



Kingdom of the Netherlands

REPLICATION GUIDELINE TO SEHATI PROGRAMME APPROACH (SUSTAINABLE SANITATION AND HYGIENE IN EASTERN INDONESIA)

An approach to expand the implementation coverage of the 5 pillars of STBM



Simavi IRC

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and hygiene services for life





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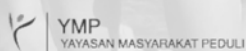
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(SUSTAINABLE SANITATION AND HYGIENE FOR EASTERN INDONESIA)**

ADVISORS

Asken Sinaga
Catur Adi Nugroho
Paul van Essen

AUTHORS

Angelina Yusridar Mustafa
Erick Baetings

TRANSLATOR

Muhammad Rafi'ie

EDITOR

Asken Sinaga

DESIGN AND LAYOUT

Angelina Yusridar Mustafa

From the experience of implementation of the SEHATI programme since 2016 in 7 districts namely Lombok Utara, Lombok Timur, Dompu, Sumba Tengah, Sumba Barat Daya, Manggarai Barat and Biak Numfor.



Photo: Jerry de Mars (SEHATI)

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GLOSSARY

Akses Universal 100-0-100	The target of national development to achieve universal access in 2019 to all communities as well as the realisation of 100% access to clean water, 0% of slum areas and 100% access to sanitation.
AMPL	Drinking Water and Environmental Health
APBD	District Annual Plan and Budget
BABS	Open Defecation
Bappeda	District Development and Planning Agency
Bappenas	National Development and Planning Agency
BOK	Health Operational Assistance Fund
BPMPD	Community Empowerment and Village Government Agency
Capacity Monitoring	Monitoring tool developed by Simavi to measure the capacity of Pokja AMPL, Health Office, sub-district government, village government, sanitation entrepreneurs and SEHATI partners, which includes the ability to arrange regulations and implement them, to allocate budget for the 5 Pillars of the STBM, to conduct facilitations and monitor its implementations.
CD Bethesda	Community Development Bethesda YAKKUM, one of Simavi partners in implementing SEHATI programme in Sumba Tengah District and Sumba Barat Daya District, Nusa Tenggara Timur Province. For further information please visit http://cdbethesda.org
Dana Desa	Village Fund: it is allocated directly by the national government to village government to accelerate development at village level. BPMPD is responsible for monitoring the utilisation of this fund.
KLH	It stands for <i>Kementrian Lingkungan Hidup</i> in Indonesian or known as Ministry of Environment.
NGO	<i>Non Government Organisation</i> also known as <i>LSM (Lembaga Sipil Masyarakat)</i> .
NTB	Nusa Tenggara Barat.
NTT	Nusa Tenggara Timur.
OPD	It stands for <i>Organisasi Perangkat Daerah</i> in Indonesian or known as Regional Apparatus Organisation.
Perda	It stands for <i>Peraturan Daerah</i> in Indonesian or known as Regional Regulation.
Plan International Indonesia	<i>Yayasan Plan International Indonesia</i> , one of Simavi partners in implementing SEHATI programmes in Lombok Utara District and Dompu District, Nusa Tenggara Barat Province. For further information please visit https://plan-international.org/indonesia
Pokja AMPL	Drinking Water and Environmental Health Working Group: an ad hoc working group chaired by Planning and Development Agency to coordinate the development of initiatives on water, sanitation and hygiene at all levels.

Posyandu	It stands for <i>Pos Pelayanan Terpadu</i> in Indonesian or also known as Integrated Service Post, is a monthly clinic for children and pregnant women, providing vaccinations and nutritional supplements.
PUPR	It stands for <i>Pekerjaan Umum dan Perumahan Rakyat</i> in Indonesian or known as Public Works and Public Housing.
Puskesmas	It stands for <i>Pusat Kesehatan Masyarakat</i> in Indonesian or known as Primary Health Centre.
Road Show	One of STBM core activities to advocate, introduce and raise awareness on STBM and gain commitment from relevant stakeholders.
Rumsram	<i>Yayasan Rumsram</i> , one of Simavi partners in implementing SEHATI programme in Biak Numfor District, in Papua. For further information please visit http://www.rumsram.org
SEHATI	<i>Sustainable Sanitation and Hygiene for Eastern Indonesia.</i>
SHAW	<i>Sanitation, Hygiene and Water</i>
Simavi	A Dutch NGO that manages SEHATI; it also play roles in coordinating SEHATI Programme and conducting advocacy at the national level. For further information, please visit https://simavi.org
STBM	Community Based Total Sanitation approach launched by the Ministry of Health since 2008 to improve hygiene practises at community level. As described in the Ministry of Health Regulation Permenkes No. 3/2014, the pillars of STBM consist of: <ul style="list-style-type: none"> • Pillar 1: Open Defecation Free (ODF) • Pillar 2: Hand washing with soap • Pillar 3: Household water treatment and safe storage • Pillar 4: Solid waste management • Pillar 5: Household liquid waste management
<i>Stunting</i>	A problem of chronic malnutrition caused by a lack of nutritional intake for a long period of time, resulting in disruption of growth in children, namely lower or shorter children's height (stunted) from their age standard and in the long run will affect children's brain development.
TTK	It stands for <i>Tim Teknis Kabupaten</i> in Indonesian or also known as District Technical Team.
YDD (Yayasan Dian Desa)	One of Simavi partners in implementing SEHATI programme in Manggarai Barat District, Nusa Tenggara Timur Province. For further information please visit http://www.diandesas.org
YMP (Yayasan Masyarakat Peduli)	One of Simavi partners in implementing SEHATI programme in Lombok Timur District, Nusa Tenggara Barat Province. For further information please visit http://ympntb.org

FOREWORD



The innovation of sanitation and hygiene programmes through STBM approach carried out by various non-governmental organisations in the past few years is acknowledged by several parties to have contributed to alleviating sanitation problems in Indonesia. However, some parties still find problems in it, namely the lack of attention of organisations involved to the sustainability aspects of the programme. Most programmes are still treated as temporary projects, which will cease when the implementors have completed their programme activities. When local governments are involved in such programmes, the local governments will no longer continue, let alone replicate them, because the programme approach is not inherent or institutionalised in the system and in local government bureaucracy.

It is this aspect of sustainability that has received special attention in SEHATI since its stage of design, causing the programme intervention is directed to strengthen the aspects that play roles in realising sustainability. The programme is also designed to produce a guidebook on how to proceed or replicate the SEHATI approach to other regions. The hope is that this guidebook can be used by stakeholders of sanitation development, especially local governments, both as a general reference and as a tool to continue and replicate sanitation programmes using the SEHATI approach. This is the background of the development of this Replication Guidebook to SEHATI Programme Approach.

The contents of this guidebook are about how local governments can replicate the SEHATI approach to other villages or sub-districts that have not been reached by the programme during the period 2016 - 2019. Nonetheless, before reaching that section, this guidebook also describes other relevant things, both from programme documents and literature reviews. The aim is so that readers can get a better understanding of the contents and recommendations of this guidebook.

Throughout this guidebook, readers will also find a variety of learning during programme implementations. Nevertheless, from various lessons learnt, there are some very unique lessons (maybe as a distinction of the SEHATI approach from other approaches), that we need to underline, namely:

- Local government commitments are required to be obtained in the early stages of the programme. Therefore, programme actors need to have lobbying and advocacy skills to obtain them.
- The capacity of stakeholders, especially of local governments at various levels, in terms of implementing the 5 pillars of the STBM, must be adequate. If it is not sufficient, capacity building must be carried out jointly by adopting local policies.
- Establishment of formal institutions focusing on implementing the 5 pillars of the STBM at various levels is very necessary; such institutions need to be given special support covering technical, managerial, human resources, leadership and financial aspects.
- Gender equality, social inclusion and human rights principles need to be ensured to have been considered in the process of local policy making and in the preparation of sanitation programmes with the approach of the 5 pillars of the STBM.
- Monitoring, evaluation of discussions and coordination of the results are important stages for the need of improvement in programme implementation through adaptation and adjustment of strategic planning and annual work plans.

We hope this document can provide inspiration and benefits for all parties.

Jakarta, July 2019

Asken Sinaga
Country Representative in Indonesia

ACKNOWLEDGEMENT

A French novelist, Marcel Proust, once said, “*The real voyage of discovery is not in seeking new landscapes but in having new eyes*” (the real journey of discovery does not lie in the act of looking for a new landscape, but in a new perspective.) This quote very much represents the experience of the programme implementing partners throughout the course of the SEHATI programme and the previous SHAW programme. The discussions conducted, especially during 2017 - 2019, have provided partners with new perspectives on sanitation programmes and the 5 pillars of the STBM approach in Indonesia. .

Upon the experience of the discovery journey, the authors express their appreciation to SEHATI partners, namely Yayasan Plan International Indonesia, Yayasan Masyarakat Peduli NTB, Yayasan Dian Desa, CD Bethesda YAKKUM and Yayasan Rumsram and the national government and local government in 7 SEHATI assisted districts for their dedication and contribution in the implementation of the programme and preparation of this guidebook.

The authors also thank the Embassy of the Kingdom of the Netherlands for its financial support for the SEHATI programme.

Jakarta, July 2019

Authors

Health must be maintained, starting with the most important thing, namely proper and clean sanitation.

(Nila Djuwita Farid Moeloek
Minister of Health of the Republic of Indonesia 2014 - 2019)



Photo: Angelina Yusridar (SEHATI)

INTRODUCTION

Indonesia still faces enormous challenges in terms of sanitation and hygiene. The results of the 2018 Basic Health Research show that the proportion of households that have access to proper sanitation facilities is only 61.6%. This means that there are still 38.4% of the total households that do not have proper sanitation facilities. The lack of sanitation facilities is suspected to be one of the contributors to cases of illness due to diarrheal diseases. The same research results also indicate a link between sanitation access and the prevalence of stunting. Regions with low sanitation access tend to have higher stunting cases.

Government of Indonesia is currently paying great attention to efforts in reducing the prevalence of diseases due to poor sanitation and stunting through sanitation and hygiene programmes using a variety of approaches, one of which is the 5 pillars of the STBM approach. Besides being seen as able to target the problems of low access to proper sanitation and clean and healthy living behavior of the community, this approach is also deemed appropriate to be a means of sensitive nutrition interventions for stunting problems, as suggested by the Lancet Study (2013)¹.

Although, the 5 pillars of the STBM approach is considered to be ideal enough to answer the existing sanitation problems, its implementation is apparently not easy. During the 10 years since this approach was proclaimed, development actors, both government and non-government actors, are still focusing only on the first pillar of the 5 pillars, namely Stop BABS (Stop Open Defecation), and even then the emphasis is still on the aspects of building sanitation facilities. Such practises are not in accordance with the enthusiasm in the approach; and continuing such practises is deemed ineffective in answering the above problems. This gap is the background of the design of the SEHATI programme that this programme gives equal attention to the 5 pillars of the STBM.

Since 2016, Simavi and 5 partner organisations in assisted regions have implemented the SEHATI programme in 7 districts in Eastern Indonesia with a focus on efforts to increase the capacity of local governments to implement the 5 pillars of the STBM approach. This means that SEHATI does not implement the 5 pillars of the STBM approach directly at the community level, but strengthens the capacity of local governments so that they are willing and able to lead the implementation of sanitation and hygiene programmes in their areas.

Until 2019, 215 SEHATI pilot villages have implemented the 5 pillars of the STBM and 161 other villages have replicated the SEHATI approach in their regions. This suggests that the approach to capacity building of local governments is effective in terms of scaling up and replication. All data on SEHATI's progress and achievements provide optimism that sanitation programmes using the 5 pillars of the STBM approach will sustain when the SEHATI programme ends.

This guidebook is a record of the journey of the implementation of SEHATI in its 3 years of implementation. It describes in details each stage taken by SEHATI to implement the 5 pillars of the STBM approach in its entirety and gradual nature, starting from its initiation (starting up), implementation, monitoring and evaluation stages.

¹Bhutta, Z.A., Das, J.K., Rizvi, A., Gaffey, M.F., Walker, N., Horton, S., Webb, P., Lartey, A., Black, R.E., Group, T.L.N.I.R. and Maternal and Child Nutrition Study Group, 2013. Evidence-based interventions for improvement of maternal and child nutrition: what can be done and at what cost?. The lancet, 382(9890), pp.452-477.

Many descriptions of experience and learning will be presented in this book. How SEHATI applies the principles and norms of fulfilling human rights, gender equality and social inclusion in the planning, implementation and evaluation processes will also be briefly described.

However, before arriving at the description, this guidebook will first briefly describe what the SEHATI programme is: theory of change and the approach it has.

Scaling up and Replication

Scaling up and replication are defined as deliberate efforts to increase the impact of proven health service innovations that have been successfully tested in the pilot regions so that they can benefit more communities and encourage sustainable development of policies and programmes². If considered more deeply, the definitions consist of several aspects, namely deliberate efforts, innovation, successfully tested and sustainable development of policies and programmes.

The lessons learnt from the implementation of the SEHATI programme in the last 3 years have shown that the above aspects have been fulfilled as outlined below:

- “Deliberate efforts” marks replication as a planned process to introduce programmes in new regions. SEHATI, from the beginning, is intended to be replicated to other regions.
- “Innovation” is a component or practise that is new or considered new in the context of sanitation and hygiene programmes. In the SEHATI approach, innovation exists in work approaches, procedures, good practises and technology that have never been used in a particular location, regardless the width of area coverage of the programme implementation.
- “Successfully tested” highlights interventions that have been proven effective and feasible through the pilot process of programmes in certain locations. In SEHATI programme, local governments conduct cross-sector learning and adopt good practises to improve achievements in their districts.
- “Sustainable development of policies and programmes” refers to the importance of capacity building and institutional sustainability in developing, building and maintaining political support, managerial structures, human resources and budgets and other service components needed for the success of the programme on a large scale. In the context of the SEHATI programme, this has been demonstrated in the focus of the programme, namely the development of budgets, regulations, and mechanisms for implementing sustainable programmes in districts, sub-districts and villages.

²Simmon R, Fajans P, Ghiron L. Introduction. In: Simmon R, Fajans P, Ghiron L, eds. Scaling up health service delivery: from pilot innovations to policies and programmes. Geneva, World Health Organization, 2007:vii-xvii.

THE CONCEPT OF SEHATI APPROACH

Theory of Change in General

The theory of change is basically a description or illustration of how and why an expected change occurs in a particular context³. In making a theory of change, various long-term goals to be achieved are first set up, then they are mapped back to the necessary conditions (outcomes) that must exist and how these conditions are interconnected and influence one another so that the long-term goals can be achieved. This theory explains how a programme or initiative will produce changes through various activities and interventions designed and how the interventions guide to the achievement of the ultimate goal (change).

The above definition can be illustrated by the following chart:

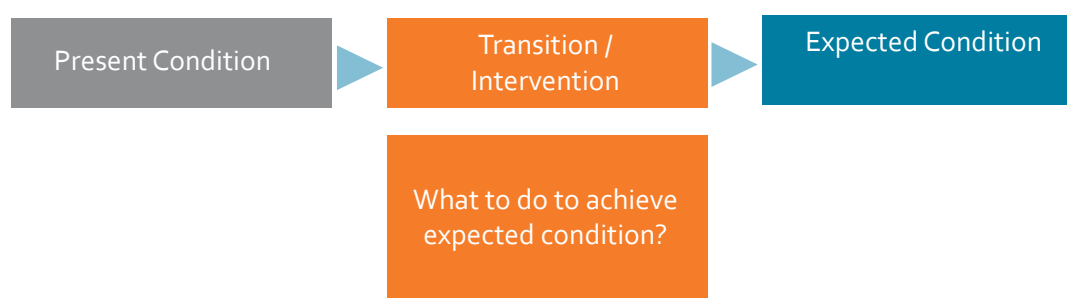


Figure 1. Simple Theory of Change

Theory of Change is not about “predicting change”, but it is about how we narrate the changes we expect. There are various considerations when we expect a change based on our current conditions. Theory of Change is an approach that involves various parties in the process of change itself. The involvement of various parties produces strategic and dynamic steps so that adaptation to reality is very likely to occur⁴.

Theory of Change and SEHATI Approach

The Sustainable Development Goals mandate that access to water and sanitation is human rights (indicator 6), and therefore, the government as the duty bearer of fulfilling these rights is responsible for the availability of water and sanitation services in the work region of the government. With the government decentralisation system in Indonesia, the role of the government in providing water and sanitation services is divided into several levels, namely the central government, the provincial government, the district government and the village government.

At the central level, the government has launched the 5 pillars of the STBM approach along with its tools and support systems since 2008 to ensure that there are standard guidelines for local governments to implement the approach. At the regional level, the provincial and district

³Schouten, T. and Moriarty, P., 2013. The Triple-S theory of change. Water services that last. The Hague. IRC.

⁴Van Es, M., Guijt Irene, Vogel Isabel. 2015. Theory of Change Thinking in Practise. The Hague. Hivos. p14.

governments have the role to implement the 5 pillars of the STBM approach at the community level starting from the regional regulations development to the technical implementation. However, even though the guidelines and regulations are available, the achievements made by local governments in the past few years have not been evenly distributed and the results are still lower than expected. This is caused by several main factors, including: (i) low commitment of local government; (ii) lack of budget and (iii) uneven expertise of implementors of the programme.

The SEHATI programme views all of these hindering factors as a capacity-related problem and therefore designs this programme to specifically target these hindering factors. That is why, the SEHATI approach is an approach (model) that emphasises the importance of building the capacity of the district government so that they are able to lead development in their respective regions. The SEHATI model views that the success of the 5 pillars of the STBM approach will depend on the extent to which the approach has become part of the existing local government structure, systems and processes; how effective cooperation between related technical units is; how harmonious the description of the main tasks and functions between each related technical unit are; and how strong the commitment of decision makers in the region is. The assumption that SEHATI has is that when the capacity is good, the local government and other relevant stakeholders will be able to start, plan, implement and monitor sustainable sanitation programmes that prosperity will ultimately be delivered to the community.

Based on this assumption, SEHATI develops a theory of change at the beginning of the programme implementation, which is the district government (enabler) will develop the capacity of the sub-district government (supporter) which will then develop the capacity of the village government (driver). In the end, the village government will implement the 5 pillars of the STBM at the community level. Simultaneously, district and sub-district governments will also build the capacity of sanitation entrepreneurs (suppliers, business actors) for them to be able to support the availability of affordable sanitation products and services for the community.

A general description of the theory of change of SEHATI can be seen in the chart below.

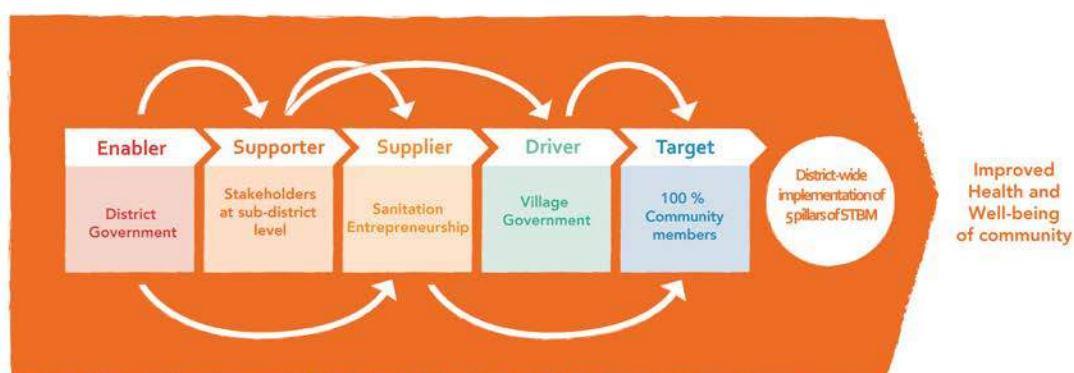


Figure 2. SEHATI Theory of Change

Figure 2 explains that the main actors in the capacity building process are the district governments. When district governments have sufficient capacity, especially in key elements such as budgets, activity plans, expertise and regulations regarding the 5 pillars of the STBM, they will build

capacities to the lower levels such as sub-district government, village government, and sanitation entrepreneurs and encourage implementation of the 5 pillars of the STBM at the community level.

Furthermore, when these capacities have been systematically integrated within the government, actors at the local level will be able to replicate the implementation of the 5 pillars of the STBM in all districts.

The framework of the SEHATI approach on field can be seen in the following chart:

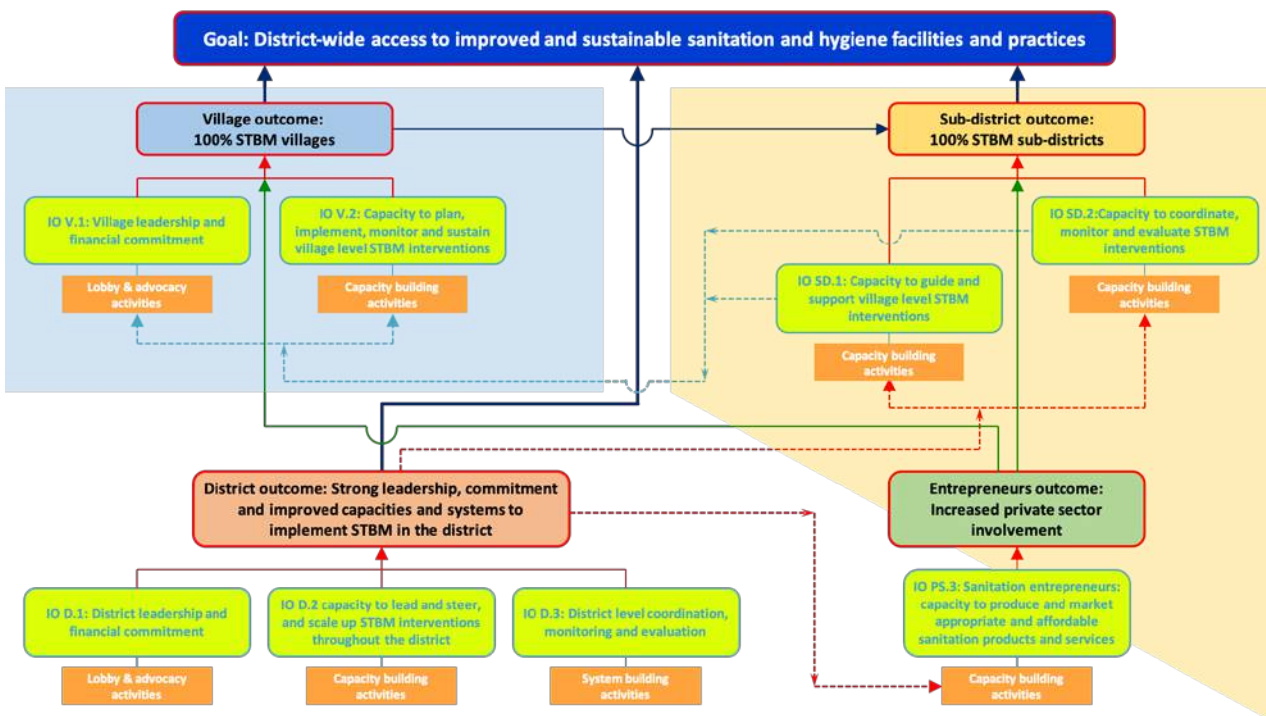


Figure 3. SEHATI Approach for the implementation of the 5 pillars of the STBM

The figure above shows how the linkages between capacity buildings made at various levels of local government contribute to the achievement of the final goal of the SEHATI programme.

From the diagram, it can be seen that there are at least 3 main activities that need to be done at the district level to produce the intended improvements, namely:

1. Lobbying and conducting advocacy to obtain commitment and financial support from relevant OPDs through APBD and BOK funds;
2. Building technical capacity to ensure local governments understand how the 5 pillars of the STBM are implemented;
3. Building the systems (bureaucracy and coordination) to ensure sustainability of the implementation of the 5 pillars of the STBM.

The three main activities that are expected to be carried out by the provincial government are intended to generate strong leadership and capacity in the district government in implementing the 5 pillars of the STBM in all districts.

The hope is that when the district governments possess good capacity, they will build capacities at the sub-district level to support the village government to implement the 5 pillars of the STBM in

all villages in the sub-district. At the same time, the sub-district government, accompanied by the district government, will also build capacities and provide support to the private sector (sanitation entrepreneurs) for them to be able to provide proper, affordable and sustainable sanitation products and services for the entire community.

In the final stage, the sub-district government whose capacity has been built is expected to be able to build capacity and lobby/advocate the village government to implement the 5 pillars of the STBM at the community level through various programmes using Village Fund (Dana Desa). Lobbying and conducting advocacy can also be carried out by the district government on the division of authority between districts and villages and the role of Village Fund in sanitation development.

From the descriptions above, it is noteworthy that although direct SEHATI programme interventions are carried out at the district level, the provincial government is still involved because they play an important role in ensuring that the programme implementations cover all districts in their province.



Photo: Ahmad Zabidi (SEHATI)

IMPLEMENTATION PHASES AND ACTIVITIES OF THE 5 PILLARS OF THE STBM IN SEHATI PROGRAMME

SEHATI Implementation Phase

Based on the lessons learnt from the SEHATI programme (and the previous SHAW programme, 2010 - 2015), activities for implementation of the 5 pillars of the STBM can be grouped into three different but overlapping phases, namely: 1) the starting up phase, 2) the learning and testing phases, and 3) the scaling up and replication phases. The following figure explains how the SEHATI model is implemented:

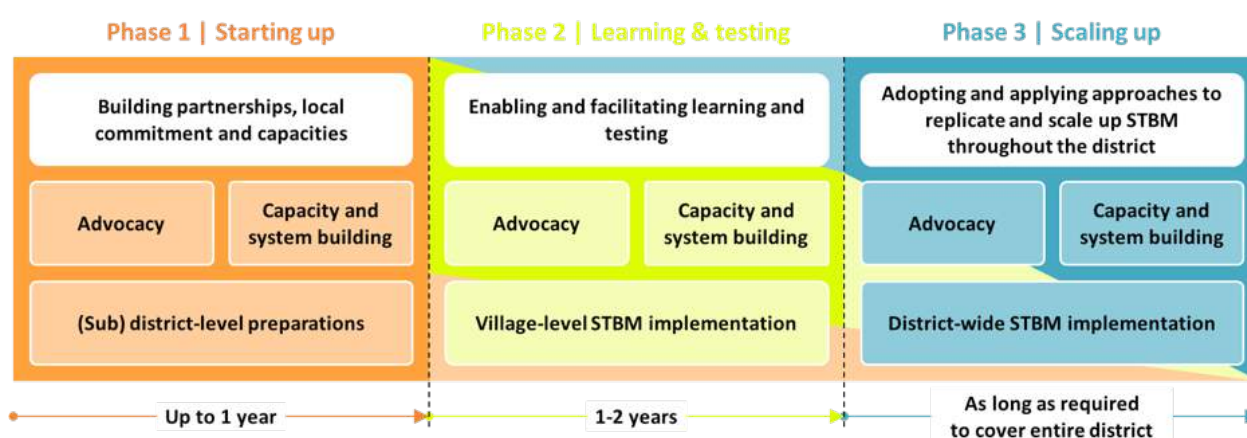


Figure 3. Strategic phase of implementation of the 5 pillars of the STBM to cover all districts

Figure 3 describes the 3 phases along with the main activities in each phase in implementing the 5 pillars of the STBM in the SEHATI programme. Seen in the figure, when activities in one phase are completed, it does not mean that the activities stop, but they continue to the next phase with the intensity adjusted to the needs. Examples are advocacy and building capacities and systems; these intensive activities are carried out in the first phase, then according to the needs they are still carried out in phases two and three. The same is true for facilitation activities for implementation and learning in the second phase; these activities continue in the third phase for replication and scaling up.

The first phase is the phase of building partnerships, local commitment and stakeholder capacity to implement the 5 pillars of the STBM. The main activities are advocacy and building capacities and systems in the district government. Preparations for the implementation of the 5 pillars of the STBM at the sub-district level are also carried out at this phase, when the capacity of the district government have already been built. This phase requires approximately one year (or it can last faster according to conditions of capacities in a district).

The second phase is the testing phase of the 5 pillars of the STBM in an area and the absorption of learning for future improvement and development implementation. In this phase, advocacy and capacity building and government system building activities in districts and sub-districts are still carried out and extended to the village level. The implementation of the 5 pillars of the STBM can also be implemented in the community level. It should be borne in mind that the second

phase can be carried out when the first phase is completed (the capacity of the district and sub-district governments is sufficient). Usually this phase takes one to two years after the program has commenced.

The third phase is the phase of replication or scaling up. Due to budget constraints, it is possible for a district to implement the 5 pillars of the STBM only in a few villages or sub-districts at first. Later, when lessons are learnt from several other villages that have implemented the 5 pillars of the STBM, the district and sub-district governments can replicate the approach to villages that have not been 'touched' by the programme. Villages that have successfully implemented can also be examples or drivers for other villages. The range of time needed in this third phase cannot be determined precisely because replication to cover all districts is greatly influenced by external factors such as population, geography and social politics in each district.

Phase 1: Starting Up

The successful implementation of the 5 pillars of the STBM depends largely on how successful the district government is in initiating the programme. The most important step in this phase is the commitment obtainment from the elected Bupati (District Head) of a district. Therefore, the role of the province is very much needed in this phase to encourage Bupati's commitment to the implementation of the 5 pillars of the STBM. The subsequent commitment of Bupati needs to be translated or followed up at a cross-sector meeting that is responsible for handling sanitation and hygiene issues in the district. This is essential because the implementation of the 5 pillars of the STBM is not the duty of the Health Office only, but of all government offices related to the development of the sanitation sector, such as Bappeda, PUPR, Education Office, Community Empowerment Agency and village government, and KLH (Ministry of Environment) particularly related to waste management.

At this stage it is important to provide an understanding to the district government that the low access to sanitation and hygiene behavior at the district level is a big problem whose solution is not enough to use 'normal' methods. Still at this stage, "champions" with official mandates, for example the existence of Bupati and Legislative Board members need to be ascertained in advance.

Bupati's role is substantial in this regard because Bupati has the authority to allocate human and financial resources for the implementation and success of the programme. Since day-to-day responsibilities are delegated to the Pokja AMPL in the district, it is very important in this phase to involve all OPDs in the programme implementation.

This first phase is essential because at this phase all stakeholders are expected to be able to understand the problem, agree on a shared vision and develop a strategy to achieve the final goal. Usually this phase requires a lot of time and attention from programme participants and that is why to begin the implementation of the 5 pillars of the STBM in new districts (which have never implemented the 5 pillars of the STBM at all) will take more time than the regions that have ever implemented it.

Various activities of the first phase can be seen in the figure below:

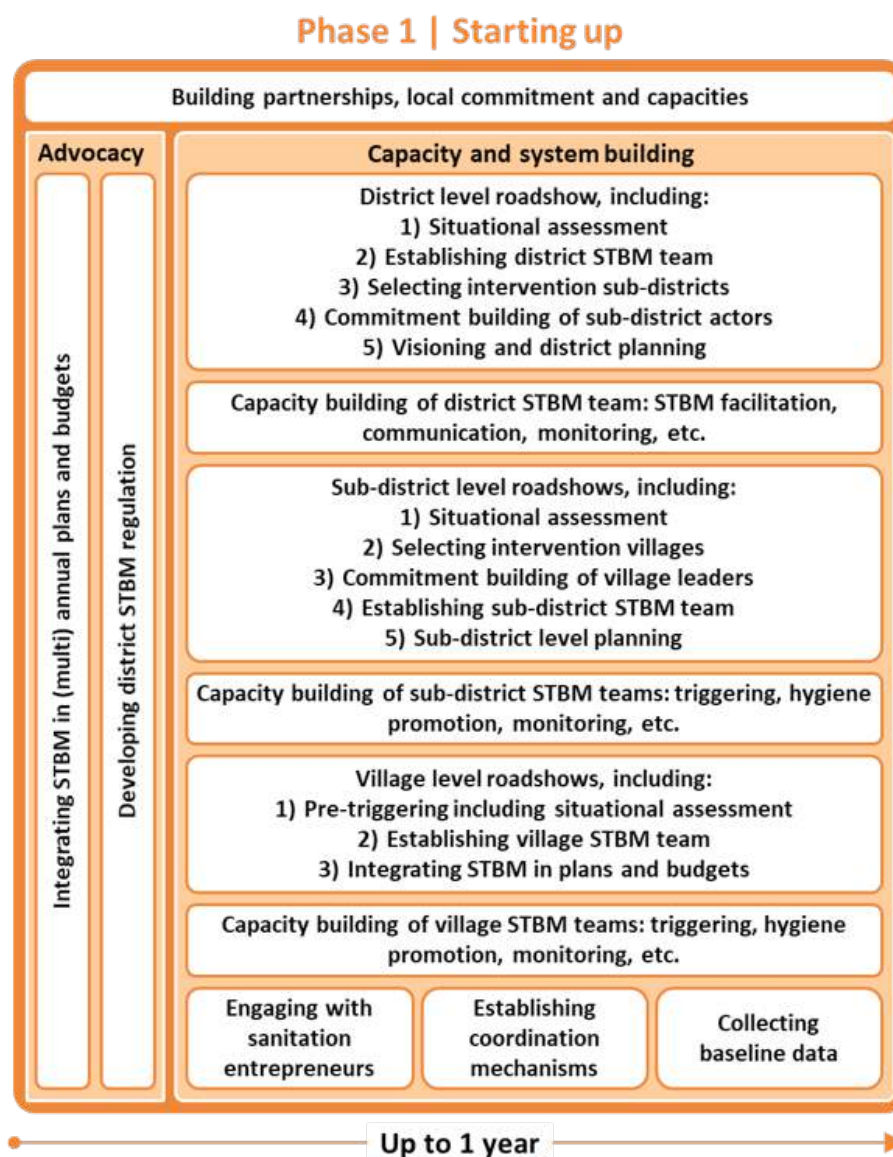


Figure 4. Phase 1 Starting Up

Figure 4 above explains the main activities in the initial phase which can be clustered into 3 groups, namely:

1. Conducting advocacy activities at the district level to integrate STBM in (multi) annual planning and budgeting and to develop regulations that support the implementation of the 5 pillars of the STBM;
2. Building the capacity of the team responsible for the implementation of the 5 pillars of the STBM at the district and sub-district levels as well as the villages selected for intervention in the initial period;
3. Establishing a system that ensures good practises to initiate, plan, implement, monitor and maintain the 5 pillars of the STBM throughout the region.

This first phase should be well prepared because its results will determine the implementation success in the next phases. It can be derived several other main activities from the three main activities, namely:

1. Incorporating of the 5 pillars of the STBM into (multi) annual planning and budgeting to ensure the availability of adequate human and financial resources in all districts.
2. Initiating steps to develop STBM conducive legislation at the district and village levels which can support the implementation of STBM. It should be underlined that the regulations that are drafted should be responsive to gender equality and social inclusion, and in line with higher hierarchy of regulations.
3. Conducting road shows at the district, sub-district and village levels to introduce the programme to all relevant stakeholders and to ensure that they are committed to implementing STBM and achieving the visions that have been set. The road shows can be carried out in various forms. The district government can organise workshops by inviting sub-district governments, puskesmas, villages and relevant stakeholders to build a mutual understanding of sanitation and hygiene.
4. Developing a simple but transparent system building in selected sub-districts and villages. Although in the end all districts will be included in the programme, it is highly recommended that the governments start from a few areas at first, so that they can be more focused and able to transmit motivation to other regions.
5. Forming responsive multi-disciplinary teams responsible for STBM at the different levels (district, sub-district, village). Selecting suitable staff and implementing sustainable capacity building are the keys to the success of such teams. Some capacity building activities can be carried out formally in the form of training or on the job training and informally (by daily assistance).
6. Establishing a coordination mechanism at and between levels (districts, sub-districts and villages). For example, at the district level a cross-sectoral coordination mechanism is usually carried out with regular meetings conducted by the Pokja AMPL. However, at the sub-district and village levels, this mechanism does not necessarily exist so it is necessary to discuss the appropriate cross-sectoral coordination mechanisms in sub-districts and villages.
7. Mapping potential and existing private actors (sanitation entrepreneurs) in the district and exploring how likely they are to be involved in this programme. Ideally, capacity building activities for sanitation entrepreneurs should be carried out adequately in the first phase, so that they can immediately provide the sanitation products and services needed when entering the second phase.
8. Building and developing a monitoring system. Baseline data must be collected at this stage, especially before intervention in the village is carried out. The data collected can be used to find out about the district situation and develop strategies that are appropriate at the village level. In addition to monitoring the 5 pillars of the STBM, the district government also needs to monitor the capacity of the STBM teams at each level to ensure that each team capacity is adequate. This capacity consists of the availability of an inclusive budget, team's expertise and technical capabilities and regulations.

Given the importance of special teams for the implementation of the 5 pillars of the STBM, it is highly recommended to form teams consisting of formal institutions. It is notable to ensure that a team will continue to implement and oversee programme activities so that the programme's final objectives can be achieved. The figure below describes the formal institutions that are expected to be involved in the process of implementing the 5 pillars of the STBM at the district and village levels.

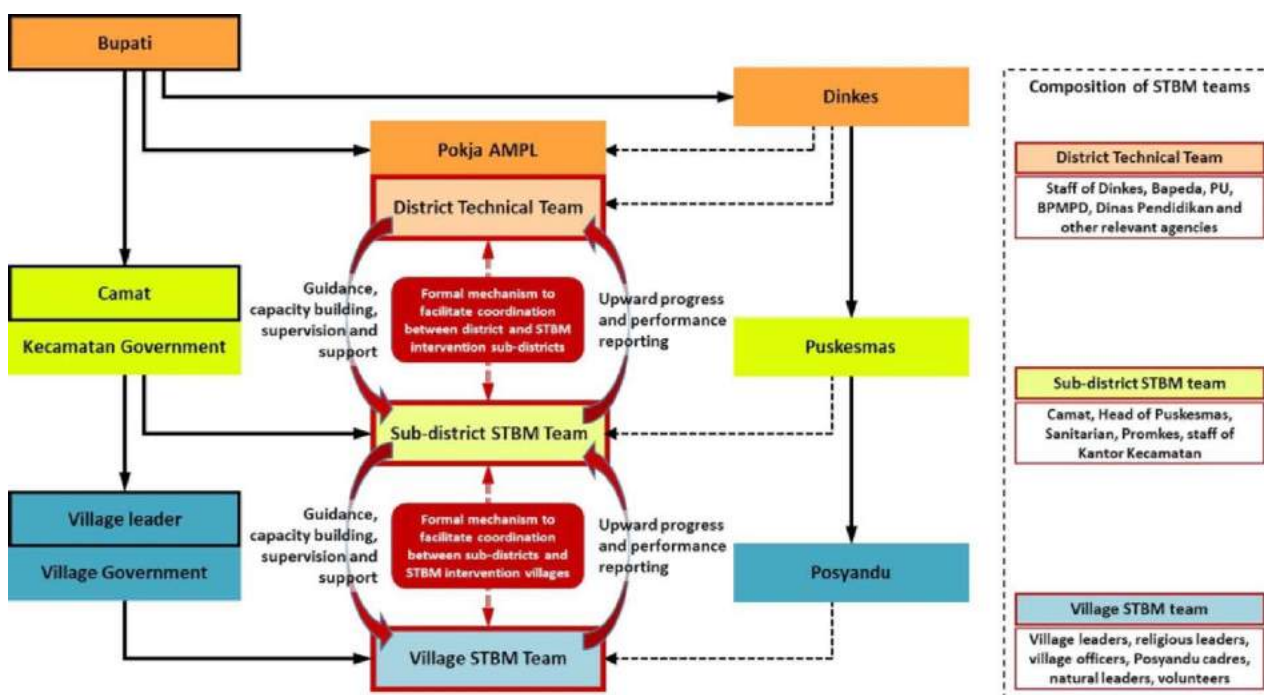


Figure 5. The formal institutions recommended are involved in the process of implementing the 5 pillars of the STBM

The left side of the image shows the instructional (delegation) flow (indicated by a black arrow), capacity building (indicated by a red arrow down), reporting (indicated by a red line up) and coordination (indicated by a red dotted line). The composition of teams at each level can be seen in the right hand side of the box.

The structure above explains how Bupati has the role of leading the implementation of the 5 pillars of the STBM in the district. Bupati will delegate the implementation of the 5 pillars of the STBM to the Pokja AMPL at the district level (in which the Health Office is a member), the Camat (Sub-District Head) and staff at the sub-district level as well as village heads and staff at the village levels. The Pokja AMPL whose members are OPD heads related to water and sanitation, has the task of coordinating and is expected to form technical teams to lead the implementation of the 5 pillars of the STBM. The Health Office is the leader of technical teams. However, the Health Office, Puskesmas and Posyandu cannot 'walk alone'. At the sub-district level, Puskesmas needs to collaborate with the sub-district government, while Posyandu needs to be supported by the village government. The involvement of members outside government institutions is highly possible, especially community leaders, religious leaders, and other "champions" who are considered influential in the region.

The key element of this flow is not only the delegation mechanism, but also capacity building by the district to the sub-district and by the sub-district to the village. Another important element is reporting the results of monitoring from the village level to the sub-district level and from the sub-district level to the district level. In addition, the cross-sectoral coordination process also plays an important role in the implementation mechanism of the 5 pillars of the STBM.



Photo: Eko Harsono (SEHATI)

Case Studies in 7 districts: ESTABLISHMENT OF STBM TEAM

In 7 pilot districts of SEHATI programme, the district governments do not only establish the Pokja AMPL and hand over the 5 pillars of the STBM to the Health Offices, but also establish the STBM implementing technical teams. In Lombok Timur, for example, under the leadership of the Pokja AMPL, a TTK (District Technical Team) is established consisting of Health Office, Bappeda, and BPMPD. A similar case is applied in Manggarai Barat with its district STBM team and in Biak Numfor with its district STBM Facilitator Team.

In Lombok Utara, Dompu, Sumba Barat Daya and Sumba Tengah, although there are no establishments of special STBM teams, their district governments delegate this specific task or function to the Pokja AMPL members through a Decree regarding the assignment of related technical staff. In Sumba Tengah and Sumba Barat Daya, the Pokja AMPLs are even established at the sub-district levels because the governments believe that the sanitation issue is not the duty of the Puskesmas only.

Phase 2: Learning and Testing

The second phase revolves around finding the most appropriate approach at the village level according to the local context of each village through the absorption of learning. This learning can later be used to carry out replication in other villages or sub-districts. This assumption is based on the hypothesis that an approach which has been successfully implemented in an area will also be successful when applied in other areas with some adjustments based on the local context of the area.

The success of the STBM intervention in a district is actually the result of successful intensive interactions between stakeholders at all levels; it is not the result of a meeting in one village which is then copied identically to various other villages. For example, conducting one time triggering activity in one village to another will not have a significant impact if the triggering process is not accompanied by various follow-up activities and coordination to the district level.

It should also be considered that the assistance of an NGO in implementing STBM in a district may provide different results compared to when the government works alone. In this case, there is a risk that when NGOs finish working on such assistance, the local government will have difficulty in continuing or replicating the approach used by NGOs. To anticipate this risk, so long as assistance takes place it is important for local government to allocate sufficient time and resources to be able to take learning in this second phase. Using these lessons, STBM teams can make various adjustments to find the suitable approach and innovation in the intervention area.

The activities in the Learning and Testing Phase are suggested to focus on a few number of sub-districts and villages at first because implementing an approach that has not been proven successful in an area will be at risk for the failure of programme implementation in the intervention area. Learning outcomes obtained in pilot areas, and limited resources (human and financial) are the keys to consider. Even if the implementation in a pilot area shows failure, it can still be a lesson to encourage the government to make improvements in other villages that will be intervened in

the next phase.

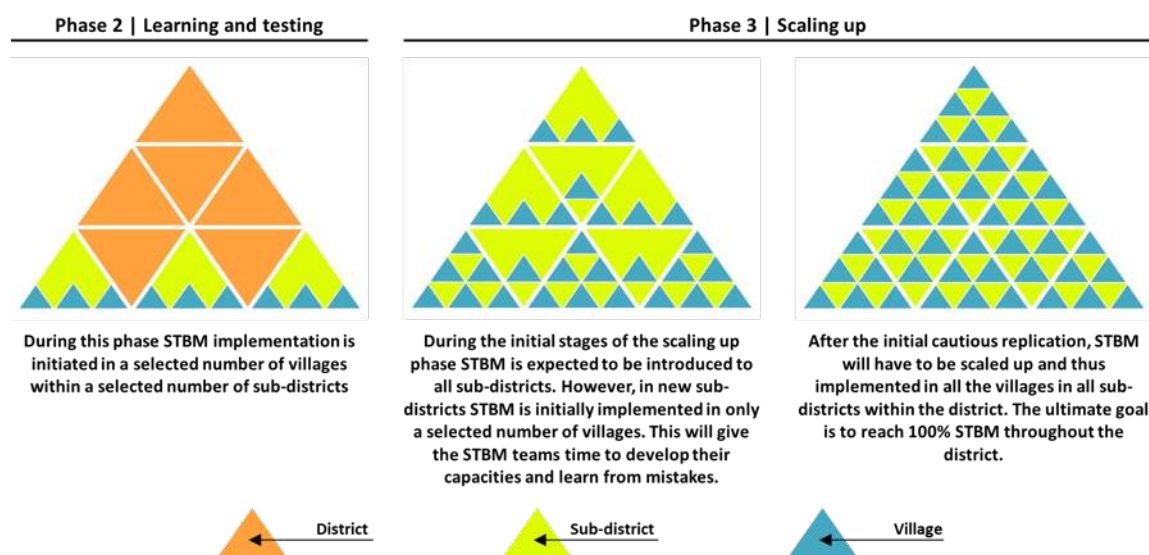


Figure 6. The process of implementing replication in villages and sub-districts in a gradual manner

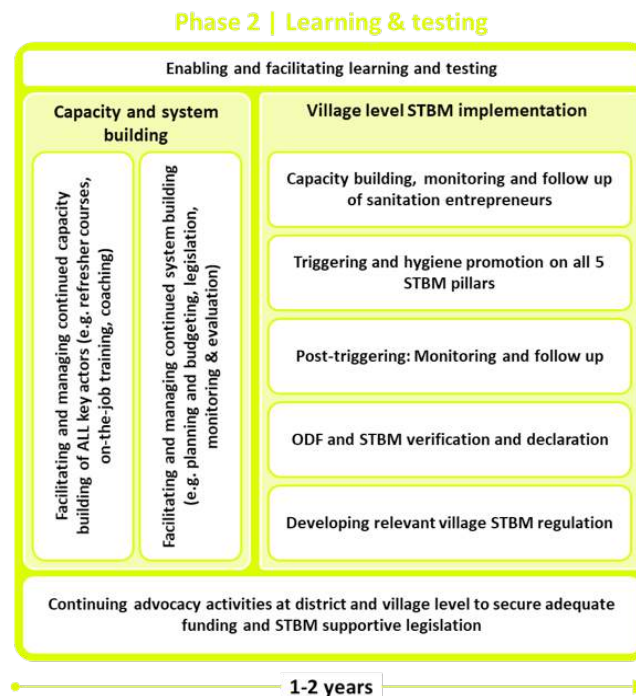
As illustrated in Figure 6 above, in the second phase, STBM is only carried out in a small part of the village and sub-district areas. However, in the third phase (which will be explained in more detail in the next sub-chapter) STBM is introduced to all sub-districts in the district. This will give the district STBM teams time to build the capacity of the sub-district and learn from mistakes or failures from previous sub-district STBM interventions.

Furthermore, in the final stage of phase 3, when all sub-districts have been able to implement the 5 pillars of the STBM in some villages, scale up should be designed in advance to all the village areas in the district. This means that the 5 pillars of the STBM will be implemented in all district areas.

The learning element in the second phase lies in the continuous capacity building processes. Continued capacity building should be designed by first looking at the performance of each team member: where there are weaknesses and strengths and what needs to be improved in the future. This learning will be advantageous for the district to innovate in implementing the 5 pillars of the STBM to be more effective and efficient in achieving the target.

This second phase consists of three main activities, namely:

1. Continuing capacity and system building activities that have been started since the first phase. On the job training, supervision and assistance can continue to be carried out simultaneously with the implementation of STBM at the village level. Additional mechanisms such as STBM verification can be introduced and tested in villages in this phase;
2. Implementing STBM at the village level can be started for just a few villages as described above;
3. Continuing advocacy activities that focus on the integration of the 5 pillars of the STBM in programme planning and (multi) annual budget and developing regulations related to the implementation of the 5 pillars of the STBM.



Gambar 7. Phase 2: Learning and Testing

The main 3 main activities above can be explained as follows:

1. Continuing pre-triggering activities in intervention villages to ensure that village heads and village STBM teams are committed and ready to implement the 5 pillars of the STBM.
2. Initiating the triggering of the 5 pillars of the STBM and promotional activities in each household of intervention villages.
3. Carrying out post-triggering activities such as monitoring, promotion and other follow-up activities in order to establish clean and healthy behavior that is in line with the 5 pillars of the STBM throughout the community. Post-triggering activities are considered to have a big role in ensuring that communities implement clean and healthy lifestyle and in ensuring the existence of commitment and capacity of the village government.
4. Preparing, testing and taking learning from the STBM verification processes at the village level.
5. Initiating and supporting the development of village regulations regarding the implementation of the 5 pillars of the STBM.
6. Continuing building the capacity of sanitation entrepreneurs and connect them with villages interested in coordination.

In addition to initiating some “new” activities in the second phase, a series of activities that have been carried out in the first phase also need to be carried out throughout the programme (including when entering the second and third phases). Some of the most notable activities to be carried out during phases one through three are:

1. Carrying out capacity building for all relevant stakeholders at the district, sub-district and village levels. Some forms of activities that can be carried out include: workshops, refresher training, on the job training, mentoring and others.
2. Developing a system that ensures that work processes are carried out systematically, effectively and efficiently.
3. Lobbying and advocating district and village governments to provide adequate funds and

- supporting regulations.
4. Monitoring and evaluating the progress of activities to see whether they are on target and to know occurring challenges that may hinder acceleration processes.
 5. Conducting regular coordination meetings to discuss existing hindrances and solutions.

Case Studies in 7 districts: VERIFICATION

One of the innovations at village level that has been implemented in Lombok Timur, Manggarai Barat and Biak Numfor districts is the implementation of a cross-verification mechanism to verify villages that have implemented the 5 pillars of the STBM. So far, verification has been carried out at the sub-district level to the village level, then on this cross verification, the sub-district will involve the STBM teams from other villages to participate and verify the villages that have submitted to be 100% STBM. In addition to improving the quality of the verification process (and ultimately improving the quality of implementation of the 5 pillars of the STBM), this cross mechanism is also beneficial for villages that participate in verification because the verification processes and results can also be used as learning materials for them.

In Lombok Utara and Dompu, cross verifications are carried out at the sub-village level led by Puskesmas. When a sub-village has implemented 100% of the 5 pillars of the STBM, other sub-villages are invited to carry out verifications in their sub-villages. This method is chosen because of the dense population in Lombok Utara and Dompu districts.

In Sumba Barat Daya and Sumba Tengah, before verification by the sub-district Pokja AMPL, villages are allowed to carry out independent verification after the village STBM team is first provided with verification criteria by the sub-district team. When a village is convinced that their village has obtained 100% value through independent verification, the village can submit an application to be verified by the sub-district level.

Learning in 7 districts: HOW TO HANDLE STAFF MUTATION?

The mutation of staff or employees at the government and institutional levels is something inevitable at every level of government. In 7 SEHATI districts, the handling of mutation is conducted by continuous capacity building in the forms of refresher training and routine cross-sector coordinations. The approach and activities are designed as anticipatory steps so that if one staff member is mutated to another department or field, the new staff will be able to fill the consequential gap.

Commitment from the leaders, which is obtained in the initial phase, also serves to help fill the gap when the mutation occurs. Leaders who are dedicated to the implementation of the 5 pillars of the STBM will immediately develop suitable strategies in order to catch up.

Learning Phase

Phase 3: Scaling up and Replication

This third phase consists of several main activities as shown in the figure below. The main activities can be grouped as follows:

1. Continuing building capacity and systems
2. Implementing STBM interventions in other villages and sub-districts by replicating approaches and practises in new intervention villages that have not been 'touched' by the programme.
3. Continuing monitoring after the declaration of STBM 100% and following up on behavior changes to maintain the achievement of the 5 pillars of the STBM. Coordination meetings at every level and between levels are also continued.

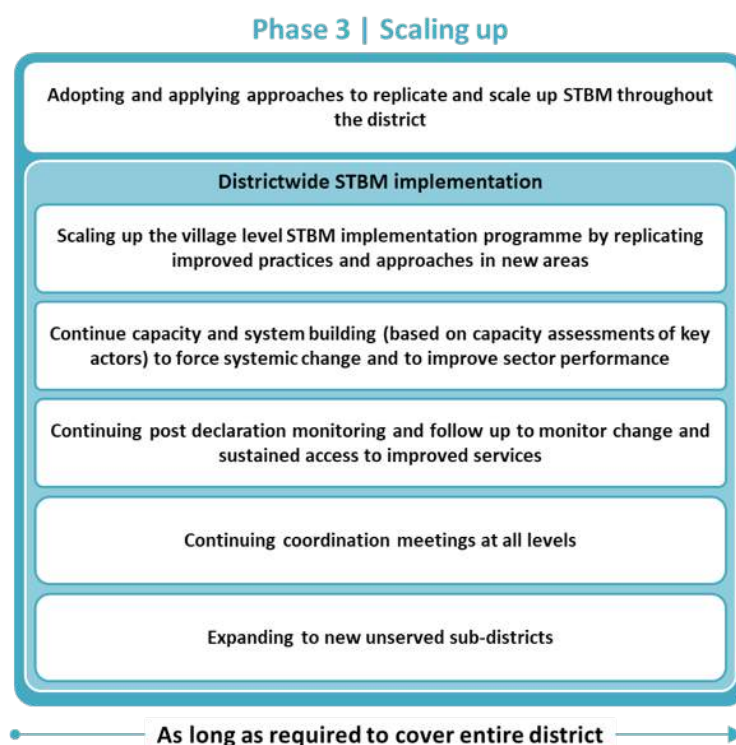


Figure 8. Phase 3: *Scaling up* and Replication

Case Studies in 7 districts: REPLICATION and SCALING UP

The implementation of the 5 pillars of the STBM in several areas is proven to have a major impact on the implementation in the district. Some villages which in the first phase are not selected for intervention actually show high enthusiasm because their village members become motivated. In Manggarai Barat and Dompu, for example, some villages are not selected as pilot areas but their members feel motivated to implement STBM, and proactively initiate and request for replications to their sub-district and district governments. With commitments from village heads and the availability of adequate budgets from Village Fund (Dana Desa), these villages actually achieve the 5 pillars of the STBM earlier compared to the villages which have been intervened before them.

Village authority for village development through Village Fund also plays a major role in replication and scale up in the district. District governments through BPMPD and sub-district governments can provide assistance regarding the use of Village Fund. For example, in Lombok Timur, BPMPD will not approve the village budget if STBM is not included in village budgeting. Likewise in Lombok Utara which issues a circular letter on the use of Village Fund to alleviate sanitation problems along with details of the preparation of the budget. Village Fund also plays a role in implementing the 5 pillars of the STBM in replication villages in Sumba and Biak Numfor districts.

Learning in 7 districts: SUPPORTING AND HINDERING FACTORS

Although the ideal situation for the successful implementation of STBM cannot be ascertained to always exist in intervention areas, some pre-existing situations or factors in an area can be advantageous, namely:

1. The higher the access to clean water in an area, the easier implementation of a sanitation programme (and the better the progress achieved) in the area.
2. The good level of education of the community contributes to the acceleration of the implementation of the 5 pillars of the STBM.
3. Programme implementation in areas with less dense populations tends to be easier applied than areas with more dense populations.

While several factors that can hinder the implementation of the 5 pillars of the STBM are:

1. Weak leadership and commitment of Bupati and Pokja AMPL in realising the 5 pillars of the STBM.
2. Topography of regions that are difficult to reach, mainly because of the lack of infrastructure access to the village.
3. Too often mutations in government that are not balanced with assistance and adequate information transfer.



ACARA D

PELAYAR STBM (SANITASI TO

1. STOP BUANG AIR BESAR S
 2. CUCI TANGAN PAKAI SABU
 3. PENGOLA BAKAN MI
 4. PENGAM AMPAH R
- PENGAM R LIMBA

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upati Dom



Photo: Sabaruddin (SEHATI)



Simavi
Basic health for all



DEKLARASI

PUSKESMAS BERBASIS MASYARAKAT

SEMARANG

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NUSANTARA RUMAH

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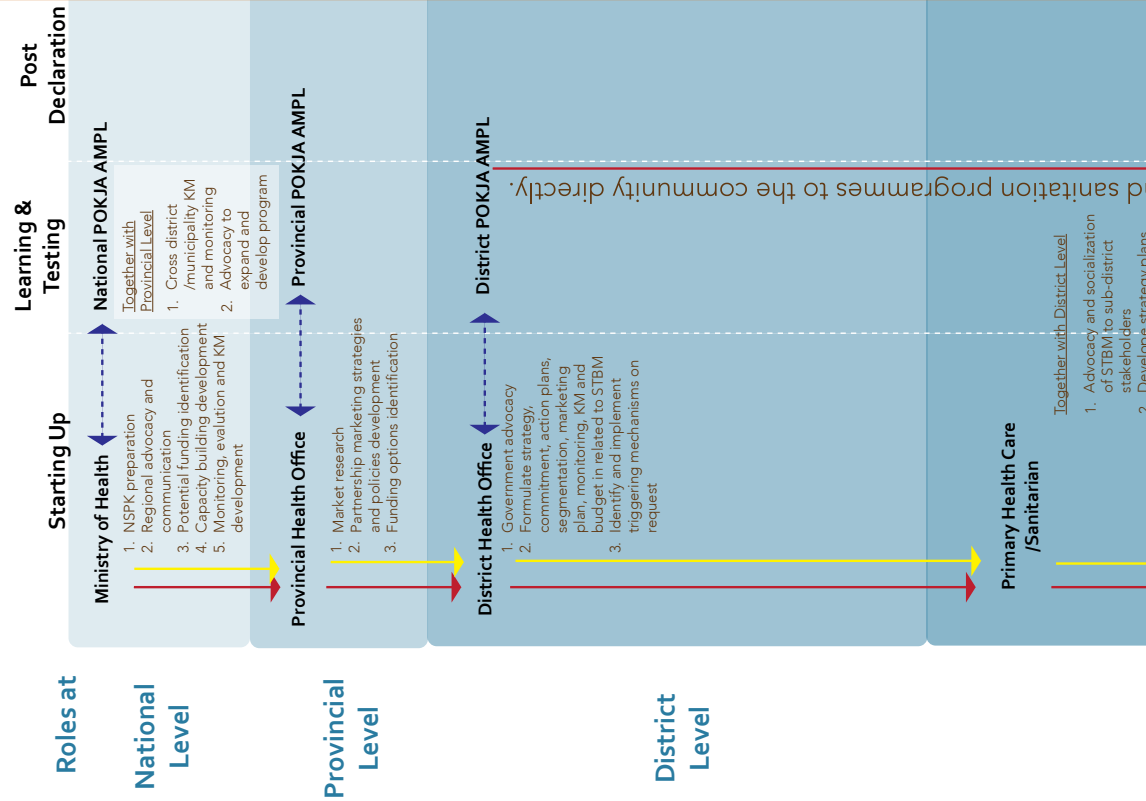
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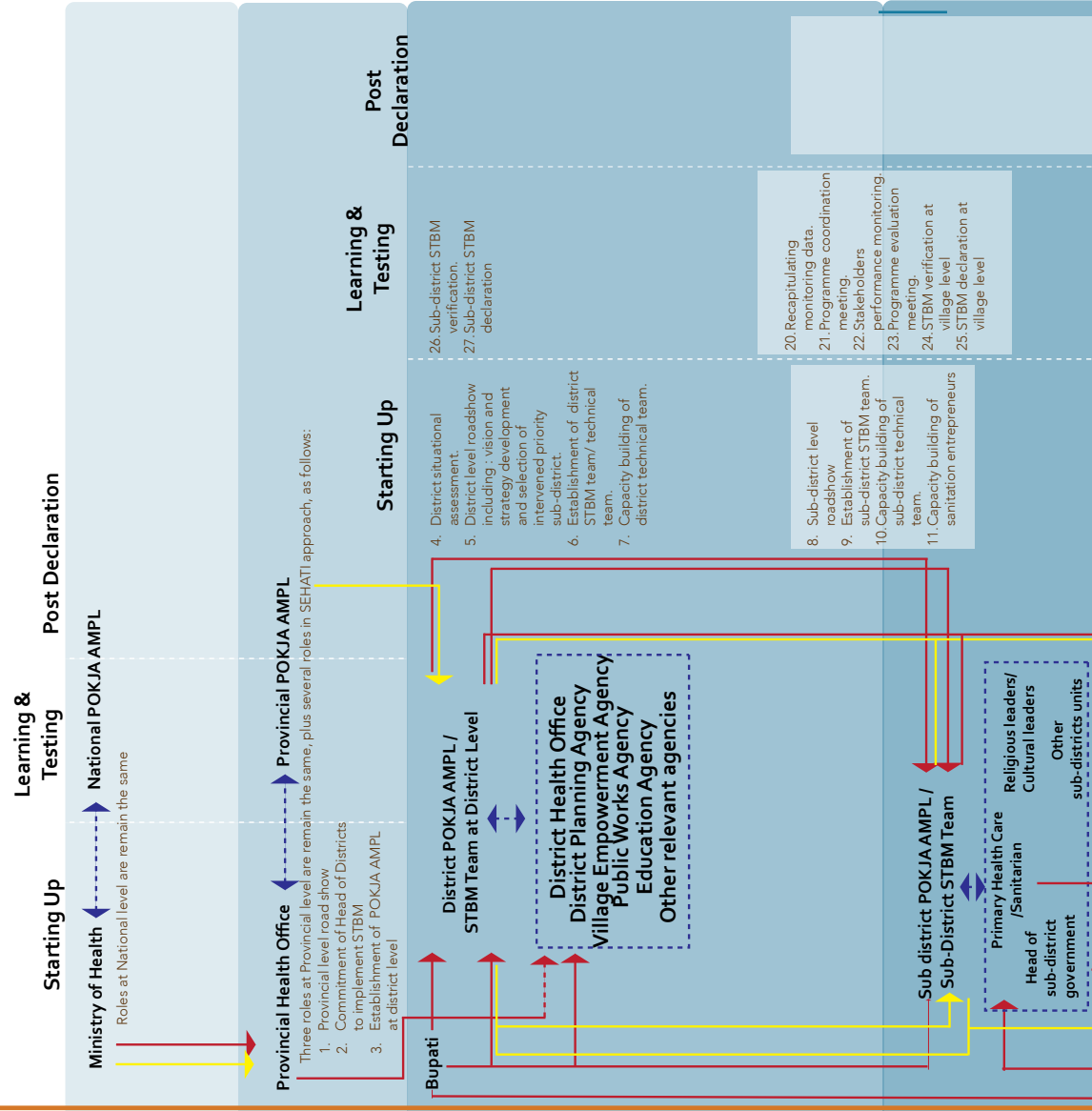


PATHWAYS OF STBM IMPLEMENTATION IN INDONESIA

Phases of STBM Implementation - National Guideline



Phases of STBM Implementation - SEHATI Guideline



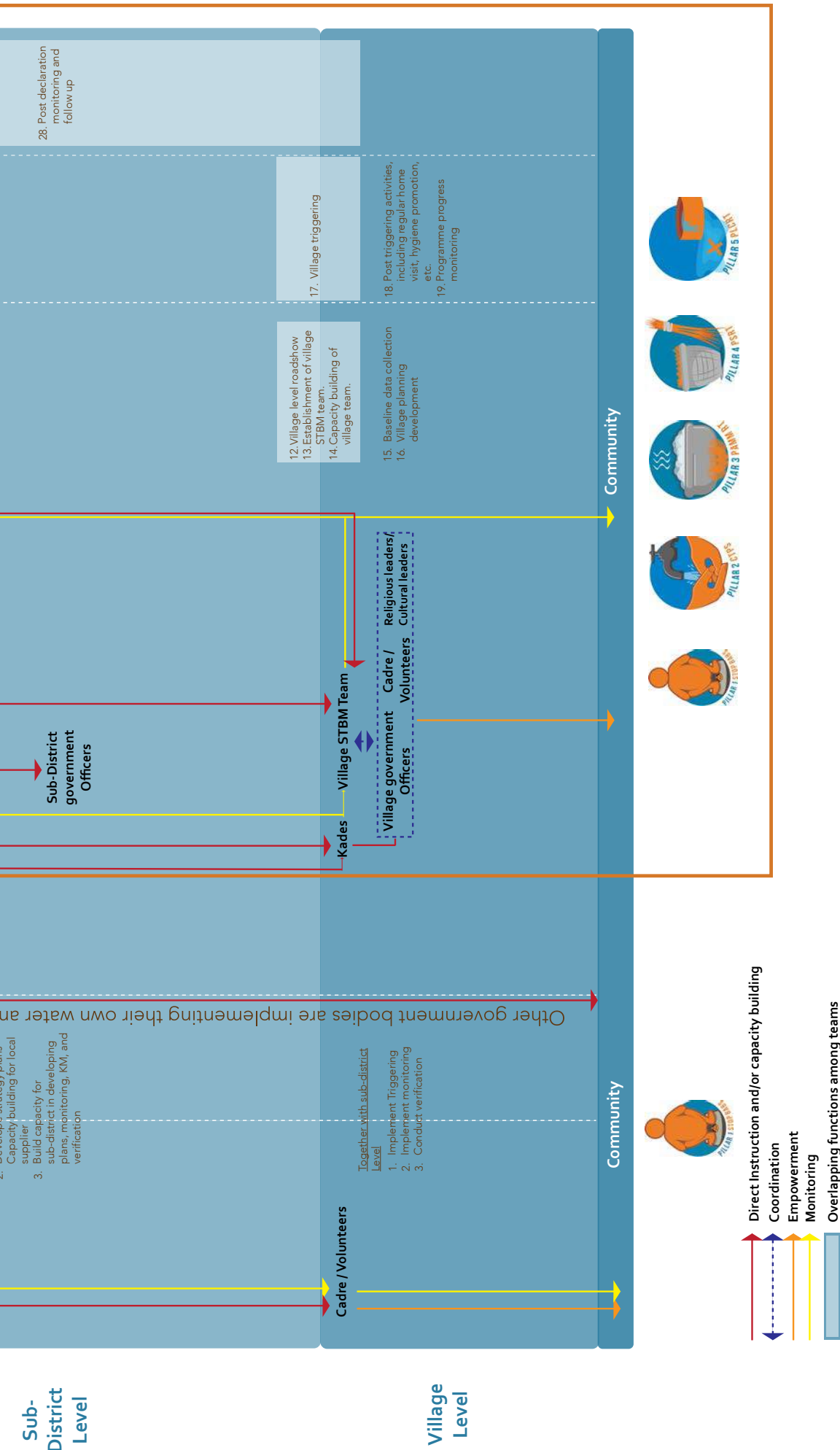


Figure 9. The detailed activities of the SEHATI model compared with the guidelines of the Minister of Health Regulations

Implementation Activities of the 5 pillars of STBM in SEHATI

Figure 9 above describes the activity flow in details starting from the central, provincial, district, sub-district to village levels in implementing the 5 pillars of the STBM. The diagram also illustrates the difference between the implementation of STBM based on the guidelines of Minister of Health Regulation: Permenkes No. 3 of 2014 with the implementation of STBM based on the SEHATI approach. The recommended activities to be carried out in the district consist of 3 components, namely the preparation, implementation and post-declaration stages.

Implementation of STBM in accordance with the national guidelines

As illustrated in the diagram above, the implementation of STBM following the national guidelines is started at the Ministry of Health level which is then passed on to the institutions below it, namely the provincial, district, sub-district and village levels. In supporting the implementation of STBM, the government (of central, provincial and district/city) is responsible for developing regulations and technical policies, facilitating the development of suitable-useful technology, facilitating the development of STBM implementation, technical training for trainers and providing guidance on information, education and communication materials. In addition, the government also has a role in coordinations of cross-sectors and cross-programmes and in conducting monitoring and evaluation for programme development and improvement⁵.

In practise, the role of the Pokja AMPL at the provincial and district levels in initiating and implementing the 5 pillars of the STBM is very limited. Collaboration with other parties at the regional level is not considered in the national guidelines, although the role of private actors is very important in implementing STBM at the district and village level.

Moreover, monitoring activities and post-declaration follow-ups to avoid large scale slippage are not discussed in the national guidelines. As a consequence, the review results of the STBM conducted by several NGOs in Indonesia conclude that the government is still focused on the implementation of the STBM pillar 1 namely Open Defecation Free (ODF).

Implementation of STBM using an alternative approach (SEHATI)

The diagram above illustrates the flow of activities used by the SEHATI programme. This type of activity and flow are based on the 8 years of experience implementing the previous SEHATI programme and the previous SHAW programme. In order to more easily follow the workflow in the figure above, the SEHATI guide activities are preceded by the use of numbers before the activity

⁵Regulation of the Ministry of Health No. 3 of 2014, concerning Community-Based Total Sanitation (STBM)

name.

Phase 1: Starting Up

Activities at the Provincial Level

- 1. Conducting road shows at the provincial level.** Ideally, the provincial government is responsible for initiating STBM at the district level. The provincial Pokja AMPL and the provincial Health Office are expected to be able to manage road show activities in the form of workshops with the intention of introducing STBM and building mutual understanding among stakeholders regarding sanitation and hygiene conditions in districts and provinces.
- 2. Obtaining commitment of Bupati (District Head).** In the activity of road shows or workshops, the provincial Pokja AMPL is expected to obtain a commitment from the Bupati to implement the 5 pillars of the STBM in his/her government area. The Bupati's commitment is essential because with that commitment relevant agencies will become more confident and directed in implementing the 5 pillars of the STBM according to their respective main tasks and functions. The Bupati, who shows a firm and clear commitment, is a "champion" for this programme because his/her position is very strategic to improve coordination, motivate staff, acquire support from other actors, and utilise additional resources. The commitment is translated into healthy medium-term and annual plans and budgets. The Provincial Health Office is responsible for supporting district level Pokja AMPL and District Health Office in preparing these plans and budgets.
- 3. Establishing district Pokja AMPL.** If in a district there is no district Pokja AMPL (or similar working groups) formed, then the provincial Pokja AMPL is expected to form a district Pokja AMPL in the district.

Activities at the District Level

The district Pokja AMPL is directly responsible to the Bupati for the initiation, coordination, monitoring and reporting of water and sanitation programs in the district. Members of this working group are heads of OPD from various related agencies, namely the Health Office, Bappeda, Public Works, Education and BPMPD. This working group is responsible for translating the Bupati's direction into a consistent vision and strategic plan.

In a normal situation, the daily implementor of the 5 pillars of the STBM is the Head of the District Health Office who in practice will be delegated to the related field.

- 4. Analysing the district situation.** The district Pokja AMPL will discuss and analyse the district situation especially in terms of sanitation and hygiene. Analysis is usually carried out by the district Health Office based on the data and the real conditions in the field. Such analysis must include conditions regarding coverage, priority areas, existing regulations, existing plans and budgets, etc. In addition, analysis must also map the opportunities of sanitation entrepreneurs and the capacity situation of existing stakeholders. The discussion of the results of analysis is intended to see the need and urgency of implementing the 5 pillars of the STBM. Based on the results of analysis, a concrete plan for implementing the 5 pillars of the STBM can be arranged.
- 5. Conducting district level road shows.** The Pokja AMPL is responsible for carrying out workshops to build mutual understanding on sanitation issues in the district along with other stakeholders. Practically this is done by the district Health Office because this office has an understanding

35

of the 5 pillars of the STBM. The road show or workshop is intended to introduce STBM to all stakeholders at the district and sub-district levels and to ensure that all parties have a shared perspective on the 5 pillars of the STBM approach. During the workshop, priority districts for intervention can be determined.

As explained earlier, it is strongly recommended to start the implementation of the 5 pillars of the STBM in only a few sub-districts at first. The number of sub-districts chosen can be different in each district. This depends on the specific situation of the region such as the size of the district, population, availability of budget and human resources, interest from Camat (Sub-District Head) and others.

Workshops also need to be continued with the formulation of strategies to realise 100% STBM in all districts. Some strategic aspects that need to be done include developing regulations on the implementation of STBM, budgets and implementation work plans, monitoring systems and others. At this stage it is very important to divide the roles among agencies in the implementation of the 5 pillars of the STBM so that all programmes under each agency can support each other without overlapping.

- 6. Establishing STBM implementing technical teams.** The process for realising the work plan that has been prepared and integrating STBM in programmes carried out by other government agencies are certainly time consuming and impossible to complete in one workshop. Therefore, Bupati or Pokja AMPL is expected to form technical teams whose task is to oversee the implementation of the mission and strategies that have been prepared. Furthermore, technical teams will be responsible for assisting in drafting regulations, budget designs and detailed work plans and providing capacity building to sub-district teams and village teams. The STBM technical team consists of technical staff from related agencies and this team will report progress on implementation to the Pokja AMPL or directly to Bupati if needed. It should be noted that the establishment of the STBM technical team should consider gender equality to ensure proper sanitation and hygiene access obtainable by everyone.
- 7. Building capacity of STBM technical teams.** Because not all members of the technical team have the same capacity in implementing the 5 pillars of the STBM, the Pokja AMPL needs to provide an amount of budgets and coordinate a series of capacity building for the teams. Capacity building activities at an early stage can be focused on training on facilitation, triggering, promotion, sanitation entrepreneurship and monitoring of the 5 pillars of the STBM and capacity monitoring - using human rights based approach.

At this stage, the STBM technical team will also analyse the existing sanitation entrepreneurs in the district and see if they have sufficient capacity to provide affordable sanitation products and services to the community.

Activities at Sub-District Level

- 8. Conducting road shows at the sub-district level.** After carrying out activities at the district level, similar road shows are carried out at the sub-district level in each of the selected sub-districts. The methods and objectives of this meeting are the same as those carried out at the district level. All village heads in selected sub-districts will be invited to participate in the meeting. Villages whose village heads are interested in implementing the 5 pillars of the STBM will be considered for intervention first; the village heads can be used as motivators for other villages.
- 9. Establishing sub-district STBM teams.** Following up on the road show at the sub-district level, sub-district STBM teams need to be formed. The team is suggested to consist of Camat, Head

of the Puskesmas, sanitarians, health promotion staff and other relevant figures. As with the district team, the formation of sub-district STBM teams needs to consider aspects of gender equality in its team composition.

10. Building capacity for sub-district STBM teams. The district level STBM technical team is responsible for the process of building the capacity of the sub-district STBM team. Capacity building can be done in the form of training, mentoring, on the job training, and others. The topics to train are facilitation, triggering, hygiene promotion and the 5 pillars of the STBM monitoring and capacity monitoring.

11. Building capacity for sanitation entrepreneurs. Capacity building for sanitation entrepreneurs can be done by the STBM team at the sub-district or the district level, depending on the agreement in the planning. The trained sanitation entrepreneurs (business actors) must have an interest in the sanitation business and have the ability and determination to do the business. Trainings can be carried out with a focus on several types of technical training such as training on the construction of healthy latrines, making latrine seats, herbal soaps, trash bins and others. However, the trainings must also be balanced with non-technical trainings such as product and service diversification, marketing and sales, selling prices, bookkeeping, social entrepreneurship and others. In the long run, a business that runs well will make the availability of sanitation products and services to meet the needs of the community always maintained.

Normally, all capacity building activities can be carried out if financial resources are available at each level. This is what underlies the importance of ensuring the availability of a budget for the implementation of the 5 pillars of the STBM.

Activities at the Village Level

Similar to the intervention at the sub-district level, the villages to be intervened will also be selected according to the priorities and interests of the village head. Again, it is strongly recommended to begin implementation with this approach slowly in several sub-districts and villages (a maximum of 5 selected villages per sub-district). The STBM team is advised to intervene first in the villages that have the greatest interest and then the villages that are less interested. The implementation phase at the village level has been described in the previous chapter in Phase 1: Starting Up.

12. Conducting village level road shows. This road show activity at the village level is defined as an initial meeting at the village level to explain STBM to the village government and explore further village commitments. This is a pre-triggering activity. In this activity the sub-district STBM team will explore the conditions in the village and prepare for its triggering in the next stage.

13. Establishing village STBM team. In the road show at the village level, the sub-district STBM team will form a village STBM team consisting of village government heads and staff, religious leaders, community leaders, traditional leaders and Posyandu cadres and communities interested and able to carry out health promotion. The village STBM team is the promoter for implementing the 5 pillars of the STBM at the village level. Although Posyandu cadres are mostly made up of women, it is strongly recommended that STBM team members also consider gender equality in the composition of their membership. Several facts show that men in the household sector still have greater power in making decisions related to the family economy so that the involvement of men in the team will have a positive influence in terms of equality of power at the household level.

14. Building capacity for village STBM teams. As with the capacity building at the district and sub-district levels, some capacity building activities need to be carried out at the village level. The sub-district STBM team is responsible for conducting trainings such as triggering, promotion,

baseline and monitoring. Capacity building for village STBM teams is very important so that they can act as ambassadors for change in their respective villages. Trainings in the villages will also build the capacity of the sub-district STBM teams, especially for the health workers.

15. Collecting baseline data at household level. Monitoring training at the village level will be continued with baseline data collection in households related to the 5 pillars of the STBM. This data collection is ideally carried out in 100% of households in the village by visiting each household and conducting interviews with household members based on set questionnaire. The results of data collection are then recapitulated to get an idea of the condition of each household in the village. The village STBM team, especially the village head, is expected to examine the baseline data in order to determine the suitable strategy in realising the 5 pillars of the STBM. This data is then sent to the sub-district STBM team for further analysis. Data of each village will be combined by the sub-district STBM team to then be reported to the district STBM team.

16. Preparing village plans. The baseline data collected will be used to prepare a village plan or revise its existing annual plan. In this process, the sub-district STBM team is expected to assist the village government to plan appropriately. Village planning activities are not enough to be done in one meeting. In the bottom-up planning process, this process begins with village-level planning and development deliberations, and it is therefore very important for the village and sub-district STBM teams to assist the village government so that the STBM is integrated into the village programme and budget plan. This deliberation process will be continued to the top level up to the national level.

Phase 2: Learning and Testing, and Phase 3: Scaling up and Replication

Activities at the Village Level

The implementation of the STBM programme at the village level is carried out at this phase. However, as explained earlier, the implementation is carried out only in priority villages at first. The coverage will increase gradually when the system and capacity that have been built are adequate.

17. Triggering STBM. After the capacity of districts, sub-districts and villages has been strengthened, triggering STBM is the first activity carried out in the village. However, this triggering is ideally carried out after baseline and pre-triggering data collection are completed. Pre-triggering activities are very important in ensuring commitment from the village head. It is also important to agree on the date and place of triggering activities and to encourage all village members to actively participate in triggering meetings. During triggering activities, the facilitator must avoid shaming (humiliating) and coercing the community and ensuring that marginalised groups such as persons with disabilities and the elderly participate in triggering.

18. Post triggering. Post-triggering activities are an important part of behavior change at the community level. Regular visits to households, promotion of hygiene, and routine monitoring are carried out to bring about behavioral changes. Promotional activities can also add insights to the community about healthy latrines and how to maintain sanitation, personal hygiene and environmental facilities. Without promotion at household level, it appears difficult for the community to adopt clean and healthy lifestyle and achieve the 5 pillars of the STBM.

At this stage, some households may change faster than others. Therefore, follow-up and

support from the village STBM team needs to be adapted to the prevailing conditions in each household.

Different types of households (consumer categories)

According to the theory of market segmentation, behavior or behavior change can be known or analysed by looking at the level of acceptance of a product. This theory can be used to see changes in people’s behavior regarding sanitation by examining their level of acceptance (or utilisation) of a sanitation product, such as a toilet at the household level. The faster they use a toilet, the greater the likelihood of behavior change. Figure 10 shows consumer categories, namely: innovators, early adaptors, early majority, late majority and laggards.

Consumers who have built toilets before programme intervention can be categorised as “innovators” (consumers who are specifically interested in new products and have a high tendency to buy new items; usually are people with high income and education) and some “early adaptors” (consumers who want to know the most about a product). After triggering, latrines built in the first group will be in the category of “early adaptors” and “early majority” (consumers who must be convinced first about the quality and benefits of a product, so they will wait for the product to be accepted by the public before deciding to buy). The “early majority” will then be followed by the “late majority”, that is, those who use a product after the product is really popular and considered important. The last category is the “laggards,” i.e. consumers who do not want to change and may not want to use new products until traditional choices are no longer available. Easily, anyone who cannot afford to build a toilet can be included in this last category.

A different strategy needs to be done to ensure that households in the “laggards” group can change their behavior. Smart subsidy scheme (combining government subsidies and community contributions) and encouraging sanitation businesses to provide inexpensive products can be done to target this group. However, for households that do not change, approaches with “sanctions and prizes” can be considered.

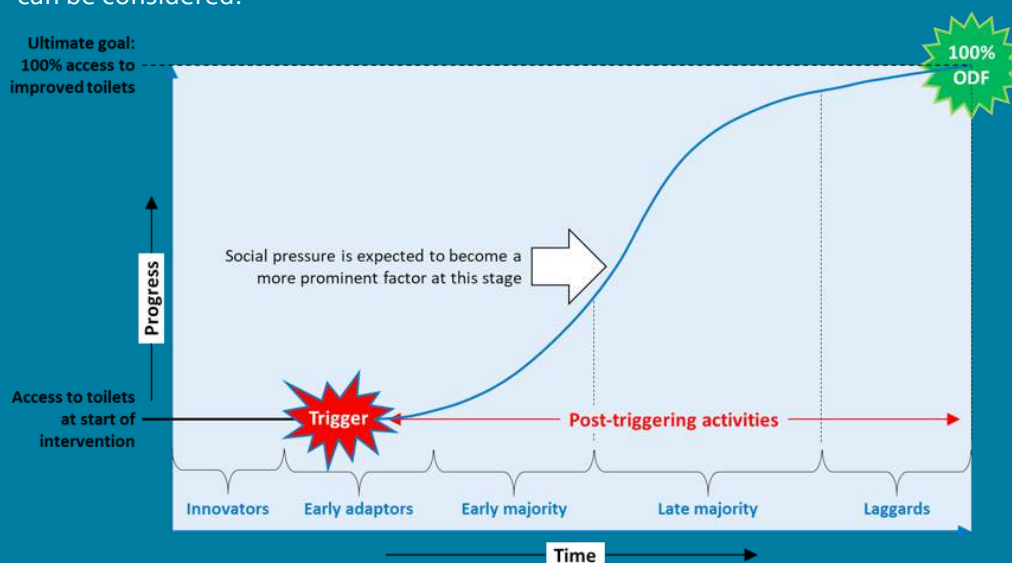


Figure 10. Programme Responsiveness based on consumer categories

To support the acceleration of the implementation of the 5 pillars of the STBM, village level regulations or village regulations need to be prepared. Its preparation can be initiated at the village planning and development deliberation stage and this will take a long period of time. District and sub-district STBM teams need to encourage the realisation of village regulations by referring to higher hierarchy of regulations. In addition to making regulations, a conducive partnership between the village government and sanitation entrepreneurs also needs to be established during the post triggering phase.

19. Monitoring and evaluating the implementation of the 5 pillars of the STBM. The village STBM team is expected to carry out a 6-monthly monitoring of the development of the 5 pillars of the STBM. The monitoring data is collected through household-to-household visits based on a set of agreed questionnaires. Its results are then recapitulated at the sub-village and village levels and then analysed together with the village government. The data obtained will be compared with the targets that have been determined at the initial stage and will be discussed over several constraints and hindrances. These results are then sent to the sub-district level.

Activities at the Sub-District and District Level

20. Recapitulating monitoring data. The sub-district STBM team is responsible for recapitulating the monitoring data received from the village team. Its analysis needs to be done comprehensively by combining data from each village to see the extent of the development. The results of this monitoring will also be useful for adjusting or developing action plans at both the sub-district and district levels.

21. Conducting coordination meetings. Following up on monitoring, coordination meetings need to be conducted every 3 to 6 months between the STBM teams and Pokja AMPLs at the village, sub-district and district levels. In fact, cross-sector meetings are also recommended to be carried out as a forum to discuss and motivate for the better implementation of the 5 pillars of STBM. At this meeting it is also possible to begin replication or scale up to other villages/ sub-districts - if the approach taken in the village at the initial intervention shows positive results or if other villages begin to be interested and show strong commitment.

22. Monitoring stakeholder capacity. In the SEHATI approach, monitoring is not only done on the 5 pillars of the STBM, but also on the capacity of the STBM teams at each level in terms of budget, regulation, planning, and other related expertises. The district STBM team is expected to be able to monitor the capacity of the sub-district team and the sub-district team to monitor the capacity of the village team. This is done to see whether the capacity is improving or not. SEHATI has composed this capacity monitoring tool and it has been used for approximately 3.5 years.

At the district level, the district STBM team will evaluate independently. Whereas sanitation entrepreneurs can be monitored by the district and/or district STBM team according to the agreement.

23. Conducting evaluation meetings. Formal evaluation meetings can be held at each level every year. These meetings must use evidence and data obtained from monitoring. Monitoring data will help the government see whether the implementation of STBM is in accordance with the road map or not. Monitoring will also see the performance of each STBM team. The results of evaluation meetings will become references to adjust the action plans for the acceleration of the programme. As with coordination meetings, evaluation meetings are held at the village, sub-district and district levels.

- 24. Conducting STBM Verification.** When a village claims to have reached the 5 pillars of the STBM, the village can submit a request for verification to the sub-district team. Several verification mechanisms can be carried out, starting from independent verification by the village (before submitting to the sub-district level) until cross verification between sub-villages/villages. However, the official verification authority is held by the sub-district team led by the Puskesmas.
- 25. Conducting STBM Declaration/Certification.** The official declaration can only be done if the results of the verification conducted formally by the district STBM team state that 100% of households have implemented the 5 pillars of the STBM. The district STBM team and/or Pokja AMPL can be involved in this activity to validate the 5 pillars of the STBM status before the village is declared 100% STBM. In the realisation, the declaration is a ceremonial event carried out by the village government as appreciation to the efforts of the people in changing their behavior to successfully implement the 5 pillars of the STBM. Sub-district/district teams will issue certificates for villages that have implemented 100% of the 5 pillars of the STBM.
- 26. 26. Conducting district level verification.** After all villages in a sub-district are declared 100% STBM, the sub-district can submit a request for verification to the district STBM team. With the authority obtained from the Pokja AMPL, the district STBM technical team can carry out official verification to the sub-district with reference to the standards of the Ministry of Health.
- 27. 27. Conducting STBM Declaration/Certification at the sub-district level.** Following up on the success of the STBM verification at the sub-district level, Bupati will declare/give a certificate of 100% STBM to the sub-district. As with declarations at the village level, the declaration of the sub-district is a ceremonial activity to reward the community.

Post-declaration activities at the village, sub-district and district levels

- 28. Monitoring and conducting post-declaration follow-up activities.** To ensure the achievement of the 5 pillars of the STBM sustainable, 6-monthly monitoring activities need to be carried out, both monitoring the 5 pillars of the STBM indicators at the household level, and monitoring the stakeholder capacity indicators, even though a village/the sub-district has been declared 100% STBM. Continuity of this monitoring needs to be done because several facts show that there are still many people who regress to their initial behavior (large scale slippage) due to such factors as weak monitoring from the government or STBM teams. By conducting monitoring and coordination activities, sanitary and hygiene behavior can be monitored. Any challenges that prevent the community from advancing in the sanitation ladder can be detected and discussed for solutions.

CLOSING

“Scaling up is a never-ending relationship building and partnership development activity. The roles, rules and institutions evolve in the process, and assumptions for determining the change.”⁵

Scaling up and replication, whose purpose is an everlasting change, are a blend of art and applied science. That is, its process requires not only reason (rationality) of the main actors, but also high dedication and commitment and willingness to do efforts wholeheartedly. This principle is evident throughout the course of the SEHATI programme which focuses on the 5 pillars of the STBM.

In the field of STBM, there is no single intervention and replication strategy that is suitable for use in a variety of situations. Making one type of innovation that is easy to implement and replicate everywhere is impossible. Because, most health programmes always intersect with different socio-political situations and involve many actors and interests in each region. As stated by John G. Haaga and Rushikesh M. Maru in a study of the effects of operational research in Bangladesh in 1996, replicating an approach is not a linear process that originates from an analysis, recommendations and then actions.⁷

The SEHATI model is an alternative approach to complement the current approach. The strength of this model lies in its ability to adopt the distinctions of each region, its special attention to the capacity of stakeholders, its integration of all 5 pillars of the STBM in the implementation, its attention at the pre-triggering stage to obtain commitment from local stakeholders, and its establishment of coordination forums that allow discussion and participation between institutions and between levels of government. In addition, the SEHATI model has so far been an approach that considers how scale up and replication can be sustainably carried out by the local government when the programme ends.

The SEHATI monitoring and evaluation tool is also a distinction from other approaches. This tool is proven to be very useful in providing a complete picture of the regional situation and in giving assistance to stakeholders in their planning and adapting their programmes so that they can target problems effectively.

The best models will not be beneficial if the implementors do not have a maintained dedication and commitment. This SEHATI model is a model that requires high commitment and dedication from its actors. Therefore, the role of the government to maintain this dedication and commitment cannot be overemphasised.

Finally, this approach can be used as it is, but it needs to be kept in mind that changes or adjustments need to be done where necessary because the field situation is very dynamic. The SEHATI approach is an approach that adopts current changes to achieve the expected change, namely 100% of the 5 pillars of the STBM.

⁵Silan, Cavite, 2000. Going to scale: can we bring more benefits to more people more quickly? Philippines, International Institute of Rural Construction, YC James Yen Center.

⁶Haaga J, Maru R. 1996. The effect of operations research on program changes in Bangladesh. Studies in Family Planning. 27(2):76-87

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ANNEXES - CAPACITY MONITORING INDICATORS

To measure the capacity of stakeholders in implementing sanitation and hygiene programmes, SEHATI has composed indicators at the district level (Pokja AMPL), Health Office, sub-districts, villages and also sanitation entrepreneurs. This monitoring indicator can also be used by local governments who are willing to replicate the implementation of the programme through SEHATI approach.

Capacity monitoring is expected to be carried out using an interactive participatory method. To facilitate the calculation of results, measurement of the monitoring process is carried out using a score card. Assessment is done by using a continuum ranking to show value, namely NONE - LIMITED - GOOD - COMPLETE.

The types of assessment ratings are as follows:

COMPLETE	GOOD	LIMITED	NO
Fully available	Strong	Between yes and no	Blank
All condition and criteria are met	Almost all conditions and criteria are met	Some conditions and criteria are met	None of conditions or criteria are met

Some of the advantages of using the score card method are as follows:

- It provides clear instructions for determining the capacity of baseline data in depth but fast through a participatory process.
- It gives capacity predictions for the next monitoring process through comparison of baseline data.
- Its use of a simple scoring system which allows quantification of the changes achieved.
- Its use of capacity assessment cards which will assist in making reports that can be understood by all relevant parties, including local government actors.

The capacity monitoring indicators set at each level of government can be seen in the tables below.

A. Capacity Indicators at District Level

Capacity Assessment Indicators at the District Level (POKJA AMPL)						
No.	Indicator	ASSESSMENT				IN %
		COMPLETE	GOOD	LIMITED	NO	
1.	STBM is included in RPJMD					
2.	STBM is included in annual plans and budgets					
	Adequate funds are released to support SEHATI programme activities	written on the notes				
3.	Adequate funds are released to support SEHATI programme activities					
	Actual amount released this year to support SEHATI Programme activities	written on the notes				
4.	Adequate funds are made available to replicate or scale up STBM in non-SEHATI target areas					
	Actual amount released this year to replicate or scale up STBM in non-SEHATI target areas	written on the notes				
5.	Clear division of roles and responsibilities to implement STBM					
6.	District STBM team is formed under district authority and functioning					
7.	Regular coordination meetings organized with all relevant district level stakeholders					
8.	A monitoring system is in place that measure progress on STBM at village, sub-district and district level					
9.	Information from regular monitoring is shared, analysed and discussed with relevant district level stakeholders					
10.	STBM supportive legislation in the form of Bupati instruction or Perda is in place					
Overall score >>						

B. Capacity Indicators at District Health Office Level

Capacity Assessment Indicators at the District Health Office Level						
No.	Indicators	Assessment				In %
		COMPLETE	GOOD	LIMITED	NO	
1.	A detailed work plan is in place to implement STBM in the district					
2.	Adequate financial resources are available to implement the plans					
	Actual funds released to implement the plan	written on the notes				
3.	Capacity exists to provide training to sub-district STBM teams in proven demand creation methodologies					
4.	Capacity exists to provide training to sub-district STBM teams in proven hygiene promotion methodologies					
5.	Capacity exists to provide training to sub-districts STBM teams in STBM monitoring					
6.	Capacity to provide follow up to the sub-district STBM teams after training in the form of guidance, coaching, motivation and/of support during implementation					
7.	Capacity exists to analyse monitoring data submitted by Kecamatan STBM teams					
8.	Regularly assesses the performance of sub-district STBM teams responsible for demand creation and follow up					
9.	Regularly organises coordination meetings with sub-districts STBM teams to discuss progress and challenges					
10.	The information from monitoring, experiences and lesson learned are used to adjust or improve implementation plans when relevant					
11.	Capacity to verify and validate village level and Kecamatan level STBM verification and declaration					
Overall score >>						

C. Capacity Indicators at Sub-district Level

Capacity Indicator Assessment at Sub-district Level						
No.	Indicators	Assessment				In %
		COMPLETE	GOOD	LIMITED	NO	
1.	A detailed work plan is in place to implement STBM in the sub-district					
2.	Adequate financial resources are available to implement the plans					
	Actual funds realised to implement the plans	written on the notes				
3.	STBM team at sub-district level is formed under district authorities and functioning					
4.	Capacity exists to provide training to village STBM teams in proven demand creation methodologies					
5.	Capacity exists to provide training to village STBM teams in proven hygiene promotion methodologies					
6.	Capacity exists to provide training to village STBM teams in monitoring					
7.	Capacity exists to provide follow - up to the village STBM teams after training in the form of guidance and/or support during implementation					
8.	Capacity exists to analyse monitoring data submitted by village STBM teams					
9.	Regularly assesses the performance of village STBM teams responsible for demand creation and follow up					
10.	Regularly organises coordination meetings with village STBM teams or village authorities to discuss progress and challenges					
11.	The information from monitoring, experiences and lesson learned are used to adjust or improve implementation plans when relevant					
12.	Capacity to organise and conduct village-level STBM verification and declaration					
Overall score >>						

D. Capacity Indicators at Private Sector Level

Capacity Indicator Assessment at Private Sector Level						
No.	Indicators	Assessment				In %
		COMPLETE	GOOD	LIMITED	NO	
1.	Entrepreneurs are involved in sanitation related business or supply chains					
2.	Number of people (customers) that accessed or acquired sanitation products or services	written on the notes				
	Entrepreneurs involved in sanitation related businesses experience increased sales compared to last year.					
3.	New sanitation products and services successfully introduced into the market					
4.	Adjustment or modification made to make the products and services more suitable to women, the poor and disabled					
Overall score >>						

Specifically for the assessment of sanitation entrepreneurs, the above indicators are filled based on the results of field data as follows:

Additional Explanatory Information to Assess Sanitation Entrepreneurs			
Indicators	Numbers	Indicators	Numbers
The number of entrepreneurs / entrepreneurs involved in sanitation		Type of business	
Number of customers			
Number of entrepreneurs /entrepreneurs with increased sales		Average increase in %	
Number of new sanitation products and services.		Types of products and services	
Number of sanitation products and services for women, the poor, and people with special needs.		Types of products and services	

E. Capacity Indicators Village level

Capacity Assessment Indicators at Village Level		
No.	Indicators	Numbers
1.	Number of village that are being supported to implement STBM by Kecamatan STBM team and SEHATI partners	
2.	Number of villages that are being supported to implement STBM as replicated by Kecamatan STBM teams	
3.	Number of villages that have STBM supportive legislation in place (e.g. Perdes)	
4.	Number of villages that have integrated STBM in village plan and budgets	
5.	Number of villages that have integrated gender and pro poor in their STBM plans and budgets	
6.	Number of villages that have allocated funds for STBM this year	
7.	Number of villages that have been trained on demand creation methodologies	
8.	Number of villages that have been trained on hygiene promotion methodologies	
9.	Number of villages that have been trained on STBM monitoring	
10.	Number of villages in which monitoring data is collected, analysed and reported in time and independently	
11.	Number of village that have successfully reached 100% ODF status	
12.	Number of villages that successfully reached 100% STBM status	

Specifically at the village level indicators, the assessment is not carried out using ratings but rather calculating the number of villages that have implemented the 5 pillars of the STBM with the indicators above. Thus, the District STBM Team got a complete picture of the implementation of the 5 pillars of the STBM in all villages.



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