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Institutionalization of Rural Sanitation Capacity Building in Indonesia

Final

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Abbreviations

BAPPENAS	: *Badan Perencanaan Pembangunan Nasional* - State Ministry of National Development Planning
CLTS	: Community-Led Total Sanitation
EH	: Environmental Health Unit of the MoH
GDP	: Gross Domestic Product
HAKLI	: Association of Environmental Health Professionals
JMP	: Joint Monitoring Programme
MDG	: Millennium Development Goal
MoH	: Ministry of Health
PAMSIMAS	: Third Water and Sanitation for Low-Income Communities Project
PPSDM	: *Pusat Pengembangan Sumber Daya Manusia Kementerian Kesehatan* - Agency for Development of Human Resources, MoH
PPSP	: *Program Percepatan Pembangunan Sanitasi Permukiman* - National Sanitation Acceleration Development Program
Poltekes	: Health Polytechnic Schools
Promkes	: Health Promotion Board
Puskesmas	: Community Health Center
RPJMN	: Medium-Term Development Plan
RPJPN	: Long-Term Development Plan
STBM	: National Strategy for Community-Based Total Sanitation
TA	: Technical Assistance
ToT	: Training of Trainers
TSSM	: Total Sanitation and Sanitation Marketing
WSP	: Water and Sanitation Program, the World Bank
WSLIC-2	: Second Water and Sanitation for Low-Income Communities Project

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This report is a synthesis of the technical assistance (TA) 'Institutionalization of Rural Sanitation Capacity Building in Indonesia' (P132118) carried out by the World Bank's Water and Sanitation Program (WSP). The synthesis including lessons and recommendations has been developed through consultations and meetings with several departments of the Ministry of Health (MoH) including the Directorate of Environmental Health, Directorate General of Communicable Disease and Environmental Health, and the Agency for Development of Human Resources of MoH. The authors acknowledge the valuable contributions made by Wilfried Purba (Director of Environmental Health, Ministry of Health) and Eka Jusuf Singka (Centre for Education and Training for Health Official, PPSDM). The Task Team Leader for this TA is Deviariandy Setiawan. The following World Bank staff and consultants have provided valuable contributions: Susanna Smets, Almud Weitz, Rahmi Kasri, and I Nyoman Oka. The peer reviewers were Puti Marzoeki, Christophe Prevost, and Steffen Souleman Janus.

In addition to the synthesis report, the following material has been produced and made available to the client under the TA:

- 5 accredited trainings modules for the National Strategy for Community-based Sanitation (STBM): (i) Training of STBM Facilitators, (ii) Training for Trainers of STBM Facilitators, (iii) STBM Training for Polytechnic Lecturers, (iv) STBM Entrepreneur Training, and (v) Training for Trainers of STBM Entrepreneurs
- 4 e-learning modules: (i) Introduction and Basic Concept of STBM, (ii) STBM Facilitator, (iii) Sanitation Entrepreneurship, and (iv) Monitoring and Evaluation – these are available both in English and Bahasa Indonesia
- Prezi presentations to launch e-learning program by MoH in September 2014
- 2 brochures introducing (i) e-learning modules, and (ii) training accreditation
- Handbook for integration of STBM with MoH's '*Desa Siaga*' training

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Executive Summary

Indonesia has made significant increase in rural sanitation access and services from 20.64% in 2006 to 44.09% in 2013. The piloting of Community-led Total Sanitation (CLTS) approach in 2005, adopting a National Community-Led Total Sanitation Strategy (*Sanitasi Total Berbasis Masyarakat or STBM)* in 2008, and issuing STBM as the national approach Minister of Health Regulation No.3 in 2014 are the basis of this achievement. However, Indonesia is still not likely to meet its sanitation Millennium Development Goal (MDG) of 55.5% rural sanitation access by 2015. With access increase in recent years improving markedly, Indonesia has now adopted a new National Medium-Term Development Plan 2015-19 which targets to provide universal access to sanitation for all by 2019.

Human resources are a key bottleneck to successful implementation of STBM. A study conducted in 2012 estimated a capacity gap of 12,000-18,000 sanitation professionals (from engineers to community workers) to meet the 2015 MDG targets, with 30% of community health centers not having frontline sanitation personnel. The adoption of the more ambitious target going forward represents exponentially increased human resource gaps as of this year.

Capacity building programs have so far been largely conducted by technical units, projects, and local government offices. However, the absence of formal standards, quality control, and incentive mechanism has led to sub-optimal training outcomes, with only a fraction of people trained with the right skill sets to continue performing their proposed task.

Against this background, in 2012 the STBM Secretariat and the Environmental Health Unit of MoH approached WSP for TA to strengthen and expand the capacity building program for STBM implementation. Following an assessment on how and where to best address the issues, the TA recommended a transformative approach, away from project-based 'cascading' training where training is done at national level and then repeated/'cascaded' to provincial, district, sub-district and village levels to an institutionalized capacity building program. Instead of establishing a new mechanism through projects which only last as long as projects last, the TA strengthened and collaborated with the existing MoH unit mandated to provide capacity building, the Agency for Development and Empowerment of Human Resources of MoH (PPSDM). The institutionalization of capacity building program targeted two primary audiences: future professionals (pre-service) addressed through integrating STBM modules into health polytechnic schools curriculae and current professionals (in-service) addressed through accredited and certified training programs, with an additional e-learning scheme to reach out to a wider group of professionals and interested parties.

Between January 2013 and February 2015 the framework, instruments, and incentives mechanisms for STBM capacity building programs have been developed and implemented. About 1,500 students from all 24 government-run health polytechnic schools and 4 private health schools have received STBM modules integrated in their three mandatory subjects; 5 curriculae, modules, and incentives schemes for training, including the e-learning have been developed and implemented; 269 people have received official "credit point" rewards upon completion of accredited training; and almost 500 people from all

provinces in Indonesia have participated in the e-learning. Additional scale up is expected upon evaluating these results as part of a 5-year curriculae assessment program implemented by PPSDM/MoH in 2015.

Given the enormity of the challenges of sanitation development in Indonesia and the associated human resources needed, the institutionalization of capacity development programs is a must for reaching the desired scale, efficiencies, and quality. The three above-mentioned instruments could help the Government of Indonesia to accelerate fulfilment of those objectives. The two years of implementation of this TA have yielded a first round of key lessons, among them: first hand observations in the field and interaction between practicioners and academicians have strengthened integration of STBM in the health schools' curriculum and helped produce competent future human resources; accredited training based on planning and preparation helps improve and maintain the quality of training and the official "credit point" reward generates more demand to use the accredited training; and the e-learning has given everyone an opportunity to learn independently about STBM with an interactive and standardized method, while at the same time overcoming quality 'leakages' compared to the cascading training method (where quality gets reduced as training is 'cascaded' through the system) and potentially reducing the number of required face-to-face training days, thereby cutting training costs by up to 30%.

To scale-up, sustain, and generate better outcomes, the STBM Secretariat and PPSDM will need to provide support to manage the STBM capacity building as well as facilitate stronger collaboration between local government and health schools in implementing STBM. The support to scale-up the use of the STBM human resource capacity building system can be provided via a circular letter of MoH to local health offices and STBM partners. Continuous support through the MoH system to follow-up and evaluate outcomes of training and education will be key to sustainability and roll-out across all provinces of Indonesia.

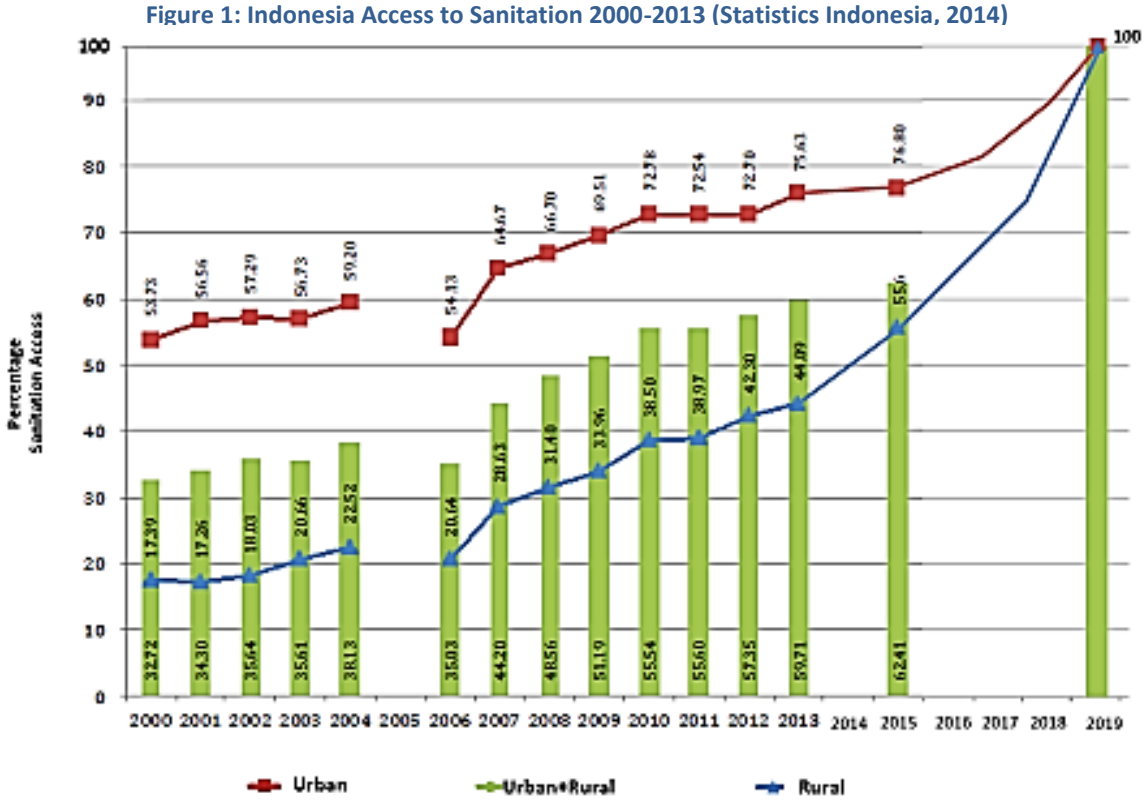
1. Rural Sanitation Context in Indonesia

Indonesia is the world's largest archipelagic country, consisting of 17,058 islands and inhabited by a population of 250 million, half of which (50.4%) lives in rural areas. Administratively, Indonesia consists of 34 provinces, which are divided into 97 municipalities and 414 districts. Provinces, districts and municipalities (commonly known as local governments) have autonomy in setting policy and administering their governance.[1]

Indonesia's economy grew by an average of 5.8% per year over the last decade, resulting in per capita income increasing from US$ 2,200 in 2000 to US$3,580 in 2013. The poverty rate has steadily fallen over the same period and is now at 11.4% as of 2013, and the debt to Gross Domestic Product (GDP) ratio decreased from 61% in 2003 to 24% in 2012. Indonesia is now lower-middle income country.[2]

While the economy grew substantially, basic service provision lagged behind for much of the decade, in particular compared to peer countries in the region. However, recent acceleration of basic access to sanitation has been impressive following a shift in the development approach from building infrastructure towards an emphasis on community empowerment, behavior change, and creation of a sanitation market. As a result, while between 2000 and 2006, rural sanitation access in Indonesia increased by a mere 0.85% per annum, access growth rates have been over 3% since then.

Figure 1: Indonesia Access to Sanitation 2000-2013 (Statistics Indonesia, 2014)



[1] Ministry of Home Affairs , May 2013 (http://www.kppod.org/datapdf/daerah/daerah-indonesia-2013.pdf)
[2] World Bank, 2014 (http://data.worldbank.org/country/indonesia) accessed on 10 October 2014

Following successful piloting of community-led total sanitation (CLTS) in 2005-6, in 2008, the Government signed off on a new National Sanitation Strategy called *Sanitasi Total Berbasis Masyarakat* (STBM), which adopted three key strategies: demand creation, supply/market improvement, and creation of an enabling environment. STBM has five pillars: Stopping Open Defecation, Hand washing with Soap, Household Drinking Water and Food Management, Household Waste Management, and Household Wastewater Management. In 2012 MoH set up the STBM Secretariat to manage and coordinate the implementation of STBM nationally.

A key rationale behind STBM is large-scale, broad-based implementation as Indonesia is trying to catch up with its neighbors to address high levels of open defecation (54 million people or 22% of the population) and unimproved toilets.[3] While the sanitation Millennium Development Goal is likely to be missed by some margin, Indonesia has recently adopted more ambitious targets as part of its 2015-2019 National Medium-Term Development Plan to reach universal access to improved sanitation by 2019, which requires redoubling efforts to substantially increase yearly access rates if the target is to be achieved.

A key bottleneck in implementing STBM is the capacity of locally available sanitarians, facilitators, entrepreneurs, and community empowerment workers in this highly decentralized country where responsibility for the provision of water and sanitation services rests with local government. A study conducted by the National Planning Development Agency (BAPPENAS) and the World Bank's Water and Sanitation Program (WSP) in 2012 estimated that there was a need for between 12,000 and 18,000 STBM professionals to meet the 2015 MDG targets[4]; the new target of universal access by 2019 will see this capacity gap figure rise substantially.

Capacity building has been largely confined to project-specific training carried out over the life of various rural water supply and sanitation projects over the past decade, with no formal standards, quality control, incentive, and reward mechanisms in place. In line with project planning and budgeting as well as the good intention to accelerate provision of skilled human resources, training was typically carried out through a mass-scale, cascading method through Training of Trainers (ToT) going down from national to provincial to district level, with eroding training quality and selection of trainees along the pathway. Alongside project-funded training, for STBM implementation local governments directly manage capacity building without much coordination or supervision from any quality unit within MoH, with capacity building initiatives targeted at sanitarians and existing community volunteers generally adopting conventional classroom-based training methods, with little two-way interaction between the trainees and trainers, and content and duration varying substantially from one local government to another depending on budget availability.

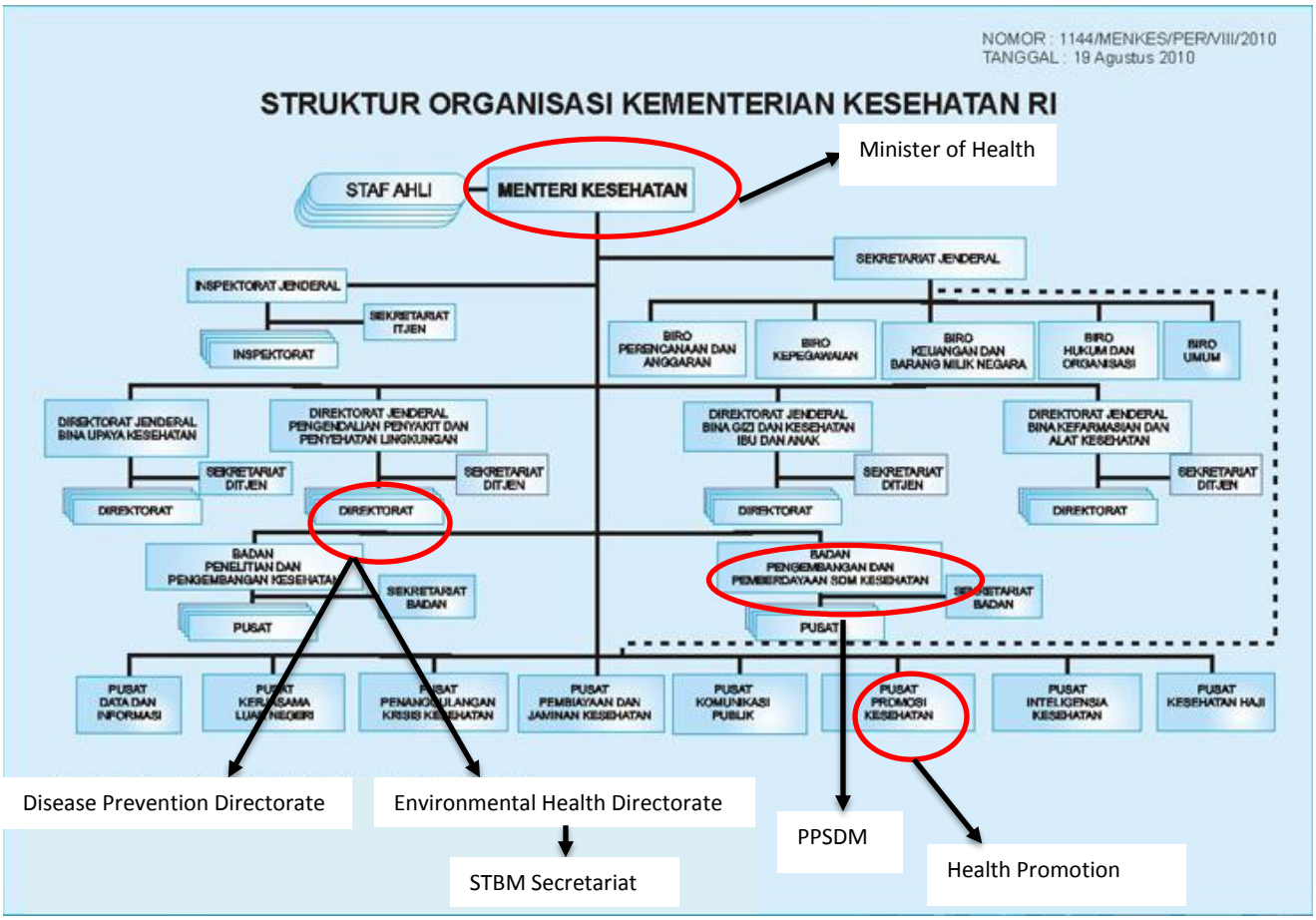
Against this background, in 2012 the STBM Secretariat and the Environmental Health (EH) Unit of MoH approached WSP for TA to address and expand the capacity building program for STBM implementation. Following an assessment on how and where to best anchor or 'institutionalize' such a capacity building

[3] Progress on Drinking Water and Sanitation: 2014 Update. WHO/UNICEF Joint Monitoring Programme (JMP)

[4] PT. Qipra Galang Kualitas (2012): Sanitation Personnel: Capacity Development Strategy, Final Report of the Sanitation Training and Capacity Study.

program in the future, the Unit and WSP approached the Agency for Development and Empowerment of Human Resources of MoH (PPSDM).[5] PPSDM is the agency responsible for the development and empowerment of health professionals and carries out its mandate through 1) development and empowerment of health professionals; 2) education and training for civil servants; 3) education and training for health workers; 4) standardization, certification and building the competency of health professionals; and 5) professional development, staff empowerment policy, and management. The PPSDM has the strengths and capacities, in terms of budget, availability of educators and trainers at various levels, setting quality standards, and offering institutionalized incentives for STBM implementers. Partnership with PPSDM for STBM implementation was deemed to provide broad and sustainable support for the training and development of STBM professionals.

Figure 2: The Organizational Structure of the Ministry of Health, Republic of Indonesia



[5] A second potential unit that was assessed was MoH's Health Promotion Unit with key strengths in community empowerment and communication, however without attached training school outlets it was deemed less of a fit than PPSDM.

2. Technical Assistance for the Institutionalization of the STBM Capacity Building

In response to these challenges and recognizing the critical role of PPSDM, TA support was designed around three components:

1. Standardization and accreditation of STBM training modules, per PPSDM standards;
2. Integration of STBM contents into health polytechnic school curriculum; and
3. Development of the STBM e-learning training scheme.

The TA under P132118 is part of a set of wider TA support on rural sanitation to the Government of Indonesia including Scaling Up Rural Sanitation (P132007) and Rural Sanitation Market Creation (P143165). The development of STBM training modules was based on evidence and learnings generated under the other 2 TAs, and implementation was set to rely on networks and capacity developed by these TAs simultaneously. A chart describing in more detail the relation among these three TAs is available in **ANNEX-1.**

The development objective of this TA was to integrate capacity building programs/curriculae for management and implementation of STBM into PPSDM, an institution that is mandated and has competencies to develop human resources for health (including environmental health) development in Indonesia. Key intermediate outcomes and indicators were set and achieved as follows:

Intermediate Outcome	Indicators	Achievements
Rural sanitation capacity building program institutionalized.	Baseline: • Training and capacity building program are conducted decentralized by local governments without quality standards and measurement against standards. • Rural sanitation capacity building framework as basis for capacity building program has not been legalized and is not used as main reference for capacity building program. Target: • Ministry of Health's HR Development Center (PPSDM) has developed a standardization and quality assurance process for rural sanitation capacity building program --Target FY14 (December 2013). • Sanitation capacity building framework has been approved and is used as the basis for a national capacity building program that differentiates the role of institutions at each level of government; development partners are aware of it with expectation of adjusting their TA accordingly --Target FY14 (December 2013). • Selected STBM curriculum is integrated in	• **Achieved** • **Achieved**

	at least three health schools (*Poltekes*) under PPSDM (and other interested universities) for early introduction of students to rural sanitation sector challenges and employment opportunities --Target FY14 (June 2014).	• **Achieved**
Instrument and tools for standardization and certification of rural sanitation expertise developed.	Baseline: • Instruments and tools to standardize capacity building program are not available. Target: • Instruments and tools to standardize capacity building program developed and implemented, such as: – Curriculum, class-based modules and tools approved and endorsed for usage by other institutions. – electronic learning modules (E-learning) and certification attached to PPSDM/STBM Secretariat portal as standardized system --Target FY14 (March 2014). – Monitoring system to track progress in implementation of nation-wide capacity building --Target FY14 (March 2014).	• **Achieved** • **Achieved** • **Achieved**
Incentive systems for certified rural sanitation personnel developed.	Baseline: • No certification and no structured incentive system in place. Target: • Well structured incentive system for certified rural sanitation personnel developed. This will include: i. certification requirement for staff included in the national projects operational guidelines (for non civil servants --Target FY14 (June 2014). ii. certification of capacity building program linked with "credit point system" implemented by government and mandatory --Target FY15 (June 2015). • Network of alumni of certified rural sanitation professionals developed—Target FY15 (June 2015).	• **Partially achieved** • **Partially achieved** • **Partially achieved**

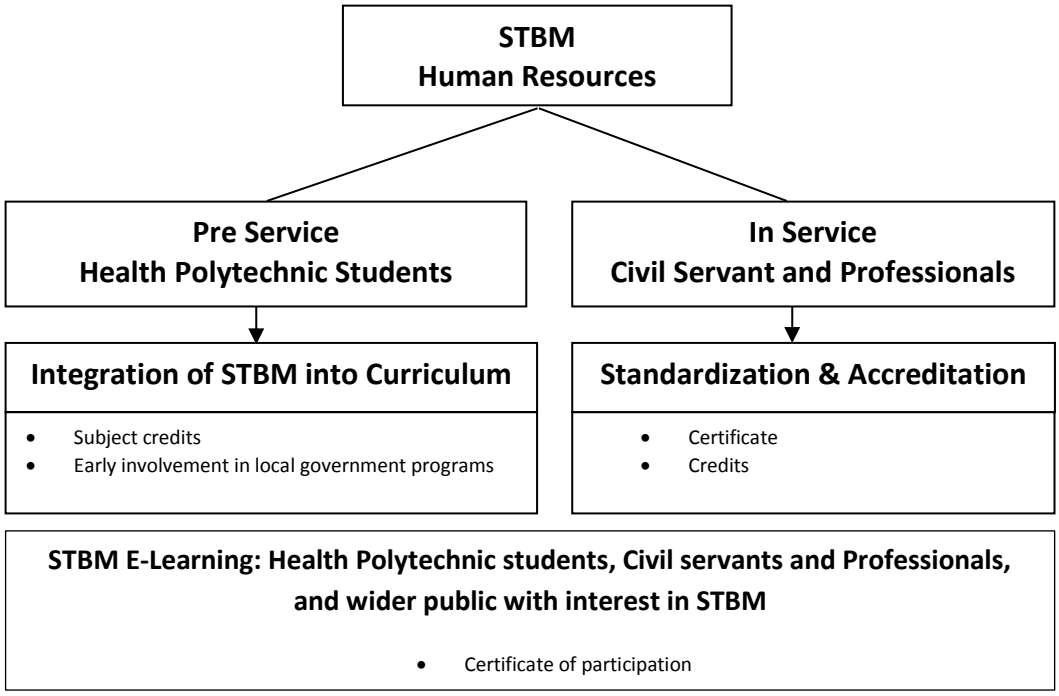
Overall, the intermediate outcomes and indicators have been largerly achieved or even exceeded (see section 4 for further details). Key results can be summarized as follows:

- Rural sanitation capacity building program institutionalized: The capacity building framework has been adopted as Ministerial Regulation (*Permenkes*) No. 3, 2014 which explains the roles and responsibilities of government institutions at each level with regard to the implementation of STBM. The regulation also mentions step-wise STBM implementation and is the basis for institutionalizing the STBM capacity building program.

  Capacity building is targeting two primary audiences: future professionals (pre-service) and current professionals (in-service), as well as other professionals interested in learning more about STBM as a secondary audience (figure 3). Based on the target audience, the STBM capacity building framework is delivered through three methods: 1) integration of STBM capacity building into at least three public polytechnic health schools out of the total 24 in the country that offer environmental health studies, 2) accredited training for those already in the system to strengthen their capacity and reward their performance, and 3) distance learning through an e-learning system to reach a larger audience beyond health professionals.

  Sanitarians are key actors of STBM as implementers of environmental health-related programs at community level. According to Regulation 32/2013 of the Minister of Health, sanitarians must have graduated from a health polytechnic school, positioning these schools as the critical in building up a new cadre of sanitarians. The recent Law No. 36/2014 on Health Workforce Act states that all students from health professional institutions have to pass the competency examination prior to graduation for health workforce registration. Hence, integrating the STBM approach in the health polytechnic curriculum was a strategic and cost-effective way to ensure that this new cadre will have gained insights into the challenges of community-based sanitation development and understands the Government's STBM program to respond to these challenges.

Figure 3: Institutionalization of Capacity Building for Rural Sanitation Human Resources



- Instruments and tools for standardization and certification of rural sanitation expertise developed: Systematically designed for specified targets, indicators, instruments, and a support system for capacity building programs to help ensure capacity building quality going forward, including measured quality of training arrangement and participants' knowledge and skill, reaching a wider audience, and accelerating the number of qualified STBM human resources. The standardized and accredited curriculae and modules are expected to not only improve the quality of delivery but also to motivate trainees through formal recognition and linking the completion of training to the MoH incentive system for career development opportunities of civil servants and enhanced training opportunities for non-civil servants.

  The development of the distance learning program aims to increase outreach of learning opportunities and resolve geographical and financial challenges around face-to-face training. Internet access has grown rapidly in Indonesia and it is estimated that by 2015 more than 50% of the Indonesian population has access to the internet. [6] It is divided into two stages: e-learning (online) focusing on the concept of STBM or cognitive aspects, and conventional learning (offline) emphasizing STBM skills such as triggering, marketing, and monitoring. The e-learning has limitations in building and evaluating practical competencies; hence the module is positioned as an entry point for further practical STBM training. Trainees of e-learning will receive a certificate of participation, which is a requirement to participate in the off-line

[6] http://kominfo.go.id/index.php/content/detail/4174/Menkominfo+Paparkan+Capaian+Kinerja+Kementerian+Kominfo+2009-2014/0/berita_satker#.VCl49fmSxa8

training. Trainees who complete the off-line training can then receive a certificate of competence from the PPSDM.

- Incentive systems for certified rural sanitation experts developed: The performance of sanitarians and many of the STBM implementers is evaluated by government (for civil servants) and project management units (for non-civil servants). For civil servants, as the training is recognized under existing evaluation mechanisms, the incentive is to receive 'credit points' required for career advancement. For non-civil servants, training certificates can be used as documentation to become a certified trainer for STBM training or to become an STBM implementer. Standardization, accreditation and record-keeping of the training program is a must for improving and developing future training models, as well as for mapping the geographical distribution and competencies of STBM professionals.

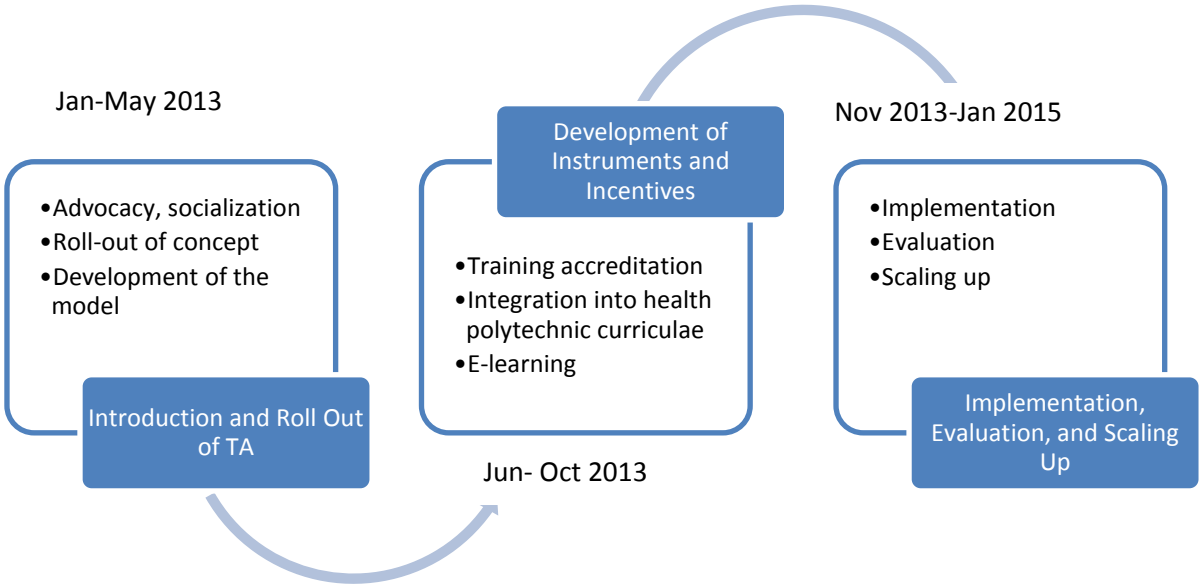
This TA was implemented through

- facilitating the formation of a working group consisting of representatives from the STBM Secretariat, PPSDM, the Health Promotion unit of MoH, the National Acceleration Program for Settlement Sanitation, and WSP to review and structure STBM curriculae;
- facilitating the design, development, and first implementation of the accredited training whilst ensuring the STBM concept was properly accommodated;
- providing master trainers to train and backstop selected health schools in carry out teaching for their students;
- designing e-learning modules and a monitoring system to map newly skilled human resources for STBM implementation; and
- facilitating the process of integrating certification requirements into relevant government and donor-funded projects and the staff administration bureau by a) including the certification requirement for non-civil servant staff in operating guidelines of projects; and b) lining certification of civil servants to MoH's mandatory credit point system.

3. Implementation Process

The implementation process under this TA is summarized in the flowchart below (figure 4), with three distinct phases that are further described below. The timeline of the process is given in **ANNEX 2.**

Figure 4: TA Implementation Phases



3.1. Introduction and Roll Out of the Technical Assistance

PPSDM was an entirely new TA partner on environmental health training for both the STBM Secretariat of MoH itself as well as WSP. To get their buy in, a series of meetings and 'roadshows' were conducted aimed at explaining the concept of the STBM approach and the collaboration and integration models being offered to PPSDM. WSP supported the STBM Secretariat in preparing a series of advocacy documents, including talking points, STBM success stories (particularly from East Java where WSP had provided a 4-year, at-scale TA program on rural sanitation), and outlining the benefits of institutionalization to both STBM and PPDSM against targets and the long-term framework of both units. Although both units of MoH, the latter was not familiar with the STBM strategy and program due to differences in functions, target audiences, and the organizational set up of MoH. Moreover, both carry out their activities in different ways, with Environmental Health emphasizing the adaptability of technical implementation issues to different situations in the field while PPSDM works to standardize a system and mechanism with more rigid procedures and less room for modification. However, intensive communication and outreach by the STBM Secretariat over several months resulted in reaching a shared understanding of the significant benefits to the parties involved and created solid support for and commitment to working together.

The STBM Secretariat and WSP then went on to officially launch the TA in January 2013 to solidify this agreement by discussing sanitation development challenges in Indonesia, building a common understanding of the HR gap and acceleration needs, consulting on the concepts and mechanisms of institutionalizing such capacity building, and agreeing on collaboration mechanisms and the capacity building framework. This event was attended by 50 sanitation development stakeholders in Indonesia

and it was agreed to form a working group that would facilitate this process of institutionalization, consisting of nine members representing the Directorate of Environmental Health, PPSDM, the Center for Health Promotion, the STBM Secretariat, the Center for Public Communication, and WSP. The two centers were deemed key partners because they play key roles in health promotion and community empowerment activities and have a wide network of partners extending to the village level where STBM implementation takes place. For example, the Center for Health Promotion collaborates with the Ministry of Home Affairs' Rural Community Empowerment Unit, which has personnel and networks for the *Desa Siaga*[7] program in the villages, while the Center for Public Communication has access to MoH's official communication unit and mass media that can help support demand creation for STBM.

The working group was provided with evidence from the implementation of STBM in East Java, and meetings and visits with program implementers and beneficiaries were organized to support the written evidence with actual testimonies and on-the-ground experience. The field visits aimed to provide a comprehensive understanding of the STBM concept and practices, identify factors required for the successful and sustainable integration of STBM into PPSDM's curriculae, and inform strategies and action plans to move forward. The result of this process was the identification and agreement to follow the two-pronged approach described above: i) to integrate STBM into the environmental health curriculum at health polytechnic schools, and ii) standardize and provide accredited training.

3.2. Development of Instruments and Incentives

The institutionalization of capacity building of STBM human resources has three distinct target groups, as outlined above: (i) current STBM implementers (in-service) and (ii) environmental health students at health polytechnic schools as future sanitation human resources (pre-service), both as primary audiences, and (iii) those interested in STBM and other members of the general public as secondary audience. To reach these target groups, three instruments were developed: (i) accredited training for STBM implementers, (ii) integrating of STBM into environmental health curriculums at health polytechnics, and (iii) e-learning for both groups and for the general public.

3.2.1. Standardization and Accreditation of STBM Training

Based on the MoH Decree No. 725/2003, accreditation is conducted to value eligibility of health training. A training program is accredited if it has passed the required components and received an accreditation letter preceding a training that include curriculum, (requirement of) participants and trainers, organizer, and venue. Accreditation is important to ensure quality of training because based on PPSDM's assessment along with the development of the health industry, health trainings were mushrooming. However, many of those trainings are not being conducted with clear (if any) quality planning, control, and improvement, resulting in little strengthened knowledge, attitute, and skills of the health workers.[8]

[7] Desa Siaga is a national program managed by MoH and MoHA to create empowered communities which have resources and capability to prevent and overcome health, disaster, and health emergency situation independently.
[8] Kemenkes RI Badan PPSDM (2014). Pedoman Manajemen Pelatihan di Bidang Kesehatan, Kemenkes RI.

The accredited training process as per PPSDM standard as shown in the figure 5 below involves three stages: before training, during training, and post training.

Figure 5: Management of Accredited Training Process

The training need assessment is aimed at clarifying the gap between existing and expected competence of current health human resources and is used as a basis to develop training goals and the program design. How the training is conducted would be evaluated during and after the training to ensure quality of the training. The length of the process of accreditation varies depending on quality of the curriculum and modules, organization of the training, and evaluation after the training. The first stage is usually the most difficult one, as it can take between 6 months to 2 years to develop a curriculum and module that passes the quality standard of PPSDM to allow for accreditation. The accreditation is valid for one year with possible extension.

The accreditation process did not require funding from the TA as PPSDM has an allocated budget for the process. To prevent long process and ensure quality as well as acceptance of curriculum and modules developed, the STBM Secretariat convinced PPSDM that the required materials, training needs assessment, curriculae, and training modules were, by and large, already available, and the target users and supporting partners had already been identified and consulted. Led by the STBM Secretariat and guided by the PPSDM, the 5 modules were developed simultaneously, with contributors divided into

three groups: lecturers, facilitators and entrepreneurs representing 11 key STBM partners: UNICEF, Waspola, SHAW-SIMAVI, High Five, IUWASH, Plan Indonesia, USDP, HAKLI, WVI and Yayasan Pembangunan Citra Insan Indonesia; representatives from 6 health polytechnic schools from Jakarta, Bandung, Purwokerto, Yogyakarta, Surabaya, and Bali; and representatives of Ciloto and Cikarang civil service training centers.

Instead of developing new modules, the team reviewed existing and strengthened the existing modules and fitted these in accordance with PPSDM standard. The biggest challenge was that PPSDM has standards in pedagogical terminology, dictions, way of delivery, learning tools, composition of time for theory, task, and practices, and attachements, which were not familiar and easily understood by the training practitioners. Along with PPSDM's work to ensure standardization, WSP had a central role in facilitating and ensuring that inputs from all stakeholders were accommodated and aligned with the principles of STBM. It was a constructive process for both field practitioners and PPSDM to learn and understand each others' ways in conducting training. Representatives from PPSDM said that they had limited experience working frequently with non-government agencies in designing a training program and this process had been valuable for them.

The draft modules developed were then discussed with a number of representatives from provincial, district and municipal health authorities as the main beneficieries of the training. This enabled the completion of the key stages of the accreditation process in a very short period: by November 2013, the STBM curriculum and training module for lecturers was accredited, and the other 4 curriculae and modules were accredited in March 2014.

Following receipt of the accreditation letter before implementation, training organizers are required to provide detailed arrangements of the training program to PPSDM one month prior to the actual training to ensure quality of the arrangement such as trainers, expected participants, suitability of venue, etc. However, these requirement and process are sometime not in line with project cycles, hence thwart their interest to conduct the accredited training and proceed with their customized model of training. To mitigate this, the STBM secretariat increased its efforts to disseminate information on accredited training and requested its partners to use the accredited curriculum and modules. Concurrently, understanding that accredited training was a new method to the STBM players, PPSDM was less strict on the submission of required documents and instead of one month accepted the documents up to few days before the training.

Considering that some of the STBM projects/partners already have their training modules prior to the initiative to make this accredited training, it was decided that at this initial stage, some modifications in devilering the methods were acceptable as long as the contents in the accredited modules were fully delivered and training hours were not less than required in the accredited training. With regard to the competence of trainers that needed to be proven with official certificate, while many of the STBM trainers did not have that, PPSDM evaluated their competence upon evaluating their background experience (curriculum vitae) in facilitating STBM training.

Ideally, PPSDM monitors the implementation, however budget limitation prevents PPSDM to do that systematically. Following the training, PPSDM will require the organizers to conduct a post-training evaluation to ensure quality improvement for the next training round; however, this is also not done systematically due to budget restrictions and HR limitations given the large number of decentralized training programs in Indonesia. To facilitate PPSDM conducting its role in evaluation, the STBM secretariat and/or its partners provide support and engage them in the training process (pre-during-post). A thorough evaluation for improvement will be conducted in April 2015 followed by improvement of the modules if deemed necessary in 2016.

The detailed process is outlined in figure Process of the accreditation appears in figure 6 below.

Figure 6: Process of Accreditation of STBM Training

Funding for this activity came from a variety of sources: from WSP for workshops and accommodation for civil service personnel; from UNICEF for specialists, administration and logistics; from the STBM Secretariat for honoraria; and from the individual partners for accommodation and the human resources involved in this activity. The pilot was conducted and funded by the Indonesian Urban Water Sanitation and Hygiene (IUWASH) project and Pembangunan Citra Insan Indonesia Foundation (YPCII).

3.2.2. Integrating STBM into Health Polytechnic Curriculae

At the launch of the TA, representatives from PPSDM and health polytechnic schools from 6 provinces expressed their support for integrating STBM into the environmental health curriculae to enable students to contribute to sanitation development in Indonesia in the future. Various options for such integration were considered: (i) as part of existing core subjects, (ii) bringing in guest lecturers, (iii) making STBM a separate subject, and (iv) providing STBM competency training in the field.

STBM is not an alien concept in environmental health education, but is a crystallization and manifestation of studies in environmental health sector.

Integrating STBM into academic curriculum encourages sustainable production of future rural sanitation human resources.

Given that STBM is not a completely new concept for environmental health education, it was decided that the third option would not be necessary. Option (i) of integrating STBM into the curriculums and option (ii) arranging guest lecturers was deemed feasible after consulting with the Environmental Health Communication Forum and PPSDM. The integration would be done in all polytechnic schools that offer environmental health studies, beyond the three health polytechnic schools targeted by the TA. MoH has 33 polytechnic schools but only 24 offer environmental health studies. While some private schools also offer this subject, they were not initially targeted as they fall under the authority of the Ministry of Higher Education and Research Technology as there was concern about a potentially different mechanism for developing curriculae and integrating new material on subjects. However, after the Environmental Health Communication Forum disseminated the STBM integration to its members which also cover private health institutes and environmental health academies, STBM integration was also possible for these private schools. By November 2014, all 24 government-run health polytechnic schools with environmental health as a teaching subject and four privately run environmental health schools had integrated STBM into their curriculae.

Education is not the same as training.

Education is pre-service to generate future human resources and training is in-service to generate "ready to use" skilled human resources.

Once the polytechnic schools received approval to go ahead with integration, introduction and training had to be given to environmental health lecturers. Emphasis was placed on integration and not generating new trainers, hence the previously envisaged training of trainers for lecturers was not deemed necessary. The lecturers only needed training and exposure visits to familiarize themselves with the STBM concept to enable them to understand and put this concept into their teaching practice.

"Teaching the STBM concept" to senior lecturers, most of whom hold doctorate degrees, would not have been an appropriate choice and very likely not been successful. Instead, WSP facilitated a preliminary meeting in May 2013 attended by representatives/lecturers from six health polytechnic schools and the Environmental Health Communication Forum. The lecturers were asked to observe the implementation of STBM in communities, including the triggering process. The aim was to allow the

lecturers to observe and make conclusions based on their own observations of and communication with communities, including those newly triggered and those that had started to make changes".

After three days of observations in the field, the lecturers had familiarized themselves with the STBM and community empowerment approach used. These first-hand observations of STBM in communities created a new mindset among the lecturers about the ways of learning and teaching STBM, away from teaching theory and more towards hands-on practice. While some lecturers had differences of opinion about the STBM concept itself, especially the no subsidy principle, in the end they all agreed to integrate STBM into their community empowerment, health promotion and basic environmental health curriculae. The fact and understanding that the health schools are under MoH which is required to supply the health sector with adequate human resources to achieve government targets has also eased the integration process.

Curriculum and modules for lecturer training were developed concurrently with the development of other training curriculae and modules, but for lecturers, the development team also included representatives from selected schools. Following its accreditation in November 2013, MoH arranged to conduct the training with support from WSP, first involving 27 lecturers from 9 health schools predominantly from Western Indonesia in November 2013, which started integration of the STBM modules in January 2014. The training succeeded in raising the interests of lecturers to teach STBM at schools as well as shaped their perception on the method of delivery, with all of them agreeing that students' understanding of the STBM concept had to be taught in class and practiced in community. The training came out with agreement on the general syllabus and contents to be delivered, while details would be developed by the individual campus upon return to their schools and submitted for approval to the study program chairman or polytechnic director. Approval is important not only as permit to deliver the teaching content but also to access budget needed to buy teaching materials, conduct field work or triggering of communities. Lecturers also had to teach their colleagues who did not attend the training to ensure full integration of the new module.

At the annual Environmental Health Schools Communication Forum in March 2014, STBM integration in 9 schools was acknowledged and endorsed for expansion into all MoH health schools and some privately run health schools. In June 2014, 39 lecturers representing 15 MoH health polytechnic schools and 4 private health schools were trained and started integration by September 2014.

Peer learning was reinforced by circulating teaching plans for others to provide insight on the delivery in each school facilitated by the Forkom JKL and discussion via the HAKLI email forum. MoH also linking health schools with local STBM implementers such as local health offices and STBM related projects through a letter requesting them to support the STBM field work to be done by the students as mandatory requirement to graduate. Normally the field work lasts for about 4-6 weeks in the community. The field work itself was seen as interesting yet challenging for students. Beyond requiring them to understand the STBM concept and having triggering skills to empower communities, the field work has opened awareness and concurrently changed the students' mindset on the magnitude of environmental issues they would address upon graduation and made them realized that behavior

change needed process and hard work. Indeed, these were memorable moments for students, while for local health offices, engagement and support from the health schools have injected a new spirit for them to implement STBM triggering. Simulatenously, it has also encouraged schools to conduct studies and research on STBM, through students' thesis or lecturers' research.

In May 2014, a review meeting of the teaching process of the first batch of 9 schools was organized. Minimum standards for teaching and facilitating communication of the schools were assigned to the Forum (Forkom JKL), while the standard for evaluation would be facilitated by PPSDM after the evaluation meeting. The evaluation meeting for all schools is expected to be held in May 2015, when they have completed their field work/community triggering.

3.2.3. The STBM E-Learning System

The E-learning system gives everyone an opportunity to learn independently about STBM via an interactive and standardize method.

A week after the launch of the STBM e-learning scheme in September 2014, 226 people from 31 provinces in Indonesia were participating.

The e-learning gives anyone who is interested in STBM an opportunity to learn about it, regardless of their location or financial situation and is free from the constraints of waiting periods or training quotas as well as erosion of contents during the delivery process. E-learning also facilitates the recording and mapping of the national distribution of sanitation human resources.

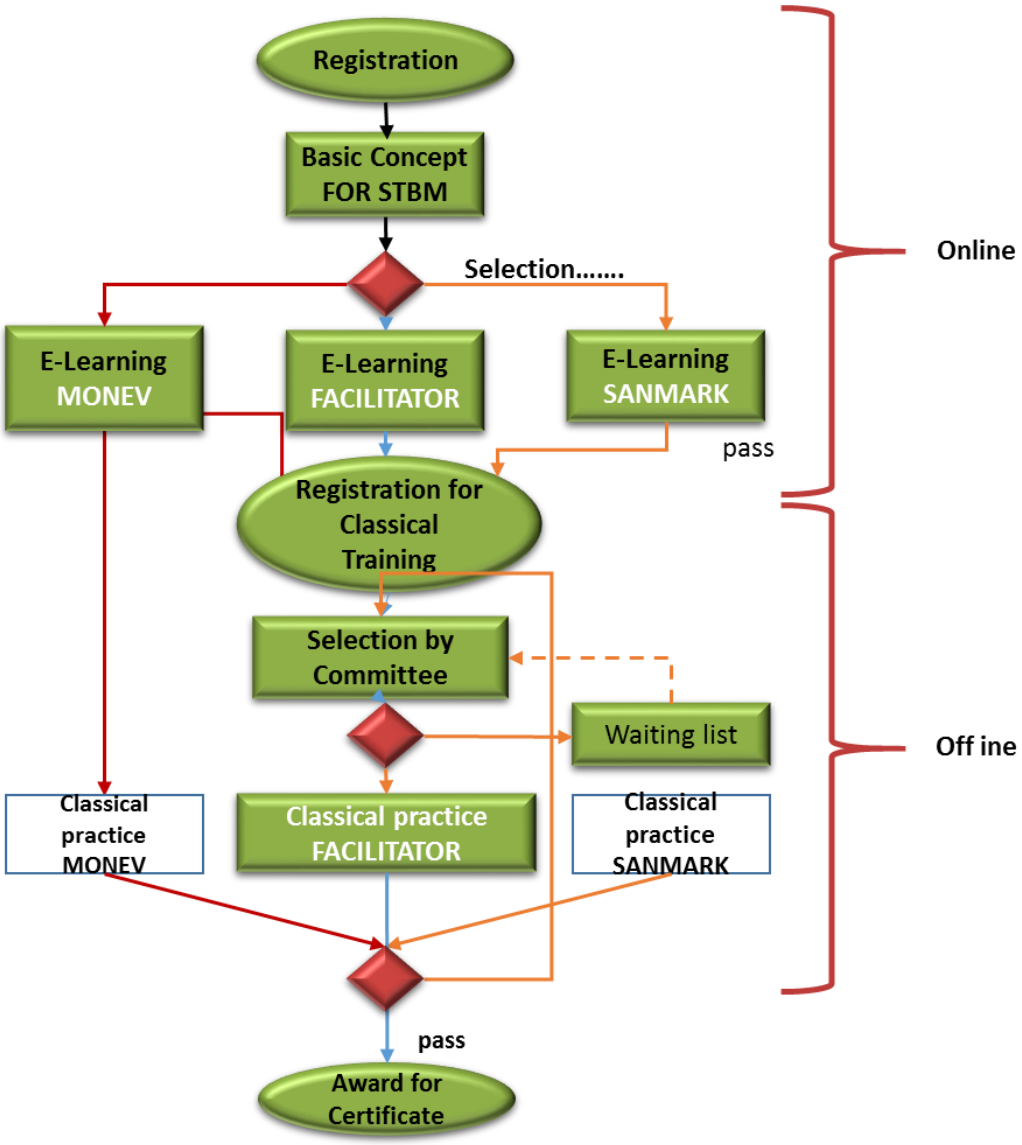
The STBM e-learning (stage one of distance training or online phase) curriculum and modules were developed based on the conventional STBM training curriculae and modules, modified to suit online learning, and equipped with a number of references and interactive tools such as video, quiz, games, and readings. It is available online in Bahasa and English at www.stbm-indonesia.org and can be accessed through any multimedia devices such as computer and mobile phone. STBM e-learning consists of 4 modules: (i) Basic concept of STBM, (ii) STBM facilitators, (iii) STBM entrepreneurs, and (iv) STBM monitoring and evaluation. Module (i) is mandatory while the others are optional upon completion of module (i). The modules can be downloaded before proceeding to the post-test. Upon completion of the mandatory module and post-test of one optional module with minimum 80 point participants can print a certificate of participation, which serves as an acknowledgement of completion of the online training as well as an entry requirement to participate in the stage 2 (face-to-face training). Those completing both stages (online and offline) are rewarded with a certificate with credit points from the PPSDM.

The e-learning is part of the structured distance training that consists of e-learning (on-line) and 'classical' training (off-line). The online part focuses on the concept of STBM to ensure everyone has the same understanding of the concept while the 'classical' part is important to ensure skills and competence of human resources which cannot be measured and accomplished through the on-line version. Besides offering up to 40% shorter classical training (3-4 days from normally 6-7 days), which tends to fit better with the financial capability and time of the organizers, the online part is used as a

preliminary selection of interest and effort taken by the prospective trainees to help ensure better outcomes of the classical training.

In the course of the development of the e-learning curriculum and modules, WSP supported the STBM Secretariat and the Civil Servant Distance Learning Unit of PPSDM to modify existing modules to curriculum standards and the multimedia that would be used. Although the agency has a distance learning unit, STBM was the first tutor-less, multimedia product for the general public to be developed by PPSDM.

Figure 7: STBM Distance Training Scheme (ONLINE and OFFLINE)



In the past, they had only ever developed a distance learning course on epidemiology, which was supported by tutors and designed for specific epidemiologists groups. This has brought the attention of PPSDM to the needs to capacitate and empower a wider set of health human resources, including facilitators and community members, not only for those working formally under the MoH.

The e-learning has also been used to support STBM teaching at health schools. Besides lecturing students of STBM, some lecturers such as from Health School in Palu, Kupang, Yogyakarta, and Padang requested students to complete the e-learning before conducting the field work. This assignment increased the completion rate compared to users with other background. Similarly, the mandatory assignment for PAMSIMAS project staff to complete the e-learning and present their certificate before attending a workshop in Solo early this year has also increased the completion of the learning program, indicating that it would be useful to proceed with this for other training programs as well.

3.2.4. Incentives Mechanism

Accredited STBM training offers the incentive of credit points, which functional personnel such as sanitarians need for their career development.

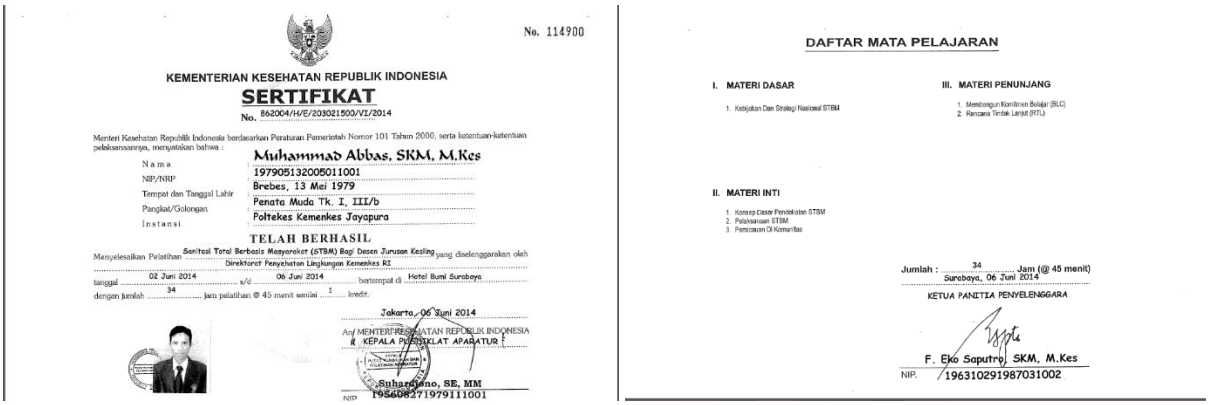
The TA institutionalization strategy had two incentive-related targets for the different target audiences of the in-service training: (i) the inclusion of a certification requirement in the STBM implementation technical manual for *non-civil servant staff*, such as STBM project staff, sanitation entrepreneurs, community facilitators, etc., and (ii) to directly link certificates of standardized training attendance with the career development credit points system for civil servants in government institution.

The first target was not applicable because the technical implementation manual was cancelled, however the capacity building framework had already been taken to a higher constitutional level and was binding, under Regulation of the Minister of Health 3/2014 concerning STBM. However, the inclusion of a certification requirement for non-civil servants in project implementation manuals was still possible and has been promoted by MoH by encrouaging development partner projects to implement the accredited trainings and prioritize hiring staff that have such STBM certificates.

The second target has been achieved through the implementation of accredited training, where successful participants are awarded a certificate of competency with credit points. Credit points are needed by the civil servants who are hired for their particular expertise – so-called 'functional' staff such as sanitarian, doctors, and lecturers. To occupy a certain position, a functional staff must collect a sufficient number of credit points within a period of time. For example, a junior sanitarian must collect 25 credit points per year to maintain his/her position. Collecting credit points is not easy: for example, based on Minister of Civil Servant Empowernment Regulation No. 1/2008, participants who passed the training examination and attended 95% of an accredited training program with a minimum 30 training hours (30 x 45 minutes) are awarded 1 credit point, while the criteria to pass the training examination such as minimum grade for post-test, participation in class, etc., are defined together between training organizer (EH) and PPSDM.

Upon successful completion, PPSDM issues a certificate with a national registry number printed on a paper with the Garuda logo (the logo of the Republic of Indonesia). That official certificate means that that the credit award is acknowledged and accepted in the HR system of all government HR offices, not only the PPSDM in MoH but also all local civil servants offices. The latter is important because in line with local autonomy, most STBM implementers at local level are categorized as local civil servants who report to the head of districts or provinces and not to MoH, thus credits much be accepted by all government HR systems. Details of the credit point incentive system through accredited training are summarized in **ANNEX 3.**

Figure 8: Sample of Official Certificate with National Logo and National Registry Number



No. 114900

KEMENTERIAN KESEHATAN REPUBLIK INDONESIA

SERTIFIKAT

No. 862004/H/E/203021500/VI/2014

Menteri Kesehatan Republik Indonesia berdasarkan Peraturan Pemerintah Nomor 101 Tahun 2000, serta ketentuan-ketentuan pelaksanaannya, menyatakan bahwa :

Nama : Muhammad Abbas, SKM, M.Kes
NIP/NRP : 197905132005011001
Tempat dan Tanggal Lahir : Brebes, 13 Mei 1979
Pangkat/Golongan : Penata Muda Tk. I, III/b
Instansi : Poltekes Kemenkes Jayapura

TELAH BERHASIL

Menyelesaikan Pelatihan Sanitasi Total Berbasis Masyarakat (STBM) Bagi Dosen Jurusan Kesling yang diselenggarakan oleh Direktorat Penyehatan Lingkungan Kemenkes RI

tanggal 02 Juni 2014 s/d 06 Juni 2014 bertempat di Hotel Bumi Surabaya

dengan jumlah 34 jam pelatihan @ 45 menit senilai 1 kredit.

Jakarta, 06 Juni 2014

An. MENTERI KESEHATAN REPUBLIK INDONESIA
KEPALA PUSDIKLAT APARATUR I

Suharyono, SE, MM
NIP 195608271979111001

DAFTAR MATA PELAJARAN

I. MATERI DASAR
1. Kebijakan Dan Strategi Nasional STBM

II. MATERI INTI
1. Konsep Dasar Pendekatan STBM
2. Pelaksanaan STBM
3. Pemicuan Di Komunitas

III. MATERI PENUNJANG
1. Membangun Kombinasi Belajar (BLC)
2. Rencana Tindak Lanjut (RTL)

Jumlah : 34 Jam (@ 45 menit)
Surabaya, 06 Juni 2014

KETUA PANITIA PENYELENGGARA

F. Eko Saputro, SKM, M.Kes
NIP. 196310291987031002

Even though the credit-points are not applicable to the career progression of a non-civil servant, having a certificate from an accredited training and acknowledged credit point would help their career working with government. It would also be an added-value should they want to work as an outsource expert of a training funded by the government.

3.3. Implementation and Scaling Up

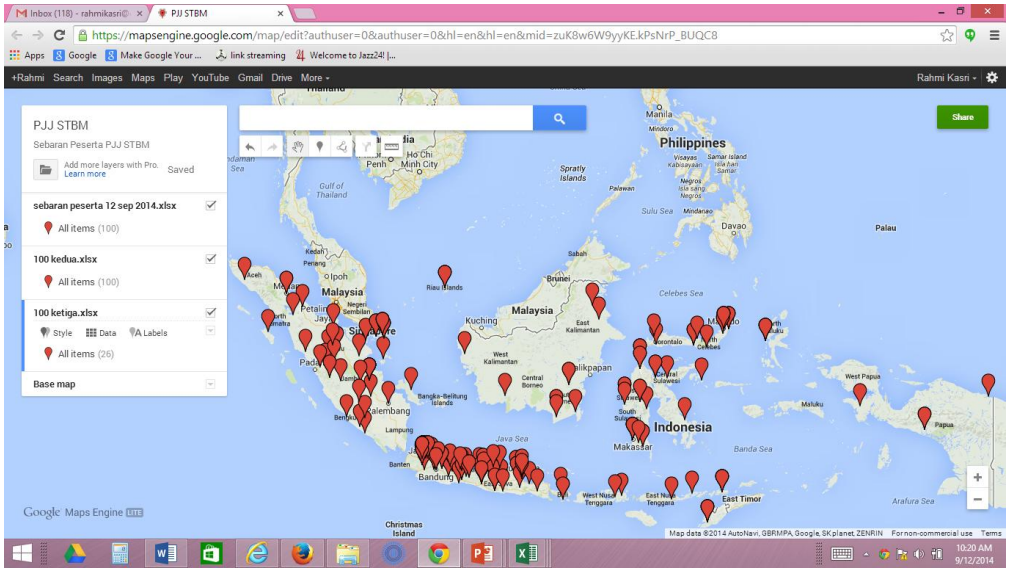
A summary of the curriculum and modules can be found in **ANNEX 4.** The five STBM training courses have been accredited and are now being used by MoH and its partners:

- As of February 2015, more than 700 people have participated in the classical STBM training following the designed curriculum and modules, arranged or supported by MoH, WSP, World Bank PAMSIMAS Project, Plan Indonesia, SPEAK, YPCII, local government of Sukabumi, LPMAK, MCAI, IUWASH, and SIMAVI. However, only 40% or 269 proceeded with the certificates.
- The Ministry of Health listed a number of future training programs that will use the accredited version and is considering releasing a circular letter to all local health offices and STBM partners to scale up accredited training following the evaluation of all STBM trainings in April 2015.

Circular letters can have substantial impact, such as the recently issued one requesting local governments to prioritize utilization of Health Operational Budget for STBM. Other options considered for the scale up are to link/integrate the STBM training with the accreditation system for the community health centre and link with BPJS (national insurance) for reaching universal access. These will ened to be studies further.

- As of September 2014, STBM had been integrated into the Diploma 3 and 4 environmental health program in 24 health polytechnic schools and 4 private health schools in Indonesia. To ensure that the STBM content will continue to be included in the curriculum, PPSDM has scheduled an evaluation of the national curriculum for 2015 (these evaluations are held every 5 years). The new curriculum will be confirmed by a ministerial decree and the inclusion to ensure sustainability.
- The e-learning module has benefitted from high-level promotion by officers at various national events such as STBM National Coordination Meeting, City Sanitation Summit, and water and sanitation national meeting. Minister, Vice Minister, high level officials from PPSDM and the Environmental Health unit invited their subordinates and partners to visit and try out the e-learning. As a result, a week after its launch on 3 September 2013, the STBM e-learning module had attracted 226 participants from 31 provinces across Indonesia (all provinces except Lampung, North Central Kalimantan, and Maluku), and by February 2015, almost 500 people participated, as shown in the figure below:

Figure 9: Distribution of E-Learning Participants



- At local level, the e-learning product has been used by local health officers and some PAMSIMAS provincial and district coordinators to inform and explain about STBM to their partners as well as to confirm that STBM was a national program and not only implemented in their area. Practically, it has accelerated adoption of the STBM program.

Although the instruments and mechanisms for institutionalized capacity building are now in place, a number of challenges still need to be addressed to ensure smooth and sustainable scale up:

a) Slow uptake of accredited training due to unfamiliarity with the modules and initial difficulties in setting up post-training coaching/backstopping mechanism:

From accreditation in March 2014 until February 2015, six accredited trainings were organized for a total of about 269 trainees. Lack of extensive dissemination on the training benefits as well as how to conduct accredited training is likely behind it; MoH is now addressing this through renewed dissemination efforts which should result in higher uptake starting this calendar year.

In addition, the accredited training requires adherence to a number of implementation arrangements and criteria. These were intentionally set to measure and ensure the quality of training, such as proven capacity and background of master of trainers and trainers, selection process for participants, measured evaluation mechanism, minimum standard of training venue, etc. The training provider is expected to inform PPSDM a month before the event on these criteria, so that PPSDM has time to do a quality check of the training. This process is often not in line with project time schedules, as most of the training is implemented by an ad-hoc committee established shortly before the event. With insufficient time for preparation, organizers decided not to proceed with the accredited training. With increased dissemanitation of information including the certification, potential trainees in particular among functional staff have started to pressure training organizers into better planning so that they can benefit from the credit point awards.

A third factor influencing limited uptake is that post-training coaching and backstopping expected by many trainees has not yet been set up. In-service training is usually expected to provide 'ready to implement' new skills; with a new curriculum, trainees need follow up support to help them practicing their new skills and improving these. Accredited training with effective procedures, mechanisms, requirements, and supporting curriculum and modules can partly respond to this if executed properly but post-training coaching mechanisms will need to be set up to ensure quality implementation of the STBM approach by the newly trained staff.

b) Variable quality teaching by polytechnic school lecturers on both theory and field practice application of the new curriculum:

While the combination of theory and practical field work in communities is enriching students' understanding of real world conditions, students have reportedly struggled to conduct practice work in villages. Many schools require their students to wear school uniforms which affect their ability to gain respect and trust from communities, especially for activities such as triggering. Students also found the field work challenging because villegers expected solutions and direct support from the students, while at the same time acknowledging that testing out their new skills in practice is very useful for their future work. Support and supervision from lecturers, local health offices, and partner organizations have helped make the field work more productive but have not been consistently mobilized. The local context, capacity of lecturers and students, availability of support from local

government and local health offices, financial support, and interest of the schools and lecturers are all influencing factors for success.

In addition, detailed teaching plans and syllabus are prepared individually by lecturers or teaching teams in each school and thus subject to variable content and delivery in terms of balancing demand, supply and enabling environment principles of STBM. In a few instances lecturers objected to the non-subsidy principle of STBM. It is essential to facilitate and inform dialogue with lecturers through regular updates and discussion forums to ensure that the same key messages of STBM are delivered to students. Such dialogues could be facilitated by the Communication Forum for Environmental Health Department (Forkom JKL) with support from PPSDM and the Environmental Health Directorate.

To further improve teaching and practical application, MoH has issued a letter requesting local health offices to collaborate with health schools in implementing STBM training to support the teaching process and field practice. Some health offices have collaborated very well but not all. By December 2014, In 22 out of 28 implementing schools, students have been engaged in triggering activities; in Yogyakarta, Riau Islands, and West Kalimantan provinces, some students were also offered to work as interns at the health office to support STBM. Dissemination of best practice collaboration between schools and health offices could help other schools. Collaboration with the private sector is another potential strategy to be further explored: in West Papua and Papua province, the triggering in communities was conducted jointly with a mining company operating in their area.

With a new government in place since October 2014, a potential change in the higher education structure is in the making where health polytechnic schools would be coordinated by or report to the new Ministry of Higher Education and Research Technology instead of MoH. While this is not seen as materially affecting the integration of STBM in the health schools, capturing best practice and evaluating the integration in 2015 will be good evidence to build upon under the new government organization.

c) <u>Technical issues and non-completion of e-learning modules:</u>

E-learning was launched in September 2014, with almost 500 people participating. Initial technical problems were connection stability of e-learning pages, quality of pictures and sound, and problem with server capacity, with infrastructure and maintenance support needed to support the system. The STBM Secretariat will need to build up its capacity to manage and maintain the e-learning system going forward.

The distribution of participants within the first month was all across Indonesia. However, non-completion of course modules is substantial and needs to be analyzed as part of the evaluation in 2015 to find out key reasons. As of mid-December 2014, of 409 participants 45% had completed module 1; 47 took module 2 with a completion and certification rate of 60% (module 1 plus one of

the others are required to get certified). Module 3 was taken by 25 participants with 31% of them completing and getting certified.

4. Achievement of Interim Outputs and Outcomes of the TA

In 18 months, the technical assistance has largely achieved and in some cases exceeded the expected targets outlined in the project concept note. Most notably, instead of conducting pilots in 3 polytecnic schools, these were actually launched in all 24 government schools and 4 private academies offering environmental health courses. The TA has also influenced other actors to address the issue of institutionalization of human resources development: for example, the Ministry of Public Works is now developing a distance-learning program for urban sanitation. The introduction of institutionalized incentives has generated interest from other STBM implementers, such as local governments and partners, in organizing accredited training. Detailed achievements compared to the concept note are presented in the table below:

4.1. Intermediate Outcome 1: Rural Sanitation Capacity Building Institutionalized

Baseline	Targets	Achievements
Human resource training and capacity building programs are run independently by local governments without standards or quality control for the training participants.	Ministry of Health develops measurable quality control standards and mechanisms for rural sanitation human resource capacity building programs - Target FY14 (December 2013)	Accreditation of conventional and online STBM training that meets training quality control standards and mechanisms for STBM human resource capacity building since November 2013 to September 2014
The framework for capacity building of rural sanitation human resources has not been legalized as the key reference for rural sanitation human resource capacity building programs.	Framework for sanitation human resource capacity building is approved and forms the basis for sanitation human resource capacity building programs, and differentiates the roles of institutions at each level of government, and partners know about this framework and are expected to support it - Target FY14 (December 2013)	The framework for the capacity building of sanitation human resources is an integral part of the national STBM implementation strategy that has been adopted in the Minister of Health Regulation No. 3/2014 concerning STBM on 10 February 2014 This regulation explains the STBM implementation steps that must be taken by each institution at each level, including national, provincial, district, and subdistrict/primary health center level. This achievement was not specifically supported via this TA, but by TA P1322007, which is wider in scope.
No STBM curriculum existing within polytechnics	Selected STBM curriculums are integrated in at least 3 health polytechnics under PPSDM (and other universities) as an introduction to students to the challenges and job opportunities in the sanitation sector--Target FY14 (June 2014)	STBM material has been integrated into the environmental health curriculums of all 24 health polytechnics and of 4 privately run health academies in three subjects (Health Promotion, Community Empowerment, and Basic Environmental Health Problems Solving) by June 2014.

4.2. Intermediate Outcome 2: Instruments for the Standardization and Certification of Rural Sanitation Human Resource Capacity Building Developed

Baseline	Targets	Achievements
No indicators or systems for standardizing capacity building programs exist/have been developed.	Indicators and systems for the standardization of human resource capacity building are developed and adopted, including: • Development of e-learning modules and a certification system that are incorporated into the mechanisms at PPSDM/STBM Secretariat as standard -- Target FY14 (March 2014) • National system in place for monitoring the progress of the implementation of human resource capacity building programs --Target FY14 (March 2014)	Curriculums, modules and incentive schemes for training, including e-learning have been developed. E-learning rolled out by the Ministry of Health on 3 September 2014, and has 226 participants from 31 provinces across Indonesia within two weeks after the launching. Monitoring systems have been incorporated into the training accreditation mechanism at PPSDM, which is also supported by an online system of recording and mapping. The e-learning scheme also includes a questionnaire to measure the participants' satisfaction with this mode of learning.

4.3. Intermediate Outcome 3: Incentive System for Rural Sanitation Human Resources Developed

Baseline	Targets	Achievements
No system of certification or structured incentive system.	A well-structured incentive scheme for rural sanitation human resource capacity building, which includes: • The requirements for certification of staff are included in STBM technical manuals (for non-civil servant staff) -- Target FY14 (June 2014) • The capacity building certification system is linked to the government's credit point system and is a mandatory requirement ---Target FY15 (June 2015).	• Ministry of Health has agreed to include these requirements in the criteria for project implementers. The formal process, via a circular letter, is underway. • The certification system has been linked to the credit point system for civil servants

Overall the TA has directly benefited the following numbers of people:

No	Instrument	Activities	Number of People Reached
1.	Integration of STBM into health schools	Training for lecturers	66 lecturers from 24 MoH health polytechnic schools and 4 private schools
		Teaching at schools	1,500 students from 28 schools
		Students field work (triggering to community)	By December 2014, 22 schools have done the field work in a number of villages in 22 provinces. It is estimated that by May 2015, all schools will have done the field work.
2.	Accredited Training	Utilization of the curriculum and modules	Used in a number of trainings done by the MoH and partners such as WSP, World Bank PAMSIMAS Project, Plan Indonesia, SPEAK, YPCII, local government, LPMAK, MCAI, IUWASH, and SIMAVI.

No	Instrument	Activities	Number of People Reached
			Up to February 2015, it is estimated that the curriculum and modules have been used by more than 700 participants. This may be understated as the modules are available online and used by local health offices, and monitoring usage is not yet well developed.
		Incentive/Certificate with Credit Point	Among those who used the curriculum and modules, up to February 2015, 269 participants received accredited certification.
3.	E-Learning	Participation	As of February 2015, there were 494 participants, with 45% having completed Module 1. Module 2 was followed by 47 participants with 60% completion and certification rate. Module 3 was followed by 25 participants with 31% completion and certification rate.

5. Conclusions and Recommendations

The TA has institutionalized capacity building programs through i) formal pre-service education, specifically environmental health studies at health polytechnic schools by integrating STBM into mandatory subjects such as Health Promotion, Community Empowerment, and Basic Environmental Health Problems Solving along with field work in community; ii) accreditation of five training modules by PPSDM for in-service training, which are also linked to iii) a credit point system for participants taking the accredited training; and (iv) e-learning that opens the opportunity for everyone to learn about STBM independently

Given the enormity of the challenges of sanitation development in Indonesia and the associated human resources needed, the institutionalization of capacity development programs is a must for reaching the desired scale, efficiencies and quality. The challenge is not rooted in the suitability and adaptability of the products and their embedded requirements and mechanism, but mostly is determined by mindset and the challenges of organizational change processes. It is important that capacity building products and mechanisms are strengthened in a structural way through institutionalization both at local and national level led by MoH by integrating them in the institutions' permanent targets, work plans, and budgets.

Accredited training helps improving and maintaining quality of training; for example, the two accredited training delivered showed an average 80% satisfaction rate for the organization of the training as well as increasing trend in understanding the content as seen in the average result of pre-testing (53.15%) and post-testing (80.06%). The training requires good planning and preparation. If done properly, the accredited training will produce more competent and skillful personnel. This is critically needed for implementation of the STBM program, and can increase the efficiency and effectiveness of training programs. To generate more demand to use the accredited training as well as increased demand from participants to get accredited certificates, robust endorsement, dissemination of information, and support from the Government and STBM Secretariat is needed.

First-hand observations in the field and facilitating interaction with field practitioners helped to influence the mindsets of lecturers on the approach and concepts of STBM. As the authority of delivering content during the teaching process is the prerogative of lecturers, it is important to establish regular updates, peer-to-peer dialogue and support to ensure correct understanding and delivering of the STBM concepts to the students. This can be facilitated by the association of environmental health schools supported by PPSDM and local health offices.

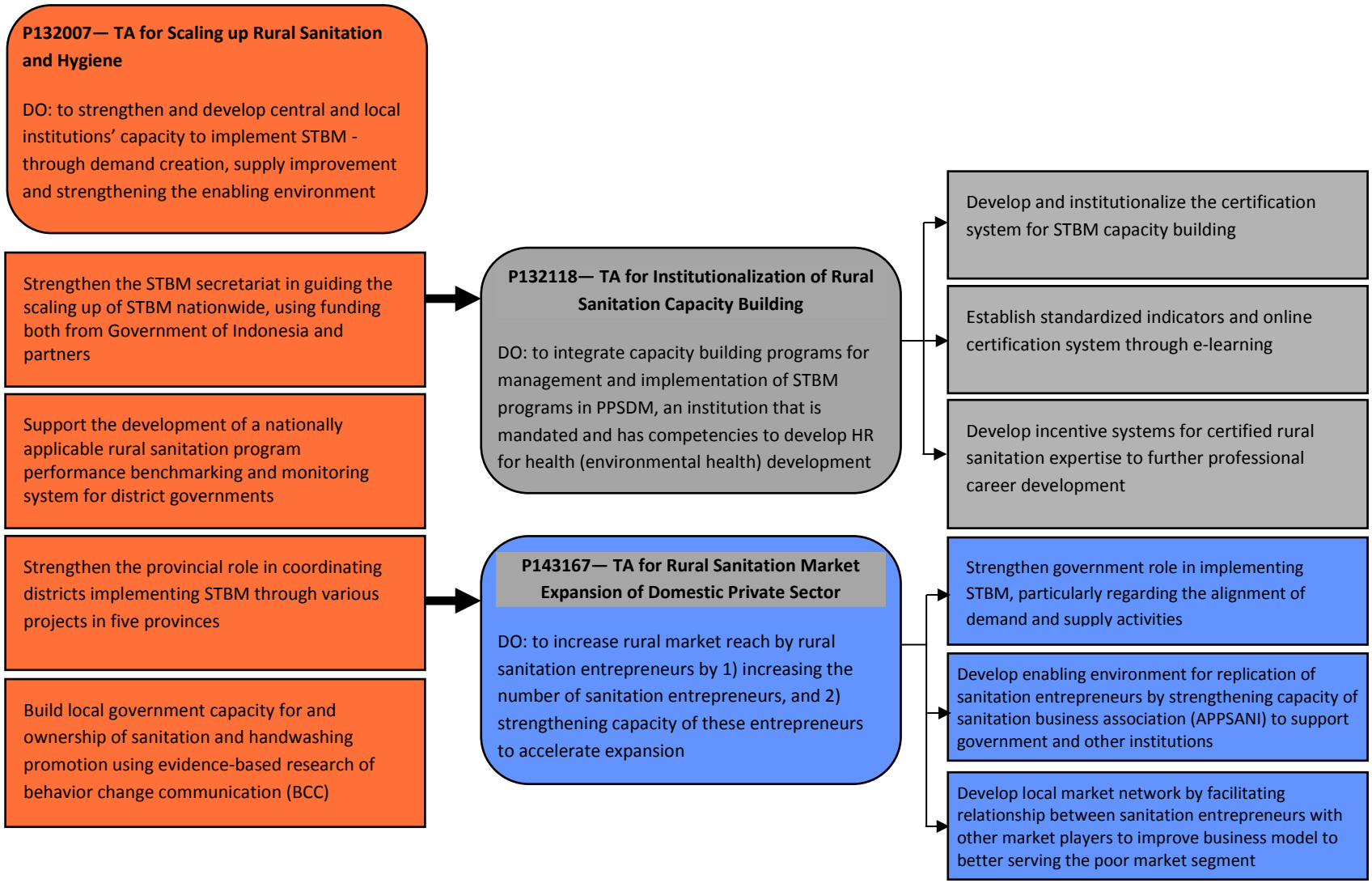
The e-learning has given everyone an opportunity to learn independently about STBM with an interactive and standardized method. This helps increasing cognitive aspects needed to understand STBM and – as a complementary requirement to participate in the classical part of STBM distance training – has the potential to make conventional training more cost-effective. To ensure sustainability, infrastructure and personnel investment for maintenance and management are critically needed.

The new curriculae and modules are in early stages of roll-out and implementation, with overall encouraging signs of progress. Key recommendations to take this to greater scale at increasing quality can be summarized as follows:

- Continued roll-out by the STBM Secretariat and PPSDM of the various types of standardized training is needed, including the systematic documentation of participant profiles towards meeting the future need for STBM personnel to achieve the target of universal sanitation by 2019.
- The STBM Secretariat should provide human resources with competency in the management of STBM capacity building, especially in facilitating accredited training and managing the e-learning.
- Stronger collaboration between local government and health schools in implementing STBM is needed for better mutual outcomes for both institutions.
- Generating support to scale up the use of the STBM human resource capacity building system, in particular accredited training and e-learning requires structural support and regular evaluation done and embedded in MoH's system. This can be done through various methods, including among others a ministerial circular letter to local health offices and STBM partners.
- Preparation and follow up are important aspects of capacity building programs. Continuous supports through the MoH system and provision of resources for such post-training follow-up are needed to ensure effective outcomes.
- A systematic evaluation of the capacity building program is needed to inform the review of curriculae at health schools in 2015 and to draw lessons on how to improve both in-service and pre-service training.

ANNEXES

Annex 1: Relationship of Technical Assistance Projects under Scaling Up Rural Sanitation and Hygiene in Indonesia



Annex 2: Summary of Timeline of Technical Assistance

Time	Activity
January 2013	Kick off and launching of TA Institutionalization of Rural Sanitation Capacity Building
January 2013	Roadshow and Introduction of STBM strategy to key partner units at the MoH: Center for Human Resource Development (PPSDM) and Center for Health Promotion (Promkes). *An ad-hoc working group was formed to assess the most appropriate and doable strategy to institutionalize STBM in the existing capacity building system of MoH.*
May 2013	Pre-Training Meeting to integrate STBM in health schools' curriculae.
October 2013	Establishment of indicators and systems to standardize and accredit STBM training. *The systems are equipped with standardized curriculum modules and training mechanisms as well as a credit point incentive for successful participants.*
November 2013	5 curriculum modules of STBM trainings completed (training for facilitators, training of trainers for facilitators, training for sanitation entrepreneurs, training of trainers for sanitation entrepreneurs, and training for lecturers). *1 curriculum module was accredited (training for lecturers).*
November 2013	STBM training for health schools' lecturers.
January 2014	9 health schools which participated in the training started inserting STBM in their school curriculae.
March 2014	4 STBM curriculae and modules were accredited.
May 2014	Evaluation workshop of STBM teaching in the 9 health schools
June 2014	All MoH health schools (24 schools) and selected private health schools (4 schools) participated in STBM training and started to insert STBM in their curriculae.
June 2014	Soft launch of the STBM e-learning by the Minister of Health. *Two of four modules were introduced and soft-launched.*
August 2014	Some projects and partners tried out the accredited STBM training mechanism.
September 2014	Second STBM National Coordination Meeting and actual launch of the STBM e-learning.

Annex 3: Credit Point Requirement: Case of Sanitarians

Credit points are needed by civil servants, specifically functional staff such as sanitarians, doctors, and lecturers. Pursuant to Law 16/1999 and Presidential Instruction 87/1999, functional staffs are civil servants who are hired for their particular expertise or ability. To occupy a certain position, functional staff must have sufficient credit points, as shown in the examples in the box below.[9]

Credit points are required in order to sustain a position or receive career promotion. Credit points can be gained by participating in a training, research, technical assessment, community empowerment, or writing an academic report/book. The accredited training such as STBM training with 30 training hours (30 x 45 minutes) is valued at 1 credit point. Below is the illustration on how much credit points should be collected by a sanitarian:

Competent Sanitarians

No	Position	Level	Minimum Credit Points
1.	Junior Sanitarian	II.A	25
2.	Practicing Sanitarian	II.B	40
3.	Senior Practicing Sanitarian	III.A III.B	100 150
4.	Supervisor Sanitarian	III.C III.D	200 300

Expert Sanitarians

No	Position	Level	Minimum Credit Points
1.	Junior Assistant Senior Sanitarian	III.A III.B	100 150
2.	Assistant Senior Sanitarian	III.C III.D	200 300
3.	Senior Sanitarian	IV.A IV.B IV.C	400 550 700

Note: Since the introduction of Regulation of the Minister of Health 32/2013, the number of credit points required is no longer valid. A new number of credit points required is still being discussed. These tables are included only for the purpose of illustrating that sanitarians need to have credit points.

[9]Civil Service Education and Training Centre, Agency for Development and Empowerment of Health Professionals, "Training Modules for Sanitarians", 2011

Pursuant to the Decree of the Minister of State Administration Reform 19/KEP/M/PAN/2011 concerning sanitarians and the credit point system, a sanitarian will no longer be eligible to hold a functional position if:

a) Within five years, the sanitarian is unable to accumulate the minimum credit points for the level above him/her;
b) The sanitarian is unable to accumulate 10 credit points as a junior sanitarian or practicing sanitarian, and 20 credit points as a supervising sanitarian from the time he or she takes up that position; or
c) The sanitarian takes leave of absence of more than six months for learning purposes, is suspended or takes unauthorized leave; he or she will be placed in a non-functional sanitarian position.

Pursuant to Regulation of the Minister of Health 32/2013 concerning Employment of Sanitarians, there are currently five levels of sanitarians:

1) Sanitarian,
2) Junior sanitarian technician,
3) Assistant sanitarian technician,
4) Senior assistant sanitarian technician, and
5) Assistant sanitarian technician.

All sanitarians are required to hold a professional qualification in environmental health, and to practice his or her profession, a sanitarian must have a certificate of competency and certificate of registration as a sanitarian.

Annex 4: Summary of the Accredited STBM Curriculum and Modules

1. Curriculum and Module of STBM Facilitator Training

Expected Role : The successors of this training shall work as STBM facilitators in their working area and able to integrate STBM approach into their daily roles and works.

Participants : Those who are willing to be a facilitator in sanitation and environmental health programs using STBM approach.

Competences :

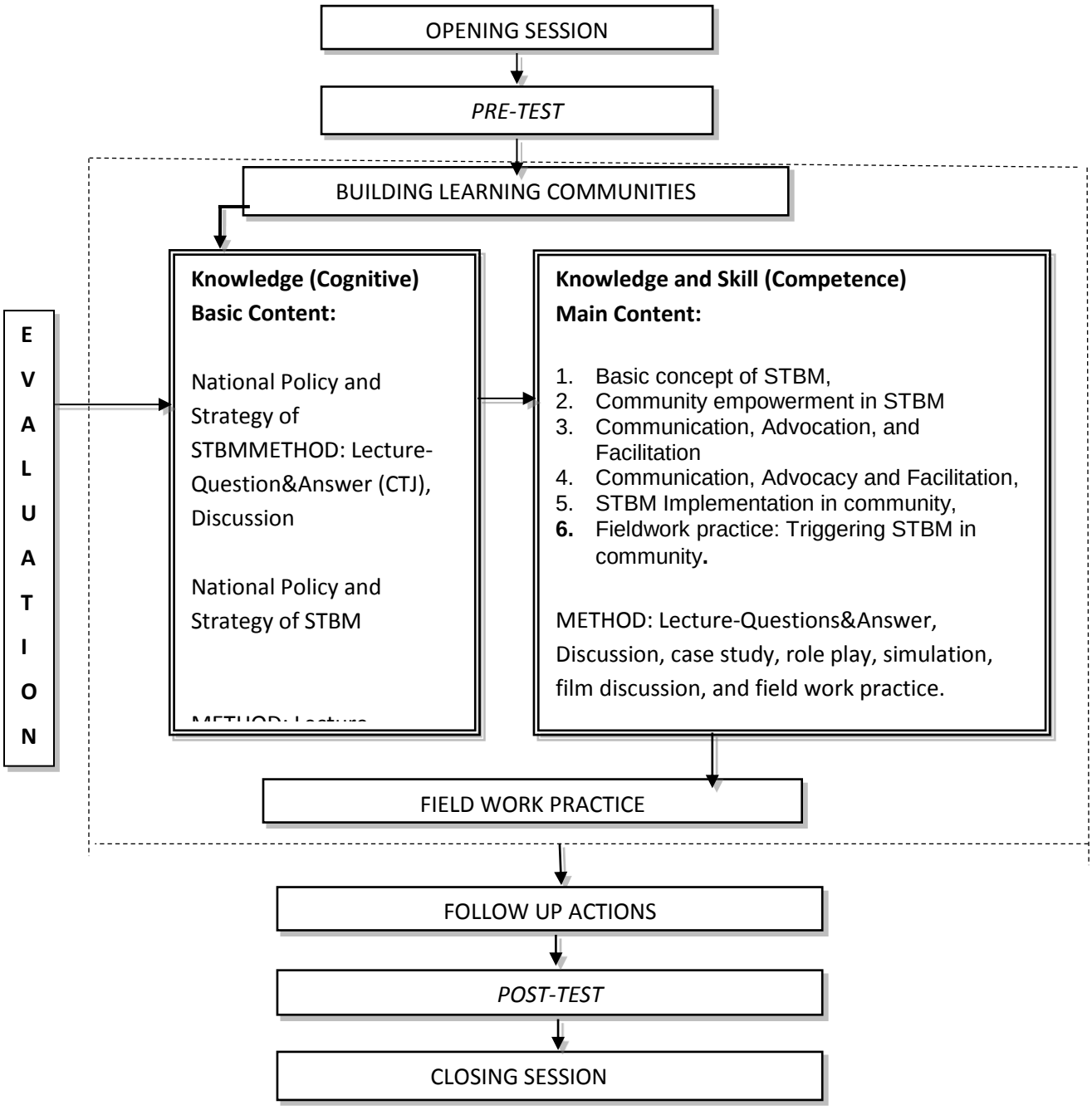
1. To explain direction and national strategy on STBM
2. To explain basic concept of STBM
3. To explain community empowerment in STBM
4. To practice communication, advocation, and facilitation
5. To practice triggering in community

Number of participants in one class: not more than 30 persons.

Program structure:

No	Content	Time			Total Hours
		Theory	Assignment	Field Practice	
A.	Basic Content				
1.	National Policy and Strategy of STBM	2	0	0	2
	Subtotal "A"	2	0	0	2
B.	Main Content				
1.	Basic Concept of STBM	2	2	0	4
2.	Community Empowerment in STBM	1	2	0	3
3.	Communication, Advocation, and Facilitation	2	6	0	8
4.	STBM Triggering in community	6	8	10	24
	Subtotal "B"	11	18	10	39
C.	Supporting Content				
1.	Building Learning Communities	1	2	0	3
2.	Follow Up Action and Evaluation	1	2	0	3
	Subtotal "C"	2	4	0	6
	TOTAL	16	22	10	47
Note: 1 training hour= 45 minutes Credit Point: 1 credit					

Training Process:



2. Curriculum and Module for Training of Trainer (ToT) STBM Facilitator

Expected Role : The successors of this training shall work as trainers of STBM facilitator training in their working area.

Participants : Those with background as follows:

a. Civil servants from local health offices working related to STBM programs,
b. Government trainers, prioritizing those who are interest in STBM,
c. Master Trainer (MT)/ STBM national trainers that already participated in leadership training and similar training,
d. Willing to complete all training series,
e. Commit to be STBM trainers at the minimum for the next 3 years.

Competences:

1. To explain basic concept of STBM
2. To explain community empowerment in STBM
3. To practice communication, advocation, and facilitation
4. To practice triggering in community
5. To train in the future STBM Facilitator training

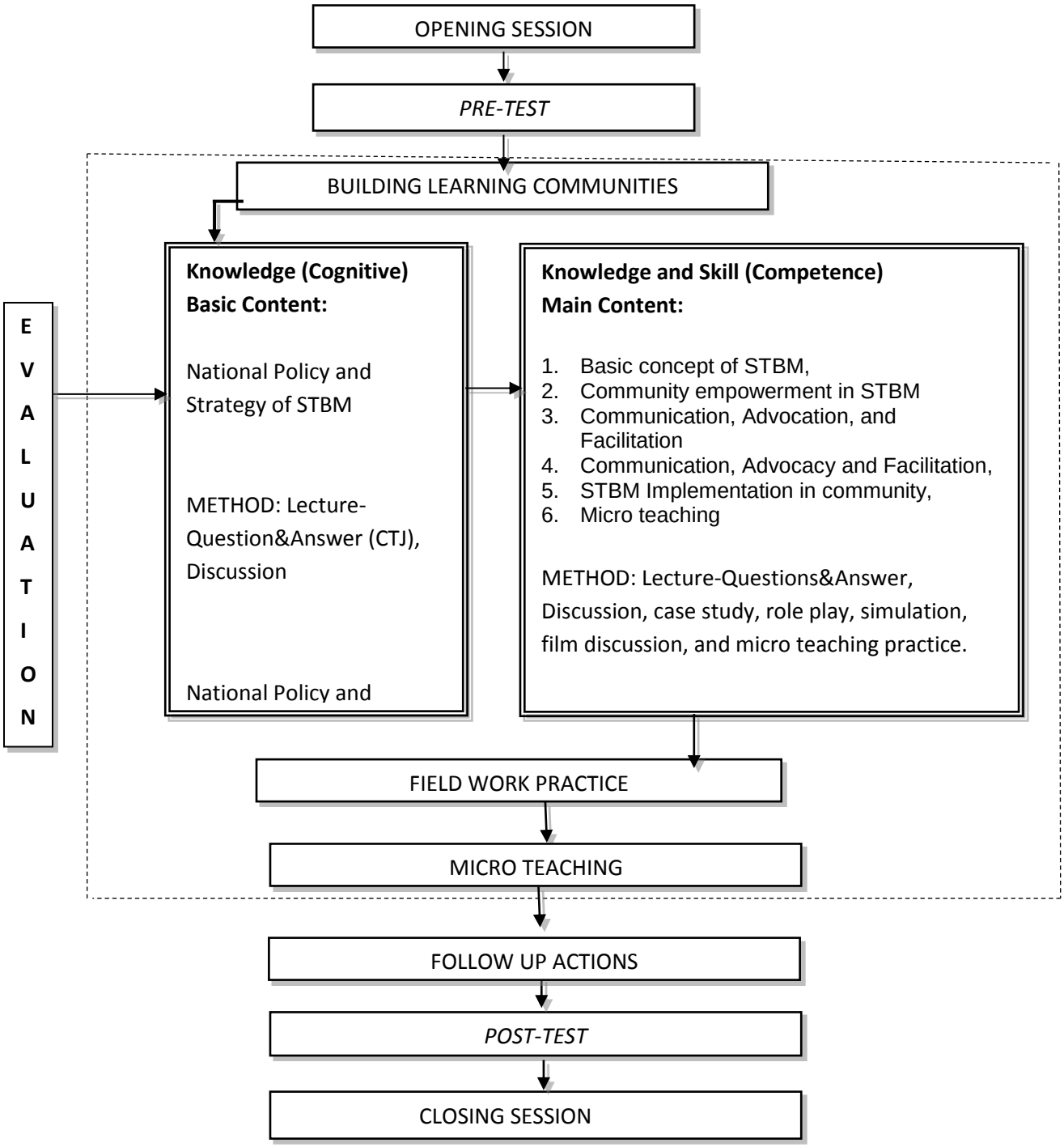
Number of participants in one class: not more than 30 persons.

Program structure:

No	Content	Time			Total Hours
		Theory	Assignment	Field Practice	
A.	Basic Content				
1.	National Policy and Strategy of STBM	2	0	0	2
	Subtotal "A"	2	0	0	2
B.	Main Content				
1.	Basic Concept of STBM	2	2	0	4
2.	Community Empowerment in STBM	1	2	0	3
3.	Communication, Advocation, and Facilitation	2	2	0	4
4.	STBM Triggering in community	4	2	10	16
5.	Micro teaching for training	6	9	0	15
	Subtotal "B"	15	17	10	42
C.	Supporting Content				
1.	Building Learning Communities	0	3	0	3
2.	Follow Up Action and Evaluation	1	2	0	3
	Subtotal "C"	1	5	0	6

	TOTAL	18	22	10	50
Note: 1 training hour= 45 minutes Credit Point: 1 credit					

Training Process:



3. Curriculum and Module for Training of STBM Entrepreneur

Expected Role : The successors of this training shall work as an entrepreneur that able to conduct STBM approach

Participants : Those with background as follows:

a. Future Entrepreneur who is willing to be an STBM entrepreneur, individual or group,
b. Have minumum of 9 years basic education and have experience in business
c. Age between 17 to 60 years old
d. Pass the selection process using application to participate in STBM entrepreneur training form.

Competences :

1. To explain national policy and strategy of STBM
2. To explain basic concept of STBM
3. To explain motivation of STBM entrepreneur
4. To explain basic concept of STBM products and services marketing
5. To explain marketing network for STBM products and services
6. To explain STBM products and services
7. To explain STBM products and services' production process (case: improved latrine)
8. To explain technics of communication and presentation of STBM products and services
9. To practice selling and production
10. To implement book keeping administration and simple financial management
11. To develop business plan
12. To conduct monitoring and evaluation of STBM marketing

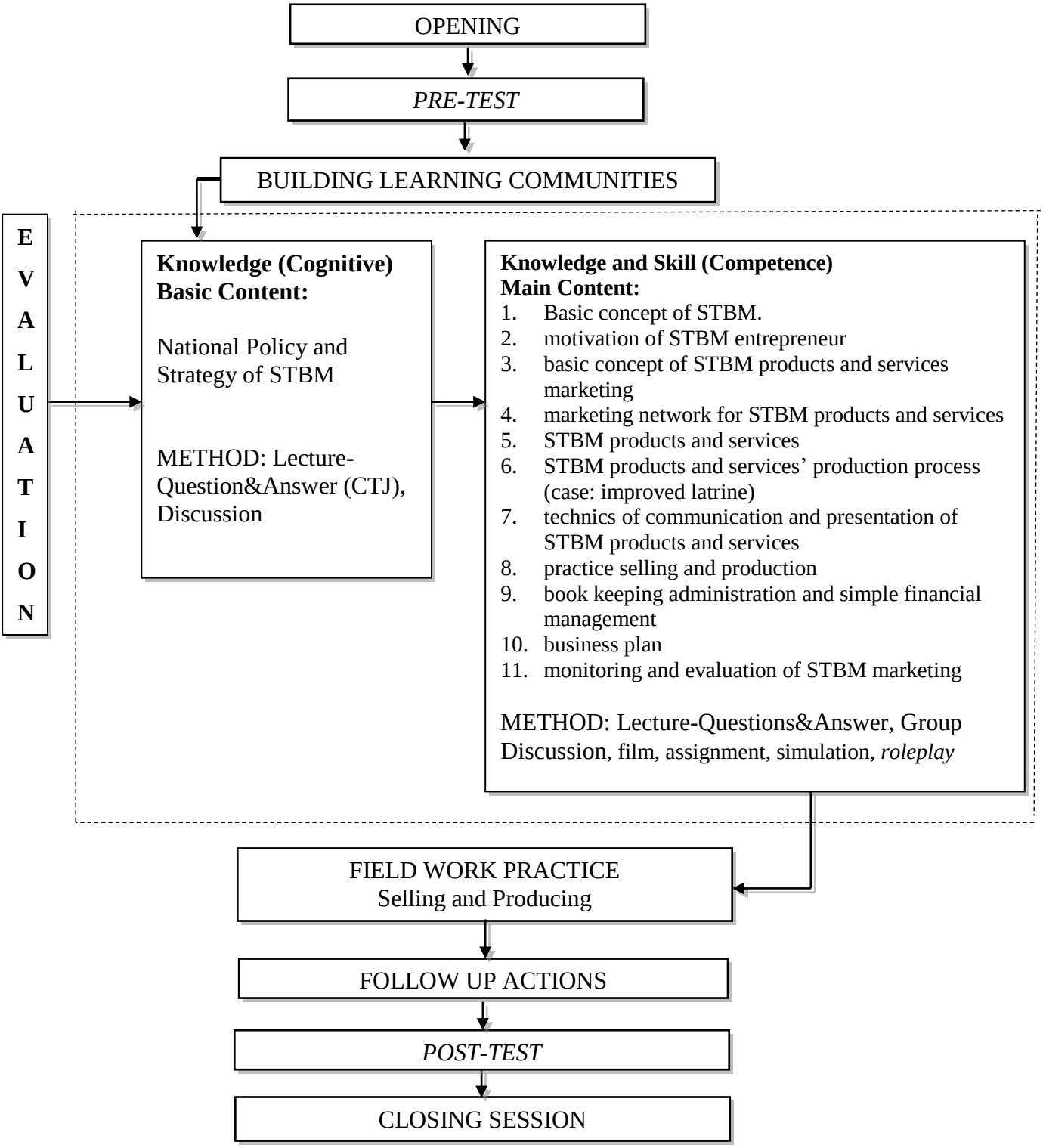
Number of participants in one class: not more than 30 persons.

Program structure:

No	Content	Time			Total Hours
		Theory	Assignment	Field Practice	
A.	Basic Content				
1.	National Policy and Strategy of STBM	2	0	0	2
	Subtotal "A"	2	0	0	2
B.	Main Content				
1.	Basic Concept of STBM	2	0	0	2
2.	Motivation of STBM entrepreneur	2	3	0	5
3.	Basic concept of STBM products and services marketing	1	1	0	2
4.	Marketing network of STBM products	1	1	0	2

	and services				
5.	STBM products and services	3	0	0	3
6.	STBM products and services' production process (case: improved latrine)	1	2	0	3
7.	Technics of communication and presentation of STBM products and services	1	3	0	4
8.	practice selling and production	1	0	9	10
9.	book keeping administration and simple financial management	1	2	0	3
10.	business plan	1	2	0	3
11.	monitoring and evaluation of STBM marketing	1	2	0	3
	Subtotal "B"	15	16	9	40
C.	Supporting Content				
1.	Building Learning Communities	0	2	0	2
2.	Follow Up Action and Evaluation	1	1	0	2
	Subtotal "C"	1	3	0	4
	TOTAL	18	19	9	46
Note: 1 training hour= 45 minutes Credit Point: 1 credit					

Training Process:



4. Curriculum and Module for Training of STBM Entrepreneur

Expected Role : The successors of this training shall work as a trainer of STBM entrepreneur training

Participants : Those with background as follows:

a. Civil servants from local health offices working related to STBM programs,
b. Government trainers, prioritizing those who are interest in STBM,
c. Master Trainer (MT)/ STBM national trainers that already participated in leadership training and similar training,
d. Willing to complete all training series,
e. Commit to be STBM trainers at the minimum for the next 3 years.

Competences :

1. To explain national policy and strategy of STBM
2. To explain basic concept of STBM
3. To explain motivation of STBM entrepreneur
4. To explain basic concept of STBM products and services marketing
5. To explain marketing network for STBM products and services
6. To explain STBM products and services
7. To explain STBM products and services' production process (case: improved latrine)
8. To explain technics of communication and presentation of STBM products and services
9. To practice selling and production
10. To implement book keeping administration and simple financial management
11. To develop business plan
12. To conduct monitoring and evaluation of STBM marketing
13. To train in the STBM entrepreneur training

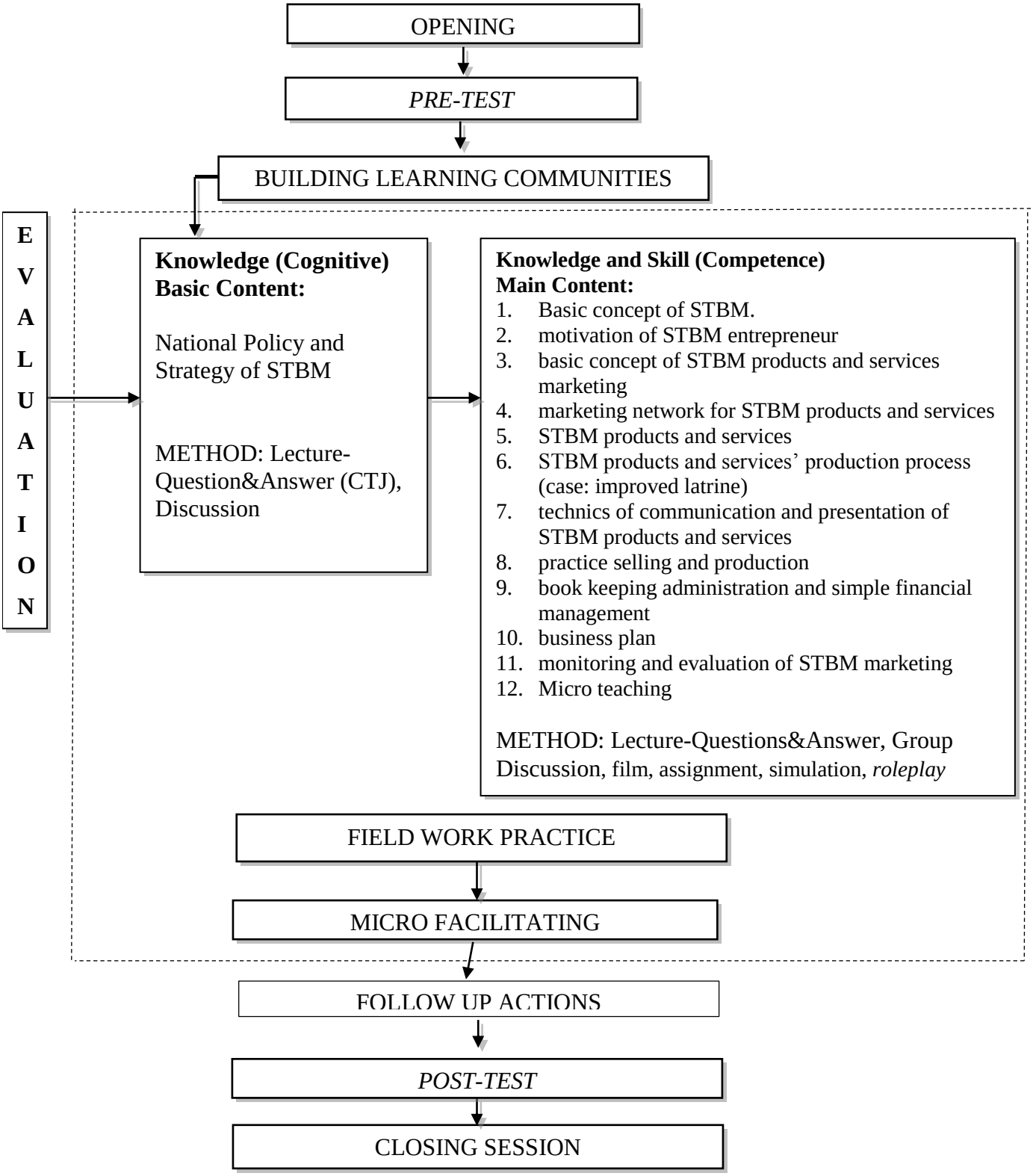
Number of participants in one class: not more than 30 persons.

Program structure:

No	Content	Time			Total Hours
		Theory	Assignment	Field Practice	
A.	Basic Content				
1.	National Policy and Strategy of STBM	2	0	0	2
	Subtotal "A"	2	0	0	2
B.	Main Content				
1.	Basic Concept of STBM	2	0	0	2

2.	Motivation of STBM entrepreneur	1	1	0	2
3.	Basic concept of STBM products and services marketing	1	1	0	2
4.	Marketing network of STBM products and services	1	1	0	2
5.	STBM products and services	2	0	0	2
6.	STBM products and services' production process (case: improved latrine)	1	2	0	3
7.	Technics of communication and presentation of STBM products and services	1	2	0	3
8.	practice selling and production	1	0	7	8
9.	book keeping administration and simple financial management	1	1	0	2
10.	business plan	1	2	0	3
11.	monitoring and evaluation of STBM marketing	1	1	0	2
12.	Micro teaching	6	1	8	15
	Subtotal "B"	19	12	15	46
C.	Supporting Content				
1.	Building Learning Communities	0	2	0	2
2.	Follow Up Action and Evaluation	1	1	0	2
	Subtotal "C"	1	3	0	4
	TOTAL	22	15	15	52
Note: 1 training hour= 45 minutes Credit Point: 1 credit					

Training process:


OPENING
PRE-TEST
BUILDING LEARNING COMMUNITIES
EVALUATION
Knowledge (Cognitive)
Basic Content:
National Policy and Strategy of STBM
METHOD: Lecture-Question&Answer (CTJ), Discussion
Knowledge and Skill (Competence)
Main Content:
1. Basic concept of STBM.
2. motivation of STBM entrepreneur
3. basic concept of STBM products and services marketing
4. marketing network for STBM products and services
5. STBM products and services
6. STBM products and services' production process (case: improved latrine)
7. technics of communication and presentation of STBM products and services
8. practice selling and production
9. book keeping administration and simple financial management
10. business plan
11. monitoring and evaluation of STBM marketing
12. Micro teaching
METHOD: Lecture-Questions&Answer, Group Discussion, film, assignment, simulation, roleplay
FIELD WORK PRACTICE
MICRO FACILITATING
FOLLOW UP ACTIONS
POST-TEST
CLOSING SESSION

5. Curriculum and Module of STBM Facilitator Training for Lecturer

Expected Role : The successors of this training shall work as lecturers teaching STBM in their school

Participants : Lecture in health promotion, community empowerment and basic problem solving of environmental health issues with minimum academic diploma in health environment.

Competences :

1. To explain direction and national strategy on STBM
2. To explain basic concept of STBM
3. To practice STBM implementation
4. To practice triggering in community

Number of participants in one class: not more than 30 persons.

Program structure:

No	Content	Time			Total Hours
		Theory	Assignment	Field Practice	
A.	Basic Content				
1.	National Policy and Strategy of STBM	2	0	0	2
	Subtotal "A"	2	0	0	2
B.	Main Content				
1.	Basic Concept of STBM	2	4	0	6
2.	STBM Implementation	4	6	0	10
3.	STBM Triggering in community	1	3	6	10
	Subtotal "B"	7	13	6	26
C.	Supporting Content				
1.	Building Learning Communities	1	2	0	3
2.	Follow Up Action and Evaluation	1	2	0	3
	Subtotal "C"	2	4	0	6
	TOTAL	11	17	6	34
Note: 1 training hour= 45 minutes Credit Point: 1 credit					

Training Process: