

Scaling up CLTS in sub-Saharan Africa

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Introduction

Of 44 countries in sub-Saharan Africa only four (Angola, Botswana, Rwanda and South Africa) are currently on track to meet the Millennium Development Goal (MDG) 7 target on sanitation.¹ Child mortality rates in the region are among the highest in the world, with the average under-five mortality rate at 135 per 1,000 (UNICEF 2009a). Diarrhoeal disease is a major cause of death in sub-Saharan Africa and is clearly linked to inadequate sanitation, hygiene and water supply. There are an estimated 565 million people in sub-Saharan Africa without access to improved sanitation and, worse, 224 million who practice open defecation – the riskiest sanitation practice of all.

The United Nations Children's Fund (UNICEF) is committed to improving sanitation access as part of its broader strategy to improve young child survival and development. It has been implementing

Community-Led Total Sanitation (CLTS) and other community approaches to total sanitation with partners in several countries towards this goal.

Community-led approaches to sanitation have been demonstrated to rapidly improve sanitation coverage in Asia (Chambers, 2009) and have recently been introduced in Africa. This positive South-South transfer is showing great promise in terms of accelerating coverage. It has real potential, when scaled up, to make a strong impact on the appalling figures cited above. This article examines some of the many opportunities and challenges met during the introduction of CLTS in Africa to date, both by UNICEF and its partners – and considers key issues for scaling up and sustainability.

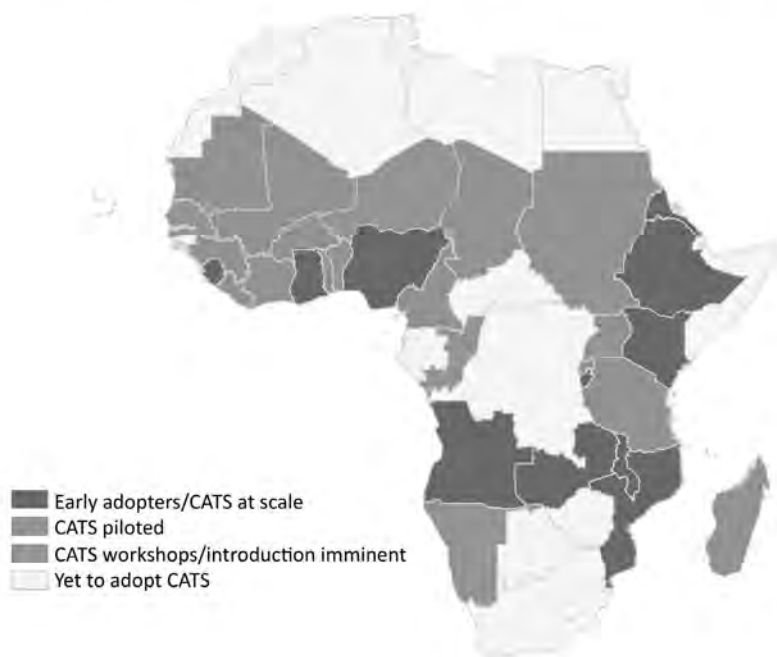
Background

CLTS was introduced in sub-Saharan Africa as far back as 2005–6 (Nigeria,

¹ WHO/UNICEF Joint Monitoring Programme (JMP) for Water Supply and Sanitation (2010). See: www.wssinfo.org

Figure 1: Adoption of Community Approaches to Total Sanitation (CATS) in Africa

Over half of African countries introduced Community Approaches to Total Sanitation



Map: DevInfo, UNICEF New York

Ghana and one area of Ethiopia). Wider introduction started from 2007.² In collaboration with numerous implementing partners across Africa, community approaches to total sanitation including CLTS are now being introduced throughout Africa in Anglophone, Francophone and Lusophone countries (see Figure 1).

As part of the UNICEF strategy of CLTS roll-out, a variety of regional level workshops and information sessions have been held. In West and Central Africa two workshops were held (November 2008 Francophone, March 2009 Anglophone). Both were facilitated by Kamal Kar, the originator of CLTS and co-author of the CLTS handbook (Kar and Chambers,

2008). Workshops were attended by government, NGO and UNICEF partners from 16 countries. They included practical 'hands on' experience of CLTS tool implementation, and the triggering of CLTS in communities. In East and Southern Africa in November 2007, a regional gathering of sanitation practitioners set in motion a number of country level 'hands on' workshops involving government, NGO and UNICEF partners from the host country as well as from neighbouring countries.

During all the workshops, a strategy of involving regional resource and training institute staff was adopted.³ The aim was to build regional institutional capacity for the long term sustainability of the approach, a

² Workshop report: CLTS Sharing and Learning Workshop at AfricaSan, Durban, South Africa, 17th February 2008.

³ Including: Centre for Low Cost Water Supply and Sanitation (CREPA), Burkina Faso; Institute of Water and Sanitation Development (IWSD), Zimbabwe; Network for Water and Sanitation (NETWAS); and Training, Research and Networking for Development (TREND), Ghana.

known key success factor in scaling up (Chambers, 2009). This is proving important for helping to meet the quality facilitation gap as demand for CLTS has grown rapidly.

Across sub-Saharan Africa CLTS has taken off at a pace that exceeded expectations. CLTS is already well established and at significant scale in many countries and is at pilot stage in others (see Figure 1). In the space of two short years, it is estimated that several hundred thousand people across Africa have stepped onto the sanitation ladder. A significant proportion of these are now using improved sanitation facilities as a direct result of CLTS. In Zambia alone, through the CLTS approach, over 245,000 people are now living in open defecation free (ODF) communities.

One finding of our experience to date is that CLTS has transferred very well to Africa. Two years ago there were very few examples of successful CLTS implementation. When CLTS and other community approaches to total sanitation were presented at AfricaSan+5 in Durban (2008), most examples came from South East Asia.⁴ Now in early 2010 there are a number of African success stories each of which can be used for advocacy and scale up both within and outside the region. Many inter-country learning exchanges as well as training workshops, both crucial to international spread in the early years of CLTS (Deak, 2008) have taken place and have helped lead to the rapid increase in uptake of the approach by convincing others of the possibilities.

As with any new approach, however, the long-term sustainability of these rapid changes remains to be proven. Implementers need to balance the benefits of rapid introduction against the intense follow-up often needed to ensure open defecation free status is achieved and

maintained. In the following sections we discuss some of the main issues that we have recognised as key to ensuring community-led approaches have the best chance of spreading widely and being sustainable.

What makes CLTS work in Africa?

Policy and ownership

Scaling up of community approaches to sanitation need to be locally owned while approved and supported by governments and external agencies.

A supportive policy environment legitimises the buy-in of partners into the CLTS approach and provides a favourable precondition for its spread. The past few years have seen a shift in the upstream environment with policies, guidelines and Sector Wide Approaches (SWAp) developed in many African countries. These are supportive of community-led approaches and the goal of eliminating open defecation – even if CLTS is not always specifically mentioned. There has been an increased focus on sanitation policy and budget issues across Africa since the International Year of Sanitation in 2008. This included the signing of the eThekweni Declaration at AfricaSan+5, which has helped maintain the profile of the sector.⁵ The indicators for progress against the Declaration include national coordination and monitoring and evaluation, as well as addressing community-led approaches. Renewed concentration on these issues has been a good opportunity to include community-led approaches in national sanitation policy documents, for example in Ghana and Eritrea, where CLTS is now the recognised national approach for rural sanitation (Magala, 2009).

Within a supportive policy environment local ownership, both by government staff and communities, is also an important

⁴ Africa Sanitation Conference – Afrisan+5, Durban, 18th–20th February 2008.

⁵ The eThekweni Declaration is a sanitation declaration which was subsequently reaffirmed by Heads of State across Africa at Sharm el Sheikh. See AfricaSan 'Traffic Lights' progress: <http://tinyurl.com/Africasan-report>. Full URL: www.unicef.org/wash/files/WA_eThekweni_ENGLISH_FINAL.pdf

Box 1: Aiming for scale in Malawi

Despite concerted efforts over the years to close the sanitation gap, in 2008 only 56% of Malawians had access to improved sanitation. Progress is insufficient to get the country on track to meet the MDG target (JMP, 2010). Nine percent of the population practised open defecation which equates to 1.3 million people. Following the participation of a strong Malawian delegation to the AfricaSan+5 conference in 2008, the two ministries concerned with sanitation jointly led a process of discussion and the development of a sanitation road map.

Malawi's Sanitation Policy (2008) establishes the basic right of every person to access information on improved sanitation, as well as individual responsibility to own and maintain sanitation facilities. Of note is that the Malawi Sanitation Policy is one of the only sanitation policies in the region that specifically focuses on the elimination of open defecation. CLTS is also one of the main vehicles for sanitation promotion in the SWAp.

By mid 2008 a national cross-sectoral core team had been equipped with the necessary skills to implement CLTS in 12 priority districts. Each district team is responsible for training and supporting frontline extension workers across line ministries, including health surveillance assistants (HSAs), water monitoring assistants (WMAs) and community development assistants. In many districts health extension staff have formed CLTS task forces to ensure follow-up and ODF monitoring. By the end of 2009, 346 villages had been declared ODF in Malawi, reaching almost 189,000 people.

In addition to the institutional framework that supports CLTS scale up and sustainability, an important feature of CLTS in Malawi is the continuous self-reflection and learning that takes place. This is done through regular national stakeholder discussion forums and the national newsletter produced by Engineers Without Borders, Canada (EWB), which provides a platform for documentation and lessons sharing (see also Raeside, this issue).

Interest in CLTS in Malawi is growing. Positive results yielded over the last 18 months have sparked donor interest as well as proposals for inclusion of CLTS under the essential health package Sector Wide Approach.

Information courtesy of Chimwemwe Nyimba, Sanitation Specialist, UNICEF Malawi.

requirement. A three country study in East and Southern Africa found that districts with the highest success rates in each country seemed to correlate with a very high level of local ownership. Local ownership by both government staff and communities is favourable to the spread of CLTS. It makes time and resources available from within communities and local government beyond external funding (Polo, 2009) and increases the intensity of follow-up and the focus on results. In Mauritania strong municipal leadership and political will has proved essential in the promotion of CLTS, which has spread well even in urban areas, despite being considered a predominantly rural approach. Rosso in southern Mauritania, a town of 34,000 inhabitants, has declared eight of its 11 wards ODF, and even after the devastating floods of August 2009 has regained that status. Challenges remain, however, with the least cohesive sectors of the town (Said, 2009). Further

adaptations of CLTS to urban African settings are continually being explored. For example in the town of Choma in Zambia, the concentration is on advocacy, education and engaging with local authorities to tighten the enforcement of environmental health laws (UNICEF, 2009b).

Cross sectoral buy-in and teamwork seem to be important factors in determining the results of CLTS. The Zambian Choma model is very strong (see e.g. Zulu *et al.*, this issue). It pulls together individuals from several line ministries, the judiciary, traditional leaders and civil society as a united front against open defecation – but this model may be difficult to replicate due to Choma's unique situation. However several other good examples exist in, for example, Malawi, Sierra Leone and Burundi (see Box 1). In Malawi, district coordinating teams are composed of staff from the water, health and community development officers, with very positive



Photo: Jane Bevan

Mrs Ogbu, Deputy Director of Sanitation in the Federal Ministry of Agriculture and Water Resources in Nigeria, taking part in a CLTS triggering in Benue State, March 2009.

results where this teamwork is strong (Polo, 2009). Sierra Leone has a thriving National Water, Sanitation and Hygiene (WASH) Behaviour Change Consortium which meets in a different district every month. It includes government and NGO

partners, and invites natural leaders to share concerns. In Burundi a core team of national facilitators from government, UN and NGOs meets regularly to discuss progress and find common solutions to challenges faced.



Photo: UNICEF Sierra Leone

Abdu Raman, Natural Leader of the Month, March 2009. Celebrated in Sierra Leone's regular sanitation newsletter.⁶

Finally, in a number of countries the speed of implementation and results has been seen as a very positive selling point for CLTS. In Mozambique, for example, front-line implementers who had been frustrated with Participatory Hygiene and Sanitation Transformation (PHAST) approaches due to the long implementation period have found the speed with which CLTS can get results has given them a renewed sense of purpose (Godfrey, 2009).

Champions

The complementary influence of traditional and non-traditional leadership structures in promoting CLTS allows for greater reach and sustainability.

The existence of influential champions

at different levels to promote CLTS is found to be a very important success factor in various countries. Strong national level government champions for the approach are often formed through their involvement with a workshop, and seeing the strong impact of CLTS on the ground. For example, Mrs Ogbe, the (recently retired) Deputy Director of Sanitation in the Federal Ministry of Agriculture and Water Resources in Nigeria, has become a strong advocate for CLTS after attending a Kamal Kar workshop in 2009. Advocates at this level can be key in helping to ensure that community-led approaches are considered when governments are engaged in policy and budget debates.

Community approaches to total sanitation have also benefited from the conviction and support of key national stakeholders in other countries including Ethiopia where the Millennium Sanitation Movement and National Sanitation Strategy and Protocol is driving a variety of total sanitation approaches.

Traditional leaders whose sphere of influence is trans-generational and trans-political have emerged as champions in Zambia, Malawi and Kenya amongst other countries (Polo, 2009). The support of a leader in a strong traditional structure is crucial for acceptance of the approach by the whole community, and can be pivotal for the social norm change desired, that is, the unacceptability of open defecation. Chief Macha of Choma has recently received recognition for his championing of CLTS in Zambia, winning first prize in the leadership category of the 2009 AfricaSan/African Ministers' Council on Water (AMCOW) awards.⁷

Natural leaders who emerge from the community are also important for success. In recognition of the important role natural leaders play as champions in their own

⁶ See: <http://tinyurl.com/amcowasawards09>. Full URL: www.dwaf.gov.za/Communications/PressReleases/2009/AMCOWAfricaSanAwards2009.pdf

⁷ See examples at: <http://tinyurl.com/WASH-SL-report>. Full URL:

www.communityledtotalsanitation.org/resource/quarterly-wash-report-unicef-sierra-leone

neighbourhoods, Sierra Leone profiles the 'natural leader of the month' in their sector-wide quarterly CLTS update, identifying also the importance of women as natural leaders. The most promising natural leaders in Sierra Leone – those which have succeeded in achieving ODF status – are now in the process of being trained to be the next wave of CLTS facilitators – a very good example of sustainable scaling up.⁸ A local dialect/picture manual is also being developed for them by the CLTS partners.

Flexibility and learning

Self-reflection, learning and documentation contribute to improved outcomes and help make the case for scaling up.

Flexibility in approach has emerged as an important factor in firstly achieving results and secondly for scaling up. For example adapting 'normal' ways of working in the sanitation sector to include a huge range of stakeholders has been pivotal in Zambia. After the first set of triggering in Malawi, CLTS teams realised the positive role traditional chiefs could play in the process and have systematically included them in subsequent trainings. An in-depth evaluation of the Mozambique One Million Initiative, which includes CLTS triggering, has led to programmatic changes to increase efficiency and build on results achieved during the first year.⁹

Recognising the need for documentation to gain government buy-in, several countries are now undertaking systematic evaluation, review and documentation – providing valuable insights into costs, timeframes, sustainability and impact. Preliminary figures suggest CLTS is costing in the order of US\$15 per household, or US\$2.50 per person.¹⁰ This compares with the cost

of \$30 per household calculated for Nigeria by WaterAid (Evans *et al.*, 2009). It also compares very favourably with subsidised latrine building programmes, where the tendency to require standard, 'high-technology' latrine models raises the unit cost (sometimes as high as \$600+), limiting scalability and impeding self-supply.

Cultural appropriateness

Cultural preferences are better catered for by community approaches to sanitation.

In some countries (e.g. Mali and Liberia) it was found that several families opted to build gender-specific latrines, including separate washing areas. In Mozambique, polygamous families have constructed multiple latrines. In some cases more than one latrine was constructed per household due to the culture of not having fathers and daughter-in-laws using the same latrine (Godfrey, 2009).

In addition to leaving room for communities to determine how to address the issue of open defecation in a way that responds to cultural norms, CLTS is also considered to be highly equitable. Both richer and poorer – including disadvantaged individuals within a community – will build latrines and be equally ODF (Evans *et al.*, 2009). The issues of equity and inclusion in CLTS are important and warrant further research in the African context.

A recent WaterAid study from West Africa found that '...most of the communities surveyed respect community customs and traditions associated with the practice of open defecation' (Dittmer, 2009). For this reason, the approach of total sanitation has a strong chance of working in commu-

⁸ See: <http://tinyurl.com/unicef-wash-newsletter>. Full URL: www.communityledtotalsanitation.org/sites/communityledtotalsanitation.org/files/December_2009_UNICEF_WASH_Newsletter.pdf

⁹ The One Million Initiative programme aims to support the efforts of the Mozambique Government to ensure adequate water supply and sanitation and the adoption of improved hygiene practices for a million rural people in 18 districts, in three provinces.

¹⁰ Personal communication with Chris Cormency – 'all-in' costs from a review of West and Central Africa regional data.

nities where leadership is strong and the collective decision is made to change that practice (see also e.g. Bwire, Musyoki, Zombo, this issue).

CLTS, which was developed in Asia, has transferred to the African context with minimal variation from the original model. This is perhaps due to the basic principles of collective pride – and of disgust and shame – being the same throughout the world.

Certification and monitoring

Certification and monitoring gives credibility to results and motivates others.

In some countries formal monitoring and certification processes have been seen as essential to increasing results and possibly to the sustainability of behaviour change. Examples include the certification process in Mauritania, the terms of reference development for the national CLTS committee in Guinea, and the proposal in Ghana that all ODF villages are re-certified and re-celebrated on an annual basis (during National Sanitation Week) to renew and sustain the community commitment. Several countries, including Eritrea, Mali, Malawi, Mauritania and Zambia include the verification of evidence of hand-washing in the ODF certification process. The addition of this further behaviour change has not been found to slow down the achievement of ODF.

Sierra Leone has linked the roll-out of CLTS to the development of a national WASH database, supporting local councils and district statisticians in the collection and input of data. In Mozambique, community ODF status is evaluated using uniform guidelines and evaluation forms by multi-sectoral teams composed of national and provincial government staff from water, educational and health ministries, UNICEF, World Bank Water and Sanitation Programme (WSP) and NGO partners at national level. This level of evaluation has given credibility to the results and thus inspired interest in scaling up further.

Challenges

Follow-up for sustainability

Experience shows that triggering communities does not always lead to achievement of ODF status. In the West African countries more advanced with CLTS – in terms of having well-established programmes for several years (Sierra Leone, Nigeria and Ghana) – there is a very high proportion (up to 80%) of triggered communities that have not yet declared ODF status. In other words, the process has begun and commitments are made, but for some reason the latrines are not being built. This suggests there are issues with either the quality of triggering facilitation or the follow-up in the triggered communities. It would be preferable to consider returning to these villages to pursue ODF before triggering any further communities (Bevan and Thomas, 2009). However, facilitators should carefully judge the need for further investment of time. There is evidence that triggering can remain ‘dormant’ or be delayed, and communities can later be re-triggered to achieve ODF due to other events, such as the action of neighbouring communities, or disease outbreaks.

Another possible reason for the seemingly high disparities between triggering and attaining ODF is the traditional project focus on reporting activities rather than results. While the positive impact of stopping open defecation is not affected by whether the result is reported outside the community or not, this represents a significant missed opportunity both for advocacy for the approach in other areas and for sustaining the job satisfaction and enthusiasm of local CLTS facilitators.

Both of these observations point to the challenge of a real ‘mindset’ change for WASH practitioners and others, including donors, with a shift to focusing on the more slowly developed ‘software’ or behaviour change aspects of provision from the traditional technical emphasis, as well as

for ‘assessing outcomes’ rather than the simpler culture of ‘counting outputs’.

Moving up the ‘sanitation ladder’ (i.e. the process of making incremental improvements to the sanitation situation) is another sustainability challenge to be addressed. The methods for supporting this vary between countries, and also with cultural and regional preferences. Encouraging and supporting the proliferation of sanitation marketing and entrepreneurial enterprises such as the SaniCentres in Nigeria (Agberemi and Onabolu, 2009) is recognised as a very sustainable option for improving latrine quality as well as catering for local cultural choices.¹¹

Speed versus quality: demand for scale up – training, facilitators and triggering

CLTS programmes can be a victim of their own success – inspiring results seen from small scale pilot programmes generate a demand for rapid replication and scale up. High demand for trainings, triggerings and results may lead to corner-cutting which undermines subsequent results.

As CLTS scales up so does the need for quality facilitators. The key facilitators in Zambia all come from one district. They are now in high demand within their own district, in other districts and in neighbouring countries. In all countries the need for a strong cadre of ‘convinced’ and capable facilitators has been a recurring theme in CLTS discussions and evaluations.

Hands-on training and mentoring of trainers are widely indicated by the literature as a fundamental factor needed to influence results positively (Chambers, 2009). It is not simply a case of training existing participatory trainers in a new tool. A rigorous training programme is required which not only teaches the methodologies

but also convinces trainers of the philosophical aspects of the approach, i.e. behaviour change, lack of subsidy and the benefits of attaining ODF (Polo, 2009). Particularly in francophone West Africa, the number of quality trainers is still limited. More frequent and comprehensive hands-on training and mentoring is needed (see also Musyoki, this issue).

In most African countries there is a cadre of extension workers that are familiar with the communities and have basic training in primary healthcare and hygiene.¹² Although their capacity can vary enormously, there are many very dedicated and experienced individuals who already command respect and have the potential to become great advocates for CLTS. However, the assumption that the CHWs as the ‘village interface’ are always best placed to be the CLTS frontline staff is sometimes misguided. Extension workers may be responsible for multiple tasks. For example, health surveillance assistants in Malawi are responsible for many other interventions including subsidised orphans and vulnerable children programmes. Others may not be suited to the role of facilitator. For example, outsiders might be more able to elicit the sense of shame and disgust required for triggering than the young women employed in their own communities as health extension workers in Ethiopia. That said, if appropriately leveraged, trained and supported, this large community-based network can be instrumental in scaling up, through prioritising villages for triggering, monitoring progress and supporting communities to become and maintain ODF status, as well as capitalising on the renewed community cohesion to promote other primary healthcare issues such as child nutrition.

¹¹ For a background on sanitation marketing see: <http://tinyurl.com/sanitation-marketing>. Full URL: www.lboro.ac.uk/well/resources/fact-sheets/fact-sheets-htm/Sanitation%20marketing.htm.

¹² Health extension workers (HEWs), community health workers (CHWs), health surveillance assistants (HSAs) etc.

Co-existence with subsidy approach

Overcoming the historical dependency on subsidies in this sector has been a challenge. In some countries there has been significant resistance to unsubsidised domestic latrine building at both government and community levels. In general, country pilots of community-led approaches have tried to avoid areas where subsidised sanitation projects have previously been implemented. In some countries, however, the two approaches appear to co-exist acceptably. In the current rollout in Ghana, the use of subsidies has not demonstrated measurable differences in latrine construction or use between communities, but does seem to correlate to pride and ownership, making community-built latrines potentially more sustainable in the long run. In the Greater Accra Region a subsidised latrine building programme co-exists alongside CLTS. The recent Ghana evaluation (Magala, 2009) found very little difference in the quality or efficacy of the latrines produced, but the sense of pride and ownership and the potential for sustainability was significantly greater in the CLTS communities, and the subsidies in adjacent villages did not appear to be envied.

Conclusion

In the span of a few short years, we have seen community approaches to sanitation being widely adopted throughout Africa. With a predominantly rural population having strong traditional structures, the CLTS approach has found fertile ground in which to grow. The rate of achievement in several countries is very promising, and our challenges are to support this strong beginning, encourage the practices that will help the approach spread and scale up, and to reorient our own outlooks to embrace the shift to demand-led sanitation.

Principal areas of future support and research for scale up will be in training, facilitation and developing monitoring and evaluation systems that can capture

community behaviour change. Continued advocacy for the acceptance of community-led approaches by opinion leaders and in sanitation policies will also be essential.

Support for individuals to improve their basic latrines with handwashing facilities to something more durable and permanent will be a focus in many countries once initial ODF status has been achieved and may open the way for sanitation marketing programmes on a larger scale.

The questions of continued follow-up and the maintenance of open defecation free status will be closely monitored for best practice and long-term sustainability. Although still in its infancy, CLTS in Africa shows great potential to make a lasting and sizeable impact on the sanitation coverage.

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