Testing CLTS Approaches for Scalability

CLTS Learning Series: Lessons from CLTS Implementation in Seven Countries

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This report can be downloaded from the Testing CLTS Approaches for Scalability project website: https://waterinstitute.unc.edu/clts.

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We support WaSH sector organizations to significantly enhance the impact, sustainability and scalability of their programs.

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About the Project
The project, Testing CLTS Approaches for Scalability, funded by the Bill & Melinda Gates Foundation, aimed to learn, capture and share reliable and unbiased information on CLTS approaches and scalability. Research activities between 2012 and 2015, sought to better understand CLTS facilitation and mobilization by rigorously evaluating three distinctive strategies to enhance the roles of local actors in CLTS interventions in Kenya, Ghana and Ethiopia. Complementary to the three pilot evaluations, researchers also conducted case studies in seven countries across Africa, Asia, and the Caribbean to further explore the role and potential of local actors in CLTS.

About the Author
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### Abbreviations

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<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>BMGF</td>
<td>Bill &amp; Melinda Gates Foundation</td>
</tr>
<tr>
<td>CLTS</td>
<td>Community-led Total Sanitation</td>
</tr>
<tr>
<td>CO</td>
<td>Plan International Country Office</td>
</tr>
<tr>
<td>DWT</td>
<td>District WaSH Team</td>
</tr>
<tr>
<td>INGO</td>
<td>International Non-Governmental Organization</td>
</tr>
<tr>
<td>JMP</td>
<td>WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation</td>
</tr>
<tr>
<td>LS</td>
<td>Learning Series</td>
</tr>
<tr>
<td>LNGO</td>
<td>Local Non-Governmental Organization</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MWE</td>
<td>Ministry of Water and Environment</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>ODF</td>
<td>Open-defecation Free</td>
</tr>
<tr>
<td>PU</td>
<td>Plan International Program Unit</td>
</tr>
<tr>
<td>PDR</td>
<td>People’s Democratic Republic</td>
</tr>
<tr>
<td>PDRD</td>
<td>Provincial Department of Rural Development</td>
</tr>
<tr>
<td>TCAS</td>
<td>Testing CLTS Approaches for Scalability</td>
</tr>
<tr>
<td>TSC</td>
<td>Technical Services Committee</td>
</tr>
<tr>
<td>UNC</td>
<td>University of North Carolina at Chapel Hill</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>VDC</td>
<td>Village Development Committee</td>
</tr>
<tr>
<td>VHT</td>
<td>Village Health Team</td>
</tr>
<tr>
<td>WaSH</td>
<td>Water, Sanitation and Hygiene</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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</table>
Executive Summary

Community-led total sanitation (CLTS) is a behavior change approach that attempts to trigger collective change to eliminate open defecation in rural communities. Between 2013 and 2014, the CLTS Learning Series (LS) was conducted as part of the “Testing CLTS Approaches for Scalability” (TCAS) project. The TCAS project evaluated the roles of natural leaders, teachers, and local government in CLTS. This report is the result of a sub-agreement to The Water Institute at UNC from Plan International USA, the recipient of a grant from the Bill & Melinda Gates Foundation (BMGF).

The LS is a collection of seven case studies of rural sanitation. The aim was to characterize variations in CLTS implementation through the perspectives of stakeholders, and to identify lessons pertaining to the potential for expanding the scale of activities. Plan International CLTS programs were studied in Cambodia, Lao PDR, Nepal, Indonesia, Uganda, Niger, and Haiti. This report presents findings from a comparative analysis of these seven cases, each of which are also documented as individual country reports.

Data collection consisted of qualitative in-depth interviews with 293 people: policymakers, Plan International staff, other non-governmental organization (NGO) partners, local government officials, village-level CLTS facilitators, and community leaders. Policy and programmatic documents were also gathered over the course of two to three weeks in each country. Thirty-four communities were visited, 44% of which were either declared or certified as open-defecation free (ODF) by the time of the visits. Interview transcripts, field notes, and documents were analyzed qualitatively to identify themes pertaining to different stages of CLTS.

Findings in this report, summarized below, are categorized by CLTS implementation context (history, policy, implementation arrangements) and by seven themes that emerged across the seven case studies, with implications and recommendations for rural sanitation interventions.

Implementation Context

Across all seven LS countries, Plan International has triggered nearly 1000 communities and is one of the main NGOs implementing CLTS. They helped introduce CLTS as a new approach to rural sanitation in four LS countries (Nepal, Cambodia, Uganda, and Haiti), and have also been key players in Lao PDR, Indonesia, and Niger in piloting, and expanding the scale of, CLTS activities. Self-reported monitoring data from Plan International CLTS programs revealed a wide range in the presence of ODF communities—from 6% of communities in Haiti being declared ODF to 97% of communities in Indonesia being certified as ODF. Plan International Indonesia, Plan International Uganda, and Plan International Laos had the most successful end-line results based on these monitoring data.

Plan International’s implementation arrangements for CLTS varied between each country. The complexity of arrangements depended largely on government support for CLTS and sanitation, as well as the capacity of different actors—including local government and village volunteers—to participate in the process. Where national government support for CLTS was strong, local government played a more important role in facilitating CLTS activities (Cambodia, Nepal, Indonesia, and Uganda); these countries are also where CLTS had been implemented the longest. These governments were directly investing in CLTS activities to train staff and support local government.
Where national government support was weaker, Plan International played a lead role in implementing CLTS.

The policy environment in all seven countries was found to be largely favorable towards CLTS; this approach served as the foundation for Indonesia and Nepal’s rural sanitation policy. All seven governments also recognized the need for demand-led sanitation strategies. However, several national policies, such as those in Lao PDR, Cambodia, and Niger, also allowed for targeted hardware subsidies for households or public facilities. In all countries where latrine subsidy projects and CLTS overlapped, CLTS practitioners cited considerable challenges.

**Thematic Findings**

The following themes were identified across the seven case studies, with related findings and recommendations for CLTS and rural sanitation practitioners:

- **Role of CLTS:** CLTS was widely perceived as being universally applicable to rural communities, even though outcomes varied depending on community characteristics. Rather than viewing it as a comprehensive solution to rural sanitation, CLTS should be considered as one component of a sanitation strategy. If communities that are more likely to be receptive to CLTS are targeted more systematically, practitioners can allocate remaining resources to test other approaches, such as sanitation marketing, in other communities less appropriate for CLTS.

- **Local government capacity:** In five of the seven case studies, local government capacity was found to be insufficient to lead CLTS activities. Where local governments are unable to lead CLTS activities, international NGOs (INGOs) can help strengthen their capacity through training, mentorship, and targeted technical support. INGOs should also engage with local NGOs (LNGOs) to trigger communities and strengthen village-level participation. At the same time, all NGOs should advocate for increased investment from national government to ensure that there are sufficient staff, finances, and resources for sanitation in local government.

- **Role of village-level actors:** A variety of village volunteers were implicated in different phases of CLTS, but they needed considerable support from Plan International and local government to motivate communities toward behavior change. CLTS practitioners need to ensure that an unfair burden is not placed on volunteers. Practitioners should allocate sufficient resources for training, financial and in-kind support, recognition, and exchange visits to sustain volunteer motivation.

- **Adaptations to triggering:** Triggering techniques had been adapted in all LS case studies, but adaptations were not always designed with the aim of improving outcomes. Programs should systematically identify adaptations to CLTS and critically analyze whether the adaptations are a result of community context or a result of convenience or logistical constraints.

- **Sanctions:** Although community-developed sanctions are encouraged in CLTS, most examples identified through the LS were enacted by village or district government. CLTS practitioners, including NGOs and government, need to carefully consider the types of
sanctions they actively encourage or passively condone, who enforces the sanctions, and how they are enforced in practice. Sanctions may be useful in creating and reinforcing social norms, but they need to be introduced at the right time, in the right manner, and target the right people.

- **Hardware supply and financing:** Latrines built as a result of CLTS were often of poor quality, adversely affecting the sustainability of CLTS outcomes. Access to durable materials, technical support, and affordability were key obstacles. Plan International can help influence the nature of post-CLTS support in communities through approaches that maintain the motivational nature of CLTS and also provide access to higher quality sanitation options, such as sanitation marketing. In countries where government or NGO subsidies are present, Plan International can help influence the mechanisms by which these subsidies are targeted to ensure that they do not negate CLTS efforts but rather enhance access and sustainability of outcomes.

- **Monitoring outcomes:** CLTS monitoring activities comprised a variety of process and outcome indicators, but ultimately focused on achievement of ODF status, except in Haiti. There were differences in indicators of success, ODF definitions, and ODF verification guidelines across all LS case study countries. Achievement of ODF status can serve as a powerful motivational tool for communities to change their sanitation practices. However, it is less useful as a metric to measure progress; its binary nature suggests that communities that have nearly achieved 100% latrine coverage may still qualify as “not ODF.” Therefore, programs should consider focusing on routinely collecting data (including baseline measurements) on household-level indicators of sanitation so they can measure and recognize incremental progress in communities. Improved monitoring of activities will help generate evidence on the potential, the effectiveness, and the limits of CLTS.
1. Background

1.1. The CLTS approach

Community-led total sanitation (CLTS) is a demand-led behavior change approach, which aims to create open-defecation free (ODF) communities. CLTS attempts to trigger collective change through facilitators, who encourage and motivate people to analyze the impact of open defecation in their communities and take action on their own. Since its inception in Bangladesh in 2000, CLTS has been adopted by many international non-governmental organizations (INGOs), and is now practiced in over 50 countries. It has also been incorporated into the national policies of many governments. Plan International was one of the first INGOs to test this approach, and they currently implement CLTS in more than 30 countries.

The process consists of three distinct stages:

- planning and pre-triggering: selecting communities, training facilitators, collecting baseline information, and coordinating community entry;
- triggering: organizing a mass meeting in communities where facilitators conduct participatory exercises intended to trigger shame and disgust. Attendees are expected to analyze their sanitation situation and be moved to change it on their own;
- post-triggering: routine monitoring and follow-up visits by facilitators, technical support on latrine construction, verifying and certifying ODF status in communities.

1.2. Testing CLTS Approaches for Scalability

Plan International USA, with Plan International offices in Ghana, Kenya and Ethiopia, implemented the Testing CLTS Approaches for Scalability (TCAS) project from 2011-2015, with an applied research component led by The Water Institute at the University of North Carolina at Chapel Hill (UNC). The project aimed to advance rural sanitation efforts, with a particular focus on the role of local actors, such as natural leaders\(^1\), teachers, and district or sub-district local government staff.

The research component included a global literature review of the evidence on CLTS; three large-scale pilot evaluations of the roles of local actors identified as important to CLTS; and seven country case studies.

1.3. CLTS Learning Series

Between May 2013 and June 2014, seven case studies were conducted of CLTS projects implemented by Plan International Country Offices (COs) to form the CLTS Learning Series (LS).

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\(^1\) For detailed information on CLTS, refer to the Handbook on community-led total sanitation (Kar et al. 2008).

\(^2\) In the CLTS approach, “natural leaders” are those who emerge as a result of triggering communities. They are not necessarily existing community leaders.
The initial objectives of the LS were as follows (focusing on Plan International CLTS programs):

1. Identify the role of local actors in CLTS implementation in each country
2. Characterize the process of implementing CLTS in each country
3. Assess CLTS outcomes, given data availability
4. Identify strengths and weaknesses of implementation efforts as perceived by different stakeholders
5. Understand the attitudes of beneficiaries and practitioners towards CLTS
6. Assess the potential for expanding the scale of different approaches to CLTS given the local context
7. Estimate the overall CLTS program costs in each country of projects implemented by COs

These objectives were used to guide the data collection process in each country. All were achieved barring the seventh objective on estimating program costs, as sufficient program data were unavailable. Individual country reports were designed around Objective 1 on the role of local actors, and address remaining objectives through this lens.

This cross-country synthesis report brings together lessons learned from the seven case studies. Section 3 provides a description of the context in which CLTS implementation occurs in these seven countries. Section 4 then presents the main findings organized around seven themes, with implications and recommendations for rural sanitation interventions.

2. Methods

2.1. Research design

A multiple-case study design was used to compare Plan International’s CLTS programs in seven countries. This design was selected to identify and understand factors that contributed to the success or failure of CLTS programs within a given context, requiring an in-depth investigation of multiple perspectives in multiple locations. Case studies are especially useful to answer “how” and “why” questions.

The multiple case study process (Figure 1) begins with developing research questions, selecting cases, and developing a data collection protocol or framework. As individual cases are analyzed and written as case study reports, hypotheses may be refined prior to data collection in subsequent case studies. This iterative process recognizes the uncertainties and adaptations that occur during field data collection, building towards a holistic understanding of CLTS implementation.

2.2. Country selection

Plan International COs submitted proposals to be included in the study. Ten countries were initially selected, using the following criteria:

- Maturity: CLTS programs which are active and no more than seven and no less than one year old.
• Relevance: CLTS programs that can demonstrate aspects about CLTS implementation that were proven to be ‘successful’ and aspects that ‘failed’ and explain why, using available evidence.

Three countries—Bangladesh, Zimbabwe, and South Sudan—were excluded from the LS due to security concerns or inability to obtain local research clearance. The following seven countries were included in this study: Cambodia, Lao People’s Democratic Republic (PDR), Nepal, Indonesia, Uganda, Niger, and Haiti (Figure 2).

![Figure 1. Case study process (Adapted from Yin 2003)](image)

**2.3. Data collection**

Data collection consisted of qualitative in-depth interviews with a variety of stakeholders and gathering of policy and programmatic documents over the course of two to three weeks in each country. A list of process indicators was developed to guide the document review and the development of semi-structured interview guides.

Separate interview guides were developed for policymakers, CLTS practitioners, and community-level participants (Appendix A). Interview questions were loosely structured around the following lines of inquiry: overall water, sanitation, and hygiene (WaSH) situation; sanitation policy; experience with CLTS implementation during training, pre-triggering, triggering, and follow-up stages; opinions on CLTS; and overall philosophy on external support (sample questions in Box 1). As these interviews were semi-structured, questions were not always asked in the same order or using the same wording.

Purposive sampling was used to identify key informants at the national, provincial, district, and village levels who could describe experiences with Plan International’s CLTS approach in each country. UNC researchers conducted interviews in the language that respondents were most
comfortable with, which involved the participation of interpreters who were not affiliated with Plan International.

Figure 2. CLTS Learning Series countries

<table>
<thead>
<tr>
<th>Sample Interview Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>In your own words, how would you explain the idea of CLTS to someone who has never heard of it?</td>
</tr>
<tr>
<td>According to you, in what kind of community is it easiest to achieve success in CLTS? Why?</td>
</tr>
<tr>
<td>Do you think there is any type community where CLTS is not possible? Why?</td>
</tr>
<tr>
<td>What kind of changes would you like to see in the way that CLTS is done?</td>
</tr>
<tr>
<td>What would you say are the most important problems your community has to deal with?</td>
</tr>
<tr>
<td>What was your favorite part about the sanitation activities done by the [local CLTS facilitators]? Why?</td>
</tr>
<tr>
<td>Was there anything you did not like about the sanitation activities? Why?</td>
</tr>
<tr>
<td>Does working on sanitation as a “natural leader” keep you away from other work?</td>
</tr>
<tr>
<td>Has anyone in your village received any support to build toilets? What kind of support and from whom?</td>
</tr>
<tr>
<td>According to you, who do you think should pay for improving sanitation in your community? Why?</td>
</tr>
</tbody>
</table>

Box 1. Sample interview questions

2.4. Data analysis

Interviews were audio-recorded, transcribed, and translated to English for analysis. The qualitative analysis process involves careful and repeated readings of interview transcripts to identify patterns in responses. This process was aided by the development of a coding scheme to categorize these patterns and identify themes and sub-themes. Two levels of analysis were conducted: at the country case-level, and across country cases. Matrices were used to aggregate data from the seven country
cases under the themes in Table 6; these themes form the structure of findings presented in this report. Atlas.ti Version 7.0 was used to manage and code data.

2.5. Study Participants

In total, 293 people were interviewed through 185 individual and group interviews (Table 1). More than half of the respondents were community leaders (57%), followed by local government officials (17%), other INGOs or local NGOs (LNGOs) involved in CLTS (12%), Plan International CLTS staff (9%), and national government officials (4%). Thirty-four communities were visited, 44% of which were either declared or certified as ODF at the time of the study.

2.6. Limitations

Boundaries of a qualitative study design
Findings described in this report are from a qualitative analysis of CLTS implementation. Relationships are not identified through statistical correlations between variables, but rather by analyzing the process of CLTS and identifying common themes. Sample sizes are intentionally small to allow in-depth analysis. Because of the variety of respondents, non-random sampling techniques, and small sample sizes, it is generally not useful to quantify data acquired from qualitative methods. Readers should be cautious about broadly generalizing findings presented in the following sections beyond the scope of Plan International’s activities, although findings may be relevant to other organizations that implement CLTS in similar contexts.

Limits of monitoring data
Quantitative outcome data in Plan International’s CLTS programs cannot be directly correlated with findings from this study because of methodological differences. These monitoring data were provided by Plan International, were not independently verified, and differed by country. Therefore, while findings from this study are compared to these quantitative data to generate hypotheses on the effectiveness of CLTS, it would not be appropriate to draw definitive conclusions on effectiveness. There may be other factors affecting the outcomes that this study may not have identified. Monitoring also data did not contain sufficient information to calculate program costs.

Practical considerations
It is likely that this study does not capture all variations in CLTS implementation, as only 34 communities were visited, using purposive sampling techniques, out of nearly 1000 communities that had been triggered across the seven case studies. Furthermore, leaders and key informants were interviewed to represent the experiences of their communities. The perceptions and opinions of other residents of the communities may differ from those of their leaders, but it was beyond the scope of this study to survey community members not directly involved in CLTS activities.

Because communities that were visited had been triggered anywhere from one day to several years before the visit, there may have been recall bias among community leaders, which could have affected the accuracy of their responses, especially with regard to recalling training and triggering events. It is also possible that some data were lost in translation.
<table>
<thead>
<tr>
<th>Country</th>
<th>Locations</th>
<th>No. of communities visited</th>
<th>Dates visited</th>
<th>Respondent Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>ODF</td>
<td>Not ODF</td>
<td>No. of communities visited</td>
</tr>
<tr>
<td>Cambodia</td>
<td>Svay Rieng and Kampong Cham provinces</td>
<td>2</td>
<td>2</td>
<td>May 2013</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>Meung and Paktha provinces</td>
<td>2</td>
<td>2</td>
<td>July 2013</td>
</tr>
<tr>
<td>Nepal</td>
<td>Makwanpur, Morang, and Banke districts</td>
<td>3</td>
<td>3</td>
<td>August 2013</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Grobogan district</td>
<td>3</td>
<td>1</td>
<td>August 2013</td>
</tr>
<tr>
<td>Uganda</td>
<td>Tororo district</td>
<td>4</td>
<td>1</td>
<td>November 2013</td>
</tr>
<tr>
<td>Niger</td>
<td>Dosso and Tilaberi département</td>
<td>1</td>
<td>3</td>
<td>April 2014</td>
</tr>
<tr>
<td>Haiti</td>
<td>Sud-Est (South-East) and Ouest (West) département</td>
<td>0</td>
<td>7</td>
<td>June 2014</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>15</td>
<td>19</td>
<td></td>
</tr>
</tbody>
</table>
Additionally, COs played the primary role in arranging interviews and community visits based on recommendations from UNC. For this reason, it is possible that respondents may have biased their answers to be more favorable towards Plan International. To minimize this, the independent nature of this study was emphasized during the informed consent process (script in Appendix B), and all interviews were conducted in private. Care was taken to ensure that analysis presented in the report could not be linked to respondents.

2.7. Ethical review

This study was approved by the Office of Human Research Ethics and Institutional Review Board (IRB) of UNC and the following national entities:

- Ministry of Rural Development, Royal Government of Cambodia
- Centre for Environmental Health and Water Supply, Ministry of Health, Lao PDR
- Ministry of Urban Development, Government of Nepal
- Ministry of Health, Government of Indonesia
- Uganda National Council for Science and Technology
- Ministry of Water and Sanitation and Ministry of Public Health, Republic of Niger
- Ministry of Public Health and Population, Republic of Haiti

3. Implementation context

This section describes the overarching context of Plan International’s CLTS implementation, with respect to the history of CLTS, monitoring data on CLTS outcomes, the national policy environment, and implementation arrangements. More detailed country-specific descriptions can be found in individual country reports.

3.1. History of CLTS implementation

In four LS countries (Nepal, Cambodia, Uganda, Haiti), Plan International helped introduce CLTS as a new way to approach rural sanitation. Of the seven countries, Nepal was the first where Plan International began implementing CLTS, in 2004 (Figure 3). After piloting the approach alongside other WaSH activities, including provision of hardware subsidies, Plan International Nepal changed its sanitation strategy to focus entirely on CLTS in 2007. Plan International COs in Cambodia and Uganda have also had considerable experience in CLTS, since 2006 and 2007, respectively.

In Indonesia, Lao PDR, and Niger, Plan International began working on CLTS after the approach had already been tested to varying degrees by other organizations in these countries. In Indonesia, the government had become convinced of CLTS as a viable approach through pilot projects implemented since 2006, and adopted CLTS as the basis of its national sanitation policy in 2008, providing a positive environment for Plan International to begin their CLTS activities in 2010. In Lao PDR and Niger, other organizations had tested CLTS for one to two years before Plan International started its own pilot projects in 2010. Plan International Haiti, along with a number of other NGOs in that country, attempted CLTS on a small scale following the 2010 earthquake, with limited success. Plan International Haiti’s first non-emergency CLTS program began in 2013.
Figure 3. Timeline of CLTS activities in case study countries

3.2. Outcomes of CLTS programs

Across all seven LS case study countries, Plan International had triggered nearly 1000 communities and is one of the main NGOs implementing CLTS. Of these, Plan International’s largest CLTS programs were in Indonesia, Nepal, and Cambodia, with respect to number of households reached. Data provided by these programs revealed a wide range in the presence of ODF communities—from five out of 83 (6%) communities in Haiti being declared ODF to 149 (97%) out of 153 communities being certified as ODF in Indonesia. However, these numbers cannot be directly compared across case studies as an indicator of success because “ODF” was defined differently in each case study, and ODF declaration and certification processes also differed. Furthermore, not all programs had data on the time taken to achieve ODF status; available data ranged from one month to several years after triggering. In general, the quality of monitoring data and type of indicators collected by Plan International in each country varied considerably, the implications of which are discussed in Section 4.7. For more country-specific outcomes, see Appendix C.

If progress is viewed by household latrine coverage—the percentage of households in a community with latrines—rather than ODF status, Plan International Indonesia, Plan International Uganda, and Plan International Laos appear to have the best end-line results (Table 2). Plan International Indonesia appear to have achieved the best results by far in their Grobogan District CLTS project, with regard to both latrine coverage and ODF status. However, without baseline data on the situation before triggering, it is not possible to know the actual change that occurred in communities in Indonesia; for example, it is possible that most communities already had a high level of latrine coverage prior to CLTS implementation.

Baseline data were available for only four of the seven case study programs. Of these, the largest absolute increase in household latrine coverage (44%) after triggering activities occurred in Uganda. However, it is not possible to attribute this progress entirely to CLTS activities, as other factors not accounted for in monitoring data may have also contributed to the increase in latrine coverage, such as campaigns by other organizations or by the government.
Table 2. Overview of Plan International’s CLTS outcomes in case study programs, 2013-2015

<table>
<thead>
<tr>
<th>Country</th>
<th>No. of communities triggered</th>
<th>No. of HH</th>
<th>Avg. no. of HH per village</th>
<th>Avg. baseline latrine coverage</th>
<th>Avg. endline latrine coverage</th>
<th>Increase in latrine coverage (percentage points)</th>
<th>No. (%) ODF communities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambodia</td>
<td>356</td>
<td>64,562</td>
<td>181</td>
<td>NA</td>
<td>40%</td>
<td>NA</td>
<td>38 (11%)</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>46</td>
<td>4,027</td>
<td>88</td>
<td>48%</td>
<td>74%</td>
<td>26%</td>
<td>17 (37%)</td>
</tr>
<tr>
<td>Nepal</td>
<td>105</td>
<td>171,212</td>
<td>1631</td>
<td>32%</td>
<td>59%</td>
<td>27%</td>
<td>29 (28%)</td>
</tr>
<tr>
<td>Indonesia</td>
<td>153</td>
<td>174,426</td>
<td>1140</td>
<td>NA</td>
<td>97%</td>
<td>NA</td>
<td>149 (97%)</td>
</tr>
<tr>
<td>Uganda</td>
<td>152</td>
<td>14,284</td>
<td>94</td>
<td>51%</td>
<td>95%</td>
<td>44%</td>
<td>67 (44%)</td>
</tr>
<tr>
<td>Niger</td>
<td>87</td>
<td>10,968</td>
<td>126</td>
<td>8%</td>
<td>33%</td>
<td>25%</td>
<td>31 (36%)</td>
</tr>
<tr>
<td>Haiti</td>
<td>83</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>5 (6%)</td>
</tr>
</tbody>
</table>

3.3. Policy environment for sanitation and CLTS

Plan International implemented CLTS in the seven countries within dynamic policy environments, most of which were largely favorable for CLTS. They have played an important role in helping to set national policy for sanitation in all seven countries.

Table 3 and Table 4 summarize characteristics of each country’s national sanitation policy that pertain to CLTS. National sanitation targets were ambitious, and focused on household access to basic or improved sanitation (Table 3). See Appendix D for country-specific graphs of sanitation trends between 1990 and 2015.

National policies in all seven countries recognize the need for demand-led sanitation, and all except Haiti’s policy mention CLTS as a viable approach. Nepal and Indonesia are the most inclusive of this approach, as their sanitation policies are based largely on the principles of CLTS (Table 4).

Multi-sectoral coordination

In four of the seven countries, one lead ministry was responsible for rural sanitation and CLTS; exceptions were Indonesia, Uganda, and Haiti, where responsibility was divided between two ministries (Table 3). This proved to be a challenge in Uganda, as both the Ministry of Water and Environment (MWE) and the Ministry of Health (MOH) were cited as the lead for sanitation in different interviews with government representatives and Plan International staff. These respondents described both ministries as responsible for formulating policies, setting standards, carrying out monitoring and evaluation, and providing technical support and supervision. Such confusion can also affect CLTS, as one national government official noted that it was not always possible to keep track of all triggered communities. The MWE may trigger communities, but the MOH was responsible for verification, and reports were not always shared between the two ministries.

In all countries, practitioners and policymakers cited coordination between different line ministries, development partners, and NGOs as a challenge. Respondents in Cambodia, Haiti, and Niger
expressed concern about the lack of regular meetings between these stakeholders, but by and large, sanitation and hygiene working groups were present in each country, meeting every one to two months (Table 4).

**Overlap in approaches**
The only national documents that do not mention hardware subsidies as an option for rural sanitation are Uganda’s 10-year Improved Sanitation and Hygiene Promotion Financing Strategy (2006) and Haiti’s Strategic Guidance Document for Sanitation in Haiti (2015; pending approval). All other policies allow for targeted hardware subsidies in some manner (Table 4). In Lao PDR, Cambodia, Nepal, and Niger, hardware subsidies are allowed for households—albeit locally decided in some cases—and in Indonesia, they are allowed for public facilities.

CLTS practitioners cited overlap in strategies as a key challenge. Practitioners in Cambodia, Lao PDR, and Indonesia all noted that the overlap of subsidy and non-subsidy approaches in communities or districts had slowed progress in latrine construction in triggered communities. In several communities visited for this study, community leaders observed that some households preferred to wait for external support to build durable latrines rather than building low-quality dry-pit latrines that were prone to collapsing in the rainy season. In the case of Haiti, this overlap in approaches was attributed to the difficulty in enforcing the national policy at the local level, allowing NGOs to choose their own implementation strategies. In Indonesia, where subsidies were technically only allowed for public facilities, poor coordination between ministries meant that different governmental schemes overlapped at the community level.

Uganda was the only LS country where subsidies did not play a significant role in rural sanitation, as the country does not have an extensive history of latrine subsidies for rural households. There was no evidence from interviews with village-level actors of the existence of latrine subsidies in their communities, and village leaders did not indicate a strong desire for financial or hardware support to build latrines.

**Decentralized investment in sanitation**
Government support for CLTS appeared to be strongest in the countries where CLTS had been implemented for at least seven years: Cambodia, Nepal, Indonesia, and Uganda. These governments directly invested in CLTS activities, with funds allocated to train staff and support local government CLTS activities (Table 4). CLTS-specific budgets were unavailable, so it is not possible to know the actual size of investment. A decentralized structure for implementing sanitation was found in all seven countries, but it was in these four countries where national government directly invested in the approach that CLTS activities were officially part of this structure, with local government explicitly responsible for engaging in CLTS. In Niger and Lao PDR—and to a much lesser extent in Haiti—Plan International worked with the local government to implement CLTS, but found it challenging to ensure dedicated participation as it was not part of their governmental duties. Across all seven countries, NGOs and policymakers viewed local government involvement as necessary to increase the scale of CLTS activities, but noted that local government faced capacity constraints to effectively implement decentralized policies, as described in Section 4.2.
3.4. Implementation arrangements for CLTS programs

A variety of implementation arrangements were found for CLTS, ranging from direct implementation by Plan International to the INGO playing a more supportive role of providing technical and capacity building assistance to local government. See Appendix E for institutional maps of each of the seven CLTS programs.

Table 5 provides an overview of actors that were implicated in different stages of CLTS, by country. The more often a country flag is depicted under each row, the more complex the implementation arrangements. For example, in Nepal multiple actors are involved in financing CLTS activities, training facilitators, and facilitating triggering events. On the other hand, few actors are involved in Haiti’s CLTS efforts. In all seven programs, community leaders played an important role in implementing CLTS (see Section 4.3 for more detail).

The complexity of implementation arrangements depended largely on national government support for CLTS and sanitation, the capacity of different actors to participate in the process, and how long CLTS had been implemented in that country (Figure 4). National government support was analyzed based on the following factors:

- National sanitation policy included CLTS
- National CLTS guidelines had been developed
- National government had a budget for CLTS activities
- Government had a pool of master trainers available
- Local government was required to work on rural sanitation

Where national government support was high and CLTS had been implemented for several years (Nepal, Indonesia, Uganda, and Cambodia), arrangements were more complex. National government was more involved in financing CLTS and training facilitators than in other countries. In general, local government capacity for triggering and follow-up with communities was also stronger in these four countries. Where there was less national government support, Plan International tended to play a more involved role in CLTS (Lao PDR, Niger, Haiti) despite involving local government.

![Figure 4. Factors influencing complexity of implementation arrangements in case study programs](image-url)
Table 3. National sanitation policy, targets, and arrangements in case study countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Main policy or strategy document</th>
<th>National targets for rural sanitation</th>
<th>Ministries responsible for sanitation</th>
</tr>
</thead>
</table>
By 2025: 100% access to improved sanitation  
Ministries responsible for sanitation: Department of Rural Health Care, Ministry of Rural Development |
| Lao       | National Plan of Action for Rural Water Supply Sanitation and Hygiene (2012)                    | By 2015: 60% access to sanitation; 32% for poor populations; 90% households w/latrines using improved facilities; 50% of households practicing handwashing with soap  
Centre for Environmental Health and Water Supply, Ministry of Health |
| Nepal     | Sanitation and Hygiene Master Plan (2011)                                                       | By 2015: 80% toilet coverage  
By 2017: universal toilet coverage  
Ministries responsible for sanitation: Department of Water Supply and Sewerage, Ministry of Federal Affairs and Local Development |
| Indonesia | National Strategy for Community Based Total Sanitation (2008)                                 | By 2014: 100% rural and urban ODF status; increase use of “healthy latrines” to 75%  
By 2015: 56% sanitation coverage  
Ministries responsible for sanitation: Ministry of Health; State Ministry of National Development Planning |
| Uganda    | 10-year Improved Sanitation and Hygiene Promotion Financing Strategy (2006)                     | By 2015: 77% access to improved sanitation  
Ministries responsible for sanitation: Ministry of Water and Environment; Ministry of Health |
2014-2018 Operational Strategy for Hygiene and Basic Sanitation (2014) | By 2015: 25% access to basic sanitation; 10% rural population triggered through CLTS  
By 2018: 50% household latrine coverage;  
By 2018: 50% rural communities ODF  
Ministries responsible for sanitation: Department of Sanitation, Ministry of Water and Sanitation |
| Haiti     | Strategic Guidance Document for Sanitation in Haiti (2015; pending approval)                   | By 2016: 70% access to household sanitation  
By 2022: 90% access to household sanitation  
Ministries responsible for sanitation: National Directorate of Drinking Water and Sanitation; Ministry of Public Health and Population |
## Table 4. Selected characteristics of the national policy environment for CLTS in case study countries

<table>
<thead>
<tr>
<th>Country</th>
<th>Policy acceptance of CLTS</th>
<th>National CLTS working groups</th>
<th>National CLTS guidelines</th>
<th>Public financing for CLTS</th>
<th>Government role in CLTS</th>
<th>Government CLTS trainers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambodia</td>
<td>Mentions CLTS alongside other approaches; allows targeted hardware subsidies</td>
<td>Technical Working Group</td>
<td>None</td>
<td>Allocated primarily for training local government facilitators</td>
<td>Local government facilitates CLTS in some provinces</td>
<td>Yes</td>
</tr>
<tr>
<td>Lao</td>
<td>Mentions CLTS alongside other approaches; allows targeted hardware subsidies</td>
<td>Technical Working Group</td>
<td>In progress</td>
<td>None</td>
<td>Formal arrangements not described for CLTS</td>
<td>Yes; limited capacity</td>
</tr>
<tr>
<td>Nepal</td>
<td>Based on principles of CLTS; allows locally designated hardware subsidies</td>
<td>National Sanitation and Hygiene Steering and Coordination Committees</td>
<td>Yes</td>
<td>Allocated to district government for training, triggering, and post-triggering</td>
<td>Local government mandated to implement CLTS nationwide</td>
<td>Yes; limited capacity</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Based on principles of CLTS; allows hardware subsidies for public facilities</td>
<td>Working/Networking Groups for Water and Environmental Sanitation</td>
<td>Yes</td>
<td>Allocated to provincial/district government for training, salaries, per diem</td>
<td>Local government mandated to implement CLTS nationwide</td>
<td>Yes</td>
</tr>
<tr>
<td>Uganda</td>
<td>Mentions CLTS alongside other no-subsidy approaches</td>
<td>National Sanitation Working Group</td>
<td>Yes</td>
<td>Allocated to district government for salaries, travel, per diem</td>
<td>Local government facilitates CLTS in some districts</td>
<td>Yes</td>
</tr>
<tr>
<td>Niger</td>
<td>Mentions CLTS alongside other approaches; allows hardware subsidies</td>
<td>“Cluster WASH”</td>
<td>Yes</td>
<td>None</td>
<td>Formal arrangements not described for CLTS</td>
<td>No</td>
</tr>
<tr>
<td>Haiti</td>
<td>Welcomes evidence-based, no-subsidy approaches</td>
<td>WASH cluster</td>
<td>In progress</td>
<td>None</td>
<td>Formal arrangements not described for CLTS</td>
<td>No</td>
</tr>
</tbody>
</table>

Note: This table reflects national policy characteristics as of June 2015
Table 5. Actors implicated in different stages of CLTS across case study programs

<table>
<thead>
<tr>
<th>Planning / Pre-Triggering:</th>
<th>National government</th>
<th>Plan International</th>
<th>Local government*</th>
<th>Local NGOs</th>
<th>Village volunteers**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financing</td>
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<td><img src="image4" alt="Flag" /></td>
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<tr>
<td>Training</td>
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<td><img src="image17" alt="Flag" /></td>
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<td><img src="image23" alt="Flag" /></td>
<td><img src="image24" alt="Flag" /></td>
<td><img src="image25" alt="Flag" /></td>
</tr>
<tr>
<td>Community selection</td>
<td><img src="image26" alt="Flag" /></td>
<td><img src="image27" alt="Flag" /></td>
<td><img src="image28" alt="Flag" /></td>
<td><img src="image29" alt="Flag" /></td>
<td><img src="image30" alt="Flag" /></td>
</tr>
<tr>
<td>(including pre-triggering</td>
<td><img src="image31" alt="Flag" /></td>
<td><img src="image32" alt="Flag" /></td>
<td><img src="image33" alt="Flag" /></td>
<td><img src="image34" alt="Flag" /></td>
<td><img src="image35" alt="Flag" /></td>
</tr>
<tr>
<td>visits and baseline</td>
<td><img src="image36" alt="Flag" /></td>
<td><img src="image37" alt="Flag" /></td>
<td><img src="image38" alt="Flag" /></td>
<td><img src="image39" alt="Flag" /></td>
<td><img src="image40" alt="Flag" /></td>
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<tr>
<td>surveys)</td>
<td><img src="image41" alt="Flag" /></td>
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<td><img src="image44" alt="Flag" /></td>
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</tr>
<tr>
<td>Triggering:</td>
<td><img src="image46" alt="Flag" /></td>
<td><img src="image47" alt="Flag" /></td>
<td><img src="image48" alt="Flag" /></td>
<td><img src="image49" alt="Flag" /></td>
<td><img src="image50" alt="Flag" /></td>
</tr>
<tr>
<td>Facilitation in community</td>
<td><img src="image51" alt="Flag" /></td>
<td><img src="image52" alt="Flag" /></td>
<td><img src="image53" alt="Flag" /></td>
<td><img src="image54" alt="Flag" /></td>
<td><img src="image55" alt="Flag" /></td>
</tr>
<tr>
<td>meetings</td>
<td><img src="image56" alt="Flag" /></td>
<td><img src="image57" alt="Flag" /></td>
<td><img src="image58" alt="Flag" /></td>
<td><img src="image59" alt="Flag" /></td>
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<tr>
<td></td>
<td><img src="image61" alt="Flag" /></td>
<td><img src="image62" alt="Flag" /></td>
<td><img src="image63" alt="Flag" /></td>
<td><img src="image64" alt="Flag" /></td>
<td><img src="image65" alt="Flag" /></td>
</tr>
</tbody>
</table>

Key:
- Cambodia
- Lao PDR
- Nepal
- Indonesia
- Uganda
- Niger
- Haiti
<table>
<thead>
<tr>
<th>Post-Triggering:</th>
<th>National government</th>
<th>Plan International</th>
<th>Local government</th>
<th>Local NGOs</th>
<th>Village volunteers**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow-up / monitoring visits</td>
<td>🇵🇭Cambodia</td>
<td>🇱🇦Lao PDR</td>
<td>🇳🇵Nepal</td>
<td>🇮🇩Indonesia</td>
<td>🇺🇬Uganda</td>
</tr>
<tr>
<td>Technical support (training community leaders, training masons, improving access to supply chain)</td>
<td>🇵🇭Cambodia</td>
<td>🇱🇦Lao PDR</td>
<td>🇳🇵Nepal</td>
<td>🇮🇩Indonesia</td>
<td>🇺🇬Uganda</td>
</tr>
<tr>
<td>ODF verification and certification</td>
<td>🇵🇭Cambodia</td>
<td>🇱🇦Lao PDR</td>
<td>🇳🇵Nepal</td>
<td>🇮🇩Indonesia</td>
<td>🇺🇬Uganda</td>
</tr>
</tbody>
</table>

* Provincial, district, or village-level government

** Can include village facilitators, Village Health Teams, natural leaders, religious leaders, and other leaders.

*** The Government of Nepal conducts “sector triggering” activities for non-community stakeholders as part of their ODF campaign.
### Table 6. Summary of themes, findings, and recommendations

<table>
<thead>
<tr>
<th>Theme</th>
<th>Finding</th>
<th>Recommendations for CLTS Practitioners</th>
</tr>
</thead>
</table>
| Role of CLTS                  | CLTS was perceived as a universally applicable approach in rural communities, even though outcomes varied depending on community characteristics.                                                              | • Consider CLTS as one component of a sanitation strategy.  
• Target CLTS to communities that will be more receptive to the message.  
• Allocate resources to test other approaches where CLTS is less appropriate.                                                                                                                                                                                                                      |
| Local government capacity     | Local government, in five of the seven case studies, had insufficient resources and motivation to take ownership of CLTS.                                                                                                                                   | • Strengthen local government capacity through training, mentorship, and targeted technical support.  
• Engage with local NGOs to trigger communities alongside local government.  
• Advocate for increased national government investment in CLTS for staff, finances, and resources in local government.                                                                                                                                                                           |
| Role of village-level actors  | A variety of village volunteers were engaged in CLTS, but they needed considerable support from Plan International and local government.                                                                                                                            | • Ensure that unfair burden is not placed on volunteers.  
• Allocate sufficient resources for training, financial and in-kind support, recognition, and exchange visits to sustain volunteer motivation.                                                                                                                                                                        |
| Adaptations to triggering     | Triggering techniques had been adapted in all seven case studies, but were not always designed with the aim of improving outcomes.                                                                                                                                | • Systematically identify adaptations to CLTS in programs.  
• Critically analyze whether adaptations are a result of community context or a result of convenience or logistical constraints.                                                                                                                                                                                  |
| Sanctions                     | Most sanctions were enacted by village or district government.                                                                                                                                                                                                     | • Carefully consider the types of sanctions that are actively encouraged or passively condoned, who enforces sanctions, and how they are enforced.  
• Sanctions need to be introduced at the right time, in the right manner, and target the right people to be effective.                                                                                                                                                                                      |
| Hardware supply and financing | Supply and financing of sanitation hardware was an important concern, with poor quality latrines affecting sustainability of outcomes.                                                                                                                           | • Identify complementary approaches to CLTS to increase sanitation access.  
• Where government or NGO subsidies are present, identify ways to target subsidies to ensure that they enhance sanitation progress.                                                                                                                                                                           |
| Monitoring outcomes           | Monitoring of CLTS varied widely across programs, with different in indicators of success, definitions, and verification guidelines.                                                                                                                            | • Incorporate baseline data collection into pre-triggering community visits.  
• Routinely collect household-level indicators to measure incremental progress rather than focusing only on ODF, which is a binary indicator.                                                                                                                                                              |
4. Thematic findings from country case studies

This section presents findings and implications categorized under seven main themes that emerged from interviews with policymakers, practitioners, and community leaders. A summary of themes, findings, and related recommendations can be found in Table 6.

4.1. Role of CLTS in rural sanitation and hygiene

CLTS was perceived as a universally applicable approach in rural communities.

Across the seven LS case studies, most CLTS practitioners and several policymakers believed that CLTS could be implemented in all rural settings (illustrative quotes in Box 2). For example, practitioners in Niger felt that CLTS raises awareness about open defecation and is not only a means to achieve universal household latrine coverage, and is therefore relevant everywhere. Only a few respondents in each country challenged the notion of CLTS as universally relevant, including a policymaker from Haiti and an NGO facilitator from Nepal (Box 3); these respondents believed in the need for alternative strategies in settings where CLTS had not worked.

However, this conviction in CLTS meant that even in challenging environments, alternatives to CLTS were less likely to be considered. For example, in Nepal, where CLTS was the primary rural sanitation approach used nationwide, Plan International practitioners repeatedly referred to slow progress in the Terai (plains) districts as a key challenge, yet had not attempted any other approach there. In Haiti, Niger, and Cambodia, practitioners suggested that even if triggering does not generate enthusiastic and positive responses from communities, the solution was to have more dedicated follow-up visits rather than reconsidering the appropriateness of the approach itself. These perspectives are likely to be a reflection of the training given to practitioners, as the CLTS Handbook3 emphasizes that “challenging conditions are simply what they are called – challenging. The challenges can be confronted and overcome” (Kar 2008).

Many respondents believed that CLTS could at least be a “starting point” to generate demand, even in settings where practitioners themselves felt it was unlikely to succeed in ending open defecation by itself. Although this perspective still suggests that CLTS would be relevant everywhere, it also indicates that some practitioners recognized the need to combine CLTS with other approaches.

Practitioners’ perceptions of CLTS are important because they determine how the approach is implemented, specifically the manner in which communities are selected for triggering. For example, practitioners listed a number of characteristics of communities that are more receptive to CLTS, such as high presence of open defecation, absence of other NGO WaSH projects, no history of subsidies, …

3 The CLTS Handbook is the basis for guidelines used across all seven countries, and is therefore referenced multiple times in this report.
and strong village leadership (Figure 5). However, these characteristics were used as criteria for selecting communities only in smaller-scale CLTS programs, such as in Lao PDR and Niger, and to a lesser extent in larger programs such as Cambodia and Uganda. In these programs, selection criteria were often applied at the district level, and all communities within target districts were triggered; in Niger, specific communities were targeted. Haiti was an exception, where despite being a smaller-scale program, practitioners were not able to appropriately target communities as they were constrained by donor requirements to work in communities close to the school WaSH project.

As the number of triggered communities in a CLTS program increased, targeting became less relevant because practitioners believed CLTS to be universally applicable. The perception was that once CLTS has been sufficiently pilot tested, its scope could be expanded to a larger scale. In Nepal and Indonesia, the national strategy contained a fundamental assumption that CLTS is universal and nationally applicable, so the concept of targeting CLTS had indeed become irrelevant.

“CLTS is more difficult in forest areas...but for me, I don't give up. I will try to work with my colleagues over there to introduce it.”
- Plan International Cambodia staff person

“Based on my observation of our working area, even some villages where we have slow progress, at least when our CLTS work comes, it has a little bit of progress. Better than not going there.”
- Plan International Laos staff person

“To me, the main constraint is not in the method, it’s rather the doubt that exists at all levels in the system. [...] And if in the whole system there is doubt, since the community depends on how you present the information, we cannot take away this doubt from the community itself.”
- Plan International Haiti staff person

“For me I think it's possible in every community. There's no discrimination that CLTS should not be implemented in any area... Maybe a context where there's a subsidy already there, then maybe [laughs]... It's not really impossible, but maybe it's hard. But for me, in terms of possibility, I think there's a possibility.”
- Government official, Cambodia

“I want to assure you that I have not seen that CLTS approach is not the right approach in a community. Instead it is giving wide coverage. I would suggest that CLTS extend to other places that it has not been.”
- Village Health Team facilitator, Uganda

Box 2. Illustrative quotes on perception of CLTS as universal

“Those that are pretending to sleep, no matter how hard we try to wake them up, they will never wake up. So no matter how much [triggering] we do, how much training we give them, we can't wake them up. So we need a new approach.”
- NGO facilitator in Nepal

“When you do something and it fails, [...] you cannot continue doing the same thing and hope that you get success.”
- National government official in Haiti

Box 3. Illustrative quotes on limits of CLTS.
Figure 5. Characteristics of communities receptive to CLTS in case study programs

Note: This figure is meant to illustrate the main characteristics mentioned by more than one participant without prompting by researchers. Therefore, it reflects what participants perceived to be most important at the time of the interview. The small sample size does not lend itself to weighting the importance of individual factors. Some of these characteristics were contradictory—such as easily accessible communities versus remote communities—reflecting that CLTS is context-specific and implemented differently across programs.

Implications

Some practitioners did recognize that alternative or complementary strategies to CLTS may be needed, but the more prevalent belief in the universal relevance of CLTS seems to have overshadowed the need for targeting appropriate communities with this approach and seeking alternative sanitation strategies for less receptive communities.

The widespread application of CLTS may help explain slow progress in several programs. By not targeting communities, it is likely that villages not appropriate for CLTS were triggered, leading to slow increases in latrine coverage and low ODF attainment. Forthcoming publications from the TCAS project in Ghana and Ethiopia indicate some necessary conditions for CLTS success in those contexts, such as high baseline open defecation and social cohesion. LS case studies also revealed that in communities with a long history of latrine subsidies, many households were expecting and willing to wait for external support in the form of free or subsidized water-sealed or cement latrines rather than building dry-pit latrines on their own, regardless of the intensity of follow-up by CLTS practitioners. This was particularly true in Haiti, Lao PDR, and Cambodia. In Niger, leaders in all communities visited for this study cited water and food security as more pressing concerns than sanitation; triggering such communities without first addressing their priorities may partially explain poor progress as well. Finally, slippage—communities reverting to open defecation due to latrine collapse, inability to afford high-quality latrines, or unwillingness to change behavior—was cited as a primary challenge to sustainability of CLTS outcomes. It is possible that such communities may not have been appropriate for CLTS in the first place, as necessary supply-side conditions were absent.
4.2. Local government role and capacity to lead CLTS

Local government, in five of the seven countries, had insufficient resources or motivation to take ownership of CLTS.

It is widely acknowledged that local government support and capacity are vital for scaling up social and public health programs. Most external support agencies working in developing countries aim to hand over leadership to local institutions, but these institutions must have the will and ability to sustain activities once the INGOs have left.

In all LS case studies except Haiti, Plan International worked closely with local government actors, even when local government was not mandated by the national government to be involved in CLTS. As summarized in Table 7, local government involvement ranged from leadership in CLTS (Nepal) to requiring considerable assistance from Plan International (Lao PDR) to no involvement at all (Haiti).

In Haiti, the local government structure as it pertained to WaSH was still being developed, and thus Plan International Haiti had been unable to engage meaningfully with them.

Table 7. Summary of local government roles in case study programs

<table>
<thead>
<tr>
<th>Country</th>
<th>Role of local government</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambodia</td>
<td>Activities delegated to Provincial Department of Rural Development (PDRD). With financial and technical support from Plan International Cambodia, PDRD helped select communities, led triggering activities, conducted follow-up visits, and helped verify ODF status in communities.</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>Plan International Laos formed District WaSH Teams (DWTs), comprising district government officials from departments of education, health, women's union, youth union, and rural development. DWTs worked with Plan International Laos to select communities, but were expected to lead triggering, follow-up, and ODF verification activities under supervision from Plan International Laos, who funded all activities.</td>
</tr>
<tr>
<td>Indonesia</td>
<td>With financial and technical support from Plan International Indonesia, district and sub-district government were expected to lead the CLTS process. Sub-district CLTS teams—comprising members of government offices, sanitarians and midwives—worked with Plan International Indonesia and village volunteers to trigger communities and conduct follow-up visits. Local government was responsible for verifying and certifying communities as ODF.</td>
</tr>
<tr>
<td>Nepal</td>
<td>District and Village Development Committee (VDC) government led the CLTS process, with financial and technical support from Plan International Nepal. District WaSH Committees were responsible for selecting communities for Plan International Nepal. VDC WaSH Committees worked with Plan International Nepal and their partner INGOs to trigger communities, but were expected to lead follow-up and ODF verification and certification activities.</td>
</tr>
<tr>
<td>Uganda</td>
<td>District and sub-county health departments conducted CLTS activities with financial and technical support from Plan International Uganda. Volunteer Village Health Teams (VHTs) supported sub-county health assistants in triggering activities and led follow-up activities in communities. Local government was responsible for verifying and certifying ODF status.</td>
</tr>
<tr>
<td>Niger</td>
<td>Plan International Niger formed Technical Services Committees (TSCs), comprising départements/district officials from water, health, education, civil engineering, and community development sectors. TSCs were responsible for working with Plan International Niger’s INGO partners to help trigger communities, and to lead the ODF verification and certification process.</td>
</tr>
<tr>
<td>Haiti</td>
<td>Local government did not play a significant role in CLTS activities.</td>
</tr>
</tbody>
</table>
In all seven case studies, government and NGO respondents cited insufficient local government capacity as a key challenge to increasing the scale of activities. Capacity in this case can be defined as factors that would allow the local government to take an active role in CLTS programming, which include:

- legal responsibility for local government to provide sanitation services;
- local government budget for CLTS;
- sufficient staff time available for sanitation;
- access to transportation to routinely follow-up in remote areas; and
- experience and skills for facilitating or managing CLTS on their own.

Using these parameters, local government capacity appeared to be largely insufficient to take full ownership of CLTS, except in Nepal and Indonesia.

Where local government was strongly involved in CLTS activities, the following factors appeared to enable progress: strong national government support; local government authority and responsibility to implement sanitation/behavior change activities; local government budget for sanitation and CLTS; sufficient numbers of local government staff available for CLTS activities; staff motivation to foster sanitation behavior change; and staff who were generally well-trained in CLTS techniques.

Where local government was not highly involved, analysis of interviews revealed that the aforementioned factors were absent or insufficient. However, because local government capacity was related to national government support for CLTS (Figure 6), modifying the political environment may have a trickle-down effect. In Nepal, Indonesia, Uganda, and Cambodia, where there was strong national government support for CLTS, activities were increasingly led by local government, and there was less concern expressed by Plan International staff regarding local government capacity to partake in CLTS compared to other LS countries. These were also the countries where CLTS had been implemented the longest, and where Plan International played a more influential role at the national level.

For example, in Nepal, the government was in charge of all sanitation activities, creating a Master Plan built on the basic principles of CLTS; this obliged local government to lead CLTS independent of NGO activity. Decentralized planning, clear delineation of roles and responsibilities, and a strong local government structure allowed district government to decide where NGOs would work. This has allowed CLTS and total sanitation activities to occur at a large scale. In Indonesia, Uganda, and Cambodia, Plan International played a more important implementation role than in Nepal in the face of slightly weaker local government capacity—the focus here was on strengthening capacity through training and technical support.

On the other hand, in Lao PDR and Niger, Plan International has had to create local government structures for CLTS (DWTs in Lao PDR and TSCs in Niger) in order to involve them and build their capacity. Local government staff here were particularly overburdened, and relied on NGOs for additional financial and technical support.
**Figure 6. Relationship between national government support and local government capacity for CLTS**

<table>
<thead>
<tr>
<th>National government support for CLTS</th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Haiti</td>
<td>Lao PDR, Niger</td>
<td></td>
</tr>
<tr>
<td>Medium</td>
<td></td>
<td>Cambodia</td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>Nepal, Indonesia</td>
<td>Uganda</td>
<td></td>
</tr>
</tbody>
</table>

High/High: government leadership of CLTS
Low/Low: INGO leadership of CLTS
Medium/Low: government recognizes CLTS as one of several approaches for rural sanitation, but local government lacks capacity to lead activities on its own.

**Implications**

Slow progress in some countries may be partly explained by local government implementing CLTS with limited capacity, including facilitation skills, resources, and motivation for routine follow-up activities. Where local government capacity was insufficient to lead CLTS, NGOs continued to play a dominant role in all stages of implementation until local government would be able to take on a leadership role. As local government capacity improves, NGOs in turn can focus on national advocacy efforts, given the positive relationship between national government support for CLTS and local government capacity.

**4.3. Engagement with village-level actors in CLTS**

A variety of village volunteers were engaged in CLTS, but they needed considerable support from Plan International and local government.

In public health programs, engagement with village-level volunteers has generally been viewed as a low-cost and sustainable solution for program implementation. As CLTS is a “community-led” process, a crucial component of the strategy is to involve community leaders to take charge of their own sanitation situation. The CLTS Handbook mainly refers to the identification of “natural leaders”, those who emerge from the triggering process. They are not necessarily existing community leaders, but have been particularly inspired by sanitation messages.

Plan International CLTS programs in Uganda, Niger, and Haiti had the clearest examples of typical “natural leaders”. These leaders were often formed into CLTS Committees and trained on the CLTS message so they could continue to encourage their community members to end open defecation. Plan International Niger also organized exchange visits between natural leaders from triggered
communities, where they heard about progress in other communities and shared lessons learned. Natural leaders described this forum as a powerful motivational tool for communities.

In other CLTS programs, those labeled as “natural leaders” were often existing community leaders, such as appointed village leaders, religious leaders, or heads of social organizations. Plan International and local government mobilized these village volunteers, recognizing the important role they can play in collectively changing behavior and social norms in their communities.

These various village volunteers were implicated in different phases of CLTS (Table 8). In Nepal and Haiti, volunteers were involved in the pre-triggering stage itself. In Nepal, community triggerers were identified by VDC WaSH Committees and often helped capture baseline assessments of villages. In Haiti, Plan International created community hygiene clubs as part of routine hygiene promotion work; these club members helped identify households without latrines and invited them to triggering events.

In all case studies except Lao PDR and Niger, volunteers were also implicated in triggering activities. In Indonesia, Nepal, and Uganda, village volunteers were recruited as facilitators or triggerers. While the intent was for these volunteers to ultimately lead triggering events, they were not yet able to do so and were supported local government or Plan International facilitators.

The heaviest involvement of village volunteers occurred after communities had been triggered. For example, in Nepal, community triggerers were responsible for door-to-door campaigning and follow-up to spread sanitation behavior change messages to remaining members of their wards who may not have attended a triggering event. Triggerers reported using a combination of shaming and pride-inducing techniques to convince their fellow community members to build toilets. In all seven case studies, there were varying degrees of financial support provided to village-level facilitators, including per-diem allowances or rewards for accomplishing milestones.

**Implications**

Village volunteers increase community-level engagement, and can also lower the cost burden for Plan International and local government since fewer follow-up visits may be required. However, costs are then transferred to volunteers, who now add sanitation monitoring activities to their regular professions as farmers, teachers, drivers, and small business owners. Public health literature is increasingly documenting the burden placed on village volunteers for a variety of health education activities, not just in sanitation. A 2008 WHO document on task-shifting in health workforce teams cautions that, “Countries should recognize that essential health services cannot be provided by people working on a voluntary basis if they are to be sustainable. While volunteers can make a valuable contribution on a short term or part time basis, trained health workers who are providing essential health services, including community health workers, should receive adequate wages and/or other appropriate and commensurate incentives” (WHO 2008). Plan International does work with a mix of local government officials, paid health workers, and volunteers in most CLTS and public health programs; however, where volunteer engagement is high, it remains pertinent to question how well these roles are balanced.
Table 8. Involvement of village volunteers in different stages of CLTS in case study programs

<table>
<thead>
<tr>
<th>Pre-triggering (baseline assessment)</th>
<th>Cambodia</th>
<th>Lao PDR</th>
<th>Indonesia</th>
<th>Nepal</th>
<th>Uganda</th>
<th>Niger</th>
<th>Haiti</th>
</tr>
</thead>
<tbody>
<tr>
<td>Triggering (community meetings)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Village heads</td>
<td>Community triggerers</td>
<td>Community triggerers</td>
<td>Village Health Teams</td>
<td>Community hygiene clubs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Natural leaders (pre-selected)</td>
<td></td>
<td></td>
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<tr>
<td>Village facilitators</td>
<td>Community triggerers</td>
<td>Village Health Teams</td>
<td>Community hygiene clubs</td>
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<tr>
<td>Village heads</td>
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</tr>
<tr>
<td>Natural leaders (existing and emerging)</td>
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<tr>
<td>Village heads</td>
<td>Community triggerers</td>
<td>Village Health Teams</td>
<td>Community hygiene clubs</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Natural leaders (monks)</td>
<td></td>
<td></td>
<td>Community triggerers</td>
<td>Village Health Teams</td>
<td>Community hygiene clubs</td>
<td></td>
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<tr>
<td>Religious leaders (existing and emerging)</td>
<td></td>
<td></td>
<td>Community triggerers</td>
<td>Village Health Teams</td>
<td>Community hygiene clubs</td>
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<tr>
<td>Village heads</td>
<td></td>
<td></td>
<td>Community triggerers</td>
<td>Village Health Teams</td>
<td>Community hygiene clubs</td>
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<tr>
<td>Natural leaders (emerging)</td>
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<td></td>
<td>Community triggerers</td>
<td>Village Health Teams</td>
<td>Community hygiene clubs</td>
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<td>Community hygiene clubs</td>
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<tr>
<td>Religious leaders (emerging)</td>
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<td>Community triggerers</td>
<td>Village Health Teams</td>
<td>Community hygiene clubs</td>
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<td>Community hygiene clubs</td>
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<tr>
<td>Natural leaders (imams)</td>
<td></td>
<td></td>
<td>Community triggerers</td>
<td>Village Health Teams</td>
<td>Community hygiene clubs</td>
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<tr>
<td>Religious leaders (imams)</td>
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<tr>
<td>Natural leaders (emerging and emerging)</td>
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<td>Community triggerers</td>
<td>Village Health Teams</td>
<td>Community hygiene clubs</td>
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<tr>
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<td></td>
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</tr>
</tbody>
</table>

ODF verification and certification

CBOs, media, political parties | Village Health Teams | Community radio
In LS case studies, volunteers were for the most part highly motivated to help their communities. However, challenges in maintaining this motivation in the long-run could hamper the sustainability of post-triggering outcomes, especially after NGO grants have ended. Similar to findings from the LS, researchers in Zambia, Tanzania, and India have also found that material support has been a significant motivator for community education and health volunteers, in addition to recognition and regular visits by program staff (Singh 2015, Yagi 2006, Mpembeni 2015). As with the LS, other researchers have also found that educational opportunities and exchange visits have helped motivate volunteers to continue their work (Topp 2015). Furthermore, the TCAS study in Ghana has found that training natural leaders can have a significant impact on CLTS outcomes. Maintaining volunteer motivation through these efforts does increase the time and financial costs for NGOs and local government, necessitating a fine balance in any development program between volunteer engagement and leadership by practitioners and government.

4.4. Adaptations of triggering techniques

Plan International used a variety of approaches to trigger communities to change sanitation behavior. The CLTS Handbook, which is the basis for guidelines used across all seven countries, notes that triggering techniques can and should be adapted to the local context. This means that there is no standard version of CLTS. Five triggering events were observed in this study; this section combines observations from these meetings and interviews with practitioners and community leaders to identify the main findings.

Across the seven CLTS programs, the most commonly cited triggering tools were the transect walk/“walk of shame,” village mapping, shit calculation, water-feces demonstration, and analysis of medical costs. However, several of these triggering tools did not appear to be used routinely in all programs. For example, in Cambodia, some community-based facilitators recalled that one step the practitioners sometimes omitted was the transect walk—arguably an essential component of triggering—because people sometimes “take this opportunity to sneak out and leave the meeting.” There was also some indication from interviews that in Cambodia and Lao PDR, local government facilitators omitted certain steps, such as the water-feces demonstration, because they themselves were too embarrassed to lead these activities.

The manner in which facilitators trigger communities can strongly influence CLTS outcomes. In Plan International’s programs in Cambodia and Lao PDR, local government facilitators also hesitated to use strong shaming techniques, reportedly due to cultural reasons. Triggering in practice appeared to be more lecture-based than participatory. CLTS facilitators are expected to help communities analyze their own situation, rather than take on the role of an educator (Kar et al. 2008). However, because local government officials were generally not familiar with participatory methods of community mobilization, these qualities were not necessarily evident in all facilitators despite being trained in CLTS. One Plan International Laos staff member admitted that, “In some cases, the people who were chosen were perhaps not the best for the job.”
Triggering techniques were also adapted in Niger, where interviews suggested that facilitators emphasized the health benefits of ending open defecation, rather than techniques that are meant to incite shame and disgust. Community-level interviews strongly indicated that before CLTS, people were not as aware of the harms of open defecation, so focusing on health benefits could indeed have been more effective than other methods.

In Nepal and Haiti, where interviews with community leaders indicated that rural communities were largely aware of the harms of open defecation, facilitators tended to follow one of two approaches to triggering. In Haiti, where CLTS was implemented most recently of the seven countries, the facilitation process occurred almost exactly as prescribed in international guidelines. When a cup with feces was placed in the middle of the meeting room, all attendees expressed disgust, and several left the room, remarking that it was “disrespectful.” However, these people later returned to the meeting room without prompting from facilitators and participated for the remainder of the triggering event. On the other hand, in two triggering events in Nepal, LNGO facilitators insisted strongly on community members’ continued participation. For example, if some community members were too disgusted to stay in place during the transect walk or the water-feces demonstration, some LNGO facilitators physically pressed them to stay at the event. The observations in Nepal highlight a manner in which local facilitators had adapted triggering techniques, and may not be indicative of Plan International Nepal’s policy as a whole. However, the behavior of LNGO facilitators, who were being observed by Plan International staff, reveals the importance of routinely reviewing decentralized facilitation arrangements to ensure that the privacy and comfort of community members is respected during these events.

**Implications**

Adaptations in triggering techniques indicate that Plan International does not follow a set template for CLTS and, per CLTS guidelines, recognizes the need to modify the approach to suit different contexts. However, all adaptations are not equal. Context-specific adaptations that emerge from community-level observations and experiences can be encouraged, such as when programs recognize the need to adjust triggering techniques to fit the baseline awareness of health effects of open defecation.

On the other hand, when facilitators are excessively persistent, careful review of training techniques may be necessary to ensure that community members’ rights are respected. When triggering techniques have been adapted out of top-down convenience because facilitators do not have the skills for participatory engagement or are too embarrassed to lead certain activities, the result may look more like sanitation or hygiene education rather than CLTS. Such adaptations may compromise the CLTS approach itself and slow progress in communities, and may need to be modified through improved training and selection of facilitators.

The context-specific nature of CLTS makes it challenging to compare results from different programs, as facilitation practices can vary substantially. However, in order to improve understanding of CLTS effectiveness, it is important to ensure that sanitation outcomes in communities are attributed to the actual approach that has been implemented.
4.5. Role of sanctions and enforcement in triggered communities

Most sanctions were enacted by village or district government.

In the CLTS Handbook, “community-innovated sanctions” against open defecation are encouraged and listed as a key indicator for monitoring progress in communities. The guidelines suggest that the presence of sanctions against individuals indicates “social sustainability” of CLTS, presumably because it indicates that communities have collectively decided that open defecation will not be tolerated (Kar 2008).

In the LS case studies, truly community-developed sanctions were only reported in a few instances, in Uganda and Lao PDR (Table 9). In Uganda, national ODF verification guidelines require the presence of village by-laws for communities to be certified as ODF. CLTS Committees or task forces were responsible for determining these by-laws, which involved fines or at least the threat of a fine. It was unclear from interviews at which point by-laws were introduced in the CLTS process and whether communities were encouraged by local government or Plan International Uganda to create them.

In Lao PDR, only one community visited in this study mentioned community sanctions, conceived by the community chief. He explained, “I made this rule [...] in writing. And then I got the signature at the district level, so everyone has to follow it. [...] If you don't follow the rule, you have to pay 50,000 Kip [...] and if you still don't do it, you have to return the materials that you received, and also you will get a fine of 100,000 Kip.” Leaders in this community said that they developed these rules themselves, and there was no instance of external influence by others to include such sanctions. Some Plan International staff questioned the appropriateness of such sanctions, however. For example, a Plan International Laos staff member posed the question: “How much is having the rules [...] in the first place an indicator that the CLTS triggering was not very effective?” This respondent implied that sanctions would not be necessary if triggering had worked.

It was more common to find sanctions developed by village or district government, such as in Indonesia and Nepal (Table 9). In Indonesia, one village facilitator admitted that the village government did “slightly force” people: “So for example, we have some donations from the government, like rice. If they still do open defecation, we will stop sharing the rice with them. We just terrorized them with words. [...] In fact it’s not real. It won’t be done. [...] Just fake words.” A Plan International Indonesia staff member also noted that in some villages—although it was not part of the project design—they persuaded the local government to withhold social insurance health cards to families without latrines. This practice appeared to be more widespread in Nepal, where open defecation is now seen as a “social crime,” and some districts were officially recommending the distribution of sanitation cards to VDC and municipality residents, with penalties for non-compliance (“First cleanliness conference” 2014). All six VDCs visited in this study reported issuing these color-coded sanitation cards—or mentioned plans to do so—as a means of compelling households to build toilets. Those without improved toilets were threatened with being cut off from essential services they are entitled to as residents of a VDC, such as declaration of citizenship, birth certificates, and allowances. In interviews with local government officials and several NGO facilitators, this form of
sanction was viewed as highly effective. One LNGO facilitator noted that in their ODF VDCs, progress only occurred once the VDC threatened to stop providing services to those without toilets. In another district, an LNGO facilitator felt that enforcement “promotes and strengthens CLTS.” This strategy was still informal in nature, as there was no law or guideline authorizing VDCs to withhold services based on sanitation status.

In Haiti and Uganda, the national government also aimed to strongly enforce existing laws against open defecation. Both countries have a history of strong dictatorships, under which laws against open defecation and laws mandating latrine construction were strictly enforced through rural police. With the advent of democratic rule, enforcement of these laws became more lax, especially in rural areas. In interviews, representatives from both governments spoke of wanting to bring back these laws through community health agents and sanitation officers, rather than police. A national government official in Uganda felt strongly that laws are necessary for sanitation, “much as Plan people might not want it. [...] In order to fit the community and put people in line, the law should be applied, especially for people who seem to be resistant.”

Table 9. Laws and sanctions against open defecation in case study countries

<table>
<thead>
<tr>
<th>Country</th>
<th>National anti-open defecation law for rural sanitation?</th>
<th>Community-level sanctions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambodia</td>
<td>No</td>
<td>Not reported.</td>
</tr>
<tr>
<td>Lao</td>
<td>No</td>
<td>Reported, but unclear whether widespread.</td>
</tr>
<tr>
<td>Nepal</td>
<td>Open defecation recognized as a social crime, but not as a law. VDC sanctions widespread. Reported, and indicated as widespread.</td>
<td></td>
</tr>
<tr>
<td>Indonesia</td>
<td>No</td>
<td>Reported, but unclear whether widespread.</td>
</tr>
<tr>
<td>Uganda</td>
<td>1964 Public Health Act makes it an offense to not have a household latrine. Reported as an indicator for ODF verification.</td>
<td></td>
</tr>
<tr>
<td>Niger</td>
<td>No</td>
<td>Not reported.</td>
</tr>
<tr>
<td>Haiti</td>
<td>1919 law requires households and commercial establishments to have latrines. Not reported.</td>
<td></td>
</tr>
</tbody>
</table>

Implications
Sanctions can be a key component in creating and enforcing social norms, and public health programs have effectively used sanctions to achieve their outcomes, with smoking and seat belt laws heralded as classic examples. Most industrialized countries also have laws banning open defecation. Therefore, the question is not whether the law has a role to play in sanitation, but rather which form is appropriate, at what stage it is introduced, how it is enforced, and how effective it is at ending open defecation and improving safe and equitable sanitation.

In the LS case studies, most forms of sanctions identified were not developed by the community themselves, but rather by local government. Such sanctions may lead to an increase in latrine
construction, but it is unclear how they influence long-term changes in behavior and social norms. They may also inadvertently harm the most vulnerable sections of society who cannot afford to build latrines. For example, one study on sanitation in India found that the targets of “shaming, fines, and withholding of benefits... were always those already on the furthest margins of society, e.g. SCs [scheduled castes], outsiders, and the poorest” (O’Reilly 2014).

The literature on enforcement suggests that raising awareness about behavior change and providing people with options to act on the change that is proposed should precede the use of law. According to Rothschild, “Law will be appropriate when the preexisting self-interest of the target [group] cannot be overcome with additional rewards through exchange” (Rothschild 1999). Therefore, enforcement may be appropriate when the majority of a community decides to build latrines and stop open defecation, but some remain who are not interested. It would not be appropriate in instances where people are unable to change their behavior because they cannot afford to build durable latrines, do not have space to build latrines, or perceive other challenges not related to lack of motivation.

4.6. Supply and financing of sanitation hardware and technical support

Supply and financing of sanitation hardware was an important concern.

In all LS case studies, practitioners, policymakers, and community leaders cited the poor quality of latrines built as a result of CLTS as the primary challenge for ensuring sustainable use of sanitation; this finding was supported by a global literature review conducted as part of this grant (Venkataramanan 2012). A forthcoming publication from the TCAS project in Ethiopia also indicates that where households cannot afford to purchase materials, or there are no construction materials or latrine components available on the market, low-durability latrines are built after triggering. According to the CLTS Handbook, “It is fundamental that CLTS involves no individual household hardware subsidy and does not prescribe latrine models” (Kar 2008). As households are encouraged to build latrines with locally available materials, the resulting latrines are sometimes unable to withstand tough environmental conditions, such as floods, poor soil conditions, or termites. A study on ODF sustainability in Ethiopia, Kenya, Uganda, and Sierra Leone found that financial constraints, lack of support, maintenance and repairs, and quality of initial construction were all barriers to maintaining ODF status (Tyndale-Biscoe 2013).

Access

In the seven LS case studies, triggered households constructed a variety of latrine types, but there was a strong preference for water-sealed latrines or durable latrines made of cement.

In the four Asian country case studies, communities tended to prefer water-sealed, pour-flush latrines that could withstand severe seasonal flooding, possibly also as a result of exposure to such latrines being subsidized by the government or NGOs. In Plan International’s program areas in Indonesia and Lao PDR, households were able to get access to durable materials; a majority of latrines built were pour-flush (70% and 72%, respectively). In Indonesia, this is likely due to Plan International Indonesia’s sanitation marketing efforts (described subsequently in this section),
whereas in Lao PDR, it is likely due to the overlap of subsidy-based projects. In Nepal, although a mix of unimproved and improved latrines was observed, the national ODF definition requires that toilets be water-sealed and permanent up to the base level; such a requirement poses a challenge for CLTS facilitators, who hesitated to recommend specific latrine technologies to communities.

In Uganda, Niger, and Haiti, simple dry-pit latrines were ubiquitous, but most community leaders and village facilitators noted households’ desire for more durable latrines constructed of cement that could withstand the elements. Apart from the cost of such latrines, community leaders also cited difficulty in accessing material and skilled masons. Remote communities were described as more appropriate for CLTS, but they were also less likely to have access to a good supply chain unless material was brought to communities by NGOs or the government, or the community itself was highly motivated to procure hardware from far away.

In all seven case studies—particularly in Cambodia, Niger, Uganda, Haiti, and Indonesia—Plan International worked to improve access to the supply chain, primarily by training masons or through broader sanitation marketing efforts. Plan International Cambodia trained youth latrine producers in communities, providing an opportunity for the provincial government to link buyers to sellers of pour-flush latrines. In Uganda, VHTs were often trained to build cement latrine slabs, and in Nepal, some natural leaders also reported being trained by NGOs.

The most successful example is perhaps from Plan International Indonesia. They developed a sanitation marketing project to follow CLTS activities, which led to the development of the Association of Sanitation Entrepreneurs of Grobogan, or Paguyuban Pengusaha Sanitasi Grobogan (PAPSIGRO). According to project reports, these entrepreneurs were able to make low-cost toilet pans for Rp. 35,000 (USD 3), and offered different payment plans. As in other LS case studies, however, masons struggled to generate adequate publicity, procure enough material, and price their latrines at an appealing yet profitable cost.

**Affordability**

Training local masons is one part of the solution to sustainable forms of sanitation in the post-triggering stage. However, households need to be able to pay for higher quality latrines. Community leaders cited affordability as the main obstacle for being able to act on behavior change messages.

Positive examples of local solutions were identified in several communities in the seven case studies. For example, in Meung district in Lao PDR, where there was no indication of overlapping subsidy projects, community leaders organized transport of materials for the whole community from the district capital market several hours away. One community had also set up a local fund for those who could not afford latrines. Community leaders also learned from each other: “We learned from the ones who already had latrines. Just mix sand, gravel, and cement. Make concrete and then put reinforced bars, steel bars, [and that’s how we] made the latrine.” Plan International Haiti has tried to encourage the idea of kombit—where the community works together towards a common goal—to mobilize communities to build latrines; for example, during a visit to one community that had recently been triggered, many people had gathered with shovels to dig a pit for a latrine for an elderly couple. In Indonesia, a similar concept is referred to as gotong rayong. In Nepal, a variety of local mechanisms were reported, such as the concept of daanaveer, where wealthier members of the
community were asked to make financial contributions for poorer members’ toilets instead of donating to temples.

However, there were also several examples of hardware subsidies in triggered communities, which were alternatively referred to as reward-based incentives, innovative financing mechanisms, or smart or targeted subsidies. For example, in Indonesia and Nepal, some village governments decided to allocate part of their sanitation budgets to provide free or discounted (subsidized) latrine material for poor households. In Nepal, The Master Plan for Sanitation and Hygiene acknowledges that “provision of financial support is crucial especially to ensure the access of socially disadvantaged communities to sanitation facilities,” as long as it is locally managed (Steering Committee 2011). Therefore, the VDC WaSH Committee has the authority to decide whether and how subsidies should be provided within their jurisdiction.

As stated in guidelines, practitioners interviewed for this study believed that CLTS should be a no-subsidy approach. However, in interviews, both Plan International staff and policymakers were often in support of some targeted financial or material support to vulnerable households, and some acknowledged that CLTS may not be enough to address the supply side of the sanitation problem.

Implications
CLTS may put people on the sanitation ladder by convincing them to end open defecation, but other approaches may also be necessary to ensure that people have access to and are able to afford improved sanitation. By training masons, implementing sanitation marketing programs, and encouraging local financing mechanisms, Plan International staff have shown that they recognize the importance of improving supply-side conditions in the post-triggering phase. Sanitation marketing in particular may help improve access to the supply chain and ensure that entrepreneurs are able to successfully market products at varying price points. In some cases, sanitation marketing can serve as a complement to CLTS activities to improve supply to products. It may also be a viable alternative to CLTS in communities that are not appropriate for triggering, or where CLTS has been attempted but did not receive a positive response. However, the challenge of increasing access to sanitation for vulnerable and marginalized populations is real, and may require the use of additional financial or material support, provided that it follows CLTS activities and is targeted to those most in need.

4.7. Monitoring and evaluating CLTS

According to the CLTS Handbook, the end goal of CLTS is “achieving and sustaining ODF status,” which is defined as a condition where “no feces are openly exposed to the air” in a community (Kar 2008). In CLTS programs, the post-triggering phase consists of follow-up activities in communities to monitor progress towards ending open defecation and building safe latrines. As described earlier, village-level volunteers played a vital role in gathering data and following up with households in this phase, supported by local government and Plan International. Across the seven case studies, a variety of monitoring strategies, definitions, and actors were found to be implicated in the process. Most programs had simple monitoring systems that did not systematically capture sufficient data to
enable cross-country comparisons. Of all programs, Plan International Laos’ quarterly monitoring system was the most robust, with indicators on latrine use and cleanliness, handwashing, safe water practices, and environmental sanitation.

**Baseline measurements**
In order to assess progress and change in triggered communities, it is necessary to have an understanding of the baseline situation prior to triggering, in addition to periodic assessments after triggering. Of the seven LS case studies, programs in Lao PDR, Uganda, and Niger consistently captured baseline measurements on latrine coverage in communities prior to triggering (Table 10). In Nepal and Cambodia, baseline status was available for some communities but not others. No baseline measurements were available from the CLTS programs in Haiti or the Grobogan CLTS project in Indonesia, although Plan International Indonesia subsequently began collecting detailed baseline data as part of a national monitoring system.

**ODF definitions**
Programs in all seven countries aimed to achieve ODF communities, but definitions of ODF varied substantially (Table 10), underscoring the challenge of measuring behavior change at the community level. Although all programs reported absence of open defecation as the primary indicator of success, this was measured differently based on each program’s ODF verification process; in some programs, ODF verification teams would visit all households, whereas in other programs, a non-random sample around the community was sufficient.

Table 10. Characteristics of monitoring CLTS progress in case study programs

<table>
<thead>
<tr>
<th>Country</th>
<th>Baseline latrine coverage data</th>
<th>National ODF Definition</th>
<th>National ODF verification process</th>
<th>ODF Definition used by Plan International</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambodia</td>
<td>Partially collected</td>
<td>None</td>
<td>None</td>
<td>&gt;=85% access to improved latrines</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>Collected in all communities</td>
<td>None</td>
<td>None</td>
<td>100% access to latrines; 80% achievement in latrine use, handwashing, safe water; presence of a CLTS Committee</td>
</tr>
<tr>
<td>Nepal</td>
<td>Partially collected</td>
<td>Present</td>
<td>Present</td>
<td>100% access to water-sealed toilets</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Not collected</td>
<td>Present</td>
<td>Present</td>
<td>100% access to latrines, garbage and liquid waste management facilities</td>
</tr>
<tr>
<td>Uganda</td>
<td>Collected in all communities</td>
<td>Present</td>
<td>Present</td>
<td>100% access to latrines; total sanitation</td>
</tr>
<tr>
<td>Niger</td>
<td>Collected in all communities</td>
<td>None</td>
<td>Present</td>
<td>100% latrine use; handwashing, overall village sanitation</td>
</tr>
<tr>
<td>Haiti</td>
<td>Not collected</td>
<td>None</td>
<td>None</td>
<td>No open defecation (no targets listed)</td>
</tr>
</tbody>
</table>

Note: All CLTS programs used absence of open defecation as a starting point.
In Lao PDR, Nepal, Indonesia, and Uganda, 100% latrine coverage was expected before a community could be declared as ODF; except for Nepal, these programs also had additional indicators of total sanitation such as handwashing, use of safe water, and solid and liquid waste management. On the other hand, Plan International Cambodia's program required at least 85% access to improved latrines and general verification of the absence of open defecation in a community before it could be certified. Plan International Niger’s monitoring forms stated that the main criteria necessary for ODF attainment were 100% latrine utilization and absence of excreta around the village, but national verification guidelines did not have specific targets for these indicators. In Haiti, as no triggered communities had reached the point of ODF status, specific indicators had yet to be developed.

**Implications**

Without baseline measurements and routine assessments, programs cannot measure change or appropriately analyze the effectiveness of their CLTS activities. By routinely collecting household-level data on latrine coverage and use, programs can track incremental progress in communities, versus a binary, community-level indicator such as ODF status. Collecting scientifically rigorous baseline data may be costly, but programs such as that of Plan International Laos have shown how robust data collection activities can be effectively incorporated into CLTS programming to improve activities in real-time.

The absence of a standard ODF definition makes it impossible to compare ODF status across programs. Furthermore, many programs aimed to measure total sanitation under the definition of ODF by adding indicators on handwashing, safe water practices, and environmental sanitation to the ODF definition. This sets a more ambitious goal for ODF attainment than the actual the term ODF would imply.

Variations in ODF verification processes was also problematic. Pre-emptive declaration and certification of ODF status—a possibility in programs without strict guidelines—may lead to a false sense of achievement. On the other hand, delayed verification—which is a risk in programs that require a time-consuming verification process—may demotivate communities.
5. Summary and Recommendations

The CLTS Learning Series analyzed the process of implementing CLTS in seven Plan International CLTS programs across Asia, Africa, and the Caribbean. Individual country reports describe the process and provide specific enabling and constraining factors for effective implementation in these contexts. This report described the main cross-cutting findings from a comparative analysis of the seven country cases. Below is a summary of the findings and related recommendations for CLTS practitioners.

Role of CLTS

CLTS was widely perceived as a universally applicable approach for rural communities, despite varying results based on community characteristics.

Recommendations

CLTS should be considered as one component of a sanitation strategy. If communities that are more likely to be receptive to CLTS are targeted systematically, practitioners can allocate remaining resources to test other approaches—e.g. sanitation marketing—in other communities less appropriate for CLTS.

Local government capacity

Local government capacity was insufficient to lead CLTS activities in five of the seven case studies.

Recommendations

Where local government is unable to lead CLTS activities, INGOs should help strengthen capacity through training, mentorship, and targeted technical support. Findings from the TCAS study in Kenya show that these activities can help local government overcome certain capacity constraints. INGOs can also engage with local NGOs for triggering communities alongside local government to reduce the burden on the latter group. They can strengthen village-level participation in post-triggering activities to enable community monitoring of progress. At the same time, NGOs must advocate for increased investment from national government to ensure that there are sufficient staff, finances, and resources for sanitation in local government.

Role of village-level actors

A variety of village volunteers, including natural leaders, were implicated in different phases of CLTS, but they needed considerable support from Plan International and local government.

Recommendations

Programs need to be mindful of the potential for an unfair burden being placed on volunteers. When involving volunteers, resources have to be budgeted to ensure that volunteer motivation is sustained through the lifetime of the program and beyond. This can include training of natural leaders, which the TCAS study in Ghana has shown to be effective in certain settings, as well as financial and in-kind support. Practitioners should also emphasize non-material support, such as recognition and exchange visits, which have the potential to help sustain volunteer motivation even after a program has ended, as volunteers may then be viewed as leaders in their communities.
Adaptations to triggering

Triggering techniques had been adapted across the seven case studies, but were not always designed with the aim of improving outcomes.

Recommendations

Programs should systematically identify adaptations to CLTS and critically analyze whether the adaptations are a result of community context or a result of convenience or logistical constraints. Programs should also be careful to attribute results in communities to the actual approach that has been implemented so that rural sanitation stakeholders can better understand the effectiveness of CLTS vis-à-vis other approaches.

Sanctions

Although community-developed sanctions are encouraged in CLTS, most examples from the LS case studies were enacted by village or district government.

Recommendations

CLTS practitioners need to carefully consider which sanctions they actively encourage or passively condone, who enforces the sanctions, and how they are enforced in practice. Sanctions may be useful in creating and reinforcing social norms, but need to be introduced at the right time, in the right manner, and target the right people. Practitioners need to ensure that laws do not unevenly affect those who are already marginalized and do not have the ability to build latrines, but rather protect the majority from the few who are unwilling to change despite having the ability to do so.

Hardware supply and financing

Latrines built as a result of CLTS were often of poor quality, affecting sustainability of CLTS outcomes. Access to durable materials, technical support, and affordability were key obstacles.

Recommendations

Plan International is in a position to influence the nature of post-CLTS support in communities through approaches that maintain the motivational nature of CLTS but still provide access to higher quality sanitation. They should continue to focus on improving supply-side conditions in communities they trigger, including testing sanitation marketing in more CLTS country programs. Lastly, in countries where government or NGO subsidies are still present, rather than dismissing the role of this type of financial or material support, Plan International can help influence the mechanisms by which these subsidies are targeted to ensure that they do not negate CLTS efforts but rather enhance access and sustainability of outcomes.

Monitoring outcomes

Monitoring processes varied across the seven case studies, with differences in indicators of success, ODF definitions, and ODF verification guidelines.

Recommendations

Programs in all LS case studies, except Haiti, had an end goal of achieving ODF communities. Achievement of ODF status can serve as a powerful motivational tool for communities to change
their sanitation practices. However, it is less useful as a metric to measure progress. Its binary nature suggests that communities that have nearly achieved 100% latrine coverage may still qualify as “not ODF.” Therefore, programs should consider focusing on routinely collecting data (including baseline measurements) on household-level indicators of sanitation so they can measure and recognize incremental progress in communities. This would be especially useful since most programs were expecting to achieve results in total sanitation (including handwashing and safe water indicators), not just latrine use or absence of open defecation. Improved monitoring of activities will help generate evidence on the potential, the effectiveness, and the limits of CLTS.
6. References

O’Reilly, Kathleen, and Elizabeth Louis. 2014. The toilet tripod: understanding successful sanitation in rural India. Health & Place. 29. 43-51.
Singh, Debra et al. 2015. The effect of payment and incentives on motivation and focus of community health workers: five case studies from low- and middle-income countries. Human Resources for Health.
Appendices

Appendix A. Semi-structured interview guides

The following three guides were used to conduct interviews. As is typical with qualitative data collection techniques, questions were not necessarily asked in the same order or using the same wording, but the content of the guides was covered in all interviews.

1. Interview Guide for Government Officials and Policymakers

1) First, please tell me about yourself.
   Probes:
   • What is your background/education?
   • What is your role in the government? How long have you worked in this role?
   • Previous experience?

2) Please describe to me the current sanitation situation here.
   Probes:
   • Overall latrine coverage levels? Any disparity across regions?
   • Overall ODF status?

3) Who are the major actors (NGOs, government departments) in CLTS here?
   Probes:
   • What is the government's role?
   • Which government departments are involved in sanitation?
   • What is the role of various NGOs?
   • Where does most funding come from for sanitation in your country?

4) In your own words, how would you explain CLTS to someone who has never heard of it?

5) According to you, what is the difference between CLTS and other approaches to sanitation?

6) When you say “ODF”, what do you mean by that?
   Probes:
   • How do you define ODF?
   • Are any rewards offered to communities or organizations for achieving ODF?

7) How would you describe the official sanitation policy of the government?
   Probes:
   • How does CLTS fit into this policy?
   • Do you have an official CLTS policy/guidelines? How about for training?

8) How long has CLTS been used here?

9) To your knowledge, which are the organizations that have used the CLTS approach here?

10) Can you tell me more about your relationship with Plan International?
    Probes:
    • How long have these activities been going on?
    • How often do you meet with them?
    • Who funds these activities?
Training
11) Does the government provide any training on CLTS?
   Probes regarding training:
   - When was the most recent training?
   - Who all were trained? (government, natural leaders, other NGOs)
   - How long was the training?
   - How many people were trained?
   - Did you provide any support (fuel, food) for trainees?
   - What did you teach in the training?
12) Have you been trained in CLTS? Can you tell me about this?
   Probes regarding training:
   - When did you receive the training? (More than once?)
   - Who trained you?
   - How long was the training?
   - How many people were trained in that session?
   - Who else was trained? (government, natural leaders, other NGOs)
   - Did you receive any support (fuel, food) for attending the training?
   - What were you taught in the training?

Opinions on CLTS
13) According to you, in what kind of community is it easiest to achieve success in CLTS? Why?
14) Do you think there is any type community where CLTS is not possible? Why?
15) Based on your experience, what is the best time of year to do CLTS?
16) Based on your experience, which step in the triggering process works best? Why?
17) What is your favorite part of CLTS? Why?
18) What is the most difficult part of CLTS according to you? Why?
   Probes: What techniques have you used to overcome this challenge?
19) What kind of changes would you like to see in the way that CLTS is done?
20) What kind of changes, if any, do you see in your country since CLTS started here? This does not only have to be related to open defecation.
   Probes:
   - Why did these changes happen according to you?
   - Any changes not related to sanitation?
   - Is there anything else you would like to change that has not yet changed?
21) Would you like to tell me anything else about CLTS, about sanitation, or any other topic? Do you have any questions for me?
2. Interview Guide for Plan International staff and field-based implementers

1) First, please tell me about yourself.
   Probes:
   • What is your background/education?
   • How long have you worked here?
   • Have you worked on any water and sanitation projects in the past?

2) What is your specific role in implementing CLTS?

3) Please describe to me the current sanitation situation here.
   Probes for Plan CO staff:
   • Overall latrine coverage levels?
   • Overall ODF status?
   • Any disparity across regions?
   Probes for field CLTS implementers:
   • What is the ODF status?
   • What percent of people have toilets? How many dry pit latrines and pour-flush latrines?

4) Who are the major actors (NGOs, government departments) in CLTS here?
   Probes:
   • What is the government’s role?
   • What is the role of various NGOs?

5) In your own words, how would you explain CLTS to someone who has never heard of it?

6) According to you, what is the difference between CLTS and other approaches to sanitation?

7) When you say “ODF” (open-defecation free), what do you mean by that? How do you define ODF?

Overall CLTS Approach

8) Please tell me about your organization’s history with CLTS here.
   Probes:
   • How long have you been doing CLTS here?
   • Do you have other water and sanitation projects here?
   • How many communities have been triggered so far?

[Q8-Q12 only for Plan CO Staff]

9) Can you describe how CLTS activities are structured and organized within Plan?
   Probes:
   • Role of Program Units?
   • Role of local NGOs?
   • Number of staff

10) Who are the CLTS facilitators? (Plan, NGO, local government)?
    Probes:
    • How are they selected?
    • What kind of training do they receive?
11) How do you decide your CLTS approach?

   Probes:
   - Do you have any guidelines? Have you adapted these guidelines?
   - Do you have any training materials you use?

12) Would you mind telling me the funding sources for your CLTS projects?

13) Do you work with other organizations on CLTS-related activities here? Please tell me more.

[Q14-Q15 only for field CLTS facilitators]

14) Can you tell me about how you do CLTS activities here? How is it organized?

   Probes:
   - How many people in your organization are involved in CLTS?
   - Who decides on the strategy?
   - Do you have any guidelines?
   - Do you work with other organizations on CLTS-related activities?

15) Can you tell me more about your relationship with Plan International?

   Probes:
   - How long have these activities been going on?
   - How often do you meet with them?
   - Who funds these activities?

Training

16) Have you been trained in CLTS? Can you tell me about this?

   Probes regarding training:
   - When did you receive the training? (More than once?)
   - Who trained you?
   - How long was the training?
   - How many people were trained in that session?
   - Who else was trained? (government, natural leaders, other NGOs)
   - Did you receive any support (fuel, food) for attending the training?
   - What were you taught in the training?

17) Has your organization trained anyone in CLTS?

   Probes regarding training:
   - When was the most recent training?
   - Who all were trained? (government, natural leaders, other NGOs)
   - How long was the training?
   - How many people were trained?
   - Did you provide any support (fuel, food) for trainees?
   - What did you teach in the training?
Field Implementation of CLTS
I want to understand how CLTS activities are structured in the field. If you don’t have much direct experience with triggering activities, please answer the following questions to the best of your understanding.

18) How are communities selected to be part of a CLTS triggering activity? What factors about the community do you think about before you select a community?

Probes:
- Do you visit the village before you do the triggering? (pre-triggering)
- Before you do triggering, do you collect data on how many toilets there are in the village? (baseline)

19) According to you, in what kind of community is it easiest to achieve success in CLTS? Why?

20) Do you think there is any type community where CLTS is not possible? Why?

21) Based on your experience, what is the best time of year to do CLTS?

Triggering and Follow-up Process
[Ask only if respondent has first-hand experience with triggering]

22) Can you remember the last time you did a triggering activity in a village? When and where? Please think back to this day for the following questions.

23) When you first reached the village, how did they react to your presence?

Probes:
- What did you say to them? How did you start talking about CLTS?
- How did they respond?
- Can you tell me about a specific example where you had a positive reaction?
- Can you tell me about a specific example where you had a negative reaction?

24) Please describe the way you did the triggering activities in this village.

Probes:
- How many people went with you?
- Did everybody join you on the walk?
- What did you do if people weren’t interested/didn’t want you to be there during triggering?
- Did you include women?
- Did you include children? What was the role of children?

25) What happened after you did the triggering?

Probes:
- Did anyone make action plans?
- What do you do if people don’t do anything with sanitation after you leave?

26) Do you go to check if toilets are being built? How many times in 1 month?

Probes:
- Where do you get your data on toilets from? Who collects the data on toilets?
- How many follow-up visits do you usually make to 1 community?

27) I would like to know more about how you identify natural leaders.

Probes:
Who are they?
How are natural leaders identified?
Who assigns their roles?
What are their different roles?
Do they receive any training? What kind?

28) Does Plan work on sanitation with schools and teachers? How about hygiene? Tell me more.
   Probes:
   • Role of teachers?
   • Do you build latrines?
   • Do you build schools?
   • Youth clubs?

29) Have you ever done more than 1 triggering event in 1 village? Why?

30) Who decides when a village is ODF? How?
   Probes:
   • What is the role of natural leaders?
   • Are incentives/rewards offered for ODF achievement? What form?

Opinions on CLTS
31) Based on your experience, which step in the triggering process works best? Why?
32) What is the most difficult part of CLTS according to you? Why?
   Probes: What techniques have you used to overcome this challenge?
33) What is your favorite part of CLTS? Why?
34) What kind of changes would you like to see in the way that CLTS is done?
35) What kind of changes, if any, do you see in the communities since you started CLTS here? This does not only have to be related to open defecation.
   Probes:
   • Why did these changes happen according to you?
   • Any changes not related to sanitation?
   • Is there anything else you would like to change that has not yet changed?
36) Would you like to tell me anything else about CLTS, about sanitation, your organization, or any other topic? Do you have any questions for me?
3. Interview Guide for Community Leaders and “Natural Leaders”

1) First, please tell me about yourself.
   Probes:
   • Have you lived in this village your whole life?
   • What is your occupation? How long?
   • Did you attend school? If so, how many years of school did you attend?

2) What would you say are the most important problems your community has to deal with?

3) In terms of health, what would you say are the top three health concerns of people in your community?

4) Can you tell me about the situation of water in your community? Where do most people get water for drinking, for bathing, for cooking, etc.? How clean is the water?

5) Before [local CLTS facilitators] came to your community to talk about sanitation, what was the overall sanitation situation like here?
   Probes:
   • How many families had toilets?
   • Where did people go to defecate?
   • Did schools have toilets?
   • Did people talk about sanitation? Was it a problem?

   [Q6 and Q7 only for Natural Leaders]

6) When were you selected to be a “natural leader” in your village?
   Probes:
   • Before or after triggering?
   • Who selected you for this role?
   • Did they say why you were selected?

7) What is your role as a “natural leader” for sanitation in your village?

Triggering Process

8) Can you remember the first time the [local CLTS facilitators] came to your village to talk about sanitation? Tell me about that experience.
   Probes:
   • How many people came?
   • What all did they talk about?
   • What activities did they do with the community?
   • How long did they stay?
   • What was their attitude towards your community?
   • How did the community react to their visit?
   • Did they say what they wanted your community to do after they left?
   • Did they involve women and children? How?
   • Did you help them? How?
Opinions on CLTS

9) What was your favorite part about the sanitation activities done by the [local CLTS facilitators] (triggering)? Why? Tell me about that.

10) Was there anything you did not like about the sanitation activities (triggering)? Why? Tell me more.

Training

11) Did you receive any training on sanitation? Please describe this for me.
    Probes:
    • Who trained you?
    • How long was the training?
    • Did you receive any support (fuel, food) for the training?
    • How many people were trained?
    • What material did they cover in the training?

Follow-up Process

12) What happened after the sanitation activities (triggering) were completed?
    Probes:
    • Did people start to build toilets? Can you tell me how this process happened?
    • Any action plans made?
    • Involvement of women and children?

13) What was your role in changing the sanitation situation?
    Probes:
    • What were some difficult experiences you faced?
    • What kind of challenges did you have when working with the [local CLTS facilitators]?

14) How long after the [local CLTS facilitators]’ first visit did they visit for the second time?
    Probes:
    • Was it days, weeks, or months later?

15) How many times would you say the [local CLTS facilitators] have visited your village in total?

16) Have their visits helped your village improve its sanitation situation? Tell me more about this.
    [Q17 only for Natural Leaders]

17) Does working on sanitation as a “natural leader” keep you away from other work? Tell me about this.

18) Has anyone in your village received any support to to build toilets? What kind of support and from whom?

19) What is the sanitation situation like now in your community?
    Probes:
    • How many people have toilets? What types of toilets?
    • Problems with toilets?

20) Where do you get this data on toilets?
    Probes:
    • Who collects the data and how often?
• Does anyone in the community check to see if people are defecating outside? How about from outside the community?
• Who do you share this information with?

21) Are there any people in your community who still defecate outside?

Probes:
• Why do you think they do this?
• What happens to them if people see them?

22) Did anybody offer you or your community any rewards to change your sanitation situation?

23) What will happen when everybody in your community gets access to toilets? Is there any special event for this? How does this make the community feel?

Overall Philosophy

24) According to you, who do you think should pay for improving sanitation in your community?

25) Do you feel like your village needed someone from outside to bring this change in sanitation, or do you think the change would have happened eventually anyway? Why do you feel this way?

26) Would you like to have people from other communities visit your village now to look at your latrines? Why or why not?

27) Would you like to see any changes to the way the [local CLTS facilitators] do their sanitation activities (CLTS)?

28) What more changes would you like to see in your community with regard to sanitation?

29) Would you like to tell me anything else about your community, about sanitation, or any other topic? Do you have any questions for me?

Thank you for your time.
Appendix B. Verbal informed consent script

Verbal consent was obtained using the following script. An information sheet was also provided to all participants about the project, their participation, and researchers’ contact information.

Script: Hello, my name is [__]. I am a student at the University of North Carolina at Chapel Hill in the USA. I am here working on a research project with Plan International [country]. Thank you for taking the time to talk to me today. I would like to ask your permission to take part in research on sanitation. We are doing this study because we want to know about ____:

[For practitioners/policymakers]: your experience with sanitation and hygiene projects, specifically community-led total sanitation, or CLTS.

[For community leaders]: your community’s experience with sanitation and hygiene.

By learning from you, we can try to improve these projects in the future.

[For community leaders]: We want to speak with you because we were told that you are one of the leaders for sanitation in your community. We want to know more about these activities that you do.

Your participation is voluntary, which means that if you do not want to take part in this study, you do not have to. You can also decide later on to say no for any reason, without any penalty. If you don’t want to answer specific questions, you can skip those questions. If you agree to take part in this study, I will ask you questions about ____:

[For practitioners/policymakers]: the sanitation situation in this country, about CLTS activities, and about your opinions on CLTS.

[For community leaders]: your experience with sanitation and hygiene activities, such as what activities you took part in and how you felt about them.

The interview should take 30 minutes to 1.5 hours. Your name will be kept secret. We will not mention your name in any report that we write, so I request you to please answer as honestly as possible. No one outside of my research team will be able to link what you said directly to you. With your permission, I would like to record this interview, so that I do not miss anything that you tell me. I will then write down what you said. The recordings will be kept safely and will be erased after the project is finished. Finally, I would like to mention that by taking part in this study, you may help us find ways to improve sanitation projects.

[For practitioners/policymakers]: It is possible that you will also get new information about CLTS from our results that may help you in your job. At the end of this study, we will share with you any reports and findings.

[For community leaders]: You will not receive any direct benefits from this project.

Please keep a copy of the information sheet, which explains the purpose of our research and what we will ask you to do if you agree to take part in the study. Do you have any questions for us?

If you agree to take part in this interview, please say into the recorder: “Yes, I agree to take part in this study.”
Appendix C. Monitoring outcomes from Plan International’s Learning Series CLTS programs

Table C1. Latrine coverage and ODF status in Plan International Cambodia’s CLTS communities, 2013

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Province</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Kampong Cham&lt;sup&gt;a&lt;/sup&gt;</td>
</tr>
<tr>
<td>No. of communities triggered</td>
<td>172</td>
</tr>
<tr>
<td>Total no. of households</td>
<td>31,548</td>
</tr>
<tr>
<td>No. of latrines built after triggering</td>
<td>9,359</td>
</tr>
<tr>
<td>Average latrine coverage after triggering</td>
<td>30%</td>
</tr>
<tr>
<td>No. (%) of communities declared ODF</td>
<td>8 (5%)</td>
</tr>
</tbody>
</table>

<sup>a</sup>Source: Plan International Cambodia, April 2013.
<sup>b</sup>Source: Plan International Cambodia’s local NGO sub-grantee, April 2013.
<sup>c</sup>Source: Plan International Cambodia, June 2013.

Table C2. Latrine coverage and ODF status in Plan International Laos’s CLTS communities, 2013

<table>
<thead>
<tr>
<th>Indicator</th>
<th>District</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Meung</td>
</tr>
<tr>
<td>No. of communities triggered</td>
<td>11</td>
</tr>
<tr>
<td>Total no. of households</td>
<td>909</td>
</tr>
<tr>
<td>Median no. of households per community</td>
<td>71</td>
</tr>
<tr>
<td>Median latrine coverage before triggering (baseline)</td>
<td>59%</td>
</tr>
<tr>
<td>Median latrine coverage after triggering</td>
<td>91%</td>
</tr>
<tr>
<td>No. (%) of communities declared ODF&lt;sup&gt;a&lt;/sup&gt;</td>
<td>5 (46%)</td>
</tr>
</tbody>
</table>

Source: Plan International Laos 2013.

<sup>a</sup> Latrine coverage after triggering for ODF communities ranged from 77% to 100%, but included other hygiene and sanitation outcomes.
### Table C3. Toilet coverage and ODF outcomes in Plan International Nepal's CLTS communities, 2014

<table>
<thead>
<tr>
<th>Indicator</th>
<th>District</th>
<th>Makwanpur</th>
<th>Banke</th>
<th>Morang</th>
<th>Rautahat</th>
<th>Sindhuli</th>
<th>Sunsari</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>ODF status</td>
<td>ODF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of VDCs triggered by Plan International Nepal</td>
<td>ODF</td>
<td>13</td>
<td>23</td>
<td>25</td>
<td>25</td>
<td>13</td>
<td>6</td>
<td>105</td>
</tr>
<tr>
<td>Total no. of households (HH)</td>
<td></td>
<td>17635</td>
<td>34021</td>
<td>63538</td>
<td>34714</td>
<td>13990</td>
<td>7314</td>
<td>171212</td>
</tr>
<tr>
<td>Average no. of HH per VDC</td>
<td></td>
<td>1357</td>
<td>1620</td>
<td>2542</td>
<td>1389</td>
<td>1076</td>
<td>1219</td>
<td>1534</td>
</tr>
<tr>
<td>No. (%) of VDCs certified ODF</td>
<td></td>
<td>13 (100%)</td>
<td>3 (13%)</td>
<td>6 (24%)</td>
<td>1 (4%)</td>
<td>3 (23%)</td>
<td>3 (50%)</td>
<td>29 (28%)</td>
</tr>
<tr>
<td>Average toilet coverage before triggering (baseline)</td>
<td></td>
<td>39%</td>
<td>16%</td>
<td>41%</td>
<td>27%</td>
<td>41%</td>
<td>28%</td>
<td>32%</td>
</tr>
<tr>
<td>Average toilet coverage after triggering</td>
<td></td>
<td>100%</td>
<td>34%</td>
<td>49%</td>
<td>41%</td>
<td>53%</td>
<td>78%</td>
<td>59%</td>
</tr>
</tbody>
</table>


Note: Baseline data available for 32 ODF VDCs. Endline data available for 103 VDCs as of November 2014.

### Table C4. Outcomes of Plan International Uganda's CLTS projects, 2015

<table>
<thead>
<tr>
<th>District</th>
<th>Luwero</th>
<th>Tororo</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-County</td>
<td>Luwero</td>
<td>Katikamu</td>
<td>Mukuju</td>
</tr>
<tr>
<td>No. of parishes triggered</td>
<td>2</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Total no. (%) of parishes</td>
<td>7 (29)</td>
<td>9 (22)</td>
<td>6 (17)</td>
</tr>
<tr>
<td>No. of villages triggered</td>
<td>13</td>
<td>17</td>
<td>12</td>
</tr>
<tr>
<td>Total no. of households (HH)</td>
<td>1458</td>
<td>2222</td>
<td>1114</td>
</tr>
<tr>
<td>Avg. no. of HH per village</td>
<td>112</td>
<td>131</td>
<td>93</td>
</tr>
<tr>
<td>Avg. baseline latrine coverage</td>
<td>57%</td>
<td>34%</td>
<td>27%</td>
</tr>
<tr>
<td>Avg. end-line latrine coverage</td>
<td>93%</td>
<td>90%</td>
<td>96%</td>
</tr>
<tr>
<td>Avg. absolute change in coverage</td>
<td>37%</td>
<td>55%</td>
<td>69%</td>
</tr>
<tr>
<td>No. (%) villages certified ODF</td>
<td>13 (100)</td>
<td>17 (100)</td>
<td>12 (100)</td>
</tr>
<tr>
<td>Avg. months to ODF</td>
<td>4</td>
<td>30</td>
<td>NA</td>
</tr>
</tbody>
</table>


Note: Endline data as of July 2015. ODF certification dates not available for Mukju sub-county.
### Table C5. Outcomes of Plan International Niger’s CLTS projects, 2013

<table>
<thead>
<tr>
<th>Department</th>
<th>Tillabéri</th>
<th>Dosso</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of villages triggered</td>
<td>35</td>
<td>52</td>
<td>87</td>
</tr>
<tr>
<td>Total no. of households (HH)</td>
<td>4,141</td>
<td>6,827</td>
<td>10,968</td>
</tr>
<tr>
<td>Average no. of HH per village</td>
<td>118</td>
<td>131</td>
<td>126</td>
</tr>
<tr>
<td>Median latrine coverage before triggering (baseline)</td>
<td>11%</td>
<td>7%</td>
<td>8%</td>
</tr>
<tr>
<td>Median latrine coverage after triggering (end-line)</td>
<td>61%</td>
<td>15%</td>
<td>33%</td>
</tr>
<tr>
<td>No. (%) communities certified ODF</td>
<td>19 (54)</td>
<td>12 (23)</td>
<td>31 (36)</td>
</tr>
<tr>
<td>No. (%) of villages with &gt;= 50% latrine coverage</td>
<td>10 (29)</td>
<td>0 (0)</td>
<td>10 (8)</td>
</tr>
</tbody>
</table>

Note: By June 2015, 22 (63%) villages in Tillabéri and 35 (67%) villages in Dosso were certified as ODF.

### Table C6. Outcomes of Plan International Haiti’s CLTS projects, 2015

<table>
<thead>
<tr>
<th>Project</th>
<th>UNICEF/INO-funded project</th>
<th>GNO-funded project</th>
<th>JNO-funded project¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of communities triggered</td>
<td>South-East</td>
<td>North-East</td>
<td>West</td>
</tr>
<tr>
<td>Total no. of households (HH)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>No. of HH that started building latrines</td>
<td>574</td>
<td>495</td>
<td>NA</td>
</tr>
<tr>
<td>No. of new latrines constructed</td>
<td>48</td>
<td>157</td>
<td>NA</td>
</tr>
<tr>
<td>No. of latrines rehabilitated</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>No. (%) communities declared ODF²</td>
<td>3 (10%)</td>
<td>2 (6%)</td>
<td>2 (13%)</td>
</tr>
<tr>
<td>No. of vulnerable HH³</td>
<td>40</td>
<td>40</td>
<td>NA</td>
</tr>
</tbody>
</table>

Source: Plan International Haiti 2012; Hayashi 2015.

¹ Sixteen communities planned in total, including in the West Department in 2016-2017.
² Based on community declaration, but not officially verified or certified as ODF.
³ HH receiving financial support from Plan International Haiti.
<table>
<thead>
<tr>
<th>Sub-District</th>
<th>No. of villages triggered</th>
<th>Total no. of households (HH)</th>
<th>Average no. of HH per village</th>
<th>% of HH reporting latrine use at end of project</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brati</td>
<td>9</td>
<td>13,997</td>
<td>1,555</td>
<td>89%</td>
</tr>
<tr>
<td>Godong</td>
<td>28</td>
<td>23,772</td>
<td>849</td>
<td>98%</td>
</tr>
<tr>
<td>Karang Rayung</td>
<td>19</td>
<td>23,688</td>
<td>1,247</td>
<td>94%</td>
</tr>
<tr>
<td>Kedung Jati</td>
<td>12</td>
<td>12,293</td>
<td>1,024</td>
<td>100%</td>
</tr>
<tr>
<td>Klambu</td>
<td>9</td>
<td>9,404</td>
<td>1,045</td>
<td>90%</td>
</tr>
<tr>
<td>Kradenan</td>
<td>14</td>
<td>20,987</td>
<td>1,499</td>
<td>100%</td>
</tr>
<tr>
<td>Penawangan</td>
<td>20</td>
<td>18,223</td>
<td>911</td>
<td>100%</td>
</tr>
<tr>
<td>Tawangharjo</td>
<td>10</td>
<td>14,722</td>
<td>1,472</td>
<td>100%</td>
</tr>
<tr>
<td>Tegowanu</td>
<td>18</td>
<td>14,422</td>
<td>801</td>
<td>100%</td>
</tr>
<tr>
<td>Wirosari</td>
<td>14</td>
<td>22,918</td>
<td>1,637</td>
<td>99%</td>
</tr>
<tr>
<td><strong>All Sub-districts</strong></td>
<td><strong>153</strong></td>
<td><strong>174,426</strong></td>
<td><strong>1,140</strong></td>
<td><strong>97%</strong></td>
</tr>
</tbody>
</table>

Source: Plan International Indonesia 2012.
Appendix D. Sanitation coverage trends in Learning Series case study countries

Figure D1. Urban, rural and total sanitation coverage trend in Cambodia, 1990-2015 (Adapted from WHO/UNICEF 2015).

Figure D2. Urban, rural and total sanitation coverage trend in Lao PDR, 1994-2015 (Adapted from WHO/UNICEF 2015).

Figure D3. Urban, rural and total sanitation coverage in Nepal, 1990-2015 (Adapted from WHO/UNICEF 2015).

Figure D4. Urban, rural and total sanitation coverage trend in Uganda, 1990-2015 (Adapted from WHO/UNICEF 2015).
Figure D5. Urban, rural and total sanitation coverage trend in Niger, 1990-2015 (Adapted from WHO/UNICEF 2015).

Figure D6. Urban, rural and total sanitation coverage trend in Haiti, 1990-2015 (Adapted from WHO/UNICEF 2015).

Figure D7. Urban, rural and total sanitation coverage trend in Indonesia, 1990-2015 (Adapted from WHO/UNICEF 2015).
Appendix E. Institutional maps for Plan International’s Learning Series CLTS programs

**Figure E1. Institutional map of Plan International Cambodia’s CLTS approach**

**Figure E2. Institutional map of Plan International Laos’ CLTS approach**
Figure E3. Institutional map of Plan International Uganda’s CLTS approach

Figure E4. Institutional map of Plan International Indonesia’s CLTS approach
Figure E5. Institutional map of Plan International Niger’s CLTS approach

Figure E6. Institutional map of Plan International Haiti’s CLTS approach
Figure E7. Institutional map of Plan International Nepal's CLTS approach