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Improving CLTS from a Community Perspective Approach in Indonesia

Submitted to Plan Indonesia

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Preface

This research study on CLTS in Indonesia was conceived and commissioned in 2010, began in 2011, and was completed in 2012 with a hiatus of about 11 months during May 2011 to March 2012. The study was commissioned and managed by Plan Indonesia with funding from Plan Australia and was undertaken across three geographically and culturally diverse regions of the country. These included Sumedang in West Java, the centre of Sundanese culture, Muara Enim in South Sumatra representing Malyanese culture, and Lembata in Nusa Tenggara Timur (NTT), the hub of East Indonesian culture.

The initial work undertaken during January-April 2011 including field visits to these three districts had to be put on hold due to less than satisfactory data from the field. The process was re-started in March 2012 with second round of field data generation during April-May 2012. Data compilation, collation and analysis were undertaken during June-July 2012.

The basic idea underlying this research initiative has been to advance the existing boundaries of knowledge and understanding about the trajectory of CLTS in Indonesia. Indonesia was the first and still remains the only country in the South East Asian region to adopt CLTS as a part of its national sanitation strategy. This was inspired by some of the early successes of CLTS in the World Bank assisted WSLIC II project in Muara Enim district in South Sumatra and other parts of the country. Inclusion of CLTS represents a major shift in policy from ‘subsidy’ to a ‘no-subsidy’ approach to dealing with the issue of sanitation at a country wide scale. This shift carries significant implications for programme and project design, budgetary allocations, funding arrangements, and actual implementation of the sanitation initiatives on the ground.

The process of decentralisation in the country set in motion around the turn of the millennium, formed the general backdrop for the implementation of CLTS at the local level and added to the complexity and challenge of the initiative. Indonesia is a highly decentralised country with 465 districts headed by elected chiefs known as bupati. Bupati is the chief policy making figure at the district level and calls the shots in terms of driving the development agenda of the district. Nature and pace of development including sanitation is determined by what Bupati considers to be of importance. This is substantially exemplified by the data from the field, particularly Muara Enim and Sumedang. Though STBM with CLTS as one of its five pillars of the national strategy is supposed to be guiding the sanitation work on the ground, what really happens at the district level is driven by the policy priorities of the local district administration presided over by bupati.

Development aid agencies including international NGOs such as Plan International have been supporting Government of Indonesia’s STBM through their direct involvement in its facilitation and implementation on the ground. Besides their contribution to national level efforts, their role has been mainly in terms of district level advocacy, planning, training,
triggering and monitoring support to the local initiatives. Plan Indonesia has been providing this support in Lembata district of Nusa Tenggara Timur with encouraging results since 2008.

It is envisaged that the learning from this research study will be of interest and use to a wide range of government and non-government stakeholders including development aid agencies, and could also be of help in formulating a strategy for scaling up CLTS effectively across the country, in case required. The findings of the research underline the need for a radical shift in strategy for implementation to create sustainable ODF villages in Indonesia.

This shift has to be in terms of identifying opportunities for local resource mobilisation for funding training, triggering, post-triggering follow-up and monitoring and verification activities at the village level. Excessive dependence on project based funding by external donors for funding CLTS activities is bound to be inhibiting the scaling up efforts, as they are and can be available only for a few districts, and not for the entire country.
Acknowledgements

This study is the outcome of Plan Indonesia’s continuing concern and commitment to help Government of Indonesia in strengthening all the five pillars of the National Strategy for Community Based Total Sanitation (STBM), with a focus on community led total sanitation (CLTS). Besides providing planning and implementation support to STBM in Lembata, a study district, and other parts of Indonesia, Plan Indonesia has also taken up to contribute to knowledge generation and strategic learning to inform policy and practice around CLTS in the country. So the first thanks goes to Plan Indonesia for conceiving, commissioning and managing this research study.

Eka Setiawan, the WASH Manager, managed the study on behalf of Plan Indonesia with great vision, patience, and personal attention. Wahyu Triwahyudi, National WASH Advisor. Plan Indonesia, contributed considerably to the overall quality of the research through his constructive comments and suggestions in the last leg of the study.

At the same time, thanks are due to Plan Australia, who has supported Plan Indonesia for this research not only financially but also in terms of providing strategic technical advice at every stage. I would like to extend special thanks to Lee Leong from Plan Australia, who has guided this research with gentle but firm hands from a distance but with an eye on the quality of the research design and outcomes.

We are hugely grateful to around 800 women and men from 12 villages across three districts of Indonesia, namely Sumedang, MuaraEnim and Lembata, who spared their valuable time to participate in household surveys and focus group discussions and shared a great deal of information and experience to make this study come alive. Their ideas, information and insights form the primary basis of this study.

District health officials and other government functionaries from the offices of bupati, chamat and bappeda were a huge help in every sense and made meetings and discussions with people possible, besides sharing the CLTS story in their respective districts in great detail during FGDs and in-depth interviews (IDIs). They deserve our deepest gratitude for their invaluable help and contribution.

The study owes a lot to Zainal Nampira and others from the Ministry of Health, who offered strategic help and advice in the early stages of the study.

But the biggest ‘thanks’ goes to Nugroho Tri Utomo from Bappenas, who provided incisive insights and advice at the initial stage of designing the study and made significant contribution in terms of helping sharpen the approach and methodology of the study.

The team of national consultants led by Edy Priyono at AKADEMICA provided the raw material for the study by collecting all the quantitative and qualitative data from the field
and deserve a big ‘thank you’. Edy also offered valuable technical advice for data analysis and sharpening the research findings.

Last, but not the least, are my colleagues at Knowledge Links, who provided valuable help both in carrying out data analysis and in putting the report together in its present form. D. Satya Suya, Dr. Sanjay Verma, Dr. Ashish Kumar Singh and Anjali Verma have been my partners in data analysis and report writing and are more like co-authors of the report. But any error of omission or/and commission in the report is certainly and totally mine.
Abbreviations and Acronyms

- **BAPPEDA**: Badan Perencana Pembangunan Daerah (Indonesian: Regional body for planning and development)
- **BAPPENAS**: Badan Perencanaan Pembangunan Nasional (National Planning Agency)
- **BHS**: Basic Human Services
- **CFR**: Case Fatality Rate
- **CLTS**: Community Led Total Sanitation
- **FGDs**: Focus Group Discussions
- **FR**: Field Researcher
- **GDP**: Gross Domestic Product
- **IDIs**: In-Depth Interviews
- **ISSDP**: Study of the Indonesian Sector Development Program
- **JMP**: Joint Monitoring Programme
- **KLB**: Kejadian Luar Biasa (Extraordinary Incidences)
- **OD**: Open Defecation
- **ODF**: Open Defecation Free
- **PAMSIMAS**: Penyediaan Air Minum Dan Sanitari Berbasis Masyarakat
- **PNPM**: Program Nasional Pemberdayaan Masyarakat
- **Pokja AMPL**: Kelompok Kerja Air Minum dan Penyehatan Lingkungan (Water Supply Environmental Sanitation Working Group)
- **RPJMN**: Rencana Pembangunan Jangka Menengah Nasional (Mid-term National Planning)
- **RT**: RukunTetangga
- **RW**: RukunWarga
- **STBM**: Sanitasi Total Berbasis Masyarakat
- **TSSM**: Total Sanitation and Sanitation Marketing
- **UNICEF**: United Nations Children’s Fund
- **WHO**: World Health Organisation
- **WSLIC II**: Water and Sanitation for Low Income Communities II
## Glossary of Local Terms

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<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
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<tbody>
<tr>
<td>Arisanjamban</td>
<td>Toilet revolving fund</td>
</tr>
<tr>
<td>Brukbrak</td>
<td>“Being open”, “Being Transparent”</td>
</tr>
<tr>
<td>Cubluk</td>
<td>Toilet hole</td>
</tr>
<tr>
<td>Cemplung</td>
<td>Simple/emergency toilet</td>
</tr>
<tr>
<td>DesaSiaga</td>
<td>Outstanding village</td>
</tr>
<tr>
<td>Dokter kecil</td>
<td>Doctor for children</td>
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<tr>
<td>Desa</td>
<td>Village</td>
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<tr>
<td>Dusun</td>
<td>Hamlet/sub-village that is two level above RT, and one level above RW (rukunwarga)</td>
</tr>
<tr>
<td>Gemohing</td>
<td>Spirit of working together</td>
</tr>
<tr>
<td>Gotong Royong</td>
<td>Mutual Self-Help</td>
</tr>
<tr>
<td>Kampong</td>
<td>A hamlet i.e. a rural settlement</td>
</tr>
<tr>
<td>Kelompent</td>
<td>Short term of kelompencapir that was a group of audience (of radio/TV) established in the Suharto era as part of his way to communicate the development (and political campaign as well). In many other places that institution does not exist anymore, so its existence and role in sanitation (which is so far away from the initial idea of the establishment) in Sukawening Village is very unusual.</td>
</tr>
<tr>
<td>Konselorsebaya</td>
<td>Peer mentor</td>
</tr>
<tr>
<td>Leherangsa</td>
<td>Pour flush toilets</td>
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<tr>
<td>LembagaKeswadayaanMasyarakat</td>
<td>Community Self-help Institution</td>
</tr>
<tr>
<td>Ngadubako</td>
<td>Informal meeting, in local Sudanese language it means exchanging cigarettes</td>
</tr>
<tr>
<td>Opsih</td>
<td>Opsih is abbreviation of operasi bersih-bersih (cleaning operation), an activity that involves community members to clean their environment.</td>
</tr>
<tr>
<td>Paciringan</td>
<td>Simple toilet above the fish pond</td>
</tr>
<tr>
<td>Posyandu</td>
<td>integrated services post</td>
</tr>
<tr>
<td>RT or rukuntetangg</td>
<td>Community group under village, usually consists of 30-40 households.</td>
</tr>
<tr>
<td>Romli</td>
<td>A group that is motivated by the God</td>
</tr>
<tr>
<td>Silihtoel</td>
<td>Reminding each other</td>
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Executive Summary

Background

The primary purpose of this research study on ‘improving CLTS from a community perspective approach in Indonesia’ has been to find out what has worked or not worked in CLTS in different parts of the country so far and why. It was envisaged that this will help identify the key elements of a potential strategy that could inform an approach to scale up CLTS across the country with faster and more sustainable results.

The study was commissioned and managed by Plan Indonesia with funding support from Plan Australia during 2011-2012. The study is primarily qualitative in nature and seeks to generate insights into the planning and implementation of CLTS, as one of the five pillars of the national Sanitasi Total Berbasis Masyarakat (STBM), i.e. Community Based Total Sanitation on the ground and the factors underlying them.

The qualitative data has been generated through focus group discussions (FGDs) and in-depth interviews (IDIs) at the village, sub-district and district levels. Participants of FGD included 180 women and 173 men from 12 villages (4 each from the 3 districts) and 46 government officials and other functionaries at the district level. IDIs were conducted with key actors at the village, sub-district and district levels. Besides the qualitative data, the research is also based on quantitative data generated through household surveys of 360 households in 12 villages across 3 study districts: this entailed 30 households surveyed across each of the 12 villages.

Four categories of villages were chosen from all the three districts as sample for the study. These categories included: ODF village; Non-ODF village; Slippage ODF village; non-CLTS ODF village/slippage village. As it was pre-empted that it may not be possible to get a non-CLTS ODF village in all the study locations, it was agreed in advance that in a case like this, another slippage ODF village would be taken up for study in its place¹. The basic idea in having these four categories of villages in the study sample was to look at factors that make CLTS work or not work in the light of data from a diverse set of villages.

¹This had to be done both in Sumedang and Muara Enim, where no village in this category could be identified. Lembata was an exception where Lusiduawutun was identified as a village which had reportedly achieved ODF status without any CLTS intervention.
Though the study findings are limited only to the study districts and cannot be used to arrive at a generalised understanding of the CLTS process and results in the other districts in the country, there could be some broader lessons to be learnt about the general trajectory of CLTS from the point of view of its functioning in three diverse locations from three different regions of the country. These broad lessons could be used as pointers for learning about CLTS in other districts, as also to try out innovative strategies for scaling up the approach and its effectiveness in terms of achieving sustainable ODF results at the village level.

**Key Findings**

The key findings of the research study are as follows:

1. **Quality of triggering and post-triggering follow-up has been the key factor in the early and sustainable achievement of ODF villages.**

   But this has not been an independent factor. There has been a hierarchy of inter-related factors, which together have created an enabling environment for good quality triggering and post-triggering follow up to take place at the community level.

   These include: availability of inspired CLTS champions and facilitators within the district health set-up responsible for implementing the STBM at the district level; institutional ownership of the CLTS/STBM; externally aided projects adopting CLTS as their project sanitation strategy and; *bupati’s* personal interest in CLTS. All these factors seem to be intimately linked.

   Most of the CLTS champions and facilitators have come out of CLTS training of trainers programs organised under externally funded projects such as WSLIC II (Muara Enim), World Bank supported PAMSIMAS (Sumedang) and Plan support for CLTS training for STBM in Lembata. This has been made possible due to the institutional ownership of the CLTS initiative by the district health set up in Sumedang and Muara Enim; *Pokja AMPL and Bappeda* in Lembata; and all these owe a lot to the personal interest of *bupati* in CLTS in Sumedang and Muara Enim. In Lembata, though *bupati* never took a personal interest in CLTS, he was the one to give his consent to begin with for Plan Indonesia to introduce CLTS in the district in 2008 soon after Government of Indonesia launched STBM.

   *Bupati’s* interest has emerged as a critical factor in CLTS implementation at the district level, but not at the community level. For example, earlier *Bupati* in Muara Enim was reported to be a CLTS champion, who not only supported CLTS initiative, but also included it as a part of his monthly monitoring agenda. This coupled with inspired CLTS facilitation by Ibu Agustine and her associates resulted in all the 18 villages in Lembak sub-district of Muara Enim becoming ODF during 2006-07. However, none of the other sub-districts in the district had any encouraging results. The determining variable in the case of Lembak turned out to be the inspired leadership of Ibu Agustine. This implies that while *bupati’s* interest is important, it is not the determining factor in what really happens on the ground in the villages.
Lembak sub-district is a remarkable exception to the CLTS experiences from all other study locations, as all the 18 villages in the sub-district became ODF during 2006-07\(^2\).

The fact that the untimely demise of Bupati came as a big blow to the CLTS uptake in Muara Enim, as his successor was not oriented well on CLTS and discontinued the practice of monitoring CLTS activities, establishes the crucial significance of the ownership at the district level as one of the key factors in making CLTS happen at the district level. The ensuing slow CLTS progress over next 4 years since 2008 is widely attributed to lack of ownership of CLTS at the Bupati level. Only 11 villages could attain the ODF status during 2008-2012. This comes to around less than 3 ODF villages per year. Thus the speed of ODF achievement slowed down to about 1/5\(^{th}\) of what it was in the year 2006-07. Given the fact that more than 297 villages in Muara Enim have yet to be ODF, at this rate, this may take around 99 years in making all the villages in the district ODF.

Field data suggests that the quality of CLTS triggering in terms of its effectiveness to trigger community resolve to end open defecation and collective local action to do so as quickly as possible, is the end outcome of a number of inter-related factors. These factors include the presence of inspired CLTS champions and facilitators, policy and budgetary support of the local district administration and programme and project support for CLTS activities related to training, triggering, follow-up and monitoring.

There has been in fact a hierarchy of factors at work having a determining influence on the rate of results in achieving ODF villages. Rate of CLTS results both in terms of time taken in achieving ODF villages and their sustainability over time across and within districts varies with the quality of CLTS triggering, follow-up and monitoring. The key variation in CLTS results is mainly in terms of the number of ODF villages and the time taken by them in becoming ODF. This ranges from 0 to 15 ODF villages in a year in a sub-district or district.

2. CLTS initiatives have focussed more on increased toilet coverage in villages than in the verified ODF status of the villages involved. Hence, CLTS results are also primarily recognised and seen in terms of 100% toilet coverage than the end of open defecation both by the communities and implementing agencies at the district level. Hundred per cent toilet coverage and end of open defecation are almost universally assumed to be directly linked for recognising ODF communities and recommending them for their formal recognition as ODF villages by the district administration. In the case of Sumedang, 80% toilet coverage is reported to be considered good enough for claiming open defecation free (ODF) status for the villages, in many cases. In the case of Muara Enim, less than 100% toilet coverage coupled with sharing of toilets but with no open defecation has been largely the criteria for declaring a village ODF, which is closer to the CLTS approach and methodology. In Lembata, 100% toilet coverage is the minimum criterion for declaring a village ODF, but not necessarily on the basis of actual verification of the ODF status of the village concerned.
3. Monitoring and verification of ODF status of villages has been the weakest link in terms of tracking the real results of CLTS in all the three study districts. There are multiple monitoring processes and practices in place not organically linked to each other in all the three districts. This has been mainly due to monitoring by different agencies with different criteria and methods for monitoring.

Differences in monitoring practices coupled with unrealistic targets for achievement seem to have resulted in distortion of practice in terms of false reporting and declaration of the ODF status of villages as in Sumedang.

4. The usual time taken by a village in becoming ODF since triggering ranges from 6 months to 12 months or more in most of the cases. Lembak sub-district in Muara Enim is an exception where 10 villages achieved the ODF status between 1 to 4 months during 2006-07. Given the fact that 8 of these 10 villages in Muara Enim took only 4-8 weeks in becoming ODF, a period of a year or more in becoming ODF since triggering in other cases seems to be indicative of weak community resolve and effort at the village level, which is mainly due to poor quality of triggering or weak community structures and processes for driving the sanitation movement within communities or both.

5. Women have been the major catalysts of sanitation behaviour change not only at the community level, but also at the sub-district and district levels in their capacity as champions and main drivers of CLTS in their respective areas.

At the community level, their participation in CLTS related socialisation and triggering events has ranged from 60% to 95% across districts. Reports from all the 12 study villages across village categories (ODF/non-ODF/Slippage/non-CLTS ODF) establish that women have been the main participants in the CLTS process at the village and community level.

At the sub-district and district levels, women have played the strategic role of champions and leaders. It is remarkable that two major CLTS champions, who have spearheaded the CLTS initiative in two of the three study districts, have been women. Ibu Agustine in Muara Enim and Ibu Ekki in Sumedang are widely known to have driven the CLTS in their respective districts as the key figures engaged in co-ordinating, training, facilitation, mentoring and internal advocacy within the local government.

6. Bupati’s role is of critical importance from the point of view of the institutional ownership of the CLTS approach and its application on the ground, as amply exemplified by the case of Muara Enim, one of the early successes of CLTS in Indonesia, where Bupati had attended a CLTS training program and was fully convinced about the efficacy of the CLTS approach in creating ODF villages; this is substantiated by the case of Sumedang as well where Bupati supported the CLTS initiative after getting triggered during an official breakfast where he realised that the bad taste of baby fish in the breakfast menu could be
due to their consuming human shit. This support came in the form of an official decree establishing the importance of safe sanitation being a part of local Sundanese culture.

7. Lack of budget to support CLTS activities has emerged as a major constraint in taking CLTS forward at the district level. This is also substantiated by the fact that areas with programme/project funding such as in Muara Enim (WSLIC II and PAMSIMAS) and Lembata (Plan Indonesia) have done relatively better than Sumedang, which has had no such funding to begin with.

8. Local CLTS champions from the district health set up, strong village leadership, committed natural leaders and influential community members have been the common factors in achieving increased toilet coverage and corresponding behaviour change in terms of stopping the practice of open defecation at the village level across the three study districts.

Leadership at various levels has been the key to driving the CLTS at village, sub-district and district levels. Leadership in Indonesia seems to be going along with formal or informal authority both at the community level and within government institutional set-ups like district health establishment. *Bidan Desa* in Muara Enim, village health cadre in Sumedang and village heads in Lembata have been the key people driving CLTS at the village level. And heads of health centres at the sub-district and district levels have been guiding the initiative at these level.

9. Role of religious leaders and institutions and invocation of sanctions in religious texts such as *hadis* have been a major catalyst for sanitation behaviour change at the community level in some of the locations, particularly in Muara Enim and Lembata. Head of Muara Enim Burung Health Center Mr. Rahmadi shared that an effective triggering by a religious leader included the quotation of a ‘hadist’ saying that ‘defecation at three places will be condemned by God if a Muslim does that: namely (i) where people take rest; (ii) on road and; (iii) near or in a water source’. This was reportedly very powerful and made people in the village decide to end open defecation immediately. Church has played an important role in making people stop open defecation and adopt the use of improved toilet facilities in Lembata. Lerahinga village in Lembata is a case in point where people have been traditionally using simple toilets—'cemplung'—since 1986, and started shifting to pour flush toilets in 2000, almost 8 years before the CLTS/STBM was launched in the district. It was easy for the people in Lerahinga village to become ODF quickly as they were already oriented to the need for safe sanitation. The local Church was instrumental in bringing this about.

10. Local cultural resources in the form of social practices of mutual self-help such as *gotong royong* and *gemohing* in Lembata, and of *brukbrak* i.e. transparency in Sumedang helped foster the spirit of community mobilisation and collective local action to achieve ODF outcomes. Local cultural events in Muara Enim were used to disseminate CLTS
messages to people to call them for meetings and triggering sessions. Indigenous ‘Kelompen’ forums were utilised for highly effective discussions, consensus building and for communications. Similarly ‘Penojian’ religious gathering has been used very effectively for CLTS related and other social issues.

In conclusion, these findings suggest that a strategy for strengthening the CLTS pillar of the national sanitation strategy and its scaling up needs to address the following key issues: uniform policy and programme support for a no-subsidy approach to the implementation of STBM across districts; good quality training aimed at creating a critical mass of trained CLTS trainers and facilitators at the district level; quality triggering capable of eliciting community resolve to end open defecation and initiating collective local action to achieve this objective; effective post-triggering follow-up and monitoring; and independent verification of ODF status of the villages declaring themselves to be ODF.

The key recommendations of the study are as follows:

- Launch a national level campaign for exposing *bupatis* to CLTS training and triggering
- Invest in training, triggering and post-triggering follow-up at the district level
- Monitor the quality of training, triggering and post-triggering follow-up at the village, sub-district, and district levels
- Nurture and support CLTS champions
- Align different national programmes supporting sanitation initiatives including PAMSIMAS, PNPM, TSSM, and STBM on issues related to the following: subsidy; incentives and rewards; CLTS process of triggering and post triggering follow-up; mentoring and monitoring; and verification and declaration of ODF village and sub-district.
- Organise CLTS triggering at RW/RT and *dusun* levels with community monitoring at the *desa* i.e. village level
- Devise institutional arrangements and practices to provide people with technology related information and know-how on demand as per specific local conditions and context.

In view of the learning from this study, the above mentioned steps may help scale up CLTS in other remaining districts across Indonesia with prospects of faster and more sustainable results in terms of having ODF villages that remain ODF and provide a safe and healthy living environment to its people.
Chapter 1: Context

Background

As per the Update 2012 of Joint Monitoring Programme (JMP) Report of UNICEF and World Health Organisation (WHO) in Indonesia, 43 million people are without an improved drinking water source; 110 million are without improved sanitation, and; 63 million are practicing open defecation. Study of the Indonesian Sector Development Program (ISSDP) in 2006 showed that 47% of the population still defecate at rivers, fields, pools, gardens and other open places.

As per another study of Basic Human Services (BHS) in Indonesia in 2006, ‘the percentage of people washing their hands (i) after defecating was 12% (ii) after cleaning of faeces of babies and children under five 9% (iii) before taking meals 14% (iv) before feeding babies 7%, and (v) before preparing meals 6%.’

There are unmistakable linkages of this with the high incidence of diarrhoea in the country. The 2006 national diarrhoea incidence was reported to be 423 per one thousand people at all ages and 16 provinces had Extraordinary Incidences (KLB) of diarrhoea with a Case Fatality Rate (CFR) of 2.52.

The National Strategy for Community Based Total Sanitation or STBM, launched in 2008 by the Department of Health, Government of Indonesia (Decree Number 852/2008) maintains that ‘such a condition can be controlled through an integrated intervention adopting total sanitation approach.’

Community Led Total Sanitation (CLTS) was launched in 6 districts in 2005 in Indonesia with very encouraging results, followed by total sanitation campaign based on CLTS approach launched by the Minister of Health in 2006 in West Sumatra. As a follow-up, CLTS was replicated by many government and non-government agencies resulting in 160 villages being declared ODF in 2006 and 500 villages being declared ODF in 2007.

Inspired by this early success CLTS was included as one of the five pillars of the national sanitation strategy called STBM launched in 2008, which is intended to be ‘used for reference in planning, implementing, monitoring and evaluating the community based sanitation program.’

‘The World Bank estimates the financial burden on poor basic sanitation in Indonesia at approximately US$6.3 billion, equal to 2.3% of GDP. Poor sanitation has its greatest impact on children, since more than 100,000 children die annually due to diarrhoea. This is the main cause of infant mortality and the third cause of overall morbidity nationally. There is a compelling need, therefore, to invest in improved sanitation in Indonesia.’

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Since 2003, the Water Supply Environmental Sanitation Working Group (Pokja AMPL), led by Bappenas (the National Planning Agency), has been mainstreaming water sanitation programmes in District Government Planning.

‘In addition, the Government of Indonesia declared its commitment to improved sanitation in rural and urban areas in the Mid-term National Planning (RPJMN) 2010-2014, highlighting the following targets:

- Having Open Defecation Free (ODF) rural and urban areas through Community-Led Total Sanitation (CLTS) triggering by 2014
- 38% households have access to improved solid waste treatment (sanitary landfill) by 2014
- A decrease in stagnant water to 22.5 Ha in 100 urban strategic areas
- Increase in percentage of households using ‘healthy latrines’ from 64% in 2010 to 75% by 2014

But the current rate of results in achieving ODF results has not been very promising despite encouraging reports of CLTS from East Java, Muara Enim, Sumedang and Lembata. The study seeks to find out what is working or not working in CLTS in Indonesia.
Chapter 2: Study Design, Methodology and Framework for Analysis

The research study is designed to be essentially a qualitative inquiry into the functioning of CLTS, as one of the five pillars of the national sanitation strategy in Indonesia. It was planned and undertaken as a rapid study based on both qualitative and quantitative data. Qualitative data involves around 400 women and men participating in focus group discussions (FGDs) and in-depth interviews (IDIs). Quantitative data from 360 household surveys across 12 villages in three districts has also been generated and analysed to supplement the qualitative data analysis.

2.1 Research Objective

The primary research objective is:

To identify factors that make CLTS work or not work in different local contexts in Indonesia with a view to generating insights for sharpening and strengthening the CLTS strategy and scaling it up across the country

2.2 Key Research Questions

These questions are:

- What motivates sustained sanitation behaviour change at the individual, household and community level?
- What are the factors affecting the achievement and sustainability of ODF initiatives in terms of toilet use, maintenance and upgrade, as well as government follow-up and support?
- If there is community that reverts back to the OD practice, what are the factors affecting the ODF slippage at the community level?
- What are the factors affecting the interest of government officials to engage with CLTS programmes?

2.3 Limitations, Biases and Assumptions

Small sample size and limited information-set have been the biggest limitations of this study. Given the fact that there are around 465 districts in Indonesia, a sample size of 3 districts is less than 1% of the universe. Similarly given 65,000 villages across the country, a sample size of 12 villages happens to be empirically negligible. This limitation, which is the
result of time and resource constraints, is sought to be overcome by making the research primarily qualitative in its focus and orientation.

One of the implicit assumptions of the study, supported by other previous studies (particularly the recent-March 2012-WSP study titled ‘Achieving and Sustaining Open Defecation Free Communities: Learning from East Java’), has been that CLTS may help bring faster and more sustainable results on the ground in the form of an increasing number of open defecation free (ODF) villages across the country. However, care has been taken to ensure that this assumption does not present itself as a bias in carrying out the study thereby adversely impacting the rigour and quality of the research.

This is sought to be done partly by making another assumption as a part of the main research objective itself, which is to find out what works or does not work in CLTS. The assumption here is that there are things in CLTS which may not be working and learning from them would be crucial for working out a sound scaling up strategy for CLTS as a part of the national sanitation strategy. Another way to offset any remaining bias in the context of CLTS has been by way of including a non-CLTS ODF village (if available) as one of the four villages to be selected as a part of the overall sample of the study in each district.

2.4 Selection of Sample Villages and Households for the Study
2.4.1. Village Selection

Four categories of villages were selected from each of the three study districts. These included: Non ODF village; Slippage ODF; ODF; and ODF non CLTS.

**ODF Village**, is a village that has been declared or/and verified as an ODF village by local authority at least a year back and reportedly still retains its ODF status.

Given the possibility that a village identified as ODF may no longer be ODF, the Field Researchers (FR) were advised to verify to make sure that villages in the list of ODF village are really ODF. It was also agreed that in case during the verification by FR, people were found to be engaging in open defecation, the village should be defined as slippage ODF.

It was decided that in case of a difficulty in identifying a real ODF village in the field, the following steps will be followed:

- Select Non ODF village first based on evaluation of local authority. No need for verification.
- Select a village that according to local authority is an ODF village, then do verification in the field. If the verification shows that the village is really ODF, choose the village as ODF Village for the survey. However, if during the verification FR finds open defecation practices, take the village as Slippage ODF Village for the survey.

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4 Only one village in Lembata could be identified in this category.
• If a village is mentioned as an ODF village by local authority but is not so in reality on the ground will be undertaken as a Slippage ODF and the search for a real ODF village will be continued on the basis of the list from local authority. Once the FR verifies a village as really ODF, the concerned village will be undertaken as an ODF Village for the study.

• In case of a genuine difficulty in identifying an ODF village, if FR finds that actually only some dusuns in the so-called ODF village have achieved ODF status, the village can be taken up as an ODF village in the survey but households selection will be done only from within the ODF dusuns. In other words, verification on the ODF village candidate for the survey is only done in not more than two villages those previously stated as ODF village by local authority.

**Slippage ODF Village**, is a village that was declared to be ODF, but is now found to be practicing OD partially or fully. It was apprehended that it may not be easy to identify a village like that, as no such data is collected by the local health department.

Hence, special efforts were made to identify a village in this category in all the study villages. But in the case of Sumedang, it was not difficult to identify these villages, as many villages were declared to be ODF without having achieved 100% toilet coverage and ownership primarily on the basis of people’s assumed access to toilets. For actual village selection, a list of ODF villages that are known to be or likely to have slipped back was requested from the local authority and the slippage village for the study sample was chosen randomly from that list.

**Non ODF Village**, is a village where CLTS triggering took place but the village has yet to become ODF. This implies that there are people in the village who are still practicing open defecation. It was envisaged that this kind of village will be easy to find for the local authority, which would be willing to help. This category of village from each district was chosen randomly on the basis of the list of non-ODF villages, having already gone through CLTS triggering, provided by the Health Department at the district level.

**Non CLTS ODF Village**, is a village where nobody defecates in the open, though the village has never experienced CLTS triggering. It was not easy to find that kind of village, as most of the villages in study districts practiced open defecation. This was agreed that selection of that kind of village should rely on notes or list of local authority and there should be no need for verification by the field research team for that. In case no such village was available, the “quota” for ‘Non CLTS ODF Village’ was agreed to be used for Slippage ODF Village, so in that case number of Slippage ODF villages in the district will be two (not one), but total number of villages remains four. This was the case both in Sumedang and MuaraEnim. Lembata was the only district where a village of this category was identified and studied.

**2.4.2 Household Selection**

Beside verifying the status of village as study location, the field researchers also consulted with the village officials to make a list of potential households as the sample for interviews.
The characteristics considered for preparing this list included: gender (female or male); socio-economic status (poor or non poor); location (covering all parts of the village). An additional characteristic of toilet ownership was considered for Non ODF and Slippage ODF villages. There was no pre-defined quantitative quota for each group of households and the field researchers were briefed to use their own best judgment in ensuring that the household sample is representative of the village under study.

2.5 Framework for Analysis

As the research was intended to be from community perspective, it is important to define at the very outset as to what ‘community perspective’ means from the point of view of this research. The framework for analysis from this perspective is as follows.

CLTS is a participatory approach that aims at bringing about total sanitation by making the process of analysis and action on the ground truly community led. Any process that fails to do so cannot be called CLTS. Mere use of triggering tools cannot be called CLTS if it fails to generate collective ownership of the need and action to end open defecation at the community level.

So the first element of the framework is about finding out if the process of achieving ODF communities has been really community led across 11 study villages in Sumedang, Muara Enim and Lembata districts of Indonesia. For the purposes of this research, the ‘community perspective’ means two things: (i) what community members think of what happened in the village and; (ii) what are the implications of what happened for CLTS and its impact on achievement of ODF villages. While the first is known directly from what people had to say at the community level, the second had to be inferred from their responses in the light of whether what happened was CLTS.

As people may or may not have known about CLTS to begin with, it would have been erroneous to assume people’s prior familiarity with CLTS in terms of what it is and how it works on the ground. It is for the trained CLTS facilitators and practitioners to appreciate and act according to the CLTS approach.

Moreover, this research also goes into issues, which were not the issues from the so-called community perspective, but had a determining influence on what eventually happened at the community level. These include issues related to outside actors such as CLTS champions, trainers and facilitators from the health set up at the sub-district and district levels, as also from other streams of the local administration. As a result, role of _bupati_, who is the elected head of the local district administration, and other institutional actors such as _Pokja AMPL_ and _Bappeda_, who had a major role in making CLTS happen on the ground, though indirectly, were included and studied as a part of this research. By the same logic, externally funded projects including WSLIC II in Muara Enim during 2005-07, PAMSIMAS in all the three study districts since 2008, and Plan Indonesia’s on-going support for STBM in Lembata...
were studied, as all these initiatives seek to bring about sustainable sanitation behavior change at the community level in their respective project areas.

So what we have in this research goes beyond ‘community perspective’ on CLTS and captures all that has a bearing on CLTS results in terms of achievement of sustainable ODF villages in Indonesia. This is done on the understanding that it is hard to get the real ‘community perspective’ on CLTS unless it is certain that what was done at the village level was ‘CLTS’ and not something else in the name of CLTS.

Moreover, as CLTS is all about communities, any factor that impacts the planning and implementation of CLTS at the village level has been included as a part of analysis and for the purpose of arriving at the findings and recommendations of the study.
Chapter 3: Key Findings

Key Findings

The key findings of the research study are as follows:

FINDING 1

3.1. Quality of triggering and post-triggering follow-up has been the key factor in the early and sustainable achievement of ODF villages.

But this has not been an independent factor. There has been a hierarchy of inter-related factors, which together have created an enabling environment for good quality triggering and post-triggering follow up to take place at the community level.

These include: availability of inspired CLTS champions and facilitators within the district health set-up responsible for implementing the STBM at the district level; institutional ownership of the CLTS/STBM; externally aided projects adopting CLTS as their project sanitation strategy and; Bupati’s personal interest in CLTS. All these factors seem to be intimately linked.

Quality of triggering and post-triggering follow up are hard to quantify, but there are features that can be identified and isolated for examination in terms of their implications for their role in accelerating the pace of making a village ODF in a manner that is sustainable.

Constituting elements of the quality of triggering include the following:

- CLTS triggering tools used
- Time taken during triggering
- Participation of people
- Community resolve to end open defecation
- Action planning to end open defecation

While the first three elements relate to the process of triggering at the village level, the last two are about the immediate outcome of that process. And there is enough evidence to suggest that the quality of ODF outcomes flows from the quality of the processes adopted.

3.1.1 Use of triggering tools and time taken during triggering

A look at the results from household survey data suggests that there has been a much higher percentage of use of multiple triggering tools in the villages that eventually became and remained ODF. These tools include: sanitation mapping, transect walk, shit and water exercise, faecal oral transmission route (also called contamination path). As many of these tools were used in ODF villages, the triggering process also took much longer such as half a day or one full day in villages in Muara Enim during 2005-07 (which became ODF quickly)
than one hour or a couple of hours in slippage and non-ODF villages across all the three districts, but more so in Sumedang, where the duration of triggering process has been generally of one hour on an average. Number of tools used and time taken during triggering are intimately inter-linked and have a determining influence on the community resolve to end open defecation and the ensuing collective local effort to achieve this into action.

**Figure 2: Use of CLTS pre-triggering and triggering tools**

<table>
<thead>
<tr>
<th>Pre triggering - Socialization</th>
<th>Triggering - Sanitation mapping</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1" alt="Pie Chart" /></td>
<td><img src="image2" alt="Pie Chart" /></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Triggering - Calculation of faecal material produced in the village</th>
<th>Triggering - Oral faecal transmission route map</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image3" alt="Pie Chart" /></td>
<td><img src="image4" alt="Pie Chart" /></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Triggering - Shit and water exercise</th>
<th>Triggering - Transect walk</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image5" alt="Pie Chart" /></td>
<td><img src="image6" alt="Pie Chart" /></td>
</tr>
</tbody>
</table>

The percentage of pre-triggering socialisation activities is slightly higher in the case of slippage and non-ODF villages as compared to ODF villages. This has been mainly because in
many cases it was never followed up by a proper triggering exercise resulting in failure to achieve effective ODF status for the villages concerned.

### 3.1.2 Awareness and participation of people

The data from the household survey indicates that the level of awareness among people and their participation in CLTS activities and the STBM of which it forms a part is significantly higher in ODF villages as compared to villages that have slipped back to the practice of OD or never achieved the ODF status. At the same time, the level of awareness and participation in slippage ODF villages is generally higher than the non-ODF villages.

![Figure 3: Awareness and Participation of People in CLTS/STBM](image)

Awareness in this case is a proxy indicator of people’s involvement in the CLTS activities and processes at the village level. This data suggests that where there has been greater awareness and involvement of people in CLTS processes, results have been better, as in the case of ODF villages, Slippage ODF and Non-ODF villages in that order.

### 3.1.3 Post-triggering follow-up

Similarly, effective post-triggering follow-up includes the following elements:

- Formation of community groups
- Daily or weekly monitoring by the community groups
- Follow-up visit by the CLTS facilitators
- Information sharing on technology issues on demand

Formation of groups by people in the village to follow-up on planned activities to end open defecation during the post-triggering phase has been found to be a critical factor in ensuring early and sustainable ODF results. As the figure below indicates, the incidence of formation of groups has been 16% higher (than slippage ODF villages) and 31% higher (than non-ODF villages) in ODF villages. Besides, toilet ownership in villages, which were found to have
retained their ODF status at the time of study, was found to be 100%, as compared to slippage and non-ODF villages.

These two sets of factors have been common to all the ODF villages, which have retained their ODF status even after a few years. But the fact that these factors have also been there partially in some of the slippage ODF villages underlines the presence of some additional enabling factors in the case of ODF villages, which have not been there to the same extent in the case of slippage ODF villages.

### 3.1.4 Other enabling factors

Field data suggests that the quality of CLTS triggering in terms of its effectiveness to trigger community resolve to end open defecation and collective local action to do so as quickly as possible has been the end outcome of a number of inter-related factors. These factors include the presence of inspired CLTS champions and facilitators, policy and budgetary support of the local district administration and programme and project support for CLTS activities related to training, triggering, follow-up and monitoring by outside agencies.

Most of the CLTS champions and facilitators have come out of CLTS training of trainers programs organised under externally funded projects such as WSLIC II (Muara Enim), PAMSIMAS (Sumedang) and Plan support for CLTS training for STBM in Lembata. These processes have been made possible due to the institutional ownership of the CLTS initiative by the district health set up in Sumedang and Muara Enim; Pokja AMPL and Bappeda in Lembata; and all these owe a lot to the personal interest of bupati in CLTS in Sumedang and Muara Enim. In Lembata, though bupati never took a personal interest in CLTS, he was the one to give his consent to begin with for Plan Indonesia to introduce CLTS in the district in 2008 soon after Government of Indonesia launched STBM.

Bupati’s interest has emerged as a critical factor in CLTS implementation at the district level, but not at the community level. For example, earlier Bupati in Muara Enim was reported to be a CLTS champion, who not only supported CLTS initiative, but also included it as a part of
his monthly monitoring agenda. This coupled with inspired CLTS facilitation by Ibu Agustine and her associates resulted in all the 18 villages in Lembak sub-district of MuaraEnim becoming ODF during 2006-07. However, none of the other sub-districts in the district had any encouraging results. The determining variable in the case of Lembak turned out to be the inspired leadership of Ibu Agustine. This implies that while bupati’s interest is important, it is not the determining factor in what really happens on the ground in the villages.

The varying inter-play of these factors in a given context is not easy to capture and articulate on the basis of available data. But there is enough evidence to suggest that no single factor can help achieve sustainable ODF outcomes at the village level. This also suggests that the actual result in terms of ODF villages is fairly sensitive to the underlying dynamics of these factors. The factors for good results such as in Lembak sub-district in Muara Enim (15 ODF villages in a year in 2006) seem to be mainly due to the following six inter-related factors:

- Quality of CLTS triggering in villages
- Post-triggering follow-up
- Leadership of a CLTS champion and facilitator
- Ownership of the local district government
- Project support
- Bupati’s personal interest and support

These factors vary in degree and intensity across the three districts of Sumedang, MuaraEnim, and Lembata over time, which also shows through in the internal variations in the rate of results across sub-districts within a district.

3.1.5 Variation in rate of achieving ODF results

The most significant variations are in the nature and rate of results over time. Rate of CLTS results both in terms of time taken in achieving ODF villages and their sustainability over time across and within districts varies with the quality of CLTS triggering, follow-up and monitoring. The rate ranges from 0 to 15 ODF villages in a year taking 1-12 months or more across districts and time and also within district over time.

Thus the key variation is mainly in terms of the number of ODF villages and the time taken by them in becoming ODF. Like in MuaraEnim, out of the 29 declared ODF villages (Mr Alius, Head of Disease Control Division, District Health Office, Muara Enim) during 2005-11, 15 became ODF only in 2006.

This ensuing slow CLTS progress over next 4 years since 2008 is widely attributed to lack of ownership of CLTS at the bupati level followed by the transfer of Ibu Agustine out of Muara Enim. As 297 more villages in the district have yet to be ODF, at the current rate of 3 ODF villages per year since 2008, Muara Enim will take around another 99 years, unless the Lembak type experiences can be multiplied within the district on scale.
Table 1: Rate of Results in Achieving ODF Villages across Study Districts during 2008-2012 and their Implications

<table>
<thead>
<tr>
<th>District</th>
<th>Total number of villages</th>
<th>Total number of villages triggered</th>
<th>Total number of villages declared ODF</th>
<th>% of ODF villages against triggered villages</th>
<th>Number of ODF villages per year</th>
<th>Number of years required to achieve full ODF status at this rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Muara Enim</td>
<td>326</td>
<td>178</td>
<td>11</td>
<td>6%</td>
<td>3</td>
<td>More than 99 years</td>
</tr>
<tr>
<td>Sumedang</td>
<td>283</td>
<td>279</td>
<td>40</td>
<td>7%</td>
<td>13</td>
<td>Around 12 years</td>
</tr>
<tr>
<td>Lembata</td>
<td>151</td>
<td>85</td>
<td>33</td>
<td>39%</td>
<td>8</td>
<td>Around 15 years</td>
</tr>
</tbody>
</table>

Source: IDIs at the district level across Sumedang, Muara Enim and Lembata

As per the available reports from FGDs and IDIs undertaken in April 2012, in Sumedang, the condition of the village being truly open defecation free is compromised in recognising, verifying, recommending and declaring the villages to be ODF. Hence, the reported number of even 40 ODF villages is misleading and is not comparable with the ODF data from other districts.

The factors responsible for the remarkable achievement in Lembak sub-district of Muara Enim include: good quality triggering involving the use of many participatory exercises helping people to analyse and plan, as also the innovative use of films for triggering people; inspired CLTS champions and facilitators including Ibu Agustine and Mr. Alius; effective post-triggering follow-up; WSLIC II adopting CLTS as its main project strategy for creating ODF villages; bupati’s personal interest in CLTS including monthly monitoring by him of the CLTS program.

These factors have been there in all the districts in different combinations and proportions, which are not really measurable, but are critical to what happens on the ground. Bupati’s personal interest and support has been there both in Muara Enim and Sumedang, though in varying degrees. While bupati in MuaraEnim was monitoring the progress of CLTS on a monthly basis, bupati in Sumedang issued a decree for safe sanitation, but was not monitoring it himself. In Lembata, though CLTS was initiated by Plan in 2008 with the consent of bupati, it was not one of his priorities and was not monitored by him.

Other factors at work include externally aided projects and the motivation and drive of trained CLTS facilitators within the district health set-up, responsible for implementing the STBM at the district level. The success of Lembak sub-district in Muara Enim is almost unanimously attributed to the inspired CLTS facilitation by Ibu Agustine and her associates including meticulously planned follow-up and monitoring of the progress towards ODF at the village level.
The factors that seem to be determining the variation in rate of ODF results across districts include district level policy and programme support, budget allocations, and planning and monitoring arrangements for key CLTS activities including training, triggering and post-triggering follow-up, driven by effective CLTS facilitation on the ground by motivated champions.

**FINDING 2**

3.2. CLTS initiatives have focussed more on the increased toilet coverage in villages, than in the verified ODF status of the villages involved. Hence, CLTS results are also primarily recognised and seen in terms of 100% toilet coverage than the end of open defecation both by participating communities and implementing agencies at the district level. 100% toilet coverage and end of open defecation are almost universally assumed to be linked for the purpose of recognising ODF communities and recommending them for their formal recognition as ODF villages by the district administration.

In the case of Sumedang, 80% toilet coverage is reported to be considered good enough for claiming open defecation free (ODF) status for the villages in many cases. In the case of Muara Enim, less than 100% toilet coverage coupled with sharing of toilets but with no open defecation had been largely the criteria for declaring a village ODF (during 2005-07), which was closer to the CLTS approach and methodology. However, the process has slowed down considerably since 2008 and the rate of results in terms of ODF villages is now less than 3 villages per year. In Lembata, 100% toilet coverage is the minimum criterion for declaring a village ODF, but not necessarily on the basis of actual verification of the ODF status of the village concerned.

“The office has never required 100%. Sukaluyu, a PAMSIMAS village is considered as ODF village. However, when I asked my friends there, the ODF they mean is 80% (not 100%).”

IDI, Village Health Cadre, Sukawening Village, Ganeas Sub-district, Sumedang Regency

Varying definitions of ODF in use in practice on the ground are in terms of percentage of toilet ownership by households. This has led to massive amount of confusion at the community level as to what ODF means. This was found to be more pronounced and visible in non-ODF and slippage villages in that order. Some of the observations by people from Malaka, a non-ODF village in Sumedang are as follows:

“We only heard at that time there were some meetings and health extension. I did not know what program it was, but people from health center and district health office were there. Some people said that was “toilet program”.

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5 As per PAMSIMAS 2012 project guidelines, ‘80% of people stopping open defecation’ is one of the indicators of behavioral change in the PHBS (Perilaku Hidup Bersih dan Sehat or Clean and Healthy Life Behaviour), whereas it is widely mis-interpreted at the local level to mean that 80% toilet coverage is good enough for the ODF status of a village.
“So far as I know, we would be given toilet. Up to now there is no follow up. Some people said that there would be Rp 500 thousands financial assistance for building a toilet. There were some households which received free closet and septic tank cover, but those were useless, because building a toilet need more than closet. Where is the fund?”

FGD, Men, Malaka (non-ODF) village, Sumedang

‘Toilet development program was ignored. However, there was free closet assistance from village for poor households (the respondents cannot remember the number), but that was useless because there was no other support such as materials for toilet building. In about 2009, the head of village instructed people to destroy their paciringans, but people reconstructed afterwards. The head of dusun said that public toilet should come first then we can destroy the paciringans.’

IDI with village cadres, Malaka Village, Situraja Sub-district, Sumedang

Identification of CLTS triggering with a toilet program by the villagers also speaks about the quality of CLTS triggering and the ways in which CLTS triggering is perceived and approached by the CLTS facilitator himself, who was the sanitarian in the case of this village.

‘If in certain dusun triggering method is used, I am the facilitator. I ask people to gather to make sanitation map, and then ask people to identify households with and without toilet, and then identify location of defecation of those who do not have toilet (usually paciringan above fish pond). Then I explain disease transmission. I insert some games during the triggering. There is no transect walk, because paciringan is easy to find. There is no ‘water and shit’ demonstration, because in this case, disease transmission is via fishes, not via well or river water. If ‘discussion method’ is used, I am the presenter.’

IDI with Sanitarian in Health Center, Situraja Sub-district, Sumedang, who did the triggering in Malaka village

This has a bearing on the verification and declaration of ODF villages as well. When the field researcher interviewed district health officials including sanitarians in Sumedang, they were very proud that many villages in their district were declared as ODF villages at the same time on National Health Day. However, when the field researcher visited 3 declared ODF villages and interviewed people about the ODF status of the village, nobody really knew about what ODF or its declaration meant. Some said that villages are “appointed” to be ODF village by sanitarian or district health official.

This trend seems to be quite subversive of the very process of creating ODF villages, which is the primary intent of the CLTS pillar of STBM.
FINDING 3

3. Monitoring and verification of ODF status of villages has been the weakest link in terms of tracking the real results of CLTS in all the three study districts. Lack of community monitoring after triggering has been the common feature across all the slippage and non-ODF villages in general.

As per the household survey data captured in section ‘Household Sanitation Behaviour’, it is observed that the frequency of open defecation ranges from 14% to 17% (around 12% on an average) across village types, where members of the households are defecating in the open ‘regularly’. This percentage is much higher in CLTS villages other than in the ODF category.

![Figure 6: Frequency of Open Defecation](image)

The Figure 7 below confirms that there is hardly any system of community monitoring to track the end of open defecation, as around 67% to 100% (83% on an average) respondents reported ‘no action’ for members defecating in the open.

![Figure 7: Action Taken against Open Defecators](image)
It is interesting that the percentage of the only substantive reported action of ‘reprimand’ against open defecators has been higher in CLTS ODF villages as compared to slippage and non-ODF villages. This suggests almost total lack of community monitoring for ensuring the stopping of open defecation in the study villages.

In all the three districts, lack of community monitoring is accompanied with multiple monitoring processes and practices in place at the project level, which are not organically linked to each other. This has been mainly due to monitoring by different agencies with different objectives, criteria and methods for monitoring. Different agencies involved in monitoring at the district and sub-district levels are:

- Bupati’s office
- District Health Office
- Externally funded projects (WSLIC II/PAMSIMAS/Plan)
- Pokja AMPL
- Village/community

These different agencies follow different criteria and methods for monitoring, means of verification and protocols for reporting, which vary across districts. The nature of CLTS monitoring on the ground is largely determined by the dominant agency, which is usually the main initiator of CLTS in the district (WSLIC II in Muara Enim, Plan in Lembata, and PAMSIMAS currently in all the three districts) and its relationship with the local authorities particularly in terms of the extent of ownership of CLTS by the local government.

Differences in monitoring practices coupled with unrealistic targets for achievement seem to have resulted in distortion of practice by way of false reporting and declaration of the ODF status of villages as in Sumedang. As reported, Sumedang Regency has the target of becoming a STBM district by 2012, which includes all the villages in the district becoming ODF this year. As per the reported practice in PAMSIMAS project, which is currently providing training and triggering support for CLTS activities in the district, 80% toilet coverage with the remaining 20% having access to neighbour’s or public toilet is considered good enough for reporting and recognising a village to be ODF. As a result, there are villages, which are wrongly reported and declared to be ODF, while they never really achieved the ODF status. In Cikandong and Cikadu, the two ‘slippage ODF’ villages studied in Sumedang, people admitted that their village was never ODF and they do not know about the ODF status of their village.

The ODF declaration was in December 2011 at district health office together with some other villages. I was there. It was National Health Day. We never knew that our village was ODF. Suddenly our head of village was invited by health office to declare our village ODF. We were given a certificate as ODF village signed by the head of district (bupati)”.

IDI with Village Cadre, Cikondang, Ganeas Sub-district, Sumedang
The issue of varying criteria for recognising, verifying and declaring ODF villages has been reported from Lembata as well. In Lembata, *Pokja AMPL* follows 100% toilet ownership to be the main criterion for declaring a village ODF. This is in potential conflict with PAMSIMAS practice on the ground of ‘80% toilet coverage with 20% assumed access’ as the qualifying characteristic of an ODF village.

‘*Pokja AMPL has different ODF criteria with PAMSIMAS project. PAMSIMAS criteria are based on access instead of ownership. Under the criteria, a village can be defined as ODF if minimum 80% of households already have private toilet, and the other 20% have access either to public toilet or they can use neighbor’s toilet. Meanwhile, Pokja AMPL criteria are based on 100% toilet ownership. Under the criteria, a village can be defined as ODF if all households in the village already have private toilet.*’

*FGD, District Level, Lembata*

Irrespective of the criteria being used, the monitoring focus seems to be on toilet ownership and access and not on the end of the practice of open defecation, which is rarely verified on the ground.

For instance, in Sumedang, monitoring has included the informal monitoring of destroying *pachiringans* (a simple toilet above a pond where shit goes directly in the pond), the favourite site for open defecation there: destruction of *pachiringans* is seen as an instrument of stopping open defecation, and hence also its indicator. The underlying assumption is that if *paciringans* are destroyed, people would have nowhere to go. But this is not at all a comprehensive and reliable indicator, as this does or tells nothing about the practice of open defecation in river, bushes and forest, where it continues unabated as per the available reports. While the destruction of *pachiringans* could be of help in discouraging the occasional practice of open defecation by elders and other members of the community, who are still resisting change in behaviour despite having access to a toilet, people do find other places like bush and forest to defecate.

“As long as I know, ‘toilet program’ was initiated by Desa Siaga (literally means “Outstanding Village”) program in 2008. Because of order by head of village, I fenced my *paciringan* so that it could not be used by people for defecating anymore*”.

*FGD, Men, Malaka (non-ODF) village, Sumedang*

What women and men from a non-ODF village in Sumedang had to say about the use and destruction of *paciringans* is quite insightful in terms of the ways in which it relates to practices related to monitoring, reporting, and even selecting villages in competitions for a good village.
“If there is no assistance, people will keep defecating in paciringan. Village government should watch and monitor. Former head of village was forceful. Now village officials do not support”.

FGD, Women, Malaka (non-ODF) village, Sumedang

“People from health center (Ms Een, Mr Ayud, Mr Yanuar) visited our village several times when we are running for Desa Siaga competition. The former head of health center (Mr Uyud) explained that to participate in Desa Siaga competition at district level, some sanitation conditions (including environment, healthy and clean behavior, STBM) should be improved. Then paciringans were destroyed. We got 4-th prize winner in Desa Siaga competition at district level in 2010”.

FGD, Men, Malaka (non-ODF) village, Sumedang

FINDING 4

4. The usual time taken by a village in becoming ODF since triggering ranges from 6 to 12 months or more in most of the cases. Muara Enim is an exception where 10 villages achieved the ODF status between 1 to 4 months during 2006-07. Given the fact that 8 of these 10 villages in Muara Enim took only 4-8 weeks in becoming ODF, a period of a year or more in becoming ODF since triggering in other cases seems to be indicative of weak community resolve and effort at the village level, which is mainly due to poor quality of triggering or weak community structures and processes for driving the sanitation movement within communities or both.

The time taken is intimately linked to the quality of triggering, as indicated by the finding 1, that has invariably involved use of multiple triggering tools at the community level and higher level of awareness and participation of people in these activities.

Table 2: Level of awareness/participation and CLTS activities

<table>
<thead>
<tr>
<th>'Yes' Responses</th>
<th>ODF</th>
<th>Non ODF</th>
<th>Slippage ODF</th>
<th>High Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness/ Participation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Awareness about CLTS</td>
<td>96%</td>
<td>41%</td>
<td>76%</td>
<td></td>
</tr>
<tr>
<td>Participation in CLTS /STBM Activities</td>
<td>56%</td>
<td>38%</td>
<td>41%</td>
<td></td>
</tr>
<tr>
<td>CLTS Activities Undertaken</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre Triggering Socialization</td>
<td>96%</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>Triggering of Sanitation Mapping</td>
<td>67%</td>
<td>43%</td>
<td>49%</td>
<td></td>
</tr>
<tr>
<td>Triggering Calculation of Shit</td>
<td>19%</td>
<td>14%</td>
<td>19%</td>
<td></td>
</tr>
<tr>
<td>Triggering-Oral Faecal Transmission Route Map</td>
<td>50%</td>
<td>36%</td>
<td>43%</td>
<td></td>
</tr>
<tr>
<td>Triggering shit &amp; Water exercise</td>
<td>33%</td>
<td>7%</td>
<td>39%</td>
<td></td>
</tr>
<tr>
<td>Triggering Transect Walk</td>
<td>42%</td>
<td>21%</td>
<td>28%</td>
<td></td>
</tr>
<tr>
<td>Post Trigging- Formation of Group</td>
<td>57%</td>
<td>21%</td>
<td>38%</td>
<td></td>
</tr>
</tbody>
</table>
As is evident from the table above, CLTS processes had better response from villages in ‘ODF’ category followed by villages in ‘Slippage ODF’ category. Other than in the category of pre-triggering socialisation, non-ODF villages have had the lowest percentage of positive response in all the CLTS tools used during triggering. This suggests that a greater number of triggering tools have been used in the villages, which eventually became ODF and probably their quality was also much better as indicated by the higher awareness of people in these villages and their greater participation in these activities.

**FINDING 5**

5. Women have been the major catalysts of sanitation behaviour change not only at the community level, but also at the sub-district and district levels in their capacity as champions and main drivers of CLTS in their respective areas.

At the community level, their participation in CLTS related socialisation and triggering events has ranged from 60% to 95% across districts. Reports from all the 12 study villages across village categories (ODF/non-ODF/Slippage/non-CLTS ODF) establish that women have been the main participants in the CLTS process at the village and community level.

Village health cadres (almost totally women-close to 100% in the study sample) in Sumedang and Lembata and bidan desa i.e. mid-wife in Muara Enim have been the main actors in facilitating action planning and being in constant touch with people to follow up on the progress of construction and use of toilets, as also of the stopping of the practice of open defecation.

Women have used the socio-cultural institutions and practices including gotong royong (mutual self-help) and gemohing (working together) for mobilising people to construct toilets. These activities have reportedly helped mobilise communities and sensitise men to the need for safe sanitation. This has included getting together to clean up the village by designating days as ‘Clean Friday’ and ‘Clean Saturday’.

‘Women are involved in gemohing, not only in providing food, but also in digging the land and bringing cement. Up to now, gemohing still works well, for example in the form of “Clean Friday’ when all villagers clean the environment together.’

Paulus Demon Tereng (head of village), Lerahinga village, Lembata

One of the explanations for the overwhelming involvement of women in CLTS, as given by the male respondents, is that they needed it more than them. However, men have recognized and supported women in this in general, but for a couple of stray incidents where men have either not constructed toilets or have been practicing open defecation despite having access to a toilet, despite the women of the household, who want to have and use toilets.
‘Women and female teenagers were willing to have toilet at home the most. They were ashamed if seen by others when defecating, or afraid of snakes when defecating in the evening in forest. Because of them, men were more motivated to build toilet.’

**FGD Male in Lubuk Semantung village, Muara Enim**

The seminal role of women in making their villages ODF is recognised by men as well including the heads of village and dusuns. ‘I admit that role of women in the success of Sukawening to be ODF village is very significant. Women here tend to be quick in absorbing information and able to ‘anger’ their husbands, while men tend to ignore sanitation.’

Mr. Bahim, Kepaladesa, Sukawening

‘Role of women was extremely high. Without support from women, I do not think we would have been successful. Significant role of women is not only for CLTS. Once people decided to build a bridge by their own resources, only about 10 men appeared, compared to about 200 women. In schools, when there is a parent gathering, 95% of the attendees are women. Initially kelompen were only for men, but now women are involved.’

Mr Suwarya, Head of Pabuaran Dusun, Sukawening

At the sub-district and district levels, women have played the strategic role of champions and leaders. It is remarkable that two major CLTS champions, who have spearheaded the CLTS initiative in two of the three study districts, have been women. Ibu Agustine in Muara Enim and Ibu Ekki in Sumedang are widely known to have driven the CLTS in their respective districts as the key figures engaged in co-ordinating, training, facilitation, mentoring and internal advocacy within the local government.

‘It is not easy to say who decided to adopt CLTS, but at that time Ms Ekki was the thinker and main motor for CLTS implementation.’ IDI, District Level, Sumedang

‘Currently the bupati is very good in talking about STBM. In some events, Bupati frequently mentions about STBM or sanitation related issues. I intentionally include STBM issues when the bupati asks me to prepare materials for interview.’ Ibu Ekki

This offers a huge opportunity and highlights the need to recognise that women as champions, facilitators, and main actors of CLTS on the ground in Indonesia are the best bet for taking CLTS forward by accelerating the pace of creating and sustaining ODF villages in the country.

**FINDING 6**

6. **Bupati’s role is of critical importance from the point of view of the institutional ownership of the CLTS approach and its application on the ground.** This is amply exemplified by the case of MuaraEnim, one of the early successes of CLTS in Indonesia, where bupati had attended a CLTS training program and was fully convinced about the
efficacy of the CLTS approach in creating ODF villages; this is substantiated by the case of Sumedang as well where bupati supported the CLTS initiative after getting triggered during an official breakfast where he realised that the bad taste of baby fish in the breakfast menu could be due to their consuming human shit. This support came in the form of an official decree establishing the importance of safe sanitation being a part of local Sundanese culture.

The fact that with the death of bupati in Muara Enim and departure of Ibu Agustine, the CLTS champion working as the head of health office at Lembak sub-district, CLTS slowed down almost to the 1/5th of its earlier speed in the district in terms of the number of ODF villages per year indicates that the CLTS processes were not sufficiently internalised in the district.

Currently Lembata, which is achieving the best CLTS results of all the three study districts, has no overt bupati support, but has been able to work well so far because of the active support of Pokja AMPL and Bappeda, who own the CLTS at the local level.

FINDING 7

7. Lack of budget to support CLTS activities has emerged as a major constraint in taking CLTS forward at the district level. This is also substantiated by the fact that areas with programme/project funding such as in Muara Enim (WSLIC II and PAMSIMAS) and Lembata (Plan Indonesia) have done relatively better than Sumedang, which has had no such funding.

“Budget availability is a problem too. Environmental health budget is very small, only Rp 1 billion a year and that is for all environmental health related programs. There is no specific budget for CLTS.” IDI, Alius, Head of Disease Control Division, District Health Office, Muara Enim, 2012

STBM and PAMSIMAS are different in their project designs. PAMSIMAS is a project, so there is no problem in replication of CLTS to other villages, because budget is available for that purpose. Meanwhile, STBM is not a project. Instead, that is part of regular government activities, so there is no budget for replication. The budget is only available for coordination, not for the implementation. As an effect, usually the intensity of CLTS activities in replication village is not good as in pilot villages, and that could be hindering factor for achieving ODF.

The funds were only available for trainings, not for triggering.

FGD at District Level, Lembata

FINDING 8

8. Local CLTS champions from the district health set up, strong village leadership, committed natural leaders and influential community members have been the common factors in achieving increased toilet coverage and corresponding behaviour change in
Improving CLTS from a Community Perspective Approach in Indonesia

Leadership at various levels has been the key to driving the CLTS at village, sub-district and district levels. Leadership in Indonesia seems to be going along with formal or informal authority both at the community level and within government institutional set-ups like district health establishment. *Bidan Desa* in Muara Enim, village health cadre in Sumedang and village heads in Lembata have been the key people driving CLTS at the village level. And heads of health centres at the sub-district and district levels have been guiding the initiative at these levels.

**FINDING 9**

9. Role of religious leaders and institutions and invocation of sanctions in religious texts such as *hadis* have been a major catalyst for sanitation behaviour change at the community level in some of the locations, particularly in Muara Enim and Lembata. Head of Muara Enim Burung Health Center Mr. Rahmadi shared that an effective triggering by a religious leader included the quotation of a ‘hadist’ saying that ‘defecation at three places will be condemned by God if a muslim does that: namely (i) where people take rest; (ii) on road and; (iii) near or in a water source’. This was reportedly very powerful and made people in the village decide to end open defecation immediately. Church has played an important role in making people stop open defecation and adopt the use of improved toilet facilities in Lembata. Lerahinga village in Lembata is a case in point where people have been traditionally using simple toilets-‘cemplung’-since 1986, and started shifting to pour flush toilets in 2000, almost 8 years before the CLTS/STBM was launched in the district. It was easy for the people in Lerahinga village to become ODF quickly as they were already oriented to the need for safe sanitation. The local Church was instrumental in bringing this about.

**FINDING 10**

10. Local cultural resources in the form of social practices of mutual self-help such as *gotong royong* and *gemohing* in Lembata, and of *brukbrak* i.e. transparency in Sumedang helped foster the spirit of community mobilisation and collective local action to achieve ODF outcomes. Local cultural events in Muara Enim were used to disseminate CLTS messages to people to call them for meetings and triggering sessions. Indigenous ‘Kelompen’ forums were utilised for highly effective discussions, consensus building and for communications. Similarly ‘Penojian’ religious gathering has been used very effectively for CLTS related and other social issues.

Local cultures are used in the triggering processes. One of the values in the culture that always used in triggering process is “punjulluhung” or “shame to do the bad thing”. “We
always use local events—including cultural events—to disseminate CLTS issues. We use ‘brukbrak’ term when we expect transparency of the village officials,”.

IDI at district level, Sumedang

Spirit of working together (gotong royong), or known as “gemohing” in local language, is one of key factors behind the success of CLTS

IDI at district level, Lembata

These findings suggest that a strategy for strengthening the CLTS pillar of the national sanitation strategy and its scaling up needs to address the following key issues: uniform policy and programme support for a no-subsidy approach to the implementation of STBM across districts; good quality training aimed at creating a critical mass of trained CLTS trainers and facilitators at the district level; quality triggering capable of eliciting community resolve to end open defecation and initiating collective local action to achieve this objective; effective post-triggering follow-up and monitoring; and independent verification of ODF status of the villages declaring themselves to be ODF.

Muara Enim will take 99 years to become ODF

Achievement of 18 ODF villages in Lembak sub-district in Muara Enim during 2006-07 was followed by a massive slowdown of ODF outcomes in the district. Slow CLTS progress since 2008 is widely attributed to lack of ownership of CLTS at the Bupati level and transfer of Ibu Agustine, the CLTS champion, out of the district. Only 11 villages could attain the ODF status over 4 years during 2008-2012. This comes to around less than 3 ODF villages per year. Thus the speed of ODF achievement slowed down to about 1/5th of what it was in the year 2006-07. Given the fact that more than 297 villages in Muara Enim have yet to be ODF, at this rate, this may take around 99 years in making all the villages in the district ODF.

Based on information from FGDs and IDIs in Sumedang

At the current rate, for example, Muara Enim, one of the study villages, will take close to 100 years in becoming ODF.

The above findings underline the urgency to re-think the sanitation strategy for Indonesia, which calls for radical steps to make sure that the country not only achieves the Millennium Development Goals (MDGs) for sanitation, but also achieves an open defecation free (ODF) and pathogen free healthy environment for its people.
Chapter 4: What Has Worked or Not Worked in CLTS

CLTS has worked in all the three study districts in varying degrees and ways. However, the overall results in terms of the speed and sustainability of achieving ODF villages have yet to pick up in all the three study districts. There are indications of CLTS not working in certain contexts and during certain periods in all the three locations. Both these contrasting scenarios present an opportunity to examine the factors that have been responsible for CLTS working or not working across sample villages and districts studied.

This section identifies and examines the two sets of factors: one, in terms of what has worked in CLTS and the enablers i.e. the factors that have helped CLTS work, and; two, what has not worked in CLTS and the inhibitors, the factors that have hindered the CLTS functioning and its results.

4.1 What has worked in CLTS?

As per the available evidence, the following seem to have worked in CLTS in Indonesia:

- Good quality triggering able to trigger shame and disgust in people as a collective
- Effective post-triggering follow-up capable of helping people make and work on a plan
- Availability of CLTS champions within government
- Inspired CLTS facilitators working at the grassroots such as village health cadre and midwife.

Good quality triggering on the ground has been made possible by inspired and committed CLTS champions and facilitators. They have also ensured effective post-triggering follow-up by creating local groups assigned with specific responsibilities such as ‘shit eradication groups’ in Babat in Muara Enim.

CLTS champions\(^6\) have been the single most important factor in making this happen. This is common to all the three districts of Sumedang, Muara Enim and Lembata, where CLTS champions from within the district health set up (in all the three study districts) or other government outfits such as Bappeda (both in Sumedang and Lembata), and functionaries from support agencies such as Plan Indonesia in Lembata, have been the main drivers of CLTS in their respective areas.

‘The outsider – from central and provincial government—called us as Romli or Rombongan Lillahita’ala (meaning a group motivated by God).’ Ms. Ekki and team, Sumedang

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\(^6\) A CLTS champion is a person who is convinced, motivated and inspired to invest additional (other than her/his regular role and responsibilities as a government, non-government or a community person) time, energy and effort in pursuing CLTS to help create ODF villages.
Ibu Ekki in Sumedang, Ibu Agustine in Muara Enim, and Siprianus Meru in Lembata have been the key drivers of the CLTS initiative in their respective areas. But these are only some of the better known champions. There have been many village and community level CLTS champions, who have played the critical role of a catalyst in mobilising and organising people to achieve ODF outcomes at RW, RT, dusun and desa levels. Their combined efforts have led to ODF results at the village, sub-district and district levels.

But champions have not been an independent force driving CLTS on the ground entirely on their own. Wherever, they have been able to achieve remarkable results such as in Lembak sub-district of Muara Enim, where all the 18 villages became ODF during 2006-07, the CLTS initiative had the full and active support of bupati and many of the related activities including training, triggering and follow-up were financially supported by the World Bank assisted WSLIC II Project. Sumedang did not have these factors at work, where CLTS practices have been diluted with villages recommended and declared to be ODF without having achieved a truly open defecation free (ODF) environment in the village.

Thus, policy and project support has been another important factor in making CLTS work in the context of Indonesia. This is amply substantiated by earlier studies as well including the recent WSP study in East Java that captures the CLTS achievements under the World Bank and Gates Foundation supported Total Sanitation and Sanitation Marketing (TSSM) project.

Meticulous planning and close monitoring have been the other enabling factors that have helped track CLTS processes and results both in MuaraEnim and Lembata.

As per Sumedang experience, there have been three main factors for success of CLTS in the district: (1) improving quality of cadres and sub-district officials, (2) institutionalization through regulations at district level, and (3) integration/coordination among sanitation programs. In sub-districts, which are locations of PAMSIMAS, heads of sub-districts are ‘triggered’ to develop sanitation strategies. Up to now, 15 PAMSIMAS sub-districts have had STBM Work Plan.

In four ODF sub-districts in Sumedang, active interest of and support from head of sub-district has been mentioned as the common factor in the success achieved. The head of the sub-districts are willing to go to villages. In some cases, withholding local government’s development budget for villages not taking up CLTS has also been reported. For instance, in Paseh sub-district, the head of sub-district is reported to have imposed sanctions – in the form of delay in village development budget disbursement-- to villages that are not supporting CLTS.
Coordination among local government offices is also mentioned as an important factor. This is conducted through informal meetings called “ngadubako”\(^7\). The informal meetings – including local parliament members -- are found to be more effective than formal meetings.

4.2 What has not worked in CLTS?

There are many things that have not been working in terms of CLTS. These include:

- Sharing of toilets (sistem tumpang) to ensure people’s access to and use of toilets has not worked well anywhere, as most of the households sharing their neighbour’s toilets have gradually slipped back to the practice of open defecation.
- Use of public toilets, though seen as an instrument to provide easy access for poor people to a toilet, has also not worked, as they have been abandoned by people because of being dirty and damaged resulting in slippage to OD.
- Monitoring on the basis of reports from below without adequate and sound verification by the local health set up or an independent agency has resulted in false reporting and declaration of the ODF villages, as in the case of Cikondang and Cikadu villages of Sumedang.
- Multiple projects (PAMSIMAS/PNPM) having varying criteria and standards with in-built subsidies like fully subsidised public toilets under PNPM have created hopes among people to get outside assistance for construction of toilets and have hampered the spirit of collective effort and action.
- Setting unrealistic targets for achievement such as an open defecation free (ODF) Indonesia by 2014 or ODF Sumedang by 2012 have not worked as they have created an artificial pressure on the delivery agency i.e. the health department to report false progress and distort the CLTS practice on the ground.

Thus the factors that create barriers in making CLTS work on the ground are many. Expectation of help from government or another outside agency in cash or kind has been a major barrier to the effective implementation of the CLTS process at the village level. People in many villages have mentioned lack of money, lack of water, old habit, or simply ‘no need’ as the reasons for their not building a toilet and continuing to defecate in the forest, river, pond or on any other open site.

This also implies that the triggering in the concerned villages has not been effective enough to trigger people to change their behaviour by stopping open defecation and constructing and using safe toilets at all times with no occasional slippage. Thus, the poor quality of triggering is another significant inhibitor of the CLTS process.

The provision of subsidy or monetary help for toilets or other related facilities such as water, presents itself as a barrier in the popular acceptance of an initiative like CLTS. While the central government programmes like PAMSIMAS/PNPMs are apparently based on

\(^7\)Local (sundanese) language, literally means “exchanging ciggarettes”
“community empowerment” approach, but in actual practice also offer subsidies to individual households: that kills the community spirit around sanitation. Subsidy subverts the empowerment agenda. Once in certain village people left CLTS triggering (which was still in the process) for attending PNPM activity that distributed money. Some people said: “Why we should build our own toilet if we can use public toilet built by PNPM?”

‘Considering that situation, district health office made an initiative to integrate CLTS with other programs coming from central government (such as PAMSIMAS and PNPM). The integration is implemented by not allowing subsidy to households at the first step of sanitation ladder (awareness to have a toilet, at any quality). Other interventions (in the form of physical facilities development or financial assistance) are allowed only if there is sanitation behavioral changes resulted from CLTS triggering, and the assistances are only for improving the quality of the toilets. The conditions are in the Bupati Regulation No 4/2012.’

‘Beside expectation to get financial assistance, reluctance among households – usually who live in sub-urban areas-- to use simple toilet is a problem too. They feel disgusted to use simple toilet, but do not have money to have a good toilet bowl. In the more rural area, people have no problem to use simple toilet, so that ODF status could be achieved more quickly.’

The attitude of village and sub-district government officials is a problem too. In some cases, people are willing to change (their behavior), but head of village still expects free toilet from health office.

The expectation of subsidy by many people in the villages including heads of villages and hamlets (desa and dusun) has emerged as a veritable barrier to the effective implementation of CLTS at the village level. Though STBM advocates a no-subsidy policy at the central government level, provision of subsidy in some of the projects like PNPM, which provides subsidised public toilets, has contributed to the continuing expectation of subsidies for toilet construction at the village and sub-village levels.

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8PNPM is Program Nasional Pemberdayaan Masyarakat or National Program for Community Empowerment.
Chapter 5: Understanding slippage from ODF to OD

Understanding the widespread phenomenon of slippage from an open defecation free (ODF) status to the practice of open defecation in a village is critical to finding out what must be avoided in planning and carrying out CLTS activities at various levels, particularly at the village and community level. A total of 5 so-called slippage villages were identified and studied.

To begin with, there was a problem in identifying the sample villages for study in this category, as no such data was reported or collected in any of the three districts. However, during informal interactions and discussions, it became increasingly clear that it was not difficult to find these villages, as truly ODF villages were very few and were well known. Even this was found to be misleading, as Cikandong village in Sumedang, which is considered to be a model CLTS/STBM village and attracts visitors from outside the district, was actually found to have never been a fully ODF village, though it is declared and popularly known as an ODF village.

Sample villages in the category of slippage ODF are of two types:

1. One, where the so-called ODF village was never fully ODF, but was declared to be ODF on the basis of 80% or more people having household toilets, even if many people in the village were still defecating in the open, as in the case of sample village from Sumedang.

   ‘In declaration of ODF status many villages have been declared as ODF even when more than 20% households did not have toilets and were defecating in the open. The ODF certificate was given on the basis of these remaining 20% having access to toilets.’ (IDI village Sukawening, Ganeas Sub district, Sumedang)

2. Two, where the village was both ODF and was declared to be ODF, but slipped back to OD partially or fully due to a range of factors that included:

   - Availability of water
   - Habit and proximity to water bodies including rivers and ponds
   - Damage to the toilet due to floods or people cutting the neck of the pot for the shit to go to the pit directly
   - Bad smell coming out of the simple toilets i.e. ‘cubluk’ or ‘cemplung’
   - People ashamed of sharing or using others’ toilets, hence preferring to go for OD

Village Lubuk Semantung, in Lembak sub-district of Muara Enim became ODF in a matter of 40 days, but slipped back to OD, mainly because the ODF status was apparently established on the basis of reported large scale sharing of toilets, which did not sustain in the longer run.

‘40 days after CLTS introduction, Lubuk Semantung village was declared by the health centre as free from open defecation. At that time toilet ownership was about 60%, but the access to toilet was already 100%’ Mr.Yabani, FGD Male, Lubuk Semantung Village, MuaraEnim
‘At that time there were some people who ‘cut’ their pour flush (leherangsa) closet because they thought if they did not do that, the shit would not go direct to septic tank. They did not understand that the water left in the closet is to avoid bad smell. After the closet was cut, they complained about bad smell from their toilet. These people gradually started going out for defecation in the open’ Mr. Nurdin, FGD Male, LubukSemantung Village, MuaraEnim.

These instances suggest that (i) there may be a large number of villages which are wrongly recognised to be ODF while they are not ODF in reality (ii) villages declared to be ODF on the basis of sharing their neighbour’s toilet or using public toilets are more likely to slip back to the practice of open defecation.

Slippage has a huge opportunity cost both in terms of time and money lost without real and sustainable results in terms of ODF communities and villages. This is a challenge that needs to be recognised and addressed in devising a strategy for scaling up CLTS across other districts in the country.
Chapter 6: Research Questions and Answers

The key objective of the research has been ‘to identify factors that make CLTS work or not work in different local contexts in Indonesia with a view to generating insights for sharpening and strengthening the CLTS strategy and scaling it up across the country’.

This was expected to be achieved by seeking answers to the following four key questions:

1. What motivates sustained sanitation behaviour change at the individual, household and community level?
2. What are the factors affecting the achievement and sustainability of ODF initiatives in term of toilet uses, maintenance and upgrade, as well as government follow-up and support?
3. If there is community that reverts back to the OD practice, what are the factors affecting the ODF slippage at the community level?
4. What are the factors affecting the interest of government officials to engage with CLTS programmes?

The previous chapters, particularly chapter 3 related to key findings, carry answers to these questions in various forms. However, on the basis of the data analysed, answers to these research questions could be summarised as follows:

Research Question 1: What motivates sustained sanitation behaviour change at the individual, household and community level?

Triggers of sanitation behaviour change at the individual, household and community level including decision to build toilets vary across regions and categories of sample villages.

Figure 8: Reasons for Households' Decision to Build Toilets
The figure above shows the reasons for households’ decision to build toilets as per the respondents of the household surveys. Health appears to be the biggest reason for building toilets across all categories of sample villages including ODF, non-ODF, slippage, and non-CLTS ODF villages ranging between 34% in slippage ODF villages to 75% in non-CLTS ODF village. And disgust appears as the least significant reason of them all ranging from 0% in slippage villages to 5% in ODF villages.

Interestingly, pressure of authority or order from above has been the highest in slippage villages at 16%, whereas it has been only 7% in non-ODF and 8% in ODF villages. This also implies that pressure may help build toilets to begin with, but slippage to OD practice might be a greater possibility, if there has not been a truly felt need for change in sanitation behaviour at the household level.

While pride has 0% response from three categories of sample villages including ODF, slippage and non-CLTS ODF in terms of the household’s decision to build toilet, with the only exception of 7% from non-ODF villages, pride and desire to be the best have been the driving factors at the community level in villages in Lembata, particularly in Lusiduawutun, the only village in the study sample that achieved ODF status without any CLTS intervention.

“We did not want to be left behind by other villages. We did not want to wait for instruction of the government. It is not a matter of money, but pride. We hope that from being ‘famous’, some development programs will come to the village”.

FGD, Lusiduawutun ODF Non CLTS Village

The following statement is indicative of post-achievement pride in being a model village. ‘Earlier we were the worst and now we are a model village’ Sudarto, Head of Bapat Village, Muara Enim

Shame as a trigger for the decision to build toilet has been present in all types of villages and has ranged from 13% to 22% of responses from the HH survey.

As per people’s responses during FGDs and IDIs, shame and disgust have been the most common triggers for sanitation behaviour change at the individual and household level across all the study villages in terms of making people stop the practice of open defecation and build and use private toilets.

In 3 ODF villages that had experienced CLTS triggering, shame and disgust were the main triggers for people to decide to end open defecation, while in 1 non-CLTS ODF village, a sense of pride and being no less than other villages was mentioned as the main motivation for changing their sanitation behaviour.
Research Question 2: What are the factors affecting the achievement and sustainability of ODF initiatives in terms of toilet uses, maintenance and upgrade, as well as government follow-up and support?

Good quality triggering capable of producing a powerful feeling of collective shame and disgust at the community level and effective post-triggering follow-up strong enough to help people plan and act on their plan to stop open defecation have been common to all the three ODF villages that experienced CLTS triggering. However, there are significant variations in terms of toilet use, maintenance and upgrade, as well as government follow-up and support across regions and village types. Moreover, the quality and duration of triggering and post-triggering activities like mentoring, formation of groups, monitoring, sanctions, facilitation and rewards have varied significantly not only across districts and villages but also within villages as well at dusun and RW/RT levels.

Toilet ownership has been used as a major proxy indicator of the ODF status of a village across all the study villages. This trend has been so pervasive that 100% toilet ownership at the village level is considered almost synonymous with being open defecation free (ODF) both by the villagers and outsiders including health staff and various project functionaries from PAMSIMAS/PNPM/Plan projects. Across village categories the percentages for owning toilet facility at the household level varies from 64% to 100%.

![Figure 9: Own Toilet facility](chart)

Only in two village categories reasons have been cited by the households for not having toilet facilities. The reasons specified by respondents in ‘others’ as option are – a) no land or space, and b) nobody helped in building the toilet. Most (88% Non-ODF villages; 65% in ‘Slippage ODF’ villages) households reportedly could not build the toilet for lack of money.
‘No money’ as the major reason for not having a toilet facility to the tune of 88% in non-ODF villages and 65% in slippage ODF villages is also indicative of weak CLTS processes in these villages, which are not able to trigger community resolve to end open defecation. This is further vindicated by the behaviour of those (as per the figure below) who defecate in the open despite having access to a toilet facility. Around 3% to 44% (on an average 23%) households have reported about family members going out for defecation in the open despite having a toilet at home.

The main reasons mentioned by respondents for this behaviour include: ‘has become habit’; ‘long queue’ etc. Highest reported incidence of this nature has been in ‘Non ODF’ (24%) and ‘Slippage ODF’ (44%) village categories. Other reasons cited by the respondents include:

- Lack of awareness
- Much water is available in the river
Outside they can do washing and take bath too
- No option when working in rice field
- Septic tank is full
- Still children, they are not aware
- Forced when far (on farm)
- Toilet is damaged
- Toilet is far away when working in estate (most stated around 15%)

In most cases the respondents do not take any action even after knowing that some people are ‘not using toilet’ and only in 11% cases households or other community members used ‘reprimand’. Almost one-third respondents had the opinion that it is ‘difficult’ to change habit from OD to ODF. This confirms that the practice of open defecation has been simply accepted by many with little or no attention to making collective effort to ensure the ODF status of the villages involved.

**Women have been the major catalysts and drivers of sanitation behaviour change in all the three study districts.** Role of village health cadres, mostly women in Sumedang and bidan desa i.e. village mid-wife in Muara Enim has been phenomenal both during triggering and post-triggering follow-up.

“Village midwives are the front-liners for CLTS at village level. They live in the village so they frequently interact with the villagers”. IDI, Lembak Sub-district, Muara Enim

**Strong village leadership has been mentioned as a major factor across ODF villages (CLTS and non-CLTS, one each) in Lembata.** The key to success in achieving and sustaining ODF has been attributed to the key role and active support of village leadership in these two villages. The fact becomes explicitly evident from the case studies of Lerahinga, Lusiduwutun and Lamadale villages of Lembata which were reported to became ODF due to the active support from head of village and hence the village government, on the other hand villages like Air Cekdam, Muara Enim and Cikondang, Sumedang could not achieve/sustain ODF status reportedly due to lack of support from the village head and hence the village government. Similarly in Malaka village CLTS was forgotten after the demise of the Head of Village.

‘The head of village passed away, and CLTS was ‘forgotten’ (FGD, Malaka Village, Sumedang)

Socio-cultural practices such as arisan, gotong royong, and gemohing (in all the three districts). In most ODF and Slippage villages the socio-cultural practices of working together, revolving fund etc., were very effective towards achieving ODF status.

The importance of the practices of ‘Gemohing’ and ‘Gotong Royong’ is evident from the fact that while in NON ODF and Slippage ODF villages about 50% and 40 % population
identified ‘need for more labour force’ as the major constraint for not having toilets, in ODF villages, where these practices were adopted, this need was not felt.

The rate and extent of success in CLTS implementation has a strong positive correlation with inspired and committed leadership especially at the district and subdistrict levels. Support, facilitation and monitoring from Bupati and District Health Office, the Pokja AMPL and subdistrict levels was critical not only for success but sustainability of efforts as well.

‘In May 2010 sub-district (camat) office conducted a coordination meeting to build commitment towards making Lebatukan a STBM sub-district by Dec 2010. In the meeting, it was agreed that triggering would be done in villages that have not implemented STBM, started in May 2010. The meeting was also attended by local parliament member, Pokja AMPL (district), sub-district government, and head of villages.’ It is remarkable that following this all remaining 10 villages were triggered between 23-29, June 2010 and the sub-district achieved STBM sub-district status within the next nine months in April 2011’.

IDI at subdistrict level, Lebatukan, Lembata

**Research Question 3: If there is community that reverts back to the OD practice, what are the factors affecting the ODF slippage at the community level?**

The issue of slippage has been discussed at length in chapter 4. The so-called slippage has been of two types: one where the so-called village was never ODF, but was wrongly declared to be ODF on the basis of misreporting or misleading project norms in practice; and two where village was declared ODF on the basis of people’s effective access to toilets and its use, but later people slipped back to the practice of OD for a number of reasons.

**False ODF declaration based on misreporting has been particularly true of Sumedang district.** Here many slippage ODF villages are of the type which are officially recognised to be ODF, but are not ODF and were not ODF at the time of their declaration as ODF. This has been largely due to lack of clarity and confusion arising out of different programmes and agencies applying different criteria for ODF declaration. A detailed comparative analysis of the same has been undertaken as a part of findings two and three of Chapter 3.

**Large scale sharing of toilets, which has not sustained, as in Muara Enim, has been one of the major factors in slippage from ODF to OD.** In Sumedang and Muara Enim a system of “sistem tumpang” i.e using neighbour’s toilet was used for those who did not have money to build toilets. Under the system village cadres asked certain household (who already had a toilet) to let their poor neighbour use their toilet. The system could not be sustained for long due to several factors that included: issues of maintenance; shame to use ‘others toilet’ and ‘disturb’ them; long queues in the morning and; financial reasons. The non-sustainability of this ‘sharing of toilets and other associated constraints related to its use have been a major reason for ‘false reporting’ of ODF status on the basis of ‘access’ and for ‘slippage’ thereafter when people fond it difficult to share toilets in actual practice.
“People are reluctant to use others’ toilet. If we do it continuously, we should contribute for piped water payment. Instead, we chose to use paciringan”. FGD, Malaka Village, Sumedang

“If one toilet is used by 5 families and each family has 3 persons, what happens if in the morning everybody needs to defecate? Certainly some of them must go to forest,”

Talang Beliung Village, Muara Enim.

Operation and maintenance issues related to public toilets as in Sumedang have been one of the factors in slippage from ODF to OD. While public toilets have been seen by many at the village level as an instrument to put an end to the practice of open defecation by allowing poor people (who cannot ‘afford’ to build a private toilet) have access to toilet, lack of operation and maintenance of public toilets and their resultant dysfunction and disuse have been mentioned as one of the reasons of slippage from ODF to OD in villages.

“Why we should build our own toilet if we can use public toilet built by PNPM?” IDI, District level-Sumedang.

“Unfortunately, the users did not maintain the toilet well, the public toilet become dirty and then people were back to the open area. The willingness of villagers to grant their land for public facilities is very low here, and willingness to maintain public toilets too is very low”

FGD, Cikadu Slippage ODF Village, Sumedang.

Difficulties in toilet maintenance due to lack of money (all three districts), difficult access (Lembata) etc have also been a factor in slippage.

The ‘difficulty in getting material’ has been the highest in Lusiduawatun, the only non-CLTS ODF village in the study sample. This difficulty is explained by the remote, inaccessible location of the village, where it is difficult to bring building material from outside.
Besides ‘difficult to get material’ in Lembata, ‘no money’ and ‘need much labour force’ have been mentioned as the two major factors in the difficulties experienced in toilet maintenance in Sumedang and Lembata. Besides the genuine difficulties being experienced by people in toilet maintenance, these factors are also indicative of the weak triggering resulting in weak resolve of communities to handle these difficulties on their own.

Main difficulties experienced in the toilet maintenance:
- **Lembata district**
  - No money: 36%
  - Need much labor force: 21%
  - Difficult to get material: 22%
  - Others: 21%

- **Muara Enim district**
  - No money: 100%

- **Sumedang district**
  - No money: 56%
  - Need much labor force: 44%
People’s perceptions about the expenditure involved in toilet construction and their septic tank getting full quickly have been mentioned as reasons for their practice of open defecation. While the first has resulted in people not building toilets, the other has led people to defecate in the open despite having a toilet at home.

Perception that toilet is expensive

“Toilet is not cheap. One toilet at least requires 15 sacks of cement (the price is Rp 57,000/sack), one closet (price Rp 100,000 to Rp 150,000, and 1,000 bricks for permanent building. Meanwhile, our income is uncertain. Also, to build toilet we need water that we must buy, to make one toilet needs one tank of water (price: Rp 300,000). Moreover, in dry season, people should buy water, a drum of water (contains 2000 litres) should be paid for Rp 13,000. That water is only for cooking and drinking only. The village is not PAMSIMAS project site. FGD, Tagawiti village, Lembata.

However, it is interesting to note that all villages raising the issue of cost of pour flush toilets are NON ODF / Slippage ODF villages.

Perception that their septic tank will get full very quickly.

“I have a toilet at home, but I choose to defecate in small water canal, because I am afraid that my septic tank will get full quickly. I only have one septic tank.” The villagers hoped that they are not only asked to build and use toilet, but also given information about technology to build septic tank that is not full quickly and no need to build new septic tank when the old one is full. “There was 5 meters septic tank, but now that is full. If the septic tank is without brick wall, that can still be used, but we know that is not good for well water.” FGD, Cikadu Village, Sumedang

The problems are not only technical but also topographical in nature and hence there is a need to develop new suitable technologies for Construction of Septic tank. ‘Land in many villages in the sub-district is rocky so that making a septic tank is very difficult’. (FGD and IDI, Lembata District Level)

‘The other problem is land condition. In some villages, water comes out when we dig only 0.5 meter. Land availability is also a constraint in urban area’. (FGD and IDI, Sumedang, District Level)

Lack of knowledge about technology has also been mentioned as one of the factors in faulty construction of toilets leading to their eventual dysfunction and disuse resulting in slippage. Slippage is associated with the lack of technological knowhow due to the lack of training on how to build and use toilets. Teaching/ training on construction of toilets and regular facilitation and monitoring during their construction had a high positive impact on attaining and sustaining ODF status in the case of Babat which became ODF village within 4 weeks’ time.
People’s aspirations for a better quality toilet coupled with the limitations of a simple / emergency toilet (‘cemplung’), which according to most responders is considered ‘unhealthy toilet’ as it invites flies, mosquitos and insects besides very bad smell, have also created a situation, where they prefer to go for open defecation that to use a cemplung, where the faeces are visible and which they find ‘disgusting’.

Expectation of subsidy i.e. ‘help in cash or kind’ from some government or externally funded program has also emerged as one of the barriers in CLTS implementation.

‘People are very familiar with subsidy. It can be said that CLTS is the only program/approach that explicitly mention “no-subsidy”. When other programs have different approach, that could be problematic for CLTS implementation’ FGD at District Level, Muara Enim

“Other programs such as PNPM and SANIMAS gave toilet subsidy. That made people criticize CLTS and turned to other programs. IDI , Situraja Sub-district, Sumedang

“We need other materials, not only closet”. “If there is no assistance, people will keep defecating in paciringan.” Some households received free closet and septic tank cover, but those were useless, because building a toilet need more than closet. Where is the fund?” The absence of financial assistance from the government was an important factor pointed by the Female FGD participants too. FGD and IDI, Malaka Village, Sumedang.

It is worth noting that Malaka is a non-ODF village, where CLTS triggering has not been effective and people still expect outside assistance for toilet construction.

Research Question 4: What are the factors affecting the interest of government officials to engage with CLTS programmes?

There has been a set of varying factors affecting the interest of the government officials to engage with CLTS programmes.

At the sub-district and district levels a newly found sense of purpose and commitment seems to have inspired CLTS champions like Ibu Agustine in Muara Enim and Ibu Ekki in Sumedang to invest time, effort and energy in CLTS way beyond their routine call of duty

Exposure to CLTS experience in other countries like India and Bangladesh also seems to have inspired many government officials in the early stages of CLTS initiative in the country ensuring the inclusion of CLTS as one of the pillars of the national sanitation strategy-STBM. Alius from Muara Enim is one such official, who is still spearheading the CLTS initiative in the district. Exposure of Mr. Alius, Head of Disease Control Division, District Health Office, Muara Enim to CLTS processes and success in India and Bangladesh turned him into a dedicated CLTS campaigner.
“If in India and Bangladesh people could change their behavior, so that can happen in Muara Enim”, IDI at District level.

**Recognition and appreciation by peers, seniors, and community members** has been another inspiring and motivating factors for government officials.

“Because of CLTS, our district became famous as reference for other districts. So far people from 4 districts have visited us. This is a matter of pride and very motivating for us to continue what we have achieved.” IDI, District Level, Lembata

Some government officials have mentioned taking interest in CLTS for more practical reasons. To begin with, some of the officials perceived CLTS to be cheap, something that could be done to achieve results even with very little budget. “**We decided to adopt CLTS because the approach is cheap. That is suitable for us, because our budget and local revenue are very limited. CLTS was proven to be able to increase toilet coverage much more than resulted by other program.**” IDI, District Level, Sumedang

At the grassroots level, the role of sanitarians as frontline health functionaries has been fairly central and seminal in driving the sanitation agenda at the village level. They have had their own reasons for taking interest and getting involved in the CLTS process on the ground.

‘Sanitarians are very motivated to get involved in CLTS/STBM because they think that CLTS/STBM is good for their existence. As per the head of HAKLI (association of sanitarians), sanitarian profession was ‘sinking’, but after CLTS some sanitarians felt that their role was important as other health centre staffs. That was one of reasons why the sanitarians established HAKLI on 15 Feb 2011. We want to have association like IDI (for medical doctors). Up to now, number of HAKLI members is 47 people (60% are women). Sanitarians are involved in every step of CLTS including triggering, monitoring and declaration.’

IDI, District Level, Lembata

Thus, the sanitarians’ interest in CLTS seems to be linked with their new found professional identity as frontline functionaries, at least in the case of Lembata.
Chapter 7: Conclusions and Recommendations

6.1 Conclusion

In conclusion community led total sanitation (CLTS) pillar of the national sanitation strategy (STBM) has yet to pick up momentum in Indonesia. While it has certainly resulted in increased toilet coverage and awareness about safe sanitation, it has yet to help create sustainable ODF communities on scale.

Most of the successes of CLTS so far have been in externally funded program/project areas that include: World Bank assisted WSLIC II area in Muara Enim during 2005-07; World Bank and Gates Foundation funded TSSM (now re-named Scaling Up Rural Sanitation) project in 29 districts across East Java during 2008-12; Plan Indonesia supported CLTS initiative in Lembata, which is on-going.

Sumedang is the only district of the three study districts, which did not have a program and project supported by an external donor/development agency to begin with. But PAMSIMAS project is now there in the district and seeks to support CLTS efforts in the project sub-districts in Sumedang.

As the study suggests that a combination of factors is what eventually determines the achievement of ODF villages on a sustainable basis and in time, a strategy for strengthening the CLTS pillar of the national sanitation strategy and its scaling up needs to address the following key issues:

- Uniform policy and programme support for a no-subsidy approach to the implementation of STBM across districts
- Good quality training aimed at creating a critical mass of trained CLTS trainers and facilitators at the district level
- Quality triggering capable of eliciting community resolve to end open defecation and initiating collective local action to achieve this objective
- Effective post-triggering follow-up and monitoring; and
- Independent verification of ODF status of the villages declaring themselves to be ODF.
6.2 Recommendations

In view of the study results, it is envisaged that the following steps may help improve the practice of CLTS as a part of the national strategy to achieve sustainable ODF outcomes. These are as follows:

- Investing in good quality training would be crucial, as this eventually determines the quality of triggering and post-triggering follow-up at the village level, besides other enabling factors.

- Improving the monitoring processes and practices so as to ensure the quality of training, triggering and post-triggering follow-up at the village, sub-district, and district levels. One of the important aspects of this exercise would be to introduce a system of independent verification of the ODF status of the village before declaring it as one.

- As CLTS champions drive the actual process of community mobilisation and wider stakeholder involvement in CLTS, identifying, nurturing and supporting CLTS champions within government has to be a top priority both of the national and local governments.

- A national strategy to align different national programmes supporting sanitation initiatives including PAMSIMAS, PNPM, TSSM, and STBM has to be developed and applied. The strategy must seek to address issues related to the following: subsidy; incentives and rewards; CLTS process of triggering and post triggering follow-up; mentoring and monitoring; and verification and declaration of ODF village and sub-district.

- As lack of budget has emerged as a constraint in funding CLTS activities related to training, triggering, post-triggering follow-up, and monitoring and verification at the village, sub-district and district levels, there is an urgent need to mobilise resources locally. BOK\(^9\) (Bantuan Operasional Kesehatan or Health Operational Fund) is a block grant from the central government for health centres (puskesmas) available for promotive and preventive programs. Sanitation forms a part of environmental health agenda of the health department. Though environmental health is one of the 6 priorities of the use of BOK fund (besides maternal and child care, immunization, nutrition, health promotion and disease control), funds available for environmental health monitoring at the district health office level could be accessed for CLTS related activities as well. This could be a potential fund for CLTS activities, particularly monitoring, but that depends on the level of priority given by the district health centre and office to the sanitation program i.e. STBM in general and CLTS in particular as one of its pillars.

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\(^9\) Regulation of Minister of Health No. 210/2011
• Prioritisation of CLTS as an important health agenda at the district level also calls for creating institutional ownership of the approach at that level. While there have been individuals like bupati in Muara Enim and Sumedang and Bappeda chief in Lembata, who have supported CLTS in their professional capacity as heads of institutions with a lot of personal interest, proper institutionalisation of the approach within the system will require putting more specific institutional arrangements and practices in place related to monitoring and reporting of CLTS activities, as also the verification of the ODF status of villages. There is also a need to create mechanisms to provide people with technology related information and know-how on demand as per specific local conditions and context. This would help avoid technology related errors made during the construction of toilets that ends up leading to slippage to the practice of open defecation, as reported from slippage villages studied as a part of this research.

• Launching a national level campaign for exposing bupatis to CLTS training and triggering would be of help in scaling up efforts: events like East Asian Conference on Sanitation (ECOSAN), national level meeting of bupatis could be used as strategic opportunities to orient and sensitise the bupatis about CLTS and elicit their interest and demand for CLTS. Association of bupatis could also be sought to be actively involved in this process.

• Support of the central government for CLTS could be extended on a demand responsive basis to willing districts so as to ensure the optimum utilisation of limited resources available.

In view of the learning from this study, the above mentioned steps may help scale up CLTS in other remaining districts across Indonesia with prospects of faster and more sustainable results in terms of having ODF villages that remain ODF and provide a safe and healthy living environment to its people.
CLTS in Indonesia: A Summary of the Literature Survey

This write-up presents a summary of the literature survey on community led total sanitation (CLTS) in Southeast Asia with focus on Indonesia. References have been made to a few studies from India and Bangladesh in the South Asian region as well, particularly where the study findings seemed relevant in terms of similar issues involved in view of the context of CLTS in Indonesia.

The primary purpose of this literature survey has been to map out the existing body of knowledge on CLTS in Indonesia in particular. This is done to set the overall backdrop for the on-going research on CLTS in Indonesia funded by Plan Australia and commissioned by Plan Indonesia.

This literature survey tries to cull out the key learning about CLTS experience in Indonesia from the available studies so far. This also looks at a few studies from Bangladesh, India, and Cambodia that throw light on emerging CLTS experience and lessons from these countries in the Asian region, as they could be of relevance to the Indonesian context as well.

The write-up has been divided in the following four sections: literature survey-an overview; studies-key findings and insights; literature review-some specific studies; concluding comments.

1. Literature Survey: An Overview

The documents studied (see Reference) are primarily of the following four types:

- Research Papers, which are part of a multi-country research on CLTS, but focus exclusively on Indonesia. (DFID supported research on CLTS across India, Indonesia and Bangladesh, 2009)
- Multi-country research study report including Indonesia as one of the countries. (WSP and World Bank study on the political economy of sanitation across India, Indonesia, Brazil and Senegal, 2011)
- Conference paper on Indonesia (Plan Indonesia/Australia paper on scaling up CLTS, presented during the 35th WEDC International Conference, 2011)

As is evident from the above mentioned details, most of the literature on sanitation in general and CLTS in particular in Indonesia is produced recently during 2009-11. And most of it is produced with the help of multi-lateral and bi-lateral development aid agencies, particularly WSP, The World Bank, and DFID. Plan Indonesia and Plan Australia is the only International NGO (INGO) with a conference paper on CLTS in Indonesia. This basically tells...
us that these agencies have been the key actors in generating knowledge about CLTS in Indonesia, which probably flows from their hands on engagement in promoting the approach and its uptake in the country

Here is a quick look at the emergence of CLTS as a methodological approach and its entry into Indonesia (see Annex 1 for details), before we get into the research findings and what they have to offer by way of insights into the uptake, spread and scaling up of CLTS in Indonesia so far.

CLTS, which is a participatory approach to eliminate open defecation through community action and without subsidies, was born in Bangladesh in 1999. It was tried out in India in 2002. And the first field trial of CLTS was undertaken in Indonesia in 2005 under the guidance of Kamal Kar, the pioneer of the CLTS approach, himself. The early experience of CLTS in Indonesia was so encouraging that by 2006, ‘The Ministry of Health had changed national water and sanitation strategies midstream making CLTS the principal vehicle for scaling up rural sanitation in Indonesia.’

In view of the remarkable results that CLTS helped achieve in Indonesia during 2005-2007 primarily through World Bank assisted (WSLIC II) project, CLTS was included as one of the five pillars of the national sanitation strategy, called Community Based Total Sanitation (STBM), launched in 2008.

‘In Indonesia, sanitation marketing was seen as complementary to CLTS, and two projects combining CLTS with sanitation marketing emerged: the World Bank supported Third Water and Sanitation for Low Income Communities Project (PAMSIMAS) in 2006 and WSP’s Global Scaling Up Rural Sanitation Project, which was launched in the East Java Province of Indonesia in January 2007.’

2. Studies: Key Findings and Insights

The key findings and insights from various research studies can be summarised as follows:

- CLTS has been more effective in producing open defecation free (ODF) outcomes at the community level on scale in areas where there have been externally aided projects.
- CLTS has also worked well in areas where international NGOs such as Plan Indonesia has adopted CLTS as their main approach to promote rural sanitation in the country.
- CLTS champions at the implementation level including bupatis (elected district chiefs) have been a major factor in making CLTS work on the ground.
- Institutional arrangements play a key role in making CLTS work or not work.
- Quality of CLTS triggering, facilitation and follow-up is a critical factor in achievement and sustainability of ODF outcomes.
• A well informed and designed supply side intervention (as in the case of TSSM project in East Java) can be a big contributor to faster scale up and better outcomes of CLTS.

The twin facts of (i) CLTS being a part of the national sanitation strategy (Community Based Total Sanitation (STBM) strategy of 2008) and (ii) most of its successes located in few pockets supported by externally funded projects so far present the following major challenges that need to be adequately addressed in order to take CLTS to scale across the country and with quality in terms of faster and more sustainable ODF results on the ground. These challenges include:

• Mainstreaming CLTS within the regular functioning of the Ministry of Health, which is responsible for sanitation in the country.
• Having more CLTS champions within the government set-up, particularly at the district level administration.
• Ensuring the quality of CLTS triggering, facilitation and follow-up on scale both in project and non-project areas.
• Generating learning on what is working or not working in terms of CLTS across different regions in the country and their contributory factors

3. Literature Review: Some Specific Studies

This section looks at two studies in depth, in particular, as they offer maximum information and insights into the functioning of CLTS in Indonesia. These are:

1. Latest WSP study (2011) undertaken as an action research in East Java under Total Sanitation and Sanitation Marketing (TSSM) project funded by Gates Foundation and implemented with the support of WSP.
2. DFID supported multi-country research study across India, Indonesia and Bangladesh carried out by the Institute of Development Studies, Sussex in collaboration with local partners (2009): focus Indonesia research papers, as available in the book ‘Shit Matters’ edited by Lyla Mehta and Synne Movik and published in 2011

These studies give a sense of CLTS in Indonesia at the interval of two years and across different regions and projects. While the first one is an intensive study across 80 communities in 20 (out of 29) districts in East Java in a single project (TSSM) area, the second study captures CLTS experience in West Java, South Sumatra and West Kalimantan areas across World Bank supported WSLIC II and PAMSIMAS project areas.

3.1 WSP Study 2011

In 2010, WSP conducted action research in East Java communities that were triggered using the CLTS approach. As per the WSP study (2011), ‘By early 2010, the fourth and final year of project implementation in East Java, with nearly 2,000 communities triggered using the CLTS
approach, over 700,000 people had gained access to improved sanitation and 35% of all triggered communities had become ODF.’

The WSP study (2011) is the latest study on CLTS in Indonesia and is significant in terms of the workings of CLTS in East Java. The key findings of the study are as follows:

1. Quickly ODF communities (i.e. self-declared ODF within two months of CLTS triggering, even if verified at a later date) represent the most efficient model for scaling up sustainably.

2. ODF outcomes that materialise after many months should be subject to periodic rechecks.

3. Implementing agencies can effectively influence most factors associated with achievement and sustainability of ODF outcomes for scaling up rural sanitation.

4. ODF and non-ODF communities were significantly different in terms of proximity to water bodies.

5. Open defecator households in rural East Java have the ability and opportunities, but often lack the motivation to acquire and use latrines.

6. Externally provided subsidies were associated with lack of ODF outcomes, but community provided subsidies were instrumental in ODF achievement.

7. When CLTS ignited demand for improved sanitation in study communities, local markets failed to meet expectations of poor consumers.

The study makes a mention of the large rural sanitation access gap in Indonesia and quotes the WHO-UNICEF Joint Monitoring Program’s 2010 Update, which states that over 58 million people currently defecate in the open in Indonesia, of which nearly 40 million are in rural areas. Another 51 million people share others’ latrines or use unimproved facilities, of which 31 million live in rural areas.

Based on the above mentioned findings, the study offers the following insights for consideration by policy makers, implementation agencies, and rural sanitation program financiers:

- To provide the basis for planning effective behaviour change interventions at scale, it is worth investing into market research before starting demand generation.

- Districts hoping to scale up sanitation access sustainably need a ‘subsidy funds management strategy’ that prevents subsidies from hampering the growth of both consumer demand and local supply capacity.

- CLTS interventions can be provided in response to expressed demand from village leadership, to improve community response to triggering.
• Improve triggering outcomes at scale based on study findings about what helped and what hindered collective behaviour change.
• Open defecators and sharers can be targeted for behaviour change more effectively by segmenting them.

If we look at the findings and insights closely, there are some obvious questions, which are not sufficiently addressed by the study. These are as follows:

• What are the key factors that lead to ‘quickly ODF communities’, which is found to be representing the most efficient model for scaling up sustainably?
• What are the key factors associated with achievement and sustainability of ODF outcomes for scaling up rural sanitation, that the study says can be influenced effectively by the implementing agencies?
• Why it is harder to have more ODF communities that are living closer to the water bodies?

The study offers only partial answers to these questions. The study identifies a number of factors that can be associated with ODF outcome achievement and sustainability. These include:

• high social capital in a village
• triggering in response to community demand
• quality of triggering
• improving consumers’ access to information about affordable latrines
• access to easier payment terms
• regular community monitoring.

The study suggests that while the local government has no direct influence on factors like high social capital, it can influence factors related to triggering and access to information and can support access to easier payment terms and community monitoring. However, a fuller understanding of the factors involved and their inter-play across different regions and projects has yet to be arrived at and needs to be captured with further exploration in the matter.

3.2 DFID/IDS Study (2009)

This was a multi-country study across India, Indonesia and Bangladesh, the first three countries in the Asian region where CLTS was tried out in rural communities with or without sufficient policy support. But Indonesia remains the only country where early CLTS successes on externally funded projects during 2005-07 led to the adoption of the CLTS approach as a part of the national sanitation strategy in 2008.

‘Shit Matters’, the book edited by Lyla Mehta and Synne Movik and published by Practical Action and IDS, Sussex in 2011, carries all the papers related to this research. There are
Improving CLTS from a Community Perspective Approach in Indonesia

three exclusive papers on CLTS in Indonesia and one a comparative analysis of institutions, incentives and politics of CLTS in India and Indonesia by Anuradha Joshi, a fellow at IDS.

All these research papers look at CLTS in Indonesia in the broader context of on-going process of decentralisation in the country, which is still in the early stages of its development, and is quite volatile as a result. These studies yield the following specific insights into CLTS in Indonesia:

- The rapid uptake of CLTS in Indonesia is largely due to their being embedded in well funded projects from outside with enough resources to invest in planning, training and monitoring with CLTS as the main project strategy for doing sanitation in the selected project areas. (Nilanjana Mukherjee and Nina Shatifan)
- ‘CLTS is not seen merely as a sanitation tool, but also as a means to support the broader agenda of decentralisation.’ (Lyla Mehta)
- There is a constellation of actors and factors at work that determine to what extent CLTS is adopted in a particular context. These include: role of natural leaders and village leadership; role of religion, gender relations and power dynamics; and access to resources such as water. (Owin Jamasy and Nina Shatifan)
- There are trade-offs between the degree of institutionalisation and the nature of CLTS as an inherently community based approach. (Edy Priyono)
- ‘It seems unlikely that larger institutional structures will change simply to make CLTS work...........it seems more practical and realistic to try and identify ways in which CLTS can work within existing structures and incentives that face public officials and politicians.’ (Anuradha Joshi)

In the ‘conclusions’ section of her paper, Anuradha Joshi mentions that ‘one of the reasons for the difficulties of institutionalising CLTS into government bureaucracies lies in its origins in experimentation in the NGO sector, outside the government, and in particular from what is considered a poor and disaster prone country like Bangladesh.’ The same applies to Indonesia with a difference in the context of externally funded projects (though not outside government), but hard to replicate in regular government functioning without outside project support.

4. Concluding Comments

Given the fact that CLTS is a part of the national sanitation strategy and is currently (2012) being tried out in around 200 of more than 400 districts in Indonesia, not much is known of CLTS experience and outcomes in different parts of the country other than the ones served by externally funded projects including TSSM and PAMSIMAS. But there are indications that the spread and scale up of CLTS in Indonesia in parts other than the ones covered by these projects has met with limited success so far. The on-going CLTS research in Indonesia, commissioned by Plan Indonesia and funded by Plan Australia seeks to fill this gap in understanding by drawing on the experience of CLTS from three diverse regions of the
country that include: Sumedang in West Java; Muara Enim in South Sumatra; and Lembata in NusaTenggara Timur (NTT).

Most of the earlier studies that focus exclusively on CLTS experience in Indonesia take community (not always defined very clearly) in a habitation, usually dusun (hamlet) as the unit of study, and not desa i.e a village, which is the unit for the implementation of the national sanitation strategy-STBM. As the natural unit for CLTS is a compact (geographically and socially) community, most of the CLTS successes are also at this level only, and not at the village level as expected in the STBM.

Verification of the ODF status of the villages is fairly skewed in most of the places and remains a grey area with varying practices and processes. What is common in East Java (as per the WSP study (2011) is the self-declaration by communities themselves. The same is true for other parts of the country as well. Verification and recognition by local governments often takes place much later. There is still a lot to be known about CLTS in Indonesia.

The Plan study on CLTS research in Indonesia aims at exploring further ground in terms of knowing what is working or/and not working in CLTS in the country, particularly from a community perspective.
A Note on CLTS Uptake and Spread: how it all began and took off

‘CLTS was pioneered by Kamal Kar in North West Bangladesh in late 1999 together with the Village Education Resource Centre (VERC), a partner of WaterAid’ (Movik and Mehta 2010). This was in the wake of an evaluation exercise led by Kamal Kar, an independent consultant, carried out to assess the on-going sanitation programme of WaterAid in the country.

Use of participatory tools such as mapping, transect walk, calculation, flow diagrams combined with Kamal Kar’s remarkable capacity and creativity to innovate and improvise on the spot inspired by a keen eye for community processes gave birth to the most powerful tool in the form of CLTS to trigger communities around sanitation. Subsequent field trials confirmed that facilitating participatory analysis by women, men and children in communities using participatory tools such as mapping of the defecation area, transect walk to the defecation site, calculation of shit, innovative methods like water and shit, and food and shit, exercises, often generate considerable amount of disgust and shame among the people present and triggers them to resolve to end open defecation.

A team of senior civil servants from India visited Bangladesh for a conference on sanitation in 2002, which entailed visits to open defecation free (ODF) villages created solely through collective community efforts without any monetary and material help from outside using a community led total sanitation (CLTS) approach, the name though did not exist then and was adopted only later for the innovative community led approach to total sanitation that was being followed in practice.

This almost looked unbelievable to sector professionals, as they had not seen anything like this before. The event gave birth both to CLTS champions and sceptics in India. One champion, Mr. B.C. Khatua, who was the secretary of the water and sanitation in the state of Maharashtra at that time, was so convinced that he persuaded Government of India to pilot CLTS in two districts (Nanded and Ahmednagar) in Maharashtra without any hardware subsidy for toilets to individual households.

Thus India was the second country where CLTS was introduced in some form without sufficient policy support for a no-subsidy approach.

A team of fairly senior policy makers and programme managers and development professionals from Indonesia visited both Bangladesh and India (in December 2004), first two countries in South Asia and globally to have used the CLTS approach. Early results were dramatic and very encouraging in both the countries and impressed the visitors. This led to first field trials of CLTS in Indonesia in South Sumatra and West Kalimantan regions in 2005. Very encouraging results from this field trial led to its quick adoption as the official approach for the on-going sanitation programme within WSLIC II supported by the World Bank in 2006. Total Sanitation and Sanitation Marketing (TSSM) initiative of WSP supported by the
Gates Foundation adopted CLTS on a large scale across 28 districts in East Java. CLTS was adopted as one of the five pillars of the national sanitation strategy of Indonesia called STBM in 2008.

Thus Indonesia was the third country where CLTS was introduced, but Indonesia is the first country, and one of only two countries (the other one is Nepal), in Asia to have CLTS as a part of its national sanitation strategy and policy. The country wide national sanitation strategy and programme called Community Based Total Sanitation (STBM), launched in 2008, has CLTS as one of its five pillars.

While there are numerous examples of remarkable early results in CLTS in many project contexts, scaling up of CLTS across the country still remains a challenge in Indonesia.
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