USD, extremely expensive for some of the poorest segments of the village. There seems to be, within the sanitation ladder, a great lack of a middle range of more durable and affordable technical options.

The mid term evaluation has highlighted that CLTS can be seen as a powerful approach to ignite the community and increase significantly and rapidly the sanitation coverage with simple and affordable facilities. However, **sustainability** of those facilities remains as a critical issue, since those options are often vulnerable to weather elements (rain, floods, storms, etc.) and poorly designed, often bringing up unhygienic problems like smell and flies.

The team also interviewed some of those villagers who did not rebuild their latrines after the rainy season. An example of those who reverted to OD practices, was a widow woman, who recognized that she did not have any external help to rebuild the latrine. Lack of solidarity among villagers in target communities has been pointed out by the mid term evaluation, since **poor social cohesion** and low sense of ‘community spirit’ seems to be a common social factor in the project area. This factor is a key determinant for the high prevalence of ODF reversion in the area.

CLTS in Oddar Meanchey Province: Short story on two villages experience, *Char and O’Romdeng*.

Char and O’Romdeng are newly established villages situated in a very remote area in Oddar Mancheay Province, with limited geographical access during rainy season. Their members have migrated to this area mostly from the same province and share a very poor background. They have been both targeted by a CLTS programme conducted by CRC, with support from French RC. Char village, with a total of 128 households, was triggered at the end of 2008. O’Romdeng village, with a total of 77 households, was triggered later on, in early 2009. Prior to the CLTS intervention, the sanitation coverage in both villages was 0%, therefore OD was the common practice.

The sanitation coverage increased rapidly for both villages as a direct result of the CLTS triggering activities conducted by CRC in early 2009. The leader of Char village played a crucial role in the mobilisation of households within the community, conducting regular home visits to follow up the construction and the proper use of latrines in the village. Char village reached complete latrine coverage at the end of April 2009. On the other hand, O’Romdeng village lost gradually the momentum and the latrine construction process got finally stagnated. The construction of latrines picked up again after the village leader participated in a CLTS exchange visit organized by CRC in mid 2009 to Takeo Province. Despite the rainy season, the village reached complete latrine coverage in August 2009.

As experienced in Takeo province, pit simple dry latrines was the common technical choice, being local materials, wood and palm leaves often the materials used for the slab and upper structure. As in Takeo area, the design have been seen to be vulnerable against the rains and up-to-date, the data collected shows that after the rainy season, latrine coverage has decreased in both villages around 20%, although some villagers have already rebuilt and improved their first latrine prototype. Improving technical designs and progressing in the sanitation ladder remain a critical challenge for those villagers, since the next available technical option (pour flush latrine) is not simply an affordable option in those communities. CRC and French RC are presently studying the possibility of introducing smart subsidies in those communities to support the construction of more durable and sustainable technical solutions and, in the long run, sustain behaviour change. CRC is also considering the option of conducting additional triggering sessions along with exchange visits in those communities, like O’Romdeng village, where villagers lose interest and motivation some time after the ignition moment.

3. Is CLTS a relevant methodology for the RC/RC?

CLTS has generated in the last years a great enthusiasm among the Watsan international community but it has also raised some **dilemmas and controversies**:

- a) Is ‘shaming people’ an acceptable approach for the humanitarian sector?;
- b) Is the no-subsidy policy excluding the poor and most vulnerable?;
- c) Can ‘local’ toilets be considered ‘hygienic and safe’ toilets and therefore, counted as contribution to the achievement of MDGs?.

This section brings together different opinions and views on these key questions within the context of Red Cross / Red Crescent Movement.

a) **Disgust & Shame**

Psychological research shows that strong feelings of **disgust** against the ingestion of human faeces is a universal human condition, not related to the cultural dimension, but a general human feeling that might help an individual to stay healthy. Creating disgust as a form of sensitization should not be seen as a dilemma within the RC/RC Movement since it can effectively contribute, as proven in CLTS approach, to raise awareness in challenging areas like hygiene and sanitation.

On the other hand, **shaming** practices can be culturally highly sensitive (e.g. the distribution of whistles to children). In Red Cross context, utilising the feeling of ‘shame’ as the driven factors for

RC activities may seem culturally insensitive, rather crude and aggressive and not respectful towards communities, clearly colliding with the red cross / red crescent Code of Conduct (*'We shall respect culture and custom'*). The risk of stigmatizing certain groups of the community due to their defecation practices seems to be a concern for most of Red Cross Watsan members.

However, a certain degree of social pressure, derived from the collective understanding that faeces disposed in open ground pose a great risk for the entire community, can be very effective, but it should not be emphasized beyond the locally acceptable. Moreover, it must be recognized that certain element of **'shock'** might clearly act as a good entry point in the community to get the momentum for a sanitation project. Several CLTS implementers (agencies and governments) share that view and, in fact, have presently adapted or adjusted original CLTS principles to a **'softer' style**, more focused on the sense of self-respect that emerges from the shock caused by natural disgust.

b) Non-Subsidy approach: reaching the poor

In Red Cross, there is the common believe that CLTS may appear as an **attractive model to governments and donors** alike because it offers the option of allocating the cost of toilets on the beneficiaries and advocate for avoiding large budgets (*'enough funding is needed but not too much'*), representing a great advantage to poorly funded government ministries or fatigued donors. It also provides a great opportunity to rapidly increase 'sanitation coverage' and therefore, governments and donors to meet the MDG no. 7 before the 2015 deadline comes closer. CLTS claims that a community can get ODF (open defecation free) status in about 40 days and quickly scaled up at district, provincial and national level, providing a powerful tool to governments when recognizing their national ODF status.

Those interviewed about CLTS within Red Cross recognized that **subsidised latrines** are less likely to be used and that programmes offering subsidies usually become too rigid to offer a choice of designs. Moreover, it has been widely recognized the difficulties for Red Cross in terms of adopting a non-subsidy approach since Red Cross is traditionally a **'relief' organization**, and its image in many countries often relies on extended donations to the community.

In this new scenario, however, Red Cross subsidies might be considered as a supplement and limited to the most vulnerable groups in the community, since those groups (orphans, widows, elderly, single mothers, etc.) often have not access to construction materials of any kind, or they are not physically able to undertake technical construction work, like digging a pit latrine. There are deep concerns on the ability of CLTS in **reaching the poor segments of the society**, since affordability and access to a low cost toilets seem to be seriously constrained in many countries. Purist CLTS promoters strictly advocate for non subsidies and examples of CLTS projects, coupled with hardware subsidies, are scarce. A recent example of a subsidized CLTS programme in India, however, indicates that the unique combination of CLTS and subsidies can be considered as a factor for the success of that programme.

Red Cross, in its efforts to reach the most vulnerable groups of the society, cannot afford to adhere to the principle of non-subsidies, but should be aware of the challenges and actually, willing to explore the concept of **'smart subsidy'**. This issue on 'smart subsidies' is further discussed in Section 4.

c) Quality of the toilets

In Red Cross/Red Crescent, WatSan programmes are often integrated within the GWSI (Global water and sanitation initiative) as the way to contribute to the achievement of MDGs. In this context, only sanitation solutions that can be considered as 'improved'¹ sanitation options should be taken into account. However, serious concerns have been raised on CLTS since the **quality of the toilets**

¹ According to JMP (by WHO / UNICEF), public or shared latrines, open pit latrines, or bucket latrines cannot be considered as improved sanitation solutions.

achieved by non-subsidized projects is highly variable and they often do not meet the standard of 'improved', 'adequate' and 'hygienic' posing a risk for the environment and human health.

Is CLTS a relevant methodology for the red cross / red crescent?

Most of those Red Cross members interviewed within Red Cross agreed that **CLTS should not replace its current sanitation / hygiene promotion methods (PHAST)**. However, at this moment, a number of governments in Asia and Africa are planning to adopt CLTS as the standard approach for rural sanitation programs within their sanitation policies (e.g. Indonesia, Laos, Timor Leste and Kenya). Some of those countries are currently taking up a modified version of CLTS (e.g. Cambodia) with a softer approach. The general recommendation for the RC/RC National Societies is to participate (when possible) on the CLTS piloting phases undertaken in-country and contribute to the discussions for further local adaptation. In all cases, National Societies should embrace CLTS in its original version only when the national sanitation policy dictates so and the government offers the necessary support to do it.

Although the purist CLTS approach does not seem an appropriate approach for Red Cross, certain technical aspects of the methodology may be positively incorporated in traditional Watsan RC/RC programmes as they have an **enormous potential as an entry point** in Watsan programmes in terms of creating momentum and ignition, promoting behaviour change and strengthening sustainability aspects at community level. Those elements and the way forward for efficient CLTS integration are discussed in detail in section 4.

4. Can CLTS be integrated in present RC/RC WatSan programming?

From the example of local CLTS adaptation in Cambodia, one can assume that a **'softer' CLTS version** seems to work satisfactorily in conjunction with another hygiene / sanitation promotional approaches such as PHAST and that a 'softer' CLTS approach can be applied with good results.

The 'softer' CLTS approach provides constructive and effective elements that reinforce and stimulate key behaviour practices, enabling the community to adhere to them on the long run. The last review study on PHAST conducted by UNICEF in Mozambique conclude that, where PHAST facilitators had used CLTS, they had really gained a sense of achievement and a renewed enthusiasm for sanitation and hygiene due to the speed at which results happened compared to use the PHAST approach alone. It is therefore recommended to explore deeply in the integration of both methodologies and extract further conclusions.

This section intends to briefly list those aspects of the so-called 'softer' CLTS approach that might be seen as beneficial and complementary to any RC/RC traditional WatSan programme:

Collective shock: A 'softer' triggering approach can be effectively applied, relating less to 'shame' than a kind of collective 'shock' derived from natural disgust, which moves quickly to a sense of purpose and community spirit to change the situation. It is also a powerful tool to create up-front demand and establish a good platform for introducing subsidies afterwards.

Communal responsibility: The safe confinement of excreta has important health benefits, but there are substantial externalities – 'my latrine protects my family but also my neighbour's latrine protect ma family from their excreta' - which can encourage joint action in the community. Mobilising the better off groups of the community and promoting spontaneous support to the poor HH which lack the facilities can be the key in a sanitation intervention.

Sanitation marketing: Sanitation marketing is seen as a complementary approach for sustained changes in sanitation and hygiene behaviour. As result of CLTS process, the increase on demand of hardware in the community may create opportunities for local entrepreneurs, traders and artisans

(masons) to manufacture sanitary hardware such as rings and slabs and sell it in their communities. Creating a market for sanitation can be also a form of exit strategy for long term projects. This new area of sanitation must be taken cautiously since merely market based approach may exclude the most poor and vulnerable groups in the community.

Smart subsidies: In the scenario of integrating PHAST and CLTS in Red Cross / Red Crescent is strongly recommended to pilot a ‘smart subsidy’ approach depending of the context, but following in all cases the principle of creating up-front demand. What would ‘smart subsidy’ mean for Red Cross? Preferably, **output-based** (“reward” or “incentive” for investment). After triggering the community and/or reaching ODF status (100% of latrine coverage in the community), subsidy elements, in different modalities (microfinance schemes, post achievement awards, community revolving funds, etc.) can be introduced in the community to help families to move up the sanitation ladder and develop more sustainable toilet solutions. In that sense, the announcement of available subsidies must be handled carefully so, after triggering, the community begins the latrine construction moved by a genuine sense of collective action, rather than by the simple motivation of rewarding. A study conducted by WSP-World Bank about sanitation financing concluded that inclusion of financial rewards in CLTS scheme can boost program performance, but care is needed. In general, even approaches that are “software” dominated tend to have a targeted hardware subsidy to improve their ability to reach the poor. This approach must be based on **strict targeting criteria**: reaching the poorest must be ensured and where possible, community-based selection should be applied.

CLTS as the entry point: CLTS triggering activities can act as a good entry point at the community to gain the momentum and ignition from where PHAST can be added on. Different models of intervention can be applied: 1) CLTS followed by the complete traditional PHAST 7 steps cycle; 2) CLTS followed by a shortened version of PHAST (Cambodian model; see Annex 2) and 3) PHAST cycle with integration of specific triggering activities along the cycle, merging both methodologies.

Specific steps from CLTS that can be effectively integrated into PHAST cycle – following modality number 3 - are:

1. **Village mapping**, calculation of faeces produced by each household in the community and the **location of OD sites in the map**. This activity might be linked to STEP 1 in PHAST cycle so a relevant analysis of transmission routes (according to the map) can be done by the community.
2. **Transect walk to OD sites**. This tool has been revealed as a formidable opportunity to ‘shock’ community members and create that ignition or momentum that will lead the community to adhere and commit for new practices. It is recommended to link this activity to the step above.
3. **Analysis of medical expenses**: It is vital to connect this activity to STEP 2 in PHAST so the community becomes aware of the main health problems, their cost and the relation to the hygiene and sanitation situation in the community.

Other elements from CLTS that can be effectively incorporated into regular RC/RC Watsan programmes are:

- **Exchange visits**: natural leaders, who became active in the process of construction, innovation, monitoring, etc. can be deployed in neighbouring villages to undertake triggering activities (activities 1 and 2) beyond their community. They can also pay courtesy visits to other communities and spread the word on latrine construction.
- **ODF verification and certification**: Inspection visits to assess, whether a community is ODF, has been seen as critical, being certification the ultimate target for the community, since this is the confirmation of the ODF status and their official recognition (specially when local authorities are involved in the certification process). Celebrating the ODF status helps to build confidence and self-esteem, and generate enthusiasm and commitment.

CLTS and Red Cross volunteers: In CLTS, a strong emphasis is paid to the community-led concept and any outside intervention is kept to a minimum. External facilitators visit the community a maximum of 5 times during the process. Voluntarism in CLTS can be associated to the so-called ‘natural leaders’ who will be responsible for most of the follow-up activities in the community after the triggering process.

It is widely believed that CLTS can benefit from the concept of Red Cross community volunteers who go along with the community, meeting their groups at least once per week, throughout the entire programme. Those volunteers, externally trained by Red Cross, often belong to the community, since they are committed to playing a good role model, hence, best placed to influence other’s behaviours.

In CLTS, RC/RC volunteers might be related to monitoring and sustaining ODF status in their communities during post-triggering phase rather than undertaking the triggering activities themselves. The assumption that not everyone can be a good facilitator is crucial for success in CLTS implementation. It seems that in terms of facilitating triggering activities and ‘shocking’ communities, what it works best, is a combination of training, community hands-on experience and being an outsider. RC/RC volunteers should rather support and accompany the process, take over the follow up and monitoring activities once the process is completed, and set a model example to their communities by adhering to ODF and encouraging / supporting their neighbors in the process.

CONCLUSIONS AND RECOMMENDATIONS

If properly conducted, PHAST shares the same **participatory learning principles** as CLTS, which aim at gaining self-esteem, believing in people's ability to understand that what they can do with their own resources is, in many cases, enough to make a significant improvement to their health. In both, experienced facilitators with the correct attitude and sensitive support from local authorities and agencies to undertake a 'community empowerment' approach rather than 'prescriptive' mode is crucial to ensure success.

CLTS requires attention and further investigation in relation to three **specific challenges**: 1) construction of latrines in challenging environment and risk of promoting unsustainable technical options, 2) sustainability of behaviour change in non-cohesive communities, 3) reaching the poorest segments of the society and flexibility in terms of non subsidies.

CLTS principle of **shame** does not seem to be well accepted within Red Cross and other NGOs forums. However, it must be recognized that the element of '**shock**' might clearly act as a good entry point in the community to get the momentum for a sanitation intervention. A '**softer**' approach, more focused on the sense of 'self-respect' that emerges from natural disgust, seems to be more appropriate for Red Cross.

Most of those Red Cross members interviewed about CLTS agreed that the Red Cross/Red Crescent should **not replace** its current sanitation / hygiene promotion methods (PHAST) with CLTS, unless the national Watsan policy in the country dictates so, and the government offers the necessary support to do it.

But CLTS represent a good opportunity for boosting up sanitation coverage and adherence to safe hygiene behaviour. On that sense, there is consensus on CLTS as a complementary component to traditional PHAST programmes, acting as an **entry point** in the community since the 'shock' gained through CLTS triggering ignites within the community a great sense of purpose and collective spirit to change the situation. CLTS can be **integrated** in two manners: 1) CLTS as an up-front component from where to add the traditional 7 steps or shortened version of PHAST cycle on, or 2) integrating some specific elements in the 7 steps (particularly in step 1 & 2). In modality number 1, CLTS would be bringing the 'mobilization' element to the community, while PHAST would be providing the tools for prolonged monitoring and follow up.

Red Cross recognizes that subsidized latrines are less likely to be sustainably used, but adopting a **non-subsidy approach** represents for the organization an intense **dilemma**. In one hand, the Red Cross/Red Crescent is universally perceived by the general public as a relief organization that undertakes extended donations to the communities, specially during emergency time. Furthermore, Red Cross is committed to alleviating the suffer of those most vulnerable groups, ensuring that the poorest are targeted by sanitation programmes and not left behind. Hence, integrating the genuine non-subsidy CLTS approach in RC/RC programmes reveals some difficulties. However, CLTS has been proven to be a powerful tool to create **up-front demand** and establish a good platform for introducing '**smart**' subsidies later on. 'Smart subsidies' (as post-reward achievement or other modalities) can be effectively introduced as a complementary approach to boost sustained changes in sanitation and hygiene behaviour among the poor segments of the society.

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ANNEX 1. CLTS: 3-steps process

1. Pre-triggering

Selecting the community is a crucial stage in the CLTS process because the communities respond in different ways to CLTS triggering. Some will be very enthusiastic about making changes immediately while others are more reluctant and have a slower reaction. Therefore, it is advisable to start with communities that have more favourable conditions in order to establish some success stories, gain experience and confidence in the facilitating process.

The pre-triggering stage consists of several visits to the community in order to introduce CLTS process to local leaders, explain the main objectives, collect information about the size of the village and number of households, history of subsidy and locations of open defecation, and finally, set a date for the triggering meeting. It is recommended that a representative from all households are present at the triggering meeting, especially those most influential members of the community who can guide their peers towards collective decisions.

2. Triggering

Triggering is based on stimulating a collective sense of disgust and shame among community members as they confront the crude facts about open defecation and its negative impacts on the entire community. The goal of the facilitator is enabling the villagers to see for themselves that open defecation has disgusting consequences and creates an unpleasant environment. It is then up to the community members to decide how to deal with the problem and to take action.

The following 7 steps are undertaken in the triggering session which often takes between 3-5 hours:

1. Introduction of CLTS process and objectives of the session
2. Transect walk to defecation areas or ‘walk of shame’.
3. Community mapping showing areas for open defecation and the flow of faeces to water sources. The map can be used to highlight also the dirtiest neighborhoods.
4. Calculations of the amount of faeces produced by each household and medical expenses incurred by the families.
5. Contamination chain activity or identification of common transmission routes for diarrhoeal diseases (from open faeces to open mouth).
6. Ignition moment and action plan.

3. Post - triggering

Follow up after the triggering session is seen as crucial since villagers respond in a different way to the ignition moment and also, dynamics within the community change rapidly, going into different directions. The community where the reaction has been the strongest needs to be revisited earliest and most; where the response has been weakest, later and less. This will stimulate initiatives and action from the villagers. Follow-up is important in order to ensure that CLTS is sustained and improvements in latrines and practices are made over the long run.

Furthermore verification and certification of the ODF status are also 2 key activities in the CLTS process.

ANNEX 2.- INTEGRATED CLTS / PHAST PROGRAMME APPLIED BY CAMBODIA RED CROSS.

The CLTS approach applied in Cambodia is a good example of local adaptation. A ‘softer’ approach has been adopted by Cambodia RC in partnership with Swiss RC in Takeo Province and French RC in Oddar Meanchey Province under **four principles**:

- 1) Shame: CLTS programme in Cambodia does not promote a police approach where public shaming and sanctions is imposed to those members practicing open defecation.
- 2) CLTS is applied as an up-front component, from where PHAST is built as a follow up / reinforcing element during post-triggering phase.
- 3) Technical advice for latrine construction is provided at the beginning of the process by PDRD and CRC staff and volunteers, using the standard ‘informed choice manual on rural household latrine selection’ from MRD.
- 4) Subsidies might be attached to the programme as post-reward ODF achievement.

Brief summary of CLTS programme in Takeo Province by CRC and SRC

CLTS activities in Takeo Province initiated in 2006, integrated in a broader health programme that includes CBFA training, hygiene promotion (PHAST), water supply (distribution of water filters) and dengue vector control. The project covers 80 villages with a total population of 63.000 (12.000 households).

The activities derived from PHAST, CBFA and CLTS are conducted in an integrated manner in a 7-months cycle. Each cycle is composed of half-day sessions undertaken on a monthly basis. The cycle starts in the community with a complete CLTS triggering session, following the ‘softer’ CLTS scheme adopted in Cambodia. The subsequent sessions include CLTS follow up and PHAST / CBFA integrated activities. PHAST activities are those related to step 2, 3, 4, 6 & 7 where the PHAST toolkit is used mainly as hygiene EIC materials. CLTS triggering session is conducted by the provincial CRC staff in close collaboration with PDRD. At the end of the 7 month cycle, all activities in the community are handed over to the CRC volunteers (RCV) for further follow up and monitoring.

In mid 2009 an evaluation looked into effectiveness, impact and sustainability of the WatSan activities in the first 44 target villages. Main outcomes from this evaluation as follows:

- From a baseline of 11,6% latrine coverage, an average **coverage rate** of 56% was achieved shortly after the CLTS/PHAST intervention in 2008. Two years later, the coverage rate had decreased at 24% due to latrine collapse after the rainy season and loss of interest in rebuilding or / and lack of physical space to erect a new latrine.
- According to the field observation, 57% of the surveyed latrines have durable and sustainable designs, 26% are unlikely to be sustainable and 17% are considered not sustainable at all.
- The coverage rate in the group of the **poorest households** only reaches 13%. Social solidarity among the community members has been seen low.
- 97% of the surveyed households presently having a latrine are continually using the facilities. The **usage rate** remains high regardless the type of latrine, showing in general a great sense of ownership and commitment to effective O&M of latrine facilities.

This table shows general steps undertaken by CLTS projects in Takeo and Oddar Mancheay Provinces. Both projects share same approaches and principles but contain some different elements that are not included in the table, since the purpose of this paper is illustrating a generic model of intervention applied in Cambodia that could be eventually used in other parts of the world.

	When	For how long	What	Tools	Participants / by whom
Pre-triggering	Month 1	5 Days	CLTS / PHAST training	Standard training package by MRD	CRC Field Officers (Provincial Level) and MRD
		2 hours	Pre-triggering visit: community selection	Questionnaire and application form	
	Month 2	5 Days	Recruitment and training of CRC community based volunteers Training in RC P&V and first aid	First Aid Kit	CRC volunteers (community level) by CRC field officers
	Month 3	3 Days	CLTS Pre-Triggering: Training on Sanitation and Health with the local opinion leaders	Training package	Village Chiefs, School Directors, Buddhist Monks, Health Centre Chief, and CRC Volunteers by CRC field officers
Triggering	Month 4	1/2 Day	CLTS Triggering	Triggering tools	Community Workshop by PDRD and CRC
Post-triggering	Month 5	1/2 Day	CLTS Follow up and monitoring PHAST Step 2 & 3 (focus on handwashing)	Distribution of soap	Community Workshop by CRC field officers & volunteers
		1/2 Day	CLTS Follow up and monitoring PHAST Step 2 & 3 (focus on water supply) targeting CRC volunteers	IEC materials	
	Month 6	1/2 Day	CLTS Follow up and monitoring PHAST Step 3 & 4 (focus on water supply) targeting all HH	IEC materials	Community Workshop by CRC field officers & volunteers
	Month 7	1/2 Day	CLTS Follow up and monitoring PHAST Step 5	IEC materials	Community Workshop by CRC field officers & volunteers
	Month 8	1/2 Day	CLTS Follow up and monitoring PHAST Step 6&7	-	Community Workshop by CRC field officers & volunteers
	Month 9	1/2 Day	CLTS Follow up and monitoring	Monitoring forms	Community Workshop by CRC field officers & volunteers
	Month 10		CLTS Follow up and Monitoring	-	CRC volunteers
	Month 11-12				CRC volunteers

Annex 3.- Photo Gallery: Pictures of simple pit latrines designed by the communities in Cambodia.

These pictures represent different simple pit latrine prototypes erected by the community members after the CLTS triggering session in Cambodia. The use of local materials and freedom to innovate and experiment choosing their toilet models is a commonality across the villages in both Provinces, Takeo and Oddar Mancheay.

