Peace Promotion Center

Community Led Total Sanitation Program

Operating Guidelines

Community Support (ASHA) Program
Care Nepal
Nepalgunj
2008
Preface
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Community Led Total Sanitation (CLTS) Campaign in ASHA Program:

“If I go alone, people will not hear me. But if forty of us go together, They will listen and respond”

Member of woman’s group of Bangladesh, Chakaria

1. **Background:**

Community Led Total Sanitation (CLTS) is an innovative approach that empowers local communities to stop open defecation by making latrines without external hardware subsidies and using toilets for defecation. Participatory Rural Appraisal (PRA) tools will be used to help the community to understand the poor sanitation situation and realize the impact on their health.

Nepal’s experience has shown the School Sanitation and Hygiene Education (SSHE) program as a model in improving health and sanitation. In the present context, sanitation improvement is the burning issue in rural community. ASHA program has been piloted the community led total sanitation since early January ’08 in its program districts. The main entry point of the program is the Peace Promotion Center (PPC).

2. **Concept of Peace Promotion Center (PPC):**

This is a functional group (25-30 members) where women or mixed group meet and discuss issues that are pertinent for claiming their rights and peace promotion activities at community level. PPC is an approach of continuous process of empowering women and getting opportunity by meeting in a group and prepare action plan to work/advocate on some of the prioritized issues. Women meet once in a week for about four hours up to 20 weeks. They will develop the group as

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1 Prepared by: Umesh Shrestha, IDTO-CSP/CARE Nepal with the reference of PRA manual of R. Chamber and documents on CLTS by Kamal Kar, VERC-Bangladesh, Plan Nepal etc.
a self-help group and will linkage with women networks at VDC and district level. The women involved in PPC will also explore the livelihood options such as life skill and income generating activities. These households will also be linked with DLAs and VDCs to access resources and services. The concept used in PPC is not new for CARE Nepal, the using concept reflects in many CARE’s programs. The model was used in UJYALO, ASHA, SAHABHAGITA (Peace Promotion Center), SAMARPAN (women advocacy literacy center), and Child Survival Project (Dabi Kendra). Now, other projects like SAGUN, JIWAN and PRP have also being conducted Governance Literacy Classes, Lok Pathshala and Advocacy Center respectively. The women gather and discuss focusing PVSE households in some place to discuss their issues and make commitments for establishing their rights through advocacy.

Participants will be selected in participatory way involving Partner’s staff, Local resource person (LRP), Social mobilizes, Social leaders and ASHA program staff and use well being ranking to identify poor, vulnerable and socially excluded households.

Participants themselves have to set criteria mainly focusing in social, human, natural, and economic indicators and categorize households into A, B, C and D. A- represents well off; B-represents moderate; C- represents poor and D- represents extreme poor households. Priority will be given to participate in PPC from those falls on D&C categories household with participatory decision making of 100% households representatives.

The process will make effective involvement of community people in all aspects on situation assessment, problem identification, planning, resource identification, implementation, monitoring and evaluation from their own perspective.
The majority of the people in Nepal have poor understanding of the link between poor hygiene and disease. People want to have latrines for reasons of convenience, privacy and status rather than health and sanitation perspectives. Traditional approaches to improving sanitation have focused to technocratic and financial patronage, rather than health and hygiene education. Water Supply coverage is relatively high but safe water alone leads to only minor health improvements and does not prevent serious diseases like cholera and dysentery.

There are number of barriers to achieving total sanitation as outlined below:

- The Government is centralized and functions in a top-down and supply-driven manner.
- Lack of coordination among development organizations.
- Lack of awareness at community level.
- Dissimilar subsidy policy and design of service provider and supporting organization
- Less prioritized in this issue as compare to other development activities.
- Fixed latrine models are too expensive for the poorest people and in many geophysical areas proven no-user friendly.
- Women’s specific sanitation-related needs are unrecognized by the community.
- Lack of tenure rights, particularly for poor people, slum dwellers.
- Slum dwellers and poor people have no rights to build latrines where they live.

### 3. ASHA program and CLTS:

Clean and safe water directly effects on the human health. It is the first measure for the vision of environmental sanitation, healthy and sustainable development. Availability of clean and safe drinking water and provision of healthy environment are the basic human rights. Considering the significance of these rights including reduce poverty and causes of conflict ASHA programs’ interventions are targeted directly to the ultra poor PVSE community groups. ASHA program has been implementing its program since 2004 in support of DFID Nepal. This program covers Gorkha, Kalikot, Pyuthan, Doti, Dadeldhura, Achham, Bajura, Bajhang and Darchula. Women, poor, excluded, dalit, ethnic are the target group of the program. ASHA program is going on capacitating target groups of voiceless and supporting to be heard their voices for promoting on access to and control over resources, services and opportunity and influence in policy making and implementation of rules and regulations to uplift the lives of targeted groups.

### 3.1 What is Community Led Total Sanitation?

It is a scaling up process of empowerment through promoting capacity and skill of community with vision of 100% or Total Clean and Healthy Community. The heart of CLTS is the creation
of Open Defecation Free communities: in other words “total sanitzated community”. The concept of self-help – "no direct subsidy and no service delivery from any external agencies", particularly the involvement of entire community and a multi-stakeholder participation is in the process. The program focuses more on local culture, context, material, creativity and innovation (‘materials, doing and knowing’). Local people are encouraged and respected to come up with their own ideas and actions, more focus will be given to implement for solutions that suited as their needs and existing resources. This process leads to sustainable outcomes and positive impact such as wishing to retain hygienic behaviors, scaling up of program. The fact is that whole villages become Open defecation free that means Peace promotion center works as peer pressure group against any relapse into traditional behaviors.

Figure 1 shows 5 Fs (Fasces, Fluids, Fields, Flies and Finger) contaminated food and people will be affected by different diseases and epidemic like water borne diseases diarrhoea, dysentery, fever, skin disease. Primary barrier is the most important thing. If we can manage the first barrier by ending the open defecation practice, we have not to give the same effort to manage other 4 Fs or second barriers. In spite of open defecation stopping we must manage our practices of managing solid and liquid waste and our behavior of spitting outside and

Figure 1. The F-diagram for transmission of faecal-oral diseases [Kawata in DFID, 1998]
public places. To eradicate mal practices for totally implementation of CLTS, we have to change our behavior.

CLTS is not target oriented, rather then it is impact oriented. It covers total community people and environment. So it is totally different as compared to the past. They are:

<table>
<thead>
<tr>
<th>Indicators</th>
<th>The past</th>
<th>Now and future</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start with</td>
<td>Things, people</td>
<td>At the start of the CLTS process</td>
</tr>
<tr>
<td>Core activities</td>
<td>Constructing latrine</td>
<td>Igniting and facilitating process</td>
</tr>
<tr>
<td>Latrine designed by</td>
<td>engineers</td>
<td>Community innovators</td>
</tr>
<tr>
<td>No of designs</td>
<td>1 or a few</td>
<td>Many</td>
</tr>
<tr>
<td>Main materials</td>
<td>Cement, pipe, brick etc</td>
<td>Bamboo, wood, tin, jute, plastic etc</td>
</tr>
<tr>
<td></td>
<td>purchased from outside</td>
<td>almost all locally available.</td>
</tr>
<tr>
<td>Cash cost</td>
<td>high</td>
<td>Low can be under US $ 7</td>
</tr>
<tr>
<td>Indicators</td>
<td>Latrine constructed</td>
<td>Open defecation ended</td>
</tr>
<tr>
<td>Sustainability</td>
<td>Partial and patchy</td>
<td>High 100 % coverage</td>
</tr>
<tr>
<td>Who benefits</td>
<td>The better off</td>
<td>All including the poorest</td>
</tr>
<tr>
<td>Key motivation</td>
<td>subsidy</td>
<td>Disgust and self respect</td>
</tr>
<tr>
<td>Coverage/usage</td>
<td>partial</td>
<td>total</td>
</tr>
<tr>
<td>Benefits</td>
<td>Lower; open defecation</td>
<td>Higher open defecation ends</td>
</tr>
</tbody>
</table>

Sources: Kamal kar, (2005) practical guide to trigger CLTS

Sanitation can be defined in a number of different ways; “a system for promoting sanitary (healthy) conditions”; and for DFID (2001) sanitation “encompasses all aspects of personal, household and public excreta and waste disposal (on-site and waterborne) and cleanliness”. Following box lists the 12 criteria for 100% sanitation as defined by VERC. However, it is after the cessation of open-defecation alone that the village announces itself 100% sanitized and receives a signboard declaring that no-one defecates in the open area.
12-pointed Basic Provisions for CLTS adopted by ASHA program

1. Use of 100% healthy, clean and safe toilet or situation of avoiding open defecation.
2. Changed habit of washing hands before and after meal and defecation.
3. Covering Food and Water Pot
4. Practice to personal hygiene.
5. Proper management of toilet.
6. Use of sandals while going to toilet.
7. Clean in front of house and around.
8. Use of proper place for household waste, cow dung, fertilizer.
9. Use of clean water for all household work
10. Manage and clean water tap, tube well, well and spring.
12. Control of coughing and spitting habit in public places.

3.2 Basic Concept of Community Led Basic Sanitation

- **Integration:** Clean and safe water, environmental sanitation and personal hygiene is integrated program and interdependent in each others. This type of program can be managed and invested through people centered development approach.

- **Participation:** Participation of excluded, poor, marginalized people should be important in all phases of project cycle: need identification and analysis, planning, implementation, monitoring and evaluation for active and meaningful participation that ensures proper distribution of benefits of investment and outputs. It is ensured to provision of leading role, selection of alternatives of drinking water and sanitation, build up capacity through knowledge and skill to promote sanitation from community.

- **Empowerment:** Community capacity, skill and indigenous knowledge are respected. There is provision of strengthening capacity of community members who have potential of transformation for facilitating in the communities. Capacity build up is for empowering of voiceless people, so that they can put and advocate their issues with policy makers, development organizations.

3.2 Approach of Community Led Basic Sanitation

- Respect of skill, knowledge and capacity of members of community.
- Construction of toilet with almost zero subsidies.
- Total community oriented approach.
- Use of local resources.
• Participation of local government.
• Use of participatory research tools for needs analysis.
• Identification of potential community leader and use of that person as a means of transformation.
• Formation of village and cluster level development committee (local rural engineering group formation).

4. **Program Operating Strategy for Community Lead Basic Sanitation**

Existing conflict situation has escalated the worse condition of excluded people of poor and illiterate and increases difficulties in their livelihood efforts. There is being seriously gap between haves and haves not. Most of the development activities is crafted beautifully in paper and discussed idyllically in round table. Outputs and benefits of the programs have been limited to the elite groups and poor and excluded people are being always in the shadow. In order to facilitate the program implementation, ASHA program has been adopting partnership with user’s group.

4.1 **Right Based approach**

Empowerment approach has to be applied in all range of development sectors for fulfilling basic rights of excluded people through institutionalizing Right Based Approach in development process. In the context of CARE Nepal, it has been shifted the programming approach in Right Based approach since 2000.

Community Support (ASHA) program has also been adopting the Right Based approach since its inception. ASHA initiative has been implementing through partnership of local NGOs and the user groups. In this extend developed strategy has been taken up center point in peace promotion centers for promoting village-VDC and district level community led basic sanitation program through awareness and advocacy. This program will be implemented by identifying common issues of community through peace promotion center. It also supports to influence policy makers as well as implementers to solve their issues.

4.2 **DDC/VDC level interaction**

Considering the importance of political-will and commitment of the political parties, GOs and I/NGOs service providers, ASHA program has taking up the strategies to develop greater constituency in the VDC and district. In this concern VDC and DDC level interaction will be facilitated. The interaction at the VDC level will be facilitated by the PPC and partner organization and the district level interaction will be facilitated by ASHA program and local
partner organization in close coordination with Division of Water and Sanitation office and district sanitation committee in order to promote open defecation free district.

At the VDC level interaction participants will be representatives of political parties, VDC level GOs, I/NGOs, local clubs, CFUGs, CBOs, teachers, students, social workers and activists. Similarly, parliament member, representatives of political parties, district level GOs, NGOs federation, FACOFUN, teachers, Students, Social workers and activists will be participants of the district level workshop. By the end of interaction workshop it is expected that the common declaration/commitment will be announced and published accordingly.

5. Phases of developing CLTS as a means of ODF

5.1. Phase-1- Development Phase

Since a decade Nepal has shown growing need of sanitation coverage in its population. Efforts have capitalized to raise awareness and formulate clear practical sanitation policies. Nepal's implementing programs is in adopting the Millennium Development Goals (MDGs) that has promised to reduce by half of the proportion of people without access to safe drinking water and basic sanitation by 2015. Country has shown some progress in improving access to drinking water; but it remains plagued by extremely low level of sanitation. The population with adequate access to sanitation was only 27% in 2002 (WHO/UNICEF, 2004).

In July 2004, following a visit to Nepal by Kamal Kar, a small number of INGOs/NGOs organized as alliance to further enlarge the magnitude of safe sanitation coverage. The organizations were Plan Nepal, WaterAid Nepal, Newah, LUMANTI, Nepal Red Cross, Environment and Public Health Organization (ENPHO), Helvatas and the Gorkha Welfare Scheme but yet to be functional for policy advocacy to raise the sanitation coverage in rural communities (Sujeet Karn, Plan Nepal, August 2006)

Nepal's experience has shown that School Sanitation and Hygiene Education (SSHE) program is a successful model in improving health and sanitation. Recognising this, Department of Water Supply and Sewerage (DWSS) in the Ministry of Physical Planning and Works, together with UNICEF, developed a proposal to link CLTS with SSHE- through a school-community partnership. They have named the integrated approach School Led Total Sanitation (SLTS). Consultation and discussion the draft proposal/SLTS guidelines took place in spring 2005, led by the DWSS National Sanitation Steering Committee. Comments were sought from other
sector organisations before finalisation of the proposal/guidelines. The decision was made to pilot the scheme in Chitwan. Two district level meetings were held and participating organisations agreed to implement the scheme in different VDCs in Chitwan. According to NEWAH, which is implementing SLTS in two VDCs, the initial survey and planning work is currently being undertaken with selected schools.

5.1.1 CLTS in ASHA program

These all sort of initiation generated encouraging result in the Rautahat, Bara, Parsa, Nawlparsabhi, Kaski, Chitwan district of Nepal. Many villages of the district were declared as open defecation free village. To know learning and impact of this initiation, observation visit of Bangladesh was conducted in November 2007 by ASHA team and the team piloted the program as new initiation since early January 2008 in its program districts. Initially the concept was designed to implement the program as model demonstration at community level as well as some of the line agencies; District development Committee, District Education Office, District Public Health Office etc. Positive response has reflected from the community within the short period of time. Two villages of Gorkha and each village of Pyuthan Kalikot and Darchula has declared open defecation free village. Many other districts have been also planning to declare the villages as open defecation free within this short time period.

Main entry point of the program is the community. Accordingly, each and every component of the program is community based. This introduces ownership of the program as well as ensures sustainability for the future. In this respect project envisioned that the scattered rural people has to be organized in an action group through Peace Promotion Center (PPC) with the objectives to promote the greater community awareness and ignition of the community level campaign. As part of the community, local Government body, NGO, CBOs and other stakeholders are also involved in the process for effectiveness of the program.

In 4 districts (Doti, Achham, Bajura and Bajhang), program has been implementing with the collaboration of CARE’s in house project of SAHABHA GITA. Each district had established 10 PPC (Peace Promotion Centre) especially focusing to work with women. Program is implementing, however some problems have been overcoming in the implementation phase. Main issues were in differently understanding in modus operandi to implement the PPC. Considering this ASHA Program organized 4 days orientation training for selected LRP (Local Resource Person), staff of partner organization and ASHA project staff. In 2 days orientation program, shared the concepts and approaches of community led total sanitation program, its issues, guiding principles, models and process to launch through Peace Promotion Center. In connection with the synergy building of the initiatives ASHA program linked the CLTS as holistically integrated with income generation through livelihood improvement plan support and capacity building through PPC.
Logical frame work for social transformation through PPC

PPC

- Community led total Sanitation
- Empowerment
- Livelihood Improvement plan

Declaration of total sanitized village
- Capacity building and exercise
- Micro enterprises

Improvement in health status
- Governance Practices
- Income generation

Dignified Society
5.1.2 Peer pressure

The heart of CLTS is the creation of Open Defecation Free (ODF) communities: in other words “total sanitation”. The concept of self-help – ‘no direct subsidy and no service delivery from any external agency’ - is focused in this process, particularly the involvement of the entire community and a multi-stakeholders’ participation process. The program is focused more in local resources, culture and context, creativity and innovation (‘doing and knowing’); local people allow to come up with their own ideas and actions, and to implement for solutions that suited their needs, idea and resources. It is felt that this led to sustainable outcomes, such as wishing to retain hygienic behaviors. The fact that whole villages become ODF means that peer pressure works against any relapse into old behaviors.

5.1.3 Training and Orientation

The approach is based on the assumption that communities have their own strength and willingness to overcome their own WATSAN problems. Therefore, the role of field workers is enabling local facilitator to communities to analyze their current situation, identify areas for improvement, plan how to improve them and then implement the plans. It focuses on social development using a process of institution building and community empowerment other than concentrating on the delivery of services. The approach also recognizes in the area of WATSAN, the behavior of an individual and household have a direct impact on the health and well being of others. Therefore, to bring about a sustainable improvement in the quality of life and health of the rural people in the program area, whole community will be targeted for CLTS program.

In order to facilitating the awareness process in PPC and implementation of CLTS, ASHA program will facilitate 3 days long facilitation training to local resource persons and orient one day about PPC and CLTS.

5.2 Phase-2- Promotional/Implementation Phase

The driving forces of CLTS are based around the sense that a latrine provides dignity, as defecation is a private practice that should not be seen by others. Indeed, there was an embedded cultural sense that latrine use and defecation is so private that they should not be discussed in meetings; and that safe or unsafe defecation is one’s own business, rather than a social responsibility. These feelings initially counteracted dignity and privacy as driving forces and slowed the speed of ignition of CLTS.

However, CLTS has given people the initial spark and once unwillingness to discuss these matters has been overcome, it was felt that it would be extremely unlikely that people would return to open defecation. The ignition process alone may not cause people to rise up the ladder, but at least it should be strong enough to ensure that they don’t fall off.
This approach empowers to community by understanding their situation with simply and involving in decision making, planning, implementing, and evaluation being more focus on their local situation. It is a scaling up process of empowerment promoting capacity and skill of community with vision of 100% or Total Clean and Healthy Community. There will be rural sanitation engineer, Public Institutional Development Specialist etc at community. In this way we can see community specialist in different sectors and go further in promoting CLTS activities mainstreaming in development process.

Basic sanitation is not only limited to the construction of drinking water and toilet structure. Its’ areas are use of clean, safe and healthy toilet, develop habit to wash hands, practice to cover food and drinking water, use of safe and clean water for all household works, break the linkage between mouth and fecal through management of clean house and environment. It is important to make standard of quality invented by local community that made by themselves as their local perspectives and practical to the community. This approach supports to accountable to community by increasing ownership, questioning like: what does the community need? For what this approach has been applying? To whom it is doing?

Do watch out for the naturally leaders from the PRA process and encourage to lead and share their idea in the whole community on the consequence of open defecation. Do involve children in the discussion and asked them what they will do stop open defecation. Often children start procession shouting loud slogans against open defecation, increase these activities obviously they will find great fun.

5.2.1 Tools to use for promoting CLTS:

A range of PRA tools are used during the process, as the key to help the community identify and analyze their current situation and planning accordingly. Following table illustrates those tools that are routinely used during the process. It is very important that field workers fully understand the purpose of the tool and are familiar with their use prior to their entry into the community.
<table>
<thead>
<tr>
<th><strong>Tools</strong></th>
<th><strong>Objectives</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transect Walk</strong></td>
<td>To observe the current situation and build rapport with community people.</td>
</tr>
<tr>
<td><strong>Social Map</strong></td>
<td>To establish the number of households, population, water point and latrines.</td>
</tr>
<tr>
<td><strong>Fasces Calculation</strong></td>
<td>To estimate the total amount of feces produced by the community annually.</td>
</tr>
<tr>
<td><strong>Defecation site visit</strong></td>
<td>To observe the current situation with regards to fasces dispersal due to open defecation.</td>
</tr>
<tr>
<td><strong>Flagging in open defecation areas</strong></td>
<td>To identify open defecation area and create feeling of shameness.</td>
</tr>
<tr>
<td><strong>Seasonal Calendar</strong></td>
<td>To analyze the availability of time and water point throughout the year.</td>
</tr>
<tr>
<td><strong>Wellbeing ranking</strong></td>
<td>To analyze the economic status of the household.</td>
</tr>
<tr>
<td><strong>Venn Diagram</strong></td>
<td>To identify the key people who have influence and are acceptable to the community.</td>
</tr>
</tbody>
</table>

**Sample of estimation for community defecation**

![Diagram showing the calculation process]

To assess the quantity of excreta for a week multiply by 7, for a month multiply by 30 and for annual multiply by 365 to quantity of excreta deposited at community in a day with discussing participants.

**Sample for calculation**

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total households in a community</td>
<td>145</td>
</tr>
<tr>
<td>Households with toilet</td>
<td>15</td>
</tr>
<tr>
<td>Households without toilet who are practicing open defecation</td>
<td>130</td>
</tr>
<tr>
<td>Total population of open defecators (5 family members in each family)</td>
<td>650</td>
</tr>
<tr>
<td>Quantity of excreta per person per day (Participants decided quantity)</td>
<td>500 gm.</td>
</tr>
<tr>
<td>Total deposited quantity of excreta in a day 650 x 500 gm (1 kg = 1000 gms)</td>
<td>325,000 gm or 325 Kg</td>
</tr>
<tr>
<td>Total deposited quantity of excreta in a week 7 x 325 Kg</td>
<td>2,275 Kg</td>
</tr>
<tr>
<td>Total deposited quantity of excreta in a month 30 x 325 Kg</td>
<td>9,750 Kg</td>
</tr>
<tr>
<td>Total deposited quantity of excreta in a year 365 x 325 Kg</td>
<td>118,625 Kg</td>
</tr>
</tbody>
</table>

In quintal = 118,625 /100 = 118.6 quintal. It comes to equivalent to 15 truck load (considering capacity of 1 truck = 8 tons)
As the process led by communities, we should be only as facilitators and some don't and do should be always remembered during community meeting and process implementation.

<table>
<thead>
<tr>
<th>Don’t</th>
<th>Do</th>
</tr>
</thead>
<tbody>
<tr>
<td>▪ Educate</td>
<td>▪ Facilitate</td>
</tr>
<tr>
<td>▪ Tell people what is good and what is bad.</td>
<td>▪ Let people realize themselves.</td>
</tr>
<tr>
<td>▪ Offer hardware subsidy.</td>
<td>▪ Trigger local action</td>
</tr>
<tr>
<td>▪ Promote particular latrine design.</td>
<td>▪ Let people innovate simple latrine</td>
</tr>
<tr>
<td>▪ Be in charge</td>
<td>▪ Hand over to local leaders</td>
</tr>
<tr>
<td>▪ Push for or demand action.</td>
<td>▪ Trigger self mobilization through a good facilitation.</td>
</tr>
</tbody>
</table>

5.3  **Phase -3- Action Planning**

Based on the interaction done in PPC-VDC level; VDC-DDC level an action plan will be developed. According to plan, the PPC, VDC and District Level Sanitation Coordination Committee (DLSCC) will act as catalyst for ignition the CLTS process mobilizing the 100% community. Regular sharing meeting will be organized and disseminated the progress and recognize that community households for achieving significant output in CLTS. At the initial stage, the facilitator will facilitates how to conduct meeting, write resolution, how to prepare and implement action plan. Apart from this, a common place is identified to disseminate sanitation awareness among the male, female, children and adolescent. Besides these, facilitator explains community roles and responsibilities for hardware implementation. On the basis of prevailing requirement some of the task force working group will be formed to accelerate the process effectively.

Encourage better of households to help the less well off to find a way to stop open defecation, as they will also benefit. They may lend land, donate wood or bamboo or allow poorer families to use their toilet in short term. Identify such generous people, bring them to front of the gathering and announce there donation in public. Often their announcement encourage to others to offer assistant. The collective benefit from stopping open defecation should help to encourage a more cooperative approach.

DLSCC and task force committee will organize coordination meeting and develop periodic plan for district level open defecation free announcement activities and support accordingly. The monitoring committee has to be coordinated with DLSCC and task force.

5.4  **Phase -4- Monitoring and upgrading**

Facilitator encourages PPC and other task groups to evaluate whether the planned safe water access promotion, sanitation and hygiene behavior practice promotion activities are accomplished significantly or not. To enhance the capacity of the PPC and task groups an
intensive and continuous support for capacity building is extended in terms of skill based training and hands on orientation to achieve the following aspects:

- Community people can raise their voice to establish their social rights and make decisions;
- Local resources are identified and utilized properly at optimum level Govt. allocation for sanitation and water supply;
- Local government institutions are accountable to community towards the confident and good relation and effective alliance building for sanitation improvement.

A monitoring committee will be formed with the participation of Policy level authority, representatives from political parties, supporting organizations and community members.

5.4 Phase -5- Declaration of open defecation free village

Mass level program will be organized to declare open defecation free at all level of district organizing different program like rally, talk program, cultural program, debate, interaction, quiz contest etc. Declaration of open defecation free in cluster and VDC level will facilitated by PPC facilitator. Similarly, district level declaration will be facilitated by the PPC network and DLSCC accordingly.

6. Project Costing at unit level

1. Complete sets of pan Rs. 352
2. 80 cm long 90 mm HDP exit pipe and air seal plastic Rs 100
3. Transportation to DHQ Rs 25
4. Contingencies Rs 23
Total NRs 500

US$ 7.14
(exchange rate=70)
Reference used:

VERS, Bangladesh (2005), *People Initiated 100% Sanitation Approach, Process Documentation*

Kamal Kar (2003), *Subsidy or self-respect? Participatory total community sanitation in Bangladesh*

Kamal Kar (2005), *Practical Guide Book to Triggering CLTS*

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Rokeya Ahammed, *Achieving 100% sanitation: WaterAid Bangladesh and VERC,*