

15 Community Led Total Sanitation in Pakistan

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Abstract

Development projects in rural areas have lagged behind their urban equivalents in post-decentralisation Pakistan. What little investment is going into sanitation projects from various line departments and municipal administrations is output oriented. The projects are implemented using traditional approaches with heavy focus on the creation of infrastructure.

The project planners and implementers are interested in counting the numbers, the tangible outputs of any infrastructure project, at the end of the project cycle. None of the projects count "outcomes", that is, the end impact or likely impact on the health of beneficiaries and the environment. Another dilemma for the sanitation sector is that there is little focus on "softer" issues, such as

healthy hygiene and behaviour change, either as part of a project or independently. Most infrastructure projects fail because they are not demand driven, through a lack of ownership, and because they do not address the issue of behaviour change. Consequently the project becomes dysfunctional some time after completion.

The new partnership between WaterAid and Integrated Regional Support Programme (IRSP) paved the way for the introduction and scaling up of Community Led Total Sanitation (CLTS) in Takht-e-Bhai in coordination with the Tehsil Municipal Administration (TMAs) in Mardan district of North West Frontier Province (NWFP). With its focus on "behaviour change" and "outcomes", the CLTS approach was implemented properly and gained success.

The successful story of CLTS in Takht-e-Bhai is spreading slowly and steadily. One day, it will replace the traditional sanitation system in Pakistan. Currently, only 42% of the population, including 65% in urban areas and 30% in rural settlements, has access to sanitation facilities. With the exception of a few big cities, sewerage is almost non-existent, causing serious health and environmental problems. Some 58% of rural households were without any form of sanitation system in 2005-06, compared to 66% in 2004-05 (PLSM, 2006). Although 42% of the population has access to sanitation, this does not mean that usage is also 42%. A significant proportion prefers to defecate in the open, despite having access to a toilet.

Introduction

Pakistan has the seventh largest population in the world with nearly 150 million people, and an annual growth rate of 2.4%. 70% live in rural areas, with an average annual per capita income of US\$470. Pakistan is listed among low-income countries (MoF, 2005). As a result of unequal distribution of wealth, almost 40% of the population lives below the poverty line (UNICEF, 2005).

These poor people mostly live in rural areas or urban slums without facilities, where there are always threats to the environment and natural resources. They also lack access to education, basic health and safe drinking water and sanitation services. This lack of facilities severely and directly affects the people's health and employment.

The situation in North West Frontier Province (NWFP) is further exacerbated by the presence of an estimated three million Afghan refugees, a substantial addition to the local population of 20 million. This has had an adverse effect on basic services and overall social economy. According to the NWFP government, only 59% of people have access to potable water while only 30% have access to hygienically safe sanitation (PLSM, 2006).

After devolution of power in 2001, under Local Government Ordinance (LGO) 2001, it was realised that the provision of water and sanitation services needed to improve. A large portion of urban and rural areas was intended to receive services. However, the complications of the devolved system mean urban areas have benefited but the rural areas still face the same uphill task.

Participating partners in development

To overcome these issues and to strengthen the efforts of the government, many development partners play crucial roles in providing sustainable water and sanitation services in urban and rural areas.

Water Aid is new to the Water and Environmental Sanitation (WES) sector in Pakistan but has a fully-fledged country office, and supports the activities of local partners in rural areas of Pakistan. In NWFP it has signed a partnership agreement with Integrated Regional Support Programme (IRSP) of Mardan District, a local NGO, and started activities in Tehsil Takht-e-Bhai of that district.

IRSP is a multi-sector non-government organisation working for rural development, poverty alleviation and development of local institutions. Using its

expertise in water and sanitation, it initiated an innovative model of community development, Community Led Total Sanitation (CLTS), in districts of NWFP. It also extends its services to others parts of the country.

The partnership of IRSP with WaterAid is unique because they are working in parallel to strengthen the efforts of Tehsil Municipal Administration (TMA) in providing sanitation services to the community. TMA consists of Tehsil municipal officer, Tehsil officer, chief officer and other local council officials and elected representatives from the whole of Tehsil. Each Union Council in the Tehsil jurisdiction is represented by union council Naib (assistant) Nazim (Chief elected official). Under the Local Government Ordinance 2001 TMA is responsible for the provision and monitoring of safe drinking water and safe sanitation. Historically the Government of Pakistan has followed traditional implementation methods for development projects, generally involving contracting out service provision. Usually communities get schemes which are full of flaws.

Now, due to the CLTS process, the TMA Takht-e-Bhai realises that only CLTS can solve their sanitation problems.

This paper tells the story of CLTS as it was developed in Mardan District. In part, we are doing this to share local experience, but we also invite observations from practitioners who have implemented CLTS in other locations.

An introduction to the programme area: District of Mardan

The area constituting Mardan district is a part of the Peshawar valley, which first appears in history

as part of the Gandhara kingdom. After the invasion of Alexander the Great, the mists of obscurity began to clear. The armies of Alexander reached the Indus valley by two separate routes, one direct through the Khyber Pass and the other led by Alexander himself through Kunar, Bajaur, Swat and Buner in 326 B.C. After Alexander's departure, the valley came under the rule of Chandragupta, who ruled the valley from 297 to 321 B.C. During the reign of the Buddhist emperor Asoka, the grandson of Chandragupta, Buddhism was the religion of the Peshawar valley. The valley saw the revival of Brahmanism after the Greeks took over in the time of King Mehanda. The Seythians and Indians followed and retained control of the valley till the 7th century A.D.

The villages are divided into Kandis (Clusters, a local traditional word used for Mohallas and streets) and are densely populated. Each Kandi is further divided into sub-sections, on the pattern of agricultural lands. Their houses generally consist of two or three rooms, a gholai (courtyard) and veranda. The house provides shelter for cattle and poultry along with the family.

Each Kandi of the village has its own mosque and its own Maulvi (Mosque Leader), and a place of meeting or for public assembly called a Hujra. In most cases it is the property of elders of the Kandi who are expected to feed and give shelter to visitors and travellers. These Hujras are commonly used for settling public disputes and business, as well as for public meetings. Residents of the Kandi assemble there to smoke, hear the news of the day and discuss their problems and politics. Nowadays, people working abroad have accumulated sufficient wealth to bring a distinct change in the life of the villagers, who construct 'pacca' houses of cement, bricks and timber.

Many houses also have a tandoor (oven) for baking bread, though sometimes three or four houses will share one tandoor. The houses have huge compound walls with gates. The well-to-do have chairs and tables, while others use the ordinary Charpaie (bed).

Lack of sanitation facilities is a big issue in these clusters. A high population density and lack of open spaces for open defecation aggravates the problem, especially in thickly populated semi-urban areas, though in rural areas there is much open space for defecation.

In initial discussions, community members cited sanitation as an urgent priority. WaterAid and IRSP selected the district for implementing CLTS because community representatives had already identified sanitation as a priority issue, and because of its unique cultural system and close social interaction. A unique model of joint cooperation between IRSP – Mardan and TMA Takht Bhai led to the selection of Tehsil Takht-e-Bhai of Mardan district for the CLTS project.

Sanitation situation

With increasing population and population density, the sanitary condition of rural areas, once known for their beauty, has been degraded to an unimaginable extent. Now cities, famous for bad smells and clogged drains, have become an attractive abode for living. Poor sanitation (e.g. the continued routine practice of open defecation) has exacerbated the problems of increasing population density. Neither has latrine construction kept pace with population growth. A large sum of money is spent on treating preventable diseases, but the state has not been able to curtail the spread of these diseases. Worsening sanitary conditions

may contribute to the prevalence of preventable diseases in Takhat-e-Bhai.

The sanitary situation of Tehsil Takhat-e-Bhai, like other parts of the country, is at the lowest ebb. Unsanitary conditions have in one way or another contributed to sanitation-related diseases like diarrhoea, scabies and eye infection. The figures from HMIS Mardan reveal the extent of sanitation-related diseases in Tehsil Takht-e-Bhai in 2005:

| S.N. | Disease | No. of patients | Percentage |
|------|---------------|-----------------|------------|
| 1 | Scabies | 2,326 | 3% |
| 2 | Eye Infection | 7,316 | 10% |
| 3 | Anaemia | 8,761 | 12% |
| 4 | Malaria | 12,301 | 16% |
| 5 | Diarrhoea | 44,472 | 59% |

Table 2 gives further evidence of the poor sanitation situation in Tehsil Takht-e-Bhai. This information suggests that low latrine coverage contributes to the current poor sanitary situation. Few people in rural areas understand the extent to which household latrines can control disease. Rural people remain shy about using latrines, and prefer to defecate in the open. Drains in most places are filled with stinking mud, water and garbage. Water remains stagnant in most of these drains providing a breeding ground for insects and microbes. Garbage is piled up in the streets and there are no proper solid waste management arrangements. The over-populated areas where refugees mix with the local population create further water, sanitation and hygiene problems.

As the above shows, the hygiene situation is very poor. If we link hygiene issues with water and sanitation, it becomes clear that where the water

and sanitation situation is bad, hygiene also suffers. The data below shows that open defecation remains common for many as household latrine coverage is low. Less than 30% of the population in these Union Council (UC) wash their hands with soap after defecation, although more than half now wash their hands with water – an encouraging trend.

Implementation of CLTS in Mardan District

WaterAid and IRSP adopted a unique approach of Community Led Total Sanitation to promote safe sanitation. This approach is based on changing attitudes and behaviour. ‘Total’ sanitation means the community needs to address three issues: stop open defecation (the highest priority); properly dispose of solid waste; manage waste water. Only

then does the community achieve the status of total sanitation.

The approach uses the main principles of participatory rural appraisal (PRA). CLTS-PRA techniques mobilize a community towards safe sanitation. Their first step is to stop open defecation, which causes water-borne diseases, affecting the living standards of the community. There are three important elements to CLTS–PRA that the facilitator triggers during the Broad Base Community Meetings (BBCM): ‘shame, shock and disgust.’ These go on to create self-respect within the community.

The NGO increased its staff to six (three male and three female, including a programme manager and

TABLE 2 Latrine coverage in Takht-e-Bhai

| S.N | Union Council | House holds | Hh. with latrine | | Hh. without latrine | | Types of latrine | | | |
|-------|---------------|-------------|------------------|-------|---------------------|-------|------------------|-------|--------|-------|
| | | | No. | % | No. | % | VIP | % | Flush | % |
| 1 | Damen-i-Koh | 2,149 | 1,402 | 65.24 | 747 | 34.76 | 15 | 1.07 | 1387 | 98.93 |
| 2 | Hathian | 1,914 | 453 | 23.67 | 1,461 | 76.33 | 144 | 31.79 | 309 | 68.21 |
| 3 | Jalala | 2,341 | 1,152 | 49.21 | 1,189 | 50.79 | 106 | 9.2 | 1,046 | 90.8 |
| 4 | Jehangir Abad | 2,309 | 549 | 23.78 | 1,760 | 76.22 | 52 | 9.47 | 497 | 90.53 |
| 5 | Kot Jungarah | 2,140 | 843 | 39.39 | 1,297 | 60.61 | 25 | 2.97 | 818 | 97.03 |
| 6 | Lund Khwar | 2,214 | 1,547 | 69.87 | 667 | 30.13 | 825 | 53.33 | 722 | 46.67 |
| 7 | Madey Baba | 2,128 | 707 | 33.22 | 1,421 | 66.78 | 15 | 2.12 | 692 | 97.88 |
| 8 | Makory | 2,357 | 1,159 | 49.17 | 1,198 | 50.83 | 596 | 51.42 | 563 | 48.58 |
| 9 | Mian Isa | 2,411 | 582 | 24.14 | 1,829 | 75.86 | 9 | 1.55 | 573 | 98.45 |
| 10 | Naray | 2,115 | 724 | 34.23 | 1,391 | 65.77 | 4 | 0.55 | 720 | 99.45 |
| 11 | Pat Baba | 2,341 | 1,319 | 56.34 | 1,022 | 43.66 | 216 | 16.38 | 1,103 | 83.62 |
| 12 | Pirsaddi | 2,278 | 301 | 13.21 | 1,977 | 86.79 | 22 | 7.31 | 279 | 92.69 |
| 13 | Purkho | 1,551 | 361 | 23.28 | 1,190 | 76.72 | 34 | 9.42 | 327 | 90.58 |
| 14 | Sari Bahlol | 2,484 | 397 | 15.98 | 2,087 | 84.02 | 57 | 14.36 | 340 | 85.64 |
| 15 | Saro Shah | 2,345 | 1,073 | 45.76 | 1,272 | 54.24 | 29 | 2.7 | 1,044 | 97.3 |
| 16 | Sher Garh | 843 | 524 | 62.16 | 319 | 37.84 | 451 | 86.07 | 73 | 13.93 |
| 17 | Takkar | 2,144 | 1,533 | 71.5 | 611 | 28.5 | 14 | 0.91 | 1,519 | 99.09 |
| Total | | 36,064 | 14,626 | | 21,438 | | 2,614 | | 12,012 | |

interns). It then developed an operational plan for field staff and initiated activities like an Alliance Building Workshop with TMA and other stakeholders. It trained 20 staff members, 50 UC staff, 40 Religious leaders, 30 sanitary shop owners, 20 Lady Health Workers (LHWs), 30 Community Based Organisations (CBOs) and 40 natural community leaders. In this process the activists/natural leaders and religious leaders/Pesh Imams played an important role in disseminating the message according to the teachings of Islam. The religious leaders especially can easily bridge the gap between community and programme, improving the perception of the NGO within the community. The NGO field staff (male and female Social Organisers [SOs]) conducted a series of corner meetings (CMs) with natural leaders/activists, religious leaders, school teachers, UC Nazim, Naib Nazim and village councillors male and female. These prepared the ground for the broad base community meeting where they applied CLTS-PRA techniques.

The elected representatives at grassroots level (from all 17 union councils and tehsil councils), local school teachers, students, playgroup children, religious leaders, government officials (including the union council secretary), CBOs, Voluntary Organisations (VOs), influential natural leaders and female councillors (who make up a third of all tiers of local government) all participated in the campaign. This made sanitation become everyone's concern and shaped a true people's movement in Tehsil Takht-e-Bhai.

PRA uses community mobilisation techniques like transect walking, social mapping, calculation of faeces, flow diagrams (demonstrating how human excreta can contaminate food and water), calculation of medical expenses on water-borne

diseases, solution ideas, action planning and monitoring systems.

The PRA session played a vital role in increasing the community's understanding of sanitation. The people decided – or rather determined – to promote safe sanitation in their community. They took a collective local decision to create an Open Defecation Free (ODF) environment. The community members started latrine construction according to their own resources. The community activists and natural leaders, with the support of IRSP – Mardan staff, declared 80 villages Open Defecation Free and allowed no one to defecate in the open. In just three and a half years, 3,220 latrines have been built in 80 villages. Women decided on much of the latrine construction process, and in most cases women themselves dug simple pits and constructed latrines. Since women and children suffer more from the unavailability of latrines, they immediately started building their own household latrines.

In the CLTS approach people have various technology options – wood, mud, plastic sheet, pipes, ash, waste cloth, tin, bricks, stone etc. With the help of these local materials, communities can construct different types of household latrines. The pour flush system uses slab, pan, pipes etc.

Some technical problems arise in constructing latrines in cases where the water table is high. Our mobilizer faced a sort of resistance in such areas. People are afraid of the risk of water contamination from the construction of underground dry pit latrines in large numbers. This, in some areas, creates a question mark for implementing partners which needs thorough research. Donors and research organisations need to intervene in resolving this issue.

It is difficult to change the behaviour of the people in a single meeting. To change people's attitudes towards the use of latrines, hand washing etc. health hygiene education sessions are conducted using IEC materials. The community members separate good behaviour and bad behaviour in the IEC material. As a result of this session, 480 male and female children became sensitised to health and hygiene issues.

CLTS mobilizes all members of the community, which benefits each and every member of the community, especially the poorest of the poor. The landless poor people in the community are always reproached by the land owners for defecating in their fields.

There is no concept of external subsidy in CLTS, but it fits the "social solidarity concept". Under the social solidarity approach, the rich help the poor and this further develops social cohesiveness within the community.

Mr Haji Abdul Khaliq, resident of the village of Jangrez killi UC Jamal Ghari, announced plans for constructing simple latrine pans in all 60 households that had no latrine facility, proving the importance of social solidarity.

CLTS helps the poorest of the poor to construct household latrines. This stops open defecation and saves them from the harmful effects of water-borne diseases and the medical expenses these bring. As a result of this change of behaviour, the community develops and moves towards prosperity.

In latrine construction, local innovation and community action is encouraged. People construct their household latrines according to their needs

and priorities. Some people construct a dry pit and cover it to stop the flow of rain water into the latrine. Others use plastic sheets where the water level is high to save water from contamination.

It is also worth mentioning that the cost of latrine construction varies from 300 to 10,000 rupees:

- A simple pit latrine can cost up to 300 rupees. Usually, the pit is dug by the members of the household and they use mud for the super-structure and boundary wall. Latrine construction uses wood, plastic, tin, stone and locally available, affordable materials.
- Hardware bought from external markets raises the cost up to 10,000 rupees. In the case of pour flush latrines, hardware is normally bought from outside the community.

In the overall process of mobilisation there are no sweet incentives or subsidy to the community for constructing latrines. The community is rewarded only after acquiring ODF status. This reward is not meant for latrine construction, however; it shows appreciation of the work already achieved.

Outcomes

The first and the most prominent outcome of the CLTS process in Pakistan is its official recognition by the federal government. They now include CLTS in the approved national sanitation policy, and it is also reflected in the provincial sanitation strategies. To measure the outcome of the CLTS programme in a community we considered two types of indicators: visible and invisible.

- By visible indicators we mean that, first, the community stops open defecation and builds household latrines.
- The invisible indicators refer to the attitudinal and behavioural changes of the community.

Field staff monitor ODF status and conduct household monitoring visits. When a village achieves ODF status, internal monitors regularly assess the process. If a latrine collapses or people start open defecation again, the natural leaders persuade the people to rebuild and continue using it. The CLTS concept is different from other approaches. In the past, the focus was on the number of latrines constructed, while in CLTS the only focus is changing people's attitudes and behaviour towards safe sanitation. The CLTS approach also encourages the local community to identify local issues and stresses collective decision making for solutions. This makes it more sustainable than other programmes.

Visible

After a village has been declared ODF, the people (children, young, old, male and female) use latrines and don't defecate in open. School children also use school latrines. The outcome is measured by staff (especially female social mobilizers) and natural leaders of the village. The female social mobilizer conducts monitoring visits at household level to see the latrine construction and healthy hygiene behaviour of the household members, especially women and children. The monitoring is part of the process and only starts when the community shows willingness.

The natural leaders are involved in internal monitoring of the development process. They draw a village map showing latrine coverage on a white sheet of paper and display it in a public place. Every household member or natural leader puts a tick mark in front of those households who have constructed latrines. This is a very strong monitoring process, which develops competition among the community. The information is shared with other

villagers and the natural leaders encourage the villagers.

NGO staff conduct monitoring visits after a village declares itself Open Defecation Free. They walk the village checking for any signs of open defecation. It is interesting to note that in Takht-e-Bhai a monitoring committee was formed, comprising the Tehsil Nazim, an NGO member and a community member. They also conducted monitoring visits to see the environment of the village. Once the monitors find the village, fields and drains to be free of excreta, the village is certified as ODF.

In some communities and areas, the older age group initially resisted the using household latrines. They were of the opinion that they cannot use household latrines in front of their family members, especially female members. With the passage of time, these elders started to use their household latrines and also built communal latrines (in public places like Hujra, Masjid and near the fields).

Data from local medical practitioners was also used to see the trend of water-borne diseases in an ODF community.

Invisible

When the community stops open defecation and follows safe hygiene behaviour, health and hygiene conditions improve.

Once a village has been declared ODF, some drastic changes are seen in health and hygiene. People spend less on medicines compared to places where there are no latrines and people defecate in the open. According to a rough calculation the villagers

spend an average of 3,000 rupees per household annually on diarrhoeal diseases which spread from open defecation. CLTS makes villagers identify how diarrhoea is spread through flies, fingers, fluids, fields, foods etc.

People in ODF communities said that they were enjoying ODF status, which had brought positive changes in their health. Fewer diseases meant less spending on diseases, ultimately decreasing poverty. They also said that after achieving ODF status the sugarcane crop improved. This is because when they practised open defecation in the fields they used to leave a minor portion of their crop during harvesting. Now, they are able to harvest the whole crop, increasing their income.

The spreading and scaling up of CLTS is very high. It creates an element of shame, disgust and fear which minimises the dependency syndrome. It also depends on the facilitator who introduces CLTS techniques. Some of the nearby communities started interventions in their own villages without NGO support and got ODF status. This proactive behaviour shows the level of interest in CLTS.

It is interesting to see that the activists of Inzar Kali (the first ODF village in Pakistan) initiated this programme in two villages, Badyano and Rahim Shah Band, and made them ODF in four months.

The reward mechanism also speeds up the pace of the CLTS programme. ODF villages are rewarded by local government (e.g. TMA) and other donors (UNICEF etc.) At local government level, TMA is also involved in water and sanitation which will give a new dimension to achieving sanitation objectives.

The national level sanitation policy and provincial sanitation draft strategy gave a new direction towards achieving sanitation objectives, including the Millennium Development Goal. When the sanitation strategy is enforced, the provincial government will reward the ODF Union Council and Tehsil through TMA.

According to our experiences some subsidy approaches that work parallel to the CLTS approach create a dependency syndrome among the community. This competition can make it difficult to interest people in an incentive-less programme.

Now, government agencies are discouraging subsidy-oriented sanitation programmes and concentrating on CLTS for the larger interest and benefit of communities. The government has observed that CLTS can provide safe sanitation to all the population.

Introducing the programme to children under five is difficult because of their age and their mothers' lack of education. These children spend much of their time outside their homes playing in the streets. These children do not understand such concepts as shame, shock, disgust or self-respect.

We also need to produce material which is durable, cheaper and easily available for the construction of latrines.

The CLTS approach brings about community development through bringing a social change but it doesn't occur immediately; it is a slow and sustainable process to meet the sanitation challenges in future.

There is a fundamental missing link between demand and supply, which should be given due importance. Demand is generated by the CLTS promoters but the supply side is not focused. In most villages there are no hardware manufacturers and shops. People have to go far away to buy a sanitary latrine and other materials that cost more money. There is, then, a need to develop a strategy for supplying sanitary latrine materials. The strategy should be developed based on estimating demand and demand-supply gap, availability of raw materials and technology, attitude of the private sector and affordability for the people of the community. After analysis of the demand and supply situation and existing conditions of the community, the strategy would provide some indications as to the appropriate measures for minimising the supply gap and making available sanitary latrine materials. In some places, small entrepreneurs may be attracted to producing sanitary materials, some may feel encouraged to keep sanitary latrine materials in the grocery shops with other products, or even set up separate hardware shops. The promoters of CLTS could introduce a mobile festival to display different materials for sanitary latrines in the villages once a month. This would motivate the villagers and create demand among the people for sanitary latrine materials.

Technology options

The project worked with limited technology options. There were inadequate technology choices, and the project did not explore many options. There was a tendency not to look beyond single pit technology, as it is considered low-cost and a simple way for the community to switch from open defecation to fixed-point defecation. There were only four technology options:

- simple pit latrine (300 rupees)
- VIP pit latrine – simple pit latrine with ventilation facility (500 rupees)
- pour flush (10,000-12,000 rupees)
- pour flush with overhead tank (12,000+ rupees).

The single pit latrine technology was highly promoted because it is cheap, affordable and easy to install. Introducing low-cost technology still needs some intervention and encouragement from other partners. In Pakistan, latrine technology is still in its initial stages, and needs to be improved to encourage private sector investment.

Conclusions

Community Led Total Sanitation, which is a unique programme for sanitation promotion adopted in Pakistan's Mardan district, has brought a revolution in the field of sanitation. In Pakistan, sanitation was given a due priority for the first time after a sanitation policy was approved in 2006. The people of Mardan district proved that the CLTS programme can be successfully implemented everywhere. They changed the centuries-old practice of open defecation and broke the dependency syndrome.

The CLTS concept successfully changed the subsidy culture and it was proved that sanitation and latrine construction is not a problem of money and poverty, but it is an issue of knowledge, which can be solved by strong motivation skill. PRA techniques analyse the situation and issues of a village and inspire the community to solve their problems according to their own planning.

The intervention of government and other donors proved to be successful in scaling up and sustaining CLTS. The Government of Pakistan has marked out

CLTS as one of the programmatic approaches for achieving the sanitation objective and Millennium Development Goal.

The involvement of the children and playgroup is very important in the scaling up of CLTS. As an exercise to attract the attention of playgroup children, they were assembled in a group and encouraged to shout “Bahir tati band karenge”, meaning “we will stop open defecation”.

CLTS involved the community in deciding to stop open defecation and constructing household latrines. The household latrine construction involved various technological options, and it is interesting to note that there is no low-cost technology model. There is a need for interventions from partners to develop suitable low-cost technology in Pakistan.

The project will have to develop monitoring and follow-up mechanisms for achieving total sanitation, where the community is responsible for supervising different areas of the process. The monitoring committee should include representatives from the project, community activists, social leaders and local government. It will create ownership among different parties. Continuous monitoring is directly related to the sustainability of the total sanitation programme. In the first phase, the committee should monitor the general progress of different activities related to stopping open defecation and installing latrines at the household level. Later on the monitoring mechanism should measure behavioural changes, hygiene practices and the installation of more improved latrines. Field workers and social activists should also develop a model for analysing this crucial monitoring process.

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