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Scaling Up Rural Sanitation and Hygiene in Indonesia

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Abbreviations

AKKOPSI	: Alliance of Districts and Cities Concern on Sanitation
BAPPENAS	: *Badan Perencanaan Pembangunan Nasional* - State Ministry of National Development Planning
BOK	: Bantuan Operasional Kesehatan (Health Operational Assistance)
CLTS	: Community-Led Total Sanitation
GDP	: Gross Domestic Product
JMP	: Joint Monitoring Programme
MCAI	: Millennium Challenge Account-Indonesia
MDG	: Millennium Development Goal
MFIs	: Micro Finance Institutions
MoH	: Ministry of Health
PAMSIMAS	: Third Water and Sanitation for Low-Income Communities Project
PPSDM	: *Pusat Pengembangan Sumber Daya Manusia Kementerian Kesehatan* - Agency for Development of Human Resources, MoH
PPSP	: *Program Percepatan Pembangunan Sanitasi Permukiman* - National Sanitation Acceleration Development Program
Poltekes	: Health Polytechnic Schools
Promkes	: Health Promotion Board
Puskesmas	: Community Health Center
RPJMN	: Medium-Term Development Plan
RPJPN	: Long-Term Development Plan
STBM	: National Strategy for Community-Based Total Sanitation
TA	: Technical Assistance
ToT	: Training of Trainers
TSSM	: Total Sanitation and Sanitation Marketing
WSP	: Water and Sanitation Program, the World Bank
WSLIC-2	: Second Water and Sanitation for Low-Income Communities Project

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Executive Summary

This report sets out the results and lessons learned from TA P132007: Scaling Up Rural Sanitation and Hygiene in Indonesia, which ran from 2013 to March 2016. This was an umbrella TA with a broad remit, and under it were two other TAs with a narrower focus: Rural Sanitation Market Creation (P143165) and Institutionalization of Rural Sanitation Capacity Building (P132118), both of which closed in 2015.

Reform in the rural sanitation sub-sector began in 2005 following the successful introduction of Community-Led Total Sanitation (CLTS) in 6 districts. In 2007, the Water and Sanitation Program (WSP) supported the Ministry of Health (MoH) to complement the use of CLTS with behavior change communication (BCC) and development of the sanitation market. This new approach was piloted at scale in 28 out of 29 districts in East Java Province in 2007-2011 under the Total Sanitation and Sanitation Marketing (TSSM) TA. Impressive results were achieved in just ten months, with 262 villages becoming Open Defecation Free (ODF). In response, MoH adopted the district-wide approach in 2008 and launched a new rural sanitation development strategy called Community-Based Total Sanitation (*Sanitasi Total Berbasis Masyarakat*) or STBM. The STBM strategy has three elements: demand creation through CLTS and BCC; supply chain improvement through developing the local sanitation market; and creation of and enabling environment through advocacy for local formal and informal regulations and resource mobilization.

Objectives of the Technical Assistance

In 2012 MoH requested TA from WSP to strengthen the capacity of national and local institutions to implement STBM in up to five provinces. The agreed TA covered four areas:

a. Strengthen the Secretariat to guide the scaling up of STBM nationwide, using funding from the Government of Indonesia and development partners.

b. Support the development of a nationwide rural sanitation performance benchmarking and monitoring system for district governments, using Joint Monitoring Program (JMP)-aligned definitions.

c. Strengthen the role of provincial government in coordinating district-level implementation of STBM through various projects including PAMSIMAS and PNPM Generasi Plus; and develop provincial and district resources for scaling-up CLTS, sanitation marketing and strengthening the enabling environment in up to five provinces.

d. Develop a new campaign and tools and build local government capacity in, and ownership of, sanitation and handwashing promotion using evidence-based research on behavior change communication (BCC).

Complementing this TA were two smaller TAs, each with a specific, narrower focus: Rural Sanitation Market Creation (P143165) and Institutionalization of Rural Sanitation Capacity Building (P132118), both of which closed in 2015.

P132007 was also complementary to a large-scale World Bank-funded program called PAMSIMAS, which has evolved from a project to a national platform through which the government intends to reach its newly adopted target of universal access to water supply and sanitation by 2019.

Key results and achievements

Intermediate Outcome 1: Well-functioning STBM Secretariat set up to co-ordinate STBM implementation nationwide

When the TA started, the Secretariat was outside the MoH structure, 100% donor-funded and managed informally. Early in the TA, in 2012, consensus was reached that the STBM Secretariat should be hosted and managed by MoH. With substantial support from donor partners, the Ministry accordingly allocated resources for operations, assigning one officer as Co-ordinator, recruiting administrative staff and providing the necessary office space and facilities. The TA then provided a pool of experts to support the Secretariat in carrying out its role in spearheading, guiding and monitoring STBM implementation. The Secretariat is now staffed by seven consultants and co-ordinated by a government official, and is functioning well. Among other things, the Secretariat has organized national STBM reviews and co-ordination meetings; developed guidelines and supported training for stakeholders at all levels; supported knowledge management and advocacy; and collaborated with other relevant platforms and institutions.

As of 2016 onwards, most funding comes from the Ministry's regular budget. The Ministry decided to selectively accept support from donors for non-budgeted activities, innovative ideas and a small selection of experts on a time-bound basis, and has elevated to Secretariat's position from under the Basic Water and Sanitation Unit to be directly under the Director of Environmental Health Department. A Director General of Public Health's decree has been drafted and circulated for this promotion in May 2016. However, the Secretariat is bound by the government's general financing standards resulting in unattractive remuneration rates for experienced and specialized consultants and restricted support for certain activities. Hence, some (low) level of external support is still required. WSP will continue to support the Secretariat through the new TA (P-158934), in particular to support them in addressing the bottom 40%, cross sectoral collaboration such as combating malnutrition and stunting, and leveraging and expanding strategic advocacy to the local governments.

Intermediate Outcome 2: Local government capacity in implementing STBM through demand creation, supply improvement and enabling environment increased

When STBM was adopted as a national strategy in 2008, there were initially some challenges to implementation at scale, including inconsistent and poor quality implementation of program methodology as well as limited support from local government. For example, the triggering fundamental to the CLTS process was often neglected or done badly and there was inconsistent sequencing of activies. In response, the TA assisted MoH in developing a capacity building framework and developed a comprehensive STBM guideline for implementation at all government levels, from national down to village level, by tapping into government's existing mechanisms and resources.

The TA strengthened capacities of the STBM Secretariat and local governments in the three components of STBM: demand creation, supply development and enabling environment. One to two consultants were deployed to work closely with provincial health offices to ensure their commitment and strengthen their capacity to implement the STBM following national framework in a way that it matched with local policy and financing. Their work was substantially strengthened by a pool of TA consultants in Jakarta who iteratively designed methods, strategies, as well as supporting tools, guidances and mechanisms such as SMS and web-based monitoring and evaluation, class-based and online training, and BCC materials. This support was scaled-up nationally through the STBM Secretariat.

The benefits of the TA extended far beyond the five focal provinces and resulted in the enactment of STBM as a national program for rural sanitation, through Minister of Health Regulation No. 3/2014 and corresponding policies at national and local level. In turn, this helped to increase financing for the sanitation program at both national and local level by 270% to 350% each year from 2012 to 2015.

STBM-derived training modules have been formally accredited by MoH and 28 health schools now teach the STBM curriculum, with 1,500 students completing it by December 2015. In addition, over 500 people completed the STBM e-learning course. The accredited modules are also used by PAMSIMAS.

Technical assistance directed at the development of the local sanitation market delivered a standardized training curriculum and standard operating procedures for sanitation entrepreneurs. By 2015, 270 active sanitation entrepreneurs were working in 65 districts and had built more than 60,000 latrines.

A further step forward came when the TA helped to establish a 'district-wide approach' which was subsequently adopted by government and mainstreamed in other large-scale national programs such as PAMSIMAS and the Community-Based Health and Nutrition to Reduce Stunting Project of the Millennium Challenge Account-Indonesia (MCA-I). This marked a strategic shift from project-specific interventions towards a programmatic approach that embedded implementation within government structures, thereby utilizing government resources. The district-wide approach has also been adopted by other international development agencies including UNICEF, SIMAVI and Plan International.

STBM implementation is now a priority for local governments. As evidence of this, by 2015, 85 out of 514 districts, and 19 out of 34 provinces, had issued local regulations to support STBM. Strong support from MOH and persistent advocacy and day-to-day support by STBM consultants under PAMSIMAS both at provincial and district level have encouraged local governments to mainstream STBM in their local policy. Moreover, by 2014 three districts (Pacitan, Magetan and Ngawi) and one city (Madiun), all in East Java, had achieved open defecation-free (ODF) status. Intensive support by WSP in East Java has significantly contributed to the achievement, building upon the two phases of engagement in the province (i.e., 2005-2007 piloting of the CLTS approach, resulting in numerous community champions for the cause and government buy-in for this new approach in generating demand; and 2007-2011 scale up across the whole province, broader and more intensive support covering demand (via CLTS), supply (working with entrepreneurs to ensure supply of sanitation products matches rising demand), and the enabling environment in the province under the Total Sanitation and Sanitation Marketing TA funded by the Bill and Melinda Gates Foundation).

Intermediate Outcome 3: More effective STBM implementation at provincial and district Level

Following a period of piloting in East Java in 2009, the TA helped MoH establish a nationwide SMS-based monitoring system covering 34 provinces. The system was first rolled out to the five provinces supported by this TA[1], where the TA supported the training and coaching of sanitarians and district health officers both in using the system and analyzing the data, developed user guidelines, and advocated use of the findings by local governments to improve STBM implementation.

Institutional roles and responsibilities for monitoring are now clearly assigned at each level of government, and the system has both SMS- and web-based components. It provides information not only on sanitation access, but also on STBM budgets at local level, training activities and sales by sanitation entrepreneurs. STBM data is widely disseminated and used by various stakeholders as an advocacy tool to address policy makers.

Access to improved sanitation in the five provinces increased by 2.57% per year over the period 2012-2015, more than the national average increase of 1.61%, while access to permanent improved sanitation (meaning pour-flush toilets) increased by 1.68% per year, compared to a national average of 1.12%. Prior to the TA implementation, the ODF 'success' rate in intervention villages was below 20% (i.e., 20% of communities 'triggered' via CLTS became verified as ODF). Acknowledging the challenges to achieve full ODF status, the TA targeted increasing the success rate 20%. By the end of the TA, the ODF conversion rate was higher in the five focal provinces (29%) compared to the country as a whole (23%). In total an additional 8 million people gained access to improved sanitation in the five supported provinces between July 2012 and December 2015. The achievement is consistent with the TA's expectation and in-line with global achievement rates in countries with comparable (and well-working) verification processes.

Lessons Learned

1. A capacity building framework to strengthen institutions at all levels is key for scaling up in a decentralized environment. The framework was developed following transformational changes in rural sanitation strengthened with Minister of Health Regulation No.3/2014. The regulation provides clear direction for actors, phases of STBM implementation, and their expected responsibilities. Capacity building was delivered through various channels, including through integration into the existing government education system, conventional class-based and online training, developing systematic tools such as for monitoring and evaluation, and coaching for STBM provincial coordinators. The accreditation of training courses was particularly useful, as it helped to ensured that an acceptable quality of training was achieved and maintained.

2. Well-crafted advocacy and communications are valuable for disseminating tested approaches and facilitating their adoption at scale. Evidence and data-backed up advocacy materials and carefully

[1] West Java, Central Java, East Java, Bali and West Nusa Tenggara.

designed communication channels and events which demonstrated the government's lead in the sector were keys to smooth adoption of the approach by local government. Local government commitment to STBM was boosted via national knowledge sharing and advocacy events plus international learning visits which provided vision and inspiration to policy makers.

3. Engagement of a range of institutions also strengthens campaign outreach. Beyond the environmental health unit in charge of sanitation, collaboration with the Center for Health Promotion and the Center for Public Communication leveraged their resources and expertise.

4. An effective monitoring system is invaluable and it use should be formally integrated into the routine operations of government agencies. The STBM Secretariat played a key role in ensuring the regular collection and submission of data to the MIS and – importantly – use of the data to inform planning, decision making and advocacy.

5. Local government can help to develop the rural sanitation market. In the WSP-supported provinces, the supply side of STBM implementation benefitted from partnerships established between local government and local micro-finance institutions. This encouraged and enabled local sanitation entrepreneurs to start working directly with rural communities. Ongoing support from the Sanitation Entrepreneurs Association APPSANI helped these actors to improve their operations and stay engaged.

6. The scaling up tested approaches can be enhanced greatly through their incorporation into established programmes. Adoption of the district-wide approach by PAMSIMAS boosted progress in rural sanitation enormously.

Recommendations

For the Government:

- Following institutional changes within the Ministry, MoH should accelerate relocation of the STBM Secretariat directly under the Director of Environmental Health and enhance coordination and collaboration with other parts of the Directorate General of Public Health, including the Health Promotion Unit, Public Communications, and the Agency for Development and Empowerment Human Resources of Health (PPSDM). Collaboration on nutrition interventions should also be pursued given the close association between poor sanitation and early childhood stunting.

- While the current STBM MIS does not specifically monitor access among poorer households, the affordability of improved sanitation facilities is known to be a constraint. Beyond MoH, therefore, the STBM Secretariat should also collaborate with social sector programs to ensure better inclusion of the poor and develop knowledge for effective pro-poor support mechanisms. A key national program platform to work with is the National Program on Community Empowerment (PNPM).

- In collaboration with the Alliance of Districts and Cities Concern on Sanitation (AKKOPSI), MoH should continue strengthening advocacy to district and cities leaders to consolidate their commitment to STBM as a key intervention to achieving the target of universal access to sanitation.

- MOH should strengthen the supply side of STBM, for example by ensuring that support structures such as APPSANI (or alternatives) are available at scale. This may entail some or all of the following:
    - Expanding capacity building support for entrepreneurs and their marketing agents and masons.
    - Further development of affordable technology options for sanitation in challenging environments such as rocky or sandy soil.
    - Facilitating loans for entrepreneurs and households, through support from local governments and APPSANI, as well as collaboration with other partners

- In collaboration with other related ministries, MoH could explore opportunities for rural sanitation development under the recently-enacted Village Law whereby village government is provided with significant resources for development; this could be done by making ODF status one of the village's key performance indicators.

For the Bank as part of ongoing operation (PAMSIMAS) and TA:

- In collaboration with the STBM Secretariat and PAMSIMAS team, and based on the experience gained with the SMS-based system and the PAMSIMAS MIS, the Bank is expected to explore the scope for introducing an interactive, smartphone-based reporting system. This could potentially improve the ease and efficiency of monitoring.

- In collaboration with STBM Secretariat and PAMSIMAS team, the Bank is expected to develop performance-based incentive schemes for STBM implementers at all levels: province, district and sub-district/Puskesmas, to encourage competition and improve the quality and scale of STBM implementation. This needs to be done in parallel with expanding the independent verification of reported results to avoid over-reporting by individuals.

- Building on the momentum achieved through PAMSIMAS and the sequence of TAs, the sustainability of the STBM Secretariat and continued program's scale-up is required if the Government is to reach its ambitious goal of universal access to sanitation by end of 2019. The Bank is expected to continue supporting innovative ideas through a small selection of experts on a time-bound basis and support for non-budgeted, nation-wide impact activities, including to reach the bottom 40%, cross-sectoral collaboration (for example to combat malnutrition and stunting), and strengthen local support for universal access of sanitation.

1. Introduction

1. This report summarizes the results and lessons learned from TA P132007, entitled Scaling Up Rural Sanitation and Hygiene in Indonesia. This was a multi-year TA program implemented from January 2013 to March 2016 with a budget of USD 3 million including fixed staff costs. It was linked to two complementary TAs: TA P143167 on sanitation marketing (from 2012 to 2015) and P32118 on institutionalizing capacity building (from 2012 to 2015). Both have contributed to the achievements discussed in the report.

1.1. Country Context

2. Indonesia is the fourth most populous country in the world, with 256 million people spread over a vast equatorial archipelago of 17,000 islands extending 5,150 kilometers from east to west. About 118 million people (46% of the country's population) live in rural areas.[2] In recent years, the country's economic growth has slowed, from 6.2% in 2011 to around 4. 7% in the second quarter of 2015, for several reasons including a slump in the mining sector. Nevertheless, the poverty rate declined from 12.5% in 2011 to 11.3% in 2015[3], and the Human Development Index (HDI) rose from 0.670 in 2010 to 0.684 in 2014, with Indonesia ranking 110 out of 188 countries and territories in 2015.[4] This achievement maintained Indonesia's status as a lower-middle income and medium human development country.

3. Politically, Indonesia's transition to democracy in 1998 was followed in 2001 by a policy of decentralization whereby significant responsibilities were devolved to districts and municipalities. Its administration has evolved accordingly from 27 provinces, 234 districts, and 64 cities in 1999, to 34 provinces, 416 districts and 98 cities in 2014.[5] Local governments have significant autonomy in administration and setting local policy. Under Law No. 23/2014, they are obliged to deliver basic services, such as education and health (including water and sanitation); and non-basic services, such as village and community empowerment and environmental services, and they are encouraged to deliver optional services relevant to local natural resources and industry.[6]

1.2. Rural Sanitation Status and Sector Changes

4. Despite economic growth and decentralization, basic service provision, particularly for rural communities, has lagged behind for much of the past decade and access to improved sanitation increased by only 23% from 1990 to 2015. Among its peers in the region, Indonesia and Cambodia did not meet their sanitation MDG targets, while Lao PDR, the Philippines and Vietnam did. At the same time, Indonesia came close as the last UNCEF/WHO Joint Monitoring Program update shows, and made the biggest gains in absolute numbers, reaching 50 million over the MDG period. Growth in access has

[2] UNICEF & WHO (2015). *25 Years Progress on Sanitation and Drinking Water, 2015 Update and MDG Assessment.*
[3] Statistics Indonesia (2015). Percentage of poor population in September 2015 was 11.13%.
[4] UNDP (2015). *Human Development Report 2015, Sustaining Human Progress.*
[5] Ministry of Home Affairs (2014). *Jumlah Provinsi, Kabupaten dan Kota. http://otda.kemendagri.go.id/index.php/2014-10-27-09-15-39*
[6] Law No. 23/2014 on Local Government.

accelerated in particular in recent years following a shift from supply- to demand-led infrastructure development through community empowerment and behavior change, the creation of a sanitation market and an enabling policy environment.[7] As a result, access to improved sanitation in rural areas grew by around 2.6% per annum from 2008 onwards. However, this still left an estimated 63 million people without access by 2015, out of which 39 million practiced open defecation.[8]

5. Reform in the rural sanitation sub-sector began in 2005 following the successful introduction of Community-Led Total Sanitation (CLTS) in 12 districts. In 2007, the Water and Sanitation Program (WSP) supported the Ministry of Health (MoH) to complement the use of CLTS with behavior change communication and development of the sanitation market. This new approach was piloted at scale in 28 out of 29 districts in East Java Province in 2007-2011 under the Total Sanitation and Sanitation Marketing (TSSM) TA. Impressive results were achieved in just ten months, with 262 villages becoming Open Defecation Free (ODF).[9] In response, MoH adopted the district-wide approach in 2008 and launched a new rural sanitation development strategy called Community-Based Total Sanitation (Sanitasi Total Berbasis Masyarakat) or STBM. The STBM strategy is built around three elements: i) demand creation through CLTS and BCC, ii) supply chain improvement through developing the local sanitation market, and iii) creation of an enabling environment through advocacy for local formal and informal regulations and resource mobilization. STBM defines 'total sanitation' based on five pillars that communities need to achieve: 1) open defecation free, 2) hand washing with soap, 3) household water supply and food management, 4) household waste management, and 5) household wastewater management. The TA support was focused on pillars 1 and 2.

1.3. Rationale for the TA: Building on Past Engagement

6. MoH acknowledged that scaling-up the STBM approach would require qualified government staff to facilitate consumer choice and community action, and to achieve multi-stakeholder cooperation at all levels of government. Comprehensive capacity building was therefore needed on a national scale. To this end, in 2009 the national STBM Secretariat was founded and has been nurtured by MoH since 2012. Following the results achieved in East Java under TSSM (see Box 1), MoH requested TA from WSP to strengthen the STBM Secretariat and develop a nationwide monitoring and evaluation system for sanitation.

[7] Shifting from from supply to CDD was introduced since 1993 through WSSLIC program. However, linking the demand to sanitation market and government institution was done by TSSM approach and formally adopted by the Government in 2008 through STBM.

[8] Statistics Indonesia *in* STBM Indonesia. *Trend Rumah Tangga dengan Akses Sanitasi Layak 1993-2011 Relatif Terhadap Pencapaian MDGs.* http://stbm-indonesia.org/?page=tentang-stbm&command=stbm&id1=116

[9] A community is considered ODF when: 1. All community households defecate and dispose of infant feces only into improved latrines (including at schools). 2. No human feces are visible in the environment. 3. The community uses sanctions, rules, or other means to check and prevent OD by anyone. 4. The community is using a monitoring mechanism to measure gains in household access to improved sanitation. ODF Verification refers to a system of physical inspection of a community by outsiders to assess whether the community is ODF in accordance with the criteria above. A community that fulfills the criteria is said to be ODF certified.

Box 1: TSSM Results

The TSSM project, implemented from 2008 to 2011, encouraged and invited district governments in East Java to scale up the STBM approach. 28 of 29 heads of districts submitted their written request for the TA and pledged their commitment to increase ODF hamlets from 870 to 6,266. As a result, an additional 1.4 million people gained access to improved sanitation, with 2,199 communities becoming ODF. Community investment was five times that of local government and the local sanitation market was expanded, with local entrepreneurs selling more than 15,000 toilets in 2009-2011, generating revenue of USD 1.3 million. The commitment and capacity of local governments were key factors in this success.

7. The TA scale-up strategy was to apply the capacity developed and lessons learned in East Java to Indonesia's five most populous provinces: West Java, Central Java, East Java, Bali, and West Nusa Tenggara This would be achieved via the STBM Secretariat and government programs such as the World Bank-financed PAMSIMAS.

2. Objectives of the Technical Assistance

8. The development objective of the TA was to strengthen the capacity of national and local institutions in up to five provinces to implement STBM through demand creation, supply improvement and strengthening the enabling environment.

9. The TA covered four areas:

a. **Capacity building of the STBM Secretariat:** Strengthen the Secretariat to guide the scaling up of STBM nationwide, using funding from the Government of Indonesia and development partners.
b. **Monitoring system for rural sanitation:** Support the development of a nationwide rural sanitation performance benchmarking and monitoring system for district governments, using Joint Monitoring Program (JMP)-aligned definitions.
c. **Capacity building at provincial and district level:** Strengthen the role of provincial government in coordinating district-level implementation of STBM through various projects including PAMSIMAS and PNPM Generasi Plus; and develop provincial and district resources for scaling-up CLTS, sanitation marketing and strengthening the enabling environment in up to five provinces.
d. **Evidence-based BCC development and implementation:** Develop a new campaign and tools and build local government capacity in, and ownership of, sanitation and handwashing promotion using evidence-based research on behavior change communication (BCC).

10. Complementing this TA were two smaller TAs, each with a specific, narrower focus: Rural Sanitation Market Creation (P143165) and Institutionalization of Rural Sanitation Capacity Building (P132118), both of which closed in 2015. Details of the linkage between the three TAs are provided in Annex 1, while a summary of the timeline of the TA is in Annex 2.

11. Table 1 summarises achievements against the intermediate outcomes of the TA, and associated indicators, as stated in the project concept note (PCN). Chapter 3 provides further details of the results achieved.

Table 1: Key Intermediate Outcomes and Indicators

Intermediate Outcome	Indicators	Achievements
Client capacity increased		
Well-functioning STBM Secretariat in coordinating STBM implementation nationwide.	*Baseline* • Secretariat just founded *Target* • Secretariat's organizational structure formalized • Work plan developed and implemented • Effective coordination role in developing capacity building modules and implementation guidelines. Best practices regularly disseminated	**Achieved** Secretariat hosted under the Basic Sanitation and Water Health Division (PASD), with one staff and administrative support assigned and functioning well.
Local government capacity in implementing STBM through demand creation, supply improvement and enabling environment increased.	*Baseline* • Local governments only focus on implementing one component of STBM (demand creation/CLTS) *Target* • Local governments implement three components (demand, supply, enabling environment) comprehensively as reflected in the ministerial decree	**Achieved** Within the five provinces targeted for TA support, sanitation entrepreneurs work in partnership with district governments. Enabling environment improved in all provinces. Includes improved monitoring, enhanced capacity and comprehensive planning and budgeting for all three STBM components.
More effective STBM implementation at both district and provincial level.	*Baseline* • Appropriate monitoring system is not in place • Low ODF achievement rate in villages where CLTS triggering takes place (< 20%) • No trained sanitation entrepreneurs in all five provinces, except East Java	**Achieved** CLTS triggering scaled up from 5,335 villages to 7,433 villages in five provinces; ODF achievement rate increased from 20% in 2012 to 30% in 2015 and 1,945 sanitation entrepreneur candidates trained.

Intermediate Outcome	Indicators	Achievements
	Target • Utilization of monitoring system; • increase in number of villages triggered and in ODF achievement rate; sanitation entrepreneurs trained; active and mechanism for replication developed	

12. The TA was carried out through a variety of methodological approaches, including:
    - Consultative and participatory meetings with central and provincial stakeholders to develop the work plan of the STBM Secretariat and an intervention plan for the five provinces;
    - Provision of 1-2 consultants in each province as provincial coordinators to work hand- in-hand with provincial governments in developing a work plan and intervention strategy;
    - Setting up a pool of consultants with specialist expertise in monitoring and evaluation, BCC and sanitation marketing, and institutional capacity building to work closely with the STBM Secretariat and to back-stop provincial coordinators;
    - Periodic 'horizontal', peer-to-peer learning opportunities between the district implementers within provinces and among provinces to enable best practice to be shared and replicated in real time (rather than at the end of an intervention);
    - Close coordination with investment projects, particularly PAMSIMAS (the health component), but also PNPM Generasi, and other interventions funded by donor agencies such as UNICEF, PLAN Indonesia, Simavi and IUWASH, both at central and provincial levels to ensure well-coordinated implementation.

3. Key Results and Achievements

13. This section provides further details of the achievements of the TA in delivering the Intermediate Outcomes summarised in Table 1.

3.1. Intermediate Outcome 1: Well-functioning STBM Secretariat set up to co-ordinate STBM implementation nationwide

14. The TA strengthened the Secretariat's technical and operational capacity and it successfully facilitated STBM implementation nationwide. Table 2 outlines what the TA has achieved against this intermediate outcome while Box 2 summarises the various regulations, guidelines and knowledge products resulting from the TA overall.

Table 2: Achievements against Intermediate Outcome 1

Baseline	Targets	Achievements
Secretariat just founded	Secretariat's organizational structure formalized	**Achieved.** Secretariat hosted under the Basic Sanitation and Water Health Division (PASD) and one staff and administrative support assigned. Proposed relocation of STBM Secretariat under General Directorate of Public Health (following MoH restructuring) is expected to strengthen and leverage its position to mainstream and facilitate STBM implementation nationwide.
	Work plan developed and implemented	**Achieved.** A work plan and budget for the STBM Secretariat has been developed. Not all activities in the work plan have been included in the MoH annual budget, but most can be implemented using the Secretariat's own resources and with support from other partners, including WSP for capacity building and M&E, and UNICEF for basic operating costs.
	Effective co-ordination of the development of modules and guidelines	**Achieved.** The Secretariat has effectively co-ordinated the development of modules and guidelines with support from the MoH, local health offices and STBM partners. The Secretariat published a roadmap for program acceleration from 2013-2015; a technical implementation manual; six modules (5 accredited training modules and 1 M&E module and guideline); a STBM district-wide implementation guideline for the PAMSIMAS project; and e-learning instruments for capacity building.
	Best practices well disseminated	**Achieved.** Dissemination has been achieved both face-to-face and via media, both online and offline. Ouputs included: - National Co-ordination Meetings in 2011 and 2014

Baseline	Targets	Achievements
		- Learning events - Policy briefs and other guidance material - Dissemination of BCC campaign materials (Plung jadi Plong, STBM kaleidoscope, testimonial video, sanitation marketing standard operation procedures) plus advocacy books, posters, and booklets. The Secretariat encouraged local government replication and local specific adaptation of BCC and advocacy material. A list of publications appears in Box 2 and is also available online at www.stbm-indonesia.org

15. When the TA started, the Secretariat was outside the MoH structure, 100% donor-funded and managed informally. This contributed to slow progress and limited adoption of the newly promoted STBM approach by local government as well as weak ownership of the MoH to carry out the approach. During a series of consultative meetings to initiate the TA in 2012, consensus was reached that the STBM Secretariat would be best hosted and directly managed by MoH. MoH accordingly allocated limited resources from its regular budget, assigning one officer as Coordinator, recruiting administrative staff and providing the necessary office space and facilities. The TA then provided a pool of experts[10] to support the Secretariat in carrying out its key functions, which were to:

- Provide clear, strategic and structured conceptual direction.
- Develop a strategy for scaling up and sustaining monitoring systems
- Review and enhance technical and operational guidelance as necessary
- Co-ordinate the actors implementing STBM
- Monitor progress and disseminate achievements and findings
- Collaborate with other strategic departments in MoH to strengthen and scale up STBM, including Human Resources Development Center to strengthen training and education[11] and Health Promotion Centre to strengthen and scale-up BCC and communication strategy[12]
- Collaborate with stakeholders to facilitate supply chain strengthening[13]

16. The Secretariat is now staffed by seven consultants and coordinated by a government official, and has regular operational budget, allocated through the Ministry's budget and also from the MoH funding of the PAMSIMAS project. One caveat is that allocations from regular budget are bound by the

[10] These include a monitoring and database management specialist, communication and advocacy specialist, a sanitation marketing specialist, and master trainers/facilitators.
[11] Activities for this function were carried out through P132118.
[12] Earlier, STBM was only implemented by the Environmental Health Department and its vertical units, i.e., provincial/district environmental health unit and sanitarians at Community Health Centers. By collaboration with the Human Resource unit and Health Promotion, STBM implementation was also supported by provincial/district health promotion unit, health information unit, and training centre and health schools.
[13] This activity was supported through P143167.

government general expenditure standard, which often results in below market price remuneration rates, in particular for very experienced and specialized consultants. Support from development agencies is thus still expected for non-budgeted activities, innovative ideas, and a small selection of experts on a time-bound basis.

17. With restructurization of MoH's organization, where Environmental Health Department moved from under Directorate General of Disease Prevention and Environmental Health to Directorate General of Public Health, the Secretariat's position will be leveraged and moved from under the Basic Water and Sanitation Unit to be under the Director of Environmental Health. A Director General's decree is being drafted and circulated in May 2016. The new position is expected to strengthen its influence to engage other public health units such as family health, public nutrition and health promotion and community empowernment implement STBM program. The organization structure under D.G of Public Health appears as Annex 3. Some of the most significant activities carried out by the Secretariat include the following:

- Organizing national STBM co-ordination meetings (biannual events) in 2011 and 2014.
- Developing publications (see Box 2) and supporting the implementation of the nationally accredited STBM training curriculum (including e-learning). This included organizing national and provincial training and mobilizing MoH funding to expand the pool of master trainers.
- Organizing the national annual review (since 2014) of the integration of STBM into health school curricula.
- Supporting the expanded functionality of the national MIS (SMS and web-based) for STBM, including the generation of sector reports for use in advocacy.
- Supporting knowledge management and advocacy via a website, social media and face-to-face events and fora; includes the dissemination of BCC tools and materials.
- Facilitating collaboration with other platforms such as the PAMSIMAS Secretariat and WASH working group.
- Facilitating collaboration between APPSANI (an association of sanitation entrepreneurs), local governments and partners on sanitation enterprise training, resulting in 100 entrepreneurs trained beyond the five focal provinces.
- Supporting collaboration between APPSANI and the MoH Water and Sanitation Technology Institute (BBTKL) for research and development and promotion of sanitation options for swampy/coastal areas
- Facilitating collaboration between micro finance institutions, NGOs/partners, and sanitation. entrepreneurs to secure household loans for sanitation hardware, resulting in a range of loan schemes, including some offered by local government-owned banks in many districts of East Java, Central Java and West Java by Water.org through their partnership with Bina Artha Ventura in East Java; and by national bank BRI in East Java.

18. Behavior Change Communication (BCC) has been fundamental to advocate the program and trigger behavior change. The TA developed BCC products based on an evidence-based and measured strategy following WSP's theory of change. Based on formative research, messages and the campaign

design were developed, pre-tested, revised, disseminated and monitored for effectiveness. Local government then develop their own campaign materials based on this but adjusted to local culture and using local languages. The utilization of the BCC materials, including budget disbursed, number of people exposed were captured in the web-based monitoring system. Data is inputted by local government with support from WSP's provincial coordinators. This was a fundamental shift from any previous sanitation campaigns which were centrally designed and procured without pretesting, feedback mechanisms or adjustments to local culture or languages. Details on the BCC strategy are in Annex 4.

19. Another important step forward for STBM implementation was government adoption of the district-wide approach, and the mainstreaming of this approach in other large-scale national programs. This is discussed further in section 3.2.

Box 2. Regulations, Guidelines and Other Knowledge Products from the TA[14]

Government documents

a. Circular Letter of the Minister of Health No. 132/2013 to all governors on the direction of STBM implementation. This letter instructs all districts and cities to monitor sanitation behavior and access; stimulate demand through CLTS and sanitation marketing; achieve at least one ODF village annually per sub-district primary health center (Puskesmas)[15]; and build on the ODF status of villages to promote the other STBM pillars.
b. Second revision of the 2013 Health Operation Support Fund guideline, which requests that sub-district primary health centers prioritize STBM for sanitation (including leading the CLTS implementation) to support achievement of Goal 7 of the MDGs.
c. Minister of Health Regulation No.3/2014 on STBM, which reaffirms and supersedes Minister of Health Decree No. 852/2008 on the National Strategy of STBM. This regulation includes an operational guideline for STBM implementation which was developed based on the lessons of the TA. As of December 2015, 19 provinces and 85 districts had issued local regulations on STBM.
d. Roadmap to accelerate STBM 2013-2015, MoH, 2013.

Other products

e. Training modules: Sanitation Entrepreneurship Training, WSP, 2014; 5 accredited classical training modules; 4 e-learning modules on STBM, MoH, 2013
f. Manuals: STBM Technical Implementation Manual, MoH, 2013; STBM verification book, MoH, 2013; M&E Guideline and starter kits, WSP, 2013; Sanitation Entrepreneurship Training, WSP, 2014
g. Printed advocacy materials: STBM Advocacy pocket book, WSP, 2012; 34 province sanitation profiles, WSP, 2015; Coffee table book on STBM, WSP, 2015
h. Advocacy videos: Plung jadi Plong, WSP, 2013; STBM Kaleidoscope, MoH, 2014; SURS program in Pacitan, KSAN, and STBM Coordination Meeting, WSP, 2013-2014.

[14] Document (a) to (h) are available at www.stbm-indonesia.org, document (i) is available at www.wsp.org, while documents (j) and (k) are available offline.
[15] There are around 9,000 sub-district health centers in Indonesia.

i. Learning Note: Scaling up Indonesia's Rural Sanitation Mobile Monitoring System Nationally, WSP, 2014.
j. Research: Hygiene and Sanitation Behavior, WSP, 2013; Managing the flow of monitoring information to improve rural sanitation in East Java, WSP, 2013; Rapid Need Assessment of PAMSIMAS' Capacity Building, 2015;
k. Advocacy and BCC tools developed by local government, including: STBM kaleidoscope in West Java; Kang Hebring in West Java.

3.2. Intermediate Outcome 2: Local government capacity in implementing STBM through demand creation, supply improvement and enabling environment increased

Table 3: Achievements against Intermediate Outcome 2

Baseline	Targets	Achievements
Local government focuses on implementing a single component of STBM (demand creation / CLTS implementation)	Local government implement all three components (demand, supply, enabling environment) as reflected in the ministerial decree	**Achieved** Enactment of Minister of Health Regulation No.3/2014 on STBM and adoption of the district-wide approach provided clear guidance on the STBM demand-supply-enabling environment strategy and demarcation of roles, functions and expected outcomes for stakeholders at all levels. By December 2015: - 85 districts and 19 provinces had issued local regulations to support STBM - 3 districts and 1 city in East Java were verified as ODF - Efforts to mainstream local government support and scale up STBM implementation had been promoted via MoH and a range of other associations and networks including AKKOPSI (a national association of mayors), an association of sanitation entrepreneurs, health schools, mass media, local NGOs and the private sector.

20. When STBM was adopted as a national strategy in 2008, there were initially some challenges to implementation at scale, including:

- Inconsistent and poor quality implementation of program methodology. Triggering, for example, which is fundamental to the CLTS process, was often not understood, neglected or done badly.

- Misunderstanding of STBM principles and definitions. An example here was ODF verification, at a term which was widely misinterpreted, with local players regarding it as simply confirmation that triggering had taken place.
- Inconsistent sequencing of activities. Product promotion by sanitation entrepreneurs was sometimes carried out before CLTS triggering, when it should be done afterwards to capitalize on the demand created.

These issues affected the results of promotional interventions and gave rise to doubts about the effectiveness of the STBM approach.

21. In response, the TA assisted MoH in developing a capacity building framework (see Figure 1) for the various actors involved in STBM implementation. The first steps were to define the roles and responsibilities of key institutions at each stage of the STBM process which was done through series of consultative meetings with MoH and selected local governments, as well as through field visit and document review. It was then followed by identifying guidance, existing training modules developed by various organizations and experience from earlier interventions. The draft framework was reviewed by the Legal Unit of MoH and finally issued as MoH Regulation No. 3/2014.[16]

22. Following the transformational changes in rural sanitation service delivery, the methods for capacity building were designed not only to cover required training but also to anchor the training within the existing government education system and MoH human resources development, coupled with additional outreach channels to match the needs of various actors. Providing a pool of experts to support national government to design and develop its program strategy, M&E system, advocacy and communication tools; implanting 1-2 provincial coordinators within provincial health offices to mainstreaming STBM at local level; developing an accredited curriculum and modules for STBM implementers, both in-service and pre-service; expanding networks for sanitation entrepreneurs; and providing expertise to master the training were among the areas of support provided by the TA. The TA provided substantive material and helped the Secretariat engage with other agencies such as donor agencies, NGOs, Health Promotion Units and Human Resources Unit of MoH to collaboratively develop tools for capacity building. This collaboration was very fruitful, not only to strengthen methods, contents and budget efficiency, but also to ensure widespread reception and adoption of the framework.

[16] The regulation has higher legal status than the decree that had guided implementation of STBM since 2008 (MoH Decree No. 852/2008).

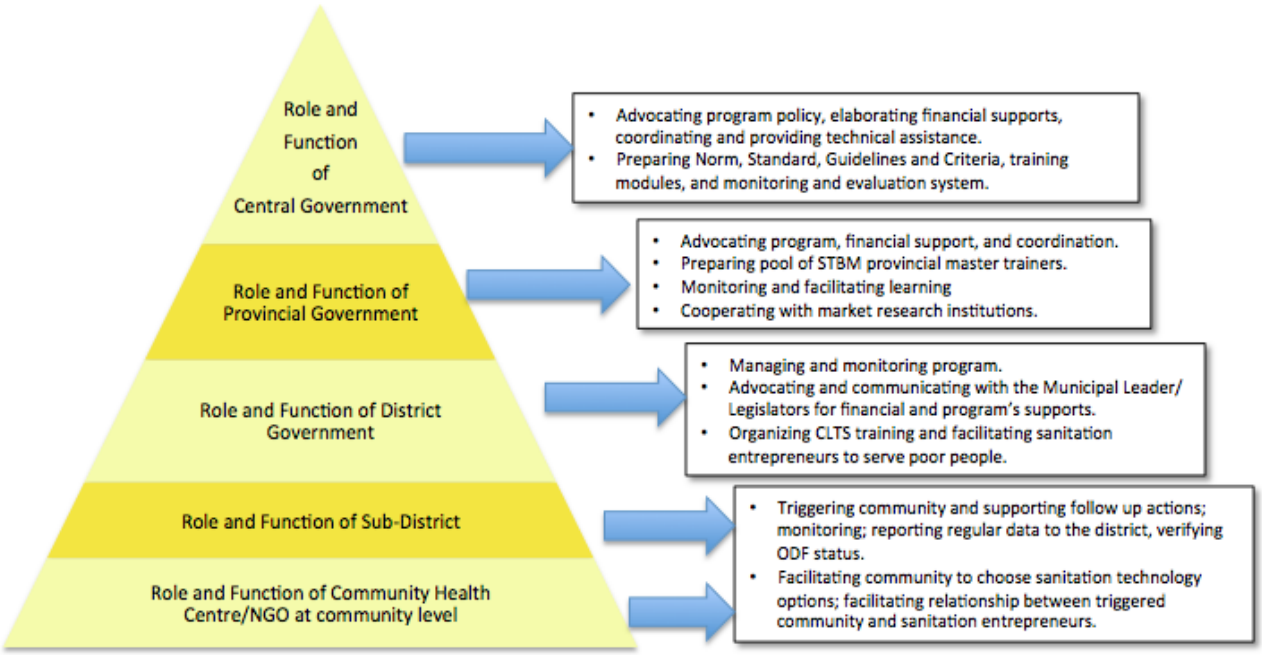


Figure 1: STBM Capacity Building Framework

23. The enactment of Minister of Health Regulation No. 3/2014 created a formal obligation for related institutions to apply the STBM approach, and in some cases this regulation was complemented by the adoption of local instruments achieved through persistent strategic advocacy done by provincial/district health offices supported by STBM Secretariat and STBM-supporting agencies and consultants.[17]

24. A further important milestone of the TA was the establishing of a 'district-wide approach' which was subsequently adopted by government and mainstreamed in other large-scale national programs such as PAMSIMAS (II and III) from 2013 onwards and the Community-Based Health and Nutrition to Reduce Stunting Project of the Millennium Challenge Account-Indonesia (MCA-I), implemented under the national PNPM Generasi Program 18 (PNPM Generasi) from 2014. This marked a strategic shift from project-specific interventions towards a programmatic approach that embedded implementation within government structures, thereby utilizing government resources. The successful implementation of this approach through STBM in five focus provinces has provided strong evidence on how to implement and deliver, and hence convinced MoH to adopt this approach to be implemented across its rural sanitation programs nationally. Table 4 highlights the key differences between project and district-wide approach. The district-wide approach is expected to expedite the achievement of universal access to sanitation by

[17] Including provincial/district regulations, regulations, instructions, decrees and circular letters of governors, district heads and mayors, and village regulations.

[18] PNPM (Community Empowerment National Program) Generasi is a national program that aims to address certain lagging human development outcomes and accelerate attainment of the MDGs on maternal and infant mortality, universal primary education and poverty reduction.

2019 and has also been adopted by other development agencies including UNICEF, SIMAVI and Plan International.

Table 4: The STBM District-Wide Approach as adopted by PAMSIMAS 3

Aspect	Project Approach	Programmatic/District Wide Approach under PAMSIMAS3
Intervention site	Selected villages only	All villages within a district in planned stages
Front liners	Project hired-facilitators	Village volunteers/cadre led by Sanitarian
Intervention focus	CLTS	Demand, Supply, Enabling Environment
Data collection for M&E	Community facilitators / consultants (project hired)	Sanitarians, district officers, online through STBM website
Consultant/project role	Project implementer	Partner and enabler
Funding	Project budget	Various sources, with project budget as supplement only
Institutions involved	Local health offices only	Coordinated by health office involving others, including entrepreneurs and MFIs

25. STBM implementation is now a priority for local governments. As evidence of this, progress by 2015 included the following:

a. 85 out of 514 districts, and 19 out of 34 provinces, had issued local regulations to support STBM.
b. Three districts (Pacitan, Magetan and Ngawi) and one city (Madiun), all in East Java, achieved district-wide ODF status in 2014. To accelerate ODF, the STBM Secretariat initiated a national network meeting in 2014 attended by local governments. With support from the TA, a collaboration of about 20 districts and the Alliance of District and Cities Concerned on Sanitation (AKKOPSI) were initiated to accelerate the achievement of ODF districts and cities.
c. 119 districts and cities in the five focus provinces allocated IDR 73 billion (USD 5.6 million) from local budget to mainstream STBM using a comprehensive approach involving CLTS, sanitation marketing, training in monitoring, production of BCC tools, implementation of BCC events and establishment of a reward mechanism for extension workers (sanitarians).[19] However, changing of government officers and policy might affect the amount contributed for STBM annually. For example, in NTB the allocation in 2015 decreased following rotation of the head of District Planning office, the champion of STBM, to another post. In Central Java, following national advice for "tight budget policy", local government responsed by decreasing budget for sectors that might have other potential source of funding, such as STBM (see Figure 2).

[19] Local budget is derived from various sources, including local revenue, balance revenue, and fiscal transfer.

d. More than 500 people from all provinces completed STBM e-learning and received certificates, with a 92% completion rate for mandatory modules and 55% for optional modules. Frequent promotion and advice by MoH to encourage local health offices, sanitarians and consultants to complete the learning accelerated these achievement rates. Placing the e-learning icon in the STBM website has also encouraged public stakeholders to take the course. However, expansion to non-STBM partners was still limited.

e. All MoH health schools in 24 provinces were teaching the STBM curriculum (including mandatory student field work for two months) in collaboration with local governments. In total more than 1,500 students had been enrolled since 2014.

f. Local public-private partnerships on STBM had expanded, engaging inter-governmental agencies, private companies through their CSR initiatives, and local and international NGOs.

g. APPSANI and its provincial branches were partnering with the STBM Secretariat and local governments in the five focus provinces to support supply chain strengthening activities. APPSANI provided services to members and local governments, including training, updating the accredited training program, providing information on sanitation technologies for specific contexts, and facilitating access to finance. This facilitated the active engagement 270 active entrepreneurs who built more than 60,000 toilets across 65 districts.

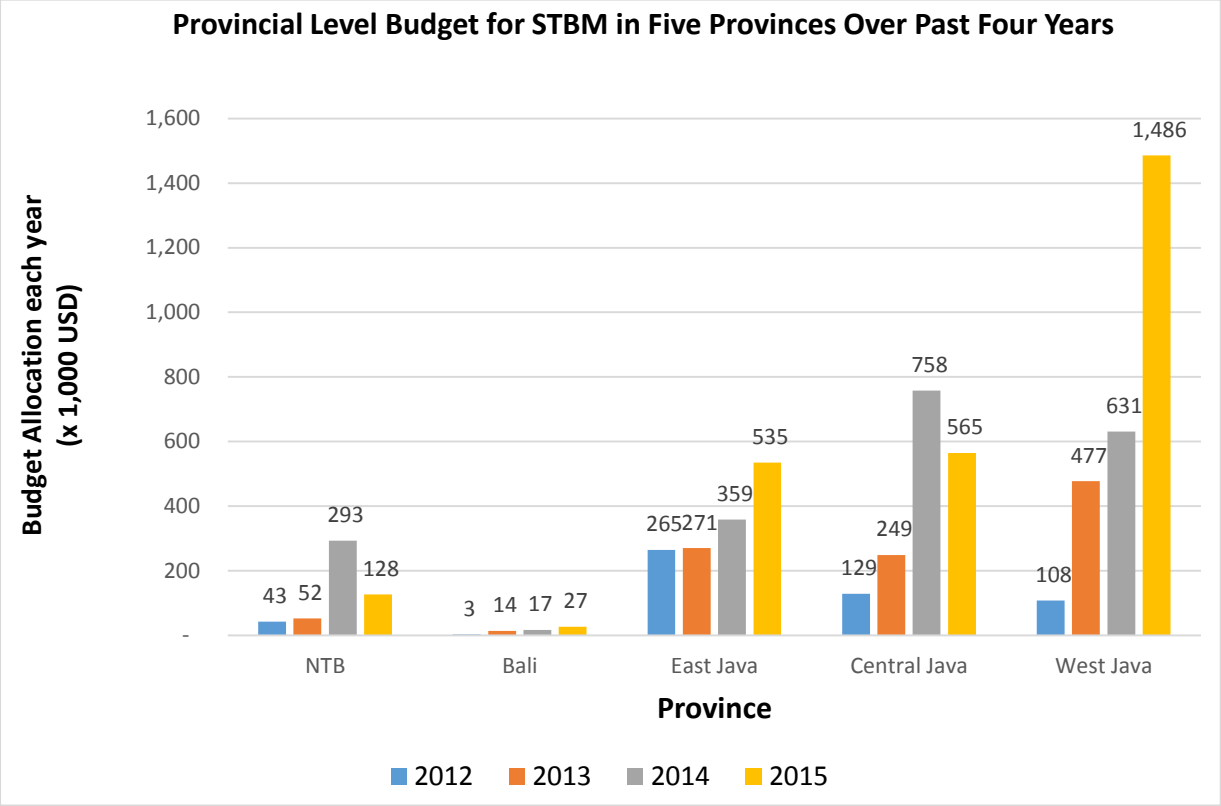


Figure 2: Provincial budget for STBM over four years in five focus provinces

26. Table 5 summarises the numbers and categories of people trained under the TA.

Table 5: Number of people reached through training

No	Instrument	Activities	Number of People Reached
1.	BCC	Workshop at national level	4 provinces; 100 people
		Workshop in province level	4 districts; 250 people
2.	Demand Creation	STBM ToT (triggering) for district facilitators and provincial coordinators in the PAMSIMAS project.	248 people: 219 district consultants and 29 provincial coordinators in the PAMSIMAS project.
		STBM training (Triggering) for environment and health officers, sanitarians, midwifes, nurses, and natural leaders / village cadres.	In 2010 - 2015, 3,693 people in the five provinces were trained (East Java: 1,326, Bali: 277, NTB: 575, West Java: 623, Central Java: 892). Funded by: National and local governments, WSP WB and other NGOs.
3.	M&E	Coaching to maintain the STBM M&E system for STBM Secretariat staff (MoH)	25 participants
		STBM M&E training in the 5 provinces	Participants involved: - 19 people at province level - 236 people at district/city level
		ToT at national level	Participants involved: - 7 people at national level - 65 people at province level
		Post national training: coaching and additional support	55 training events, involving 1,560 people in 34 provinces. 433 events, involving 9,750 sanitarians in 433 districts/cities.
		Updating data	6,221 sanitarians in 433 districts/cities updated data via the SMS/Smart monitoring system.
4.	Sanitation Marketing	Sanitation entrepreneurship training events	Number of training events: 52 Participants: 1,945 people
		Post training support: coaching and additional support	Number of active entrepreneurs: 273 people working in 65 districts Number of masons involved in the business process: 764 people

3.3. Intermediate Outcome 3: More effective STBM implementation at provincial and district Level

Table 6: Achievements against Intermediate Outcome 3

Baseline	Targets	Achievements
Appropriate monitoring system is not in place, less effective triggering process (ODF rate below 20%), no sanitation entrepreneurs in the provinces, except in East Java	Use of monitoring system, increase in number villages triggered, increase in ODF achievement rate, sanitations entrepreneur emerged and replicated	**Achieved** According to STBM M&E data (www.stbm-indonesia.org/monev), the five provinces achieved the following results: • Before 2012, there were 5,335 triggered villages; from 2012 to 2015, 7,443 villages were triggered, an increase of 140%. • In 2012, there were 720 verified ODF villages. By December 2015, there were an additional 2,370, an increase of 370%. • The average ODF achievement rate in the triggered villages was 29%. • Eight million people in the five WSP-supported provinces gained access to improved latrines from 2012 to 2015, of which 2.7 million were in 7,433 newly-triggered villages, 2.49 million were in 12,085 non-triggered villages,[20] and 2.84 million were in 5,335 villages that had been triggered before 2012. • 52 sanitation entrepreneur training courses in five provinces attended by 1,945 candidates, of whom 273 became active entrepreneurs selling 63,760 improved latrines worth IDR 90 billion (USD 7 million) since 2010.

Improved monitoring

27. The Government of Indonesia realized that the lack of reliable data on sanitation access and behavior was an obstacle to developing, implementing and mobilizing funding for a rural sanitation program. In 2009, under the previous TA, an SMS-based monitoring system was piloted in two districts in East Java. The pilot found that the progress towards ODF status and data on household access could be collected via SMS and stored in a database at district level.

[20] These villages may have seen a natural increase in sanitation access, even without CLTS triggering. This can be the result of extended promotion of sanitation marketing, exchange of information between villagers or between village government and neighboring villages, general awareness of sanitation due to mass media coverage, gradually changing social norms, and higher incomes.

28. Encouraged by the pilot, the MoH decided to scale up, with support from the TA, to a nationwide monitoring system covering 34 provinces, for which robust server and hosting arrangements were provided in MoH. The new system was first introduced in the five supported provinces, where the TA supported the training and coaching of sanitarians and district health officers both in using the system and analyzing the data, developed user guidelines and advocated use of the findings by local governments to improve STBM implementation.

29. Sanitation access rates and ODF status can be followed in real time through through www.stbm-indonesia.org/monev. The data is presented as tables, graphics, and maps. All website visitors can access sanitation data down to the village level. The utilization of regular updated and accurate information has advanced collaboration. For example, district health officers in Brebes used this data for district planning with the district Planning Agency and district Public Works office. This best practice had been adopted by Central Java's health office to harmonize its sanitation data through "one sanitation data policy" and had been successfully accepted by provincial planning and public works offices.

30. Consistent capacity building at all levels has increased the effectiveness of the system, utilization of recorded data, and local government's capacity plan and improve implementation. Regular supervision was found to be essential to ensure routine data updates and feedback mechanism were conducted dilligently and in a constructive manner. The capacity building model for STBM SMS and Web-based system is illustrated in **figure 3**.

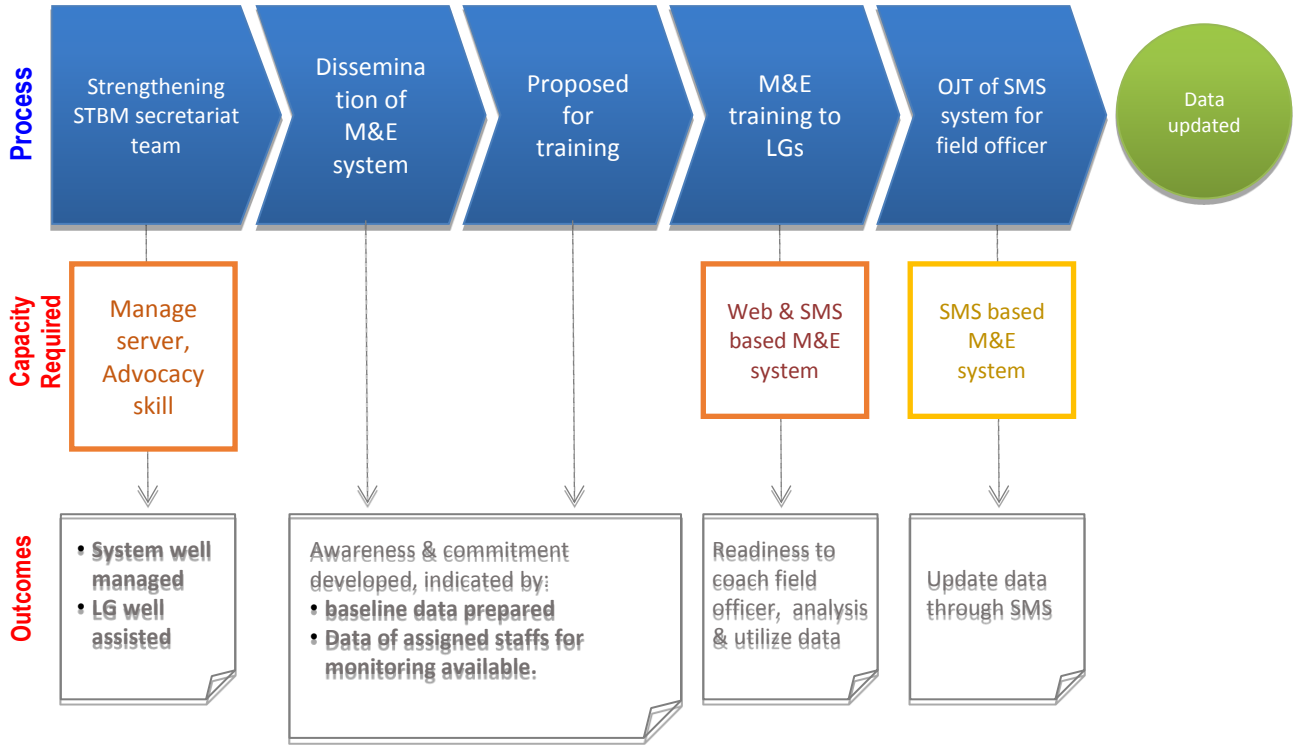


Figure 3: Capacity Building Model for nationwide Monitoring System

31. Institutional roles and responsibilities for monitoring are now clearly assigned at each level of government, from sanitarians at community level to health office staff at district level to Secretariat staff at national level. The monitoring framework is strengthened with input, output and outcome indicators collected through SMS and web-based components for systematic analysis. These enable real-time updates, enhanced data analysis, mapping options[21] and automation of sector performance reports. The system provides information not only on sanitation access, but also on STBM budgets at local level, training activities and sales by sanitation entrepreneurs. STBM data is widely disseminated and used by various stakeholders as an advocacy tool to address policy makers. One very useful innovation has been for the Secretariat and local government to incentivize data collection and reporting through a 'Top 20 sanitarians' system (see Annex 5)**.**

32. Monitoring has helped to improve the quality of STBM implementation through mechanisms for direct feedback between program managers and implementers, not only to increase quantity and quality of data but also to increase data usage. Brief information on STBM feedback mechanism appears as Annex 5. To support a district-wide approach towards universal access to water and sanitation, the system was adapted to encompass data entry on rural water supply, for which access is being scaled up through the PAMSIMAS project.

Acclerated growth in access to sanitation

33. Table 7 shows that access to improved sanitation in the five provinces increased by 2.57% per year over the period 2012-2015, more than the national average increase of 1.61%, while access to permanent improved sanitation (meaning pour-flush toilets) increased by 1.68% per year, compared to a national average of 1.12%.[22] Similarly Table 8 shows that the ODF conversion rate was higher in the five focal provinces (29%) than in the country as a whole (23%).

Table 7: Increased access to improved sanitation by province

Province	Baseline (%)		End line (%)		Increase per year (%)	
	Permanent	Total Access	Permanent	Total Access	Permanent	Total Access
West Java	45.42	64.45	48.27	69.91	0.95	1.82
Central Java	45.97	69.55	53.55	78.42	2.53	2.96
East Java	47.67	72.46	53.87	80.49	2.07	2.68
W. Nusa Tenggara	41.62	59.4	50.34	74.84	2.91	5.15
Bali	74.31	88.11	75.9	89.19	0.53	0.36
Five Provinces	47.02	69.4	52.09	77.11	1.69	2.57
National	33.72	53.48	37.09	58.32	1.12	1.61

[21] Including an overlay map and data of the PAMSIMAS project.

[22] The distribution curve is an average based on population average at the baseline in 2012 and end line in 2015.

Table 8: Comparison of STBM progress implementation in the five focus provinces and nationally

	Total Villages	Triggered villages		ODF Villages		ODF Verified		Verified + document	
		No.	%	No.	%	No.	%	No.	%
Five provinces	24,863	12,778	51	3,988	29	3,376	67	517	15
National	80,275	26,383	33	6,771	23	5,052	49	1,036	20

34. Figures 4 and 5 below show that the WSP-supported intervention triggered 51% of the 24,863 villages targeted, equivalent to 31% of the the national total of 80,275 villages, while nationwide just 33% villages were triggered overall. By the end of 2015, 5,052 villages were verified as ODF of which 3,400 (67%) were in the five focus provinces; and 11 million people gained access to improved latrines, of which 8 million (73%) were in WSP-supported provinces. WSP support to the Government of Indonesia therefore made a substantial contribution to Indonesia's efforts to accelerate sanitation access. At the same time it should be noted that the TA was unable to monitor access for the bottom 40% of households because there is no specific policy addressing quintile monitoring in Indonesia. This remains a knowledge gap.

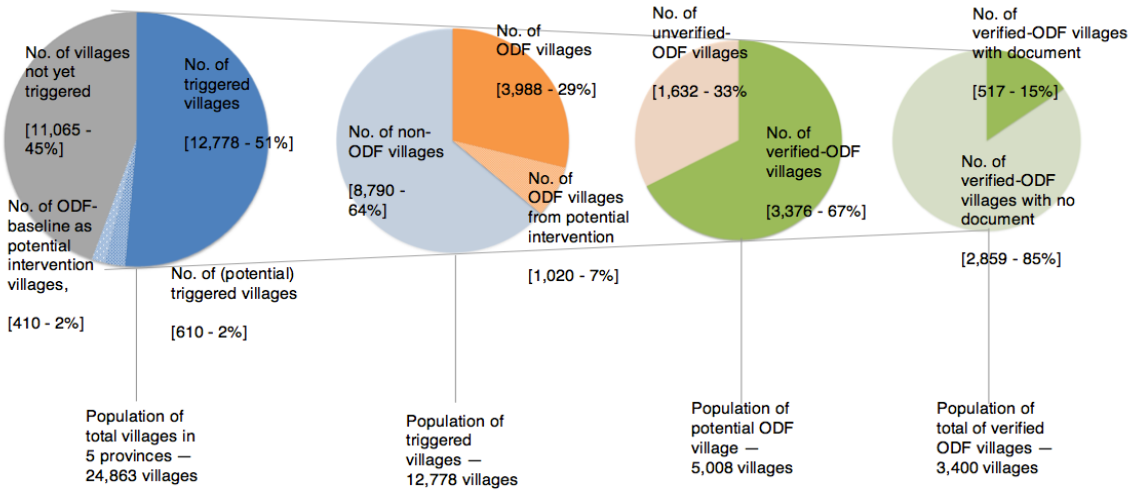


Figure 4: Overview of STBM intervention achievement in 5 focus provinces

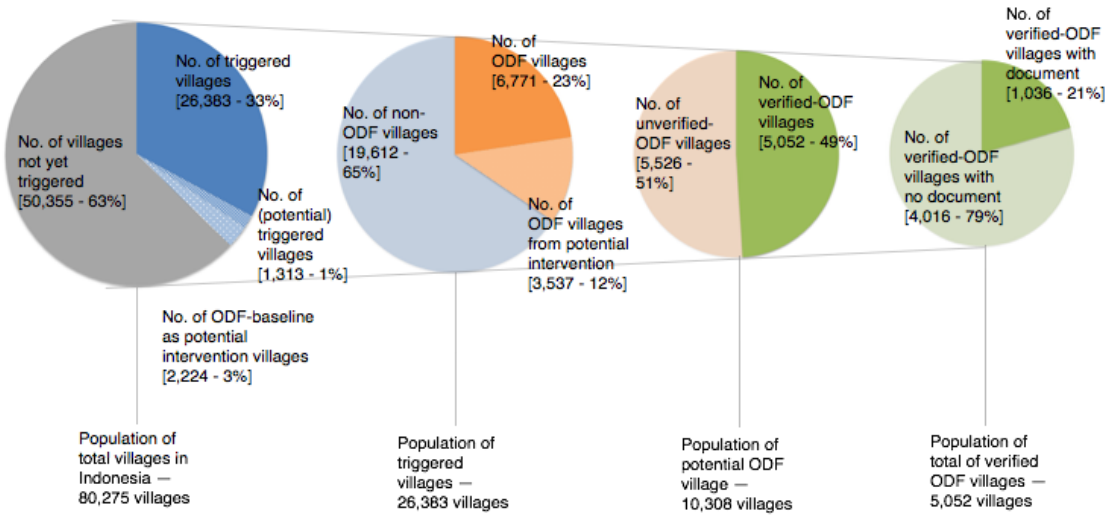


Figure 5: Overview of STBM intervention achievement nationwide

4. Lessons Learned and Recommendations

35. The TA was successful in mainstreaming STBM in development programs at local level, not only in the five focus provinces but nationwide, through a strengthened STBM Secretariat and national projects such as PAMSIMAS. The mainstreaming was not limited to the demand creation component (CLTS), but included sanitation market strengthening and creation of an enabling environment. Instruments developed by the STBM Secretariat under this TA have been adopted by a range of government agencies and development partners. Lessons learned from the experience are outlined below.

4.1. Lessons learned

1. A capacity building framework to strengthen institutions at all levels is key for scaling up in a decentralized environment. The framework was developed following transformational changes in rural sanitation service delivey, through: 1) anchoring capacity building in the existing health schools system, 2) developing a new guideline to implement the capacity building strategy through accredited training, distance training, and credit point rewards linking to MoH's human resources system, and 3) shifting the approach from project-based to district-wide approach. The framework adopted in Indonesia clearly defined roles and skill requirements then developed capacity through a mix of conventional training and e-learning, backed by a solid monitoring and evaluation system which revealed trends in operational performance, enabling government and TA providers to revise operational approaches and capacity building interventions where necessary. The accreditation of training courses was particularly useful, as it helped to ensured that an acceptable quality of training was achieved and maintained.

2. Well-crafted advocacy and communications are valuable for disseminating tested approaches and facilitating their adoption at scale. Evidence-based and data-backed up advocacy materials and

carefully designed communication channels and events through formative study and collaboration with local and national government were keys to smooth adoption of the approach by local government. Local government commitment to the district-wide approach was boosted via national fora including national coordination meetings, and occasional international learning visits which provided vision and inspiration to policy makers. Periodic national and regional meetings also helped to motivate local actors, facilitate the sharing of lessons and ensure a consistent operational approach.

3. Engagement of a range of institutions also strengthens campaign outreach. Beyond the usual Environmental Health Unit in charge of sanitation, collaboration with the Center for Health Promotion and the Center for Public Communication at national level leveraged their technical expertise and mass media resources access for promoting the STBM approach. Furthermore, it increased funding and human resource deployment for rural sanitation at national and local levels.

4. An effective monitoring system is invaluable and it use should be formally integrated into the routine operations of government agencies. The STBM Secretariat played a key role in ensuring the regular collection and submission of data to the MIS and – importantly – use of the data to inform planning, decision making and advocacy. The effective operation of the MIS was underpinned by a two key features:

- formal appointment of district M&E account holders by the head of the health office; and
- user-friendly processes and outputs which were set out in standard operating procedures - including explicit feedback loops between operational tiers to ensure that the information generated was communicated and acted upon, and data validation processes which were partly built into the MIS itself but supplemented by spot checks in the field.

5. Local government can help to develop the rural sanitation market. In the WSP-supported provinces, the supply side of STBM implementation benefitted from partnerships established between local government and local micro-finance institutions. This encouraged and enabled local sanitation entrepreneurs to start working directly with rural communities, following up swiftly after CLTS triggering events to capitalize on the demand generated for sanitation products and services. Ongoing support from the Sanitation Entrepreneurs Association helped these actors to improve their operations and stay engaged.

6. The scaling up tested approaches can be enhanced greatly through their incorporation into established programmes. While the TA focused primarily on five provinces, the framework and capacity building provided by the TA covered all provinces through the STBM Secretariat. With adoption of the district-wide approach by PAMSIMAS, which has been accepted as national platform for rural water and sanitation, the path to nation-wide implementation is now well established. The PAMSIMAS Interim Implementation Completion Report found that by mid-June 2015, an additional 7.6 million people had gained access to improved sanitation facilities, exceeding the programme target by 0.2 million (2.7%). This target had earlier been revised downward to 3.4 million, which was thought to be a more realistic

level of ambition, but was increased to 7.4 million following the introduction of the district-wide approach.[23]

4.2. Recommendations

36. Lessons from the TA program are already mainstreamed in the next phase of TA[24], which will support PAMSIMAS 3 and other platforms to implement the government's rural water and sanitation strategy, which is aligned with the Law No. 23/2014 on Local Government, Law No. 6/2014 on Villages, and Government Regulation No. 122/2015 on Water Service Delivery. The World Bank team will continue to support the Government of Indonesia to achieve universal access of sanitation in 2019 through strengthening the STBM Secretariat, collaboration with AKKOPSI, supporting supply side through APPSANI, and more intensive strengthening of local governments to implement district-wide STBM through PAMSIMAS. Integration of lesson learned has already been initiated in close collaboration with the PAMSIMAS task team, including in improving training curriculum and methods of delivery for PAMSIMAS facilitators, integrating web and smart-phone data base, and developing strategic advocacy and dissemination materials for PAMSIMAS. Some initiatives to collaboratively support the World Bank's engagement in the rural sanitation sector have also been (and will continue to be) conducted. The TA engaged PNPM colleagues to introduce stunting issues in a number of workshops. A number of discussions and data sharing with the PSF team have also been conducted to elaborate on a more effective strategy supporting the Government in achieving universal access to sanitation.

37. Scaling up will, in addition, benefit from clear demarcation of the roles and responsibilities of STBM stakeholders at national and local level and strong local government ownership, which has led to the institutionalization of STBM within local government processes.

38. The following recommendations are offered to further enhance STBM implementation from the Government's side:

- Following institutional changes within the Ministry, MoH should accelerate relocation the STBM Secretariat directly under the Director of Environmental Health and enhance coordination and collaboration with other parts of the Directorate General of Public Health including the Health Promotion Unit, Public Communications, and the Agency for Development and Empowerment Human Resources of Health (PPSDM). Collaboration on nutritional interventions should also be pursued given the close association between poor sanitation and nutritional stunting.

- While the current STBM MIS does not specifically monitor access among poorer households, the affordability of improved sanitation facilities is known to be a constraint. Beyond MoH, therefore, the STBM Secretariat should also collaborate with social sector programs to ensure

[23] Interim Implementation Completion and Results Report, The Third Water Supply and Sanitation for Low-Income Communities (PAMSIMAS) Project, The World Bank, 30 June 2015.
[24] See Project concept Note P158934, which consists of three components: (i) Strengthening Policy and Institutional Capacity of Government; (ii) Support to Public Sector for Last-Mile Service Delivery; and (iii) Innovations in Private Sector Service Delivery and Finance

better inclusion of the poor and develop knowledge for effective pro-poor support mechanisms. A key national program platform to work with is the National Program on Community Empowerment (PNPM).

- In collaboration with the Alliance of Districts and Cities Concern on Sanitation (AKKOPSI), MoH should continue strengthening advocacy to district and cities leaders to consolidate their commitment to STBM as a key intervention to achieving the target of universal access to sanitation.

- MOH should strengthen the supply side of STBM, for example by ensuring that support structures such as APPSANI (or alternatives) are available at scale. This may entail some or all of the following:
  - Expanding capacity building support for entrepreneurs and their marketing agents and masons.
  - Further development of affordable technology options for sanitation in challenging environments such as rocky or sandy soil.
  - Facilitating loans for entrepreneurs and households, through support from local governments and APPSANI, as well as collaboration with other partners

- In collaboration with other related ministries, MoH could explore opportunities for rural sanitation development under recently-enacted Village Law whereby village government is provided with significant resources for development; this could be done by making ODF status one of the village's key performance indicators.

- Sustainability of STBM Secretariat and continued program's scaled-up to reach universal access of sanitation in 2019 should be strengthened. The Bank is expected to continue support innovative ideas through a small selected of experts on a time-bound basis and support for non-budgeted nation-wide impact activities, including to reach the bottom 40%, cross sectoral collaboration (for example to combat malnutrition and stunting) and strengthen local politics support for universal access of sanitation. The link to Bank New TA P-158934 appears as Annex 7.

39. For the Bank as part of ongoing operation (PAMSIMAS) and TA:

- In collaboration with the STBM Secretariat and PAMSIMAS team, and based on the experience gained with the SMS-based system and the PAMSIMAS MIS, the Bank is expected to explore the scope for introducing an interactive, smartphone-based reporting system. This could potentially improve the ease and efficiency of monitoring.

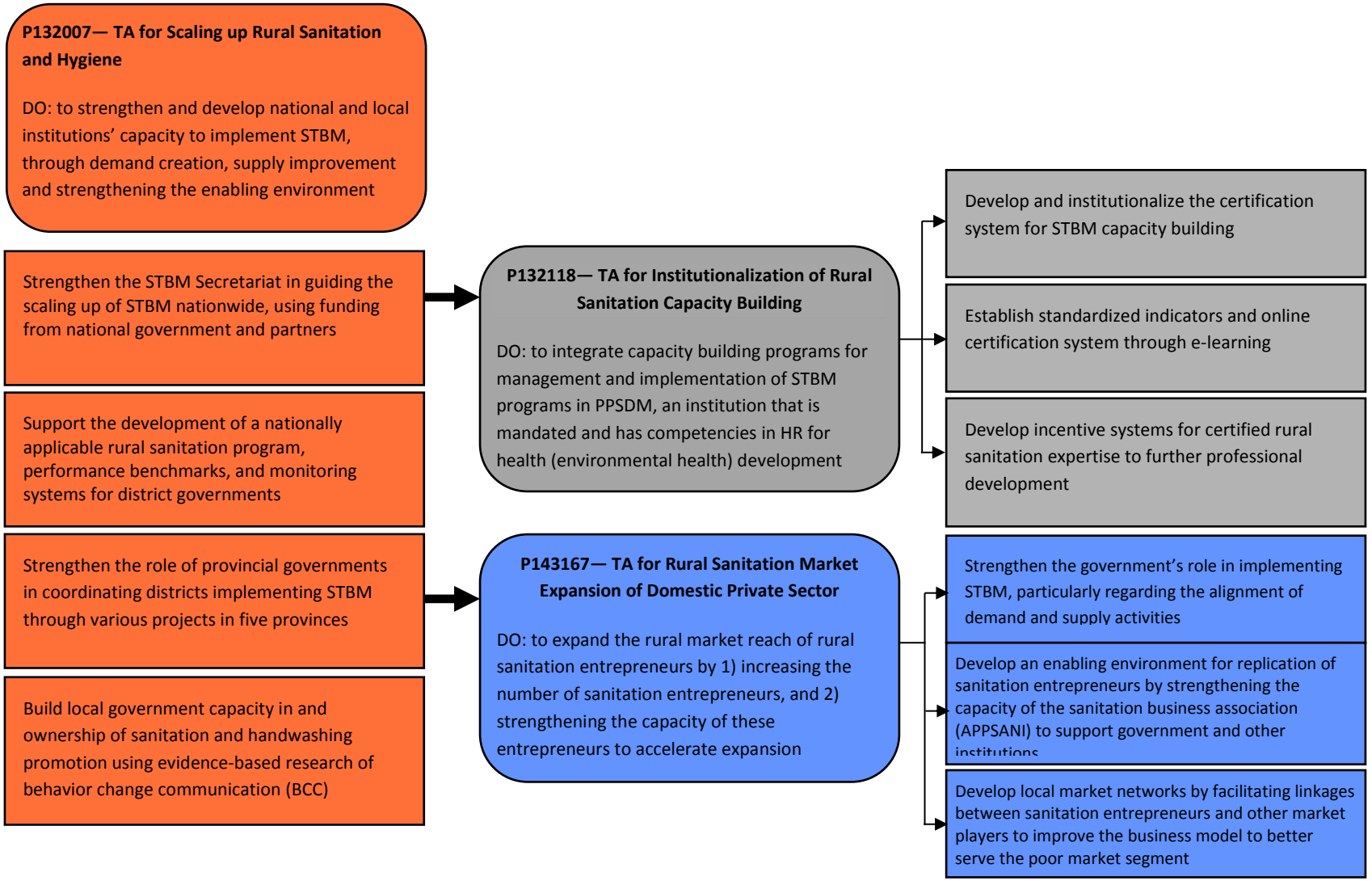
- In collaboration with STBM Secretariat and PAMSIMAS team, the Bank is expected to develop performance-based incentive schemes for STBM implementers at all levels: province, district and sub-district/Puskesmas, to encourage competition and improve the quality and scale of

STBM implementation. This needs to be done in parallel with expanding the independent verification of reported results to avoid over-reporting by individuals.

- Building on the momentum achieved through PAMSIMAS and the sequence of TAs, the sustainability of the STBM Secretariat and continued program's scale-up is required if the Government is to reach its ambitious goal of universal access to sanitation by end of 2019. The Bank is expected to continue supporting innovative ideas through a small selection of experts on a time-bound basis and support for non-budgeted, nation-wide impact activities, including to reach the bottom 40%, cross-sectoral collaboration (for example to combat malnutrition and stunting), and strengthen local support for universal access of sanitation.

ANNEXES

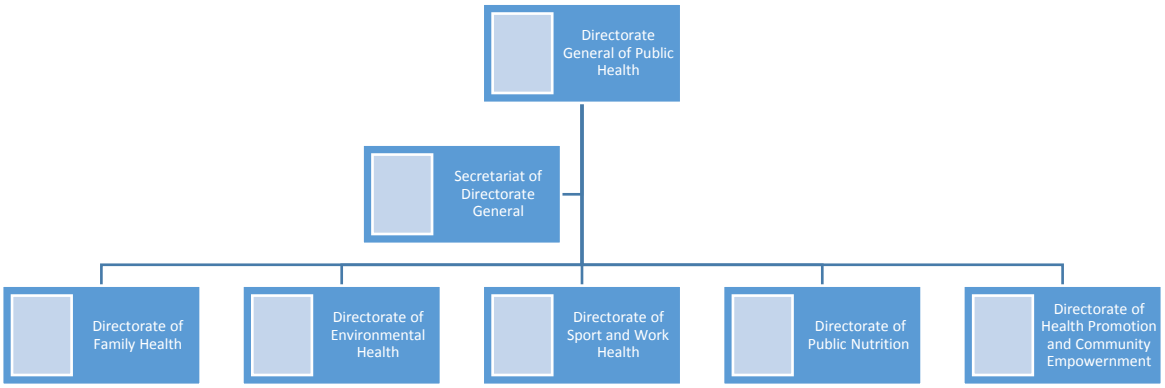
Annex 1: Relationship between TAs under Scaling Up Rural Sanitation and Hygiene in Indonesia



Annex 2: Summary of Timeline of Technical Assistance

Time	Activity
May 2011	Kick off and launch of TA Scaling Up Rural Sanitation in Indonesia and introduction of Rural Sanitation Capacity Building Framework
June -October 2011	Development of SMS and Web based monitoring system and STBM Operational Guideline
October 2011	STBM National Coordination Meeting and launch of the SMS monitoring system and Operational Guideline by the Minister of Health.
October 2012	Dissemination of the operational guideline to national stakeholders, including donor partners, and agreement to select five provinces for provincial level pilot
December 2011-January 2012	Rapid assessment in five provinces
February 2012	Workshop to develop the work plan for STBM intervention in five provinces
February 2012-September 2015	STBM Implementation in five provinces, which included: • Strengthening institutions at the provincial level • SMS and web based outcome monitoring • Sanitation marketing initiative • Behavior change communication
January 2013	Scaling up to 32 provinces/219 districts through the PAMSIMAS 2 Project
February 2014	Formalization of the operational guideline as a Minister of Health Regulation
September 2014	Second STBM National Coordination Meeting; national learning event; launch of STBM e-learning, and study visits by three countries.
December 2015	Learning consolidation and roadmap to 80,000 STBM villages
2016-2020	Scaling up to 33 provinces/400 districts through the PAMSIMAS 3 Project

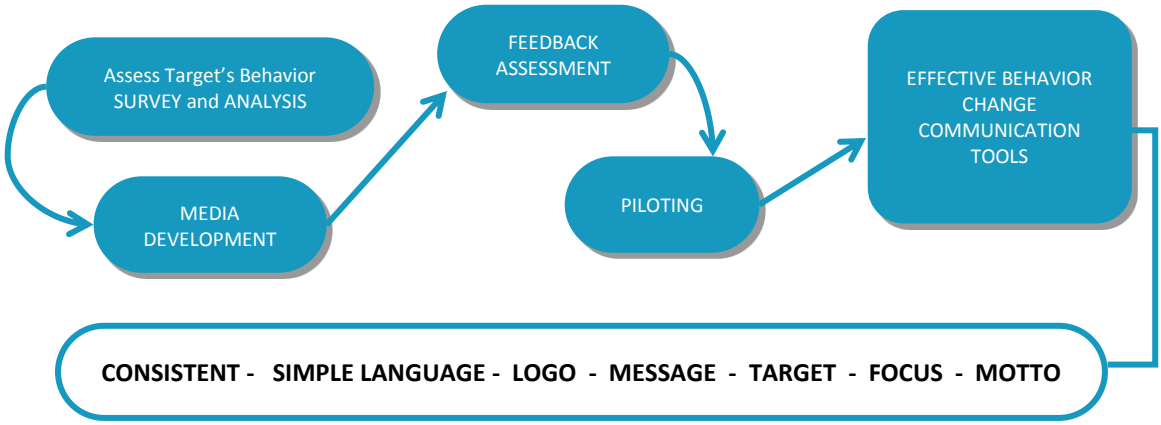
Annex 3 Structure of the Directorate General of Public Health of the Ministry of Health



Main role: to define and implement policy on public health in compliance with prevailing statutory provisions in Indonesia

Annex 4: Behavior Change Communication Strategy

Behavior Change Communication Strategy for Scaling Up Rural Sanitation



Annex 5: STBM Monitoring Framework

STBM PILLAR-1 MONITORING FRAMEWORK

No.	INDICATOR	DATA SOURCE/Who	REPORT FREQUENCY	FORMS/ INSTRUMENTS	REPORTING SYSTEM AND DATABASE
	Outcome indicator				
1	Number and percentage of households using improved latrines	Primary health centre staff (based on compilation of participatory community monitoring)	Monthly	Social mapping; latrine observation checklist, LB-1 recapitulation form	CBTS web- and SMS-based monitoring
2	Number of villages in the district that are ODF, rechecked annually after ODF declaration	ODF verification team	Quarterly	Linked to LB-1; ODF verification form; ODF recapitulation form	CBTS web- and SMS-based monitoring
	Input and output indicators				
1	Number and percentage of villages that have received CBTS intervention (either triggering or other demand promotion)[25]	Primary health centre staff (based on compilation of participatory community monitoring)	Monthly	CBTS village intervention recapitulation form	CBTS web- and SMS-based monitoring
2	Time taken to achieve ODF status after triggering.	Primary health centre staff (based on compilation of participatory community monitoring)	Quarterly	CBTS village intervention recapitulation form	CBTS web- and SMS-based monitoring
4	Number of CBTS facilitators who have been trained to do triggering or other demand promotion	Environmental Health Section, District Health Service	Biannual	Capacity building record	Web-based monitoring system
5	Number of trained CBTS facilitators who are actively engaged in triggering or other demand promotion	Environmental Health Section, District Health Service	Biannual	Capacity building record	Web-based monitoring system
9	District sanitation budget allocation	Environmental Health Section,	Annual	Sanitation program performance	Web-based monitoring

[25] *Locations that have not received intervention but have been introduced to CBTS can be counted*
The operational definition of triggering needs to be given in this manual

No.	INDICATOR	DATA SOURCE/Who	REPORT FREQUENCY	FORMS/ INSTRUMENTS	REPORTING SYSTEM AND DATABASE
	per unserved household	District Health Service		evaluation recapitulation form	system
10	Proportion of total local sanitation budget allocated to non-construction sanitation activities	Environmental Health Section, District Health Service	Annual	Sanitation program performance evaluation recapitulation form	Web-based monitoring system
11	Proportion of sanitation budget for non-construction activities used for media promotion of sanitation	Environmental Health Section, District Health Service	Annual	Sanitation program performance evaluation recapitulation form	Web-based monitoring system

At community, STBM monitoring should be done by and with the participation of the local community, and with the active participation of natural leaders and community organisations such as the Family Welfare Movement, *dasawisma* groups, etc. Sanitarians play an active role as facilitator and catalyst at the subdistrict/district level in terms of managing the data and information resulting from this monitoring of environmental health activities. At district level, this monitoring function will be reinforced by the use of district consultants/facilitators to transfer knowledge and expertise with the primary health centre personnel/sanitarians and directly with the community (natural leaders/participating community organisations.

A simple illustration of the implementation of STBM monitoring is show in **figure-10**. Sanitation access and ODF status can be followed in real time through through www.stbm-indonesia.org/monev. The data is presented as tables, graphics, and maps, such as seen in **figure A and B** below.

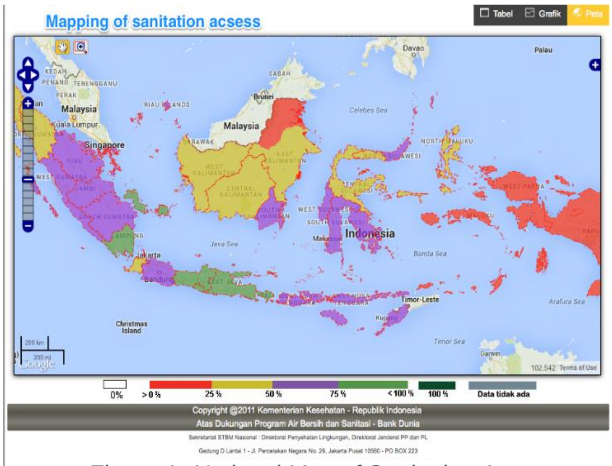


Figure A: National Map of Sanitation Access (source: www.stbm-indonesia.org

Figure B: Mapping of ODF Village (www.stbm-indonesia.org)

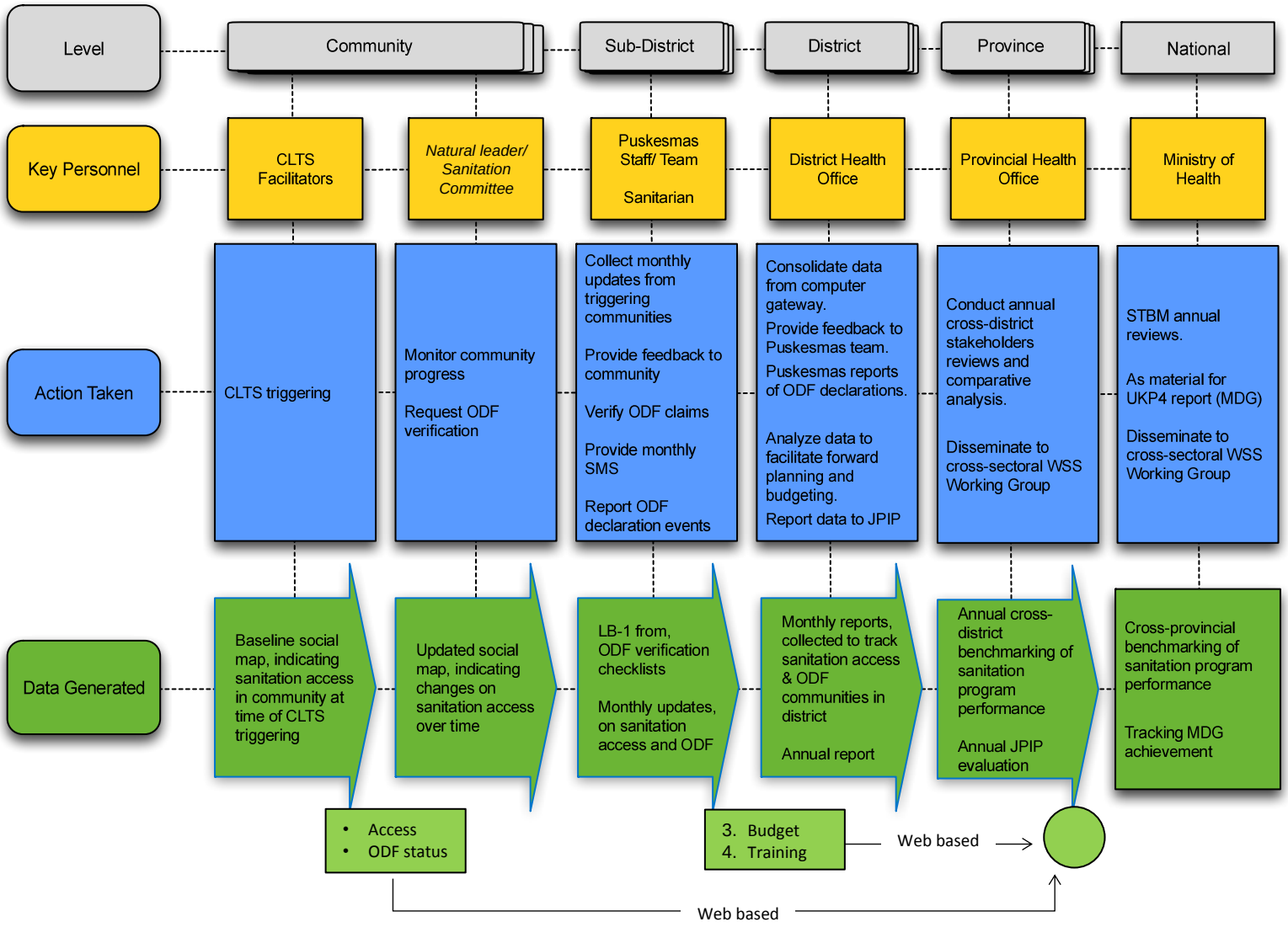


Figure C: Flow of monitoring and reporting, from community to national level

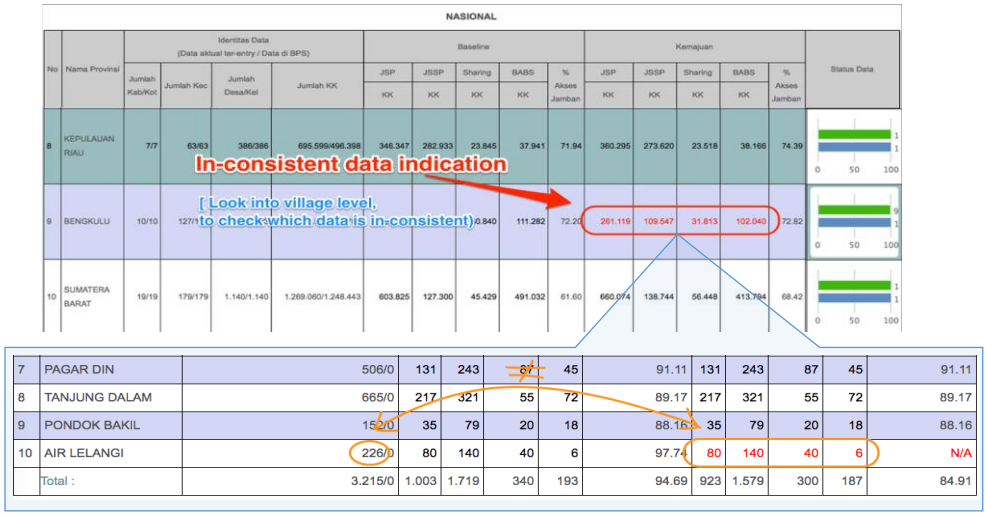
Annex 6: Monitoring Feedback Mechanism under STBM

Feedback mechanisms are essential for a well functioning M&E system, as an enabler of flow and use of data and information. Feedback is both created automatically by the system and through standard operating procedures by system users. Benefits of feedback and incentive mechanism have been the following:

- **Increased quantity and quality of data**

Feedback mechanism through an "autoresponse system" helped to ensure data accuracy and consistency. Sanitarians receive a realtime status of their inputted data, make any clarification if needed, and update their data in just a click. As an incentive mechanism, the Top 20 most active sanitarians in updating data appear on the website as an acknowledgement of their excellence. This has also triggered competition among puskesmas, distrist, and provinces to update their data.

An example, is that in West Nusa Tenggara, local government has allocated budget to provide rewards to districts/cities based on accuracy and consistency of data in STBM website. Data from all levels in 5 provices could be completed only in 11 months using the principle to focus on the flow of data first and data validation at the later stage.



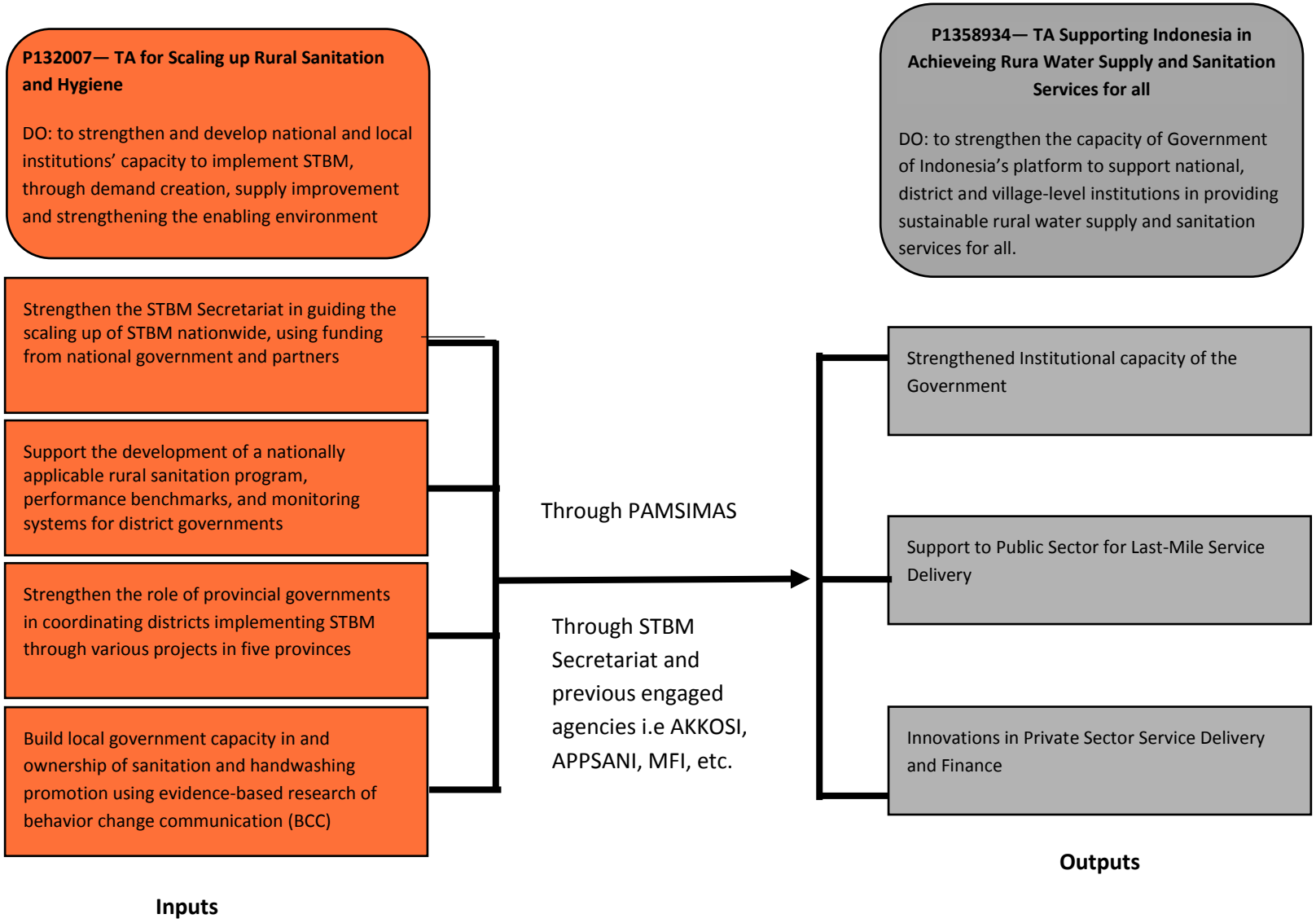
7	PAGAR DIN	506/0	131	243	87	45	91.11	131	243	87	45	91.11
8	TANJUNG DALAM	665/0	217	321	55	72	89.17	217	321	55	72	89.17
9	PONDOK BAKIL	152/0	35	79	20	18	88.16	35	79	20	18	88.16
10	AIR LELANGI	226/0	80	140	40	6	97.74	80	140	40	6	N/A
	Total :	3.215/0	1.003	1.719	340	193	94.69	923	1.579	300	187	84.91

Figure D: inconsistent data in website STBM

- **Increase Data Usage**

On the use and publication of data and simple analytics through various media and events has proved effective in advocating STBM. Districts have used data and information to gain stronger support for STBM from other programs/sectors and to get support from the municipal leaders, mayors, or governors. In districts/cities with comprehensive and high quality data on sanitation access this information is used for planning and budgeting. Automatic reports, advanced analysis and visualization feautures of the system were introduced by the TA to increase data-utilization across all districts and provinces.

Annex 7: ***Link between TA P132007 and P158934***



Annex 8: Financial Report P132007

FY	Labor		Travel		Other		Total Actuals	
	PCN	Actual	PCN	Actual	PCN	Actual	PCN	Actual
2013	297,545	156,408	*204,000*	163,941	580,435	603,704	1,081,980	924,053
2014	214,500	134,188	*150,000*	170,519	350,500	612,091	715,000	916,798
2015	158,785	191,323	100,000	173,078	270,500	365,781	529,285	730,182
2016		205,997		62,424		199,619		468,040
Total	**670,830**	**687,916**	**454,000**	**569,962**	**1,201,435**	**1,781,195**	**2,326,265**	**3,039,073**

- The approved PCN budget in 28 January 2013 was $2.326 million.
- The actual expenses is $3,039,072, which is 30% over the original, largely because of extension of its scope to support PAMSIMAS provinces.