Indonesia National Sanitation (Sanitasi Total Berbasis Masyarakat) Programme

Endline Evaluation

UNICEF-BMGF SANITATION PROGRAMME INDONESIA 2013-2017

EVALUATION REPORT

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VISUALS

Abbreviations and Acronyms

BAPPENAS	Ministry of National Development Planning
BMGF	Bill and Melinda Gates Foundation
CATS	Community Approaches to Total Sanitation
CLTS	Community Led Total Sanitation
CSO	Civil Society Organisation
DAC	Development Assistance Committee
DHO	District Health Office
EAPRO	East Asia and the Pacific UNICEF Regional Office
EM	Evaluation Matrix
EEM	Endline Evaluation Matrix
EQ	Evaluation Question
FGD	Focus Group Discussion
GoI	Government of Indonesia
HH	Household
HHS	Household Survey
HRBA	Human Rights Based Approach
HW	Handwashing
HWWS	Handwashing with Soap
IDI	In-Depth Interview
INGO	International Non-Governmental Organisation
JMP	Joint Monitoring Programme
KAP	Knowledge Attitudes and Practices
KII	Key Informant Interview
KM	Knowledge Management
KSAN	National Conference on Sanitation
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MoH	Ministry of Health
MUI	Majelis Ulama Indonesia (Indonesian Council of Ulama)
NGO	Non-Governmental Organisation
NTT	Nusa Tenggara Timur
OD	Open Defecation
ODF	Open Defecation Free
OECD	Organisation for Economic Cooperation and Development
PHO	Provincial Health Office
POKJA AMPL	Water and Sanitation Working Group
PME	Programme Monitoring and Evaluation
PPSP	Program Pembangunan Sanitasi Permukiman (Accelerated Sanitation Development in Human Settlements)
QL	Qualitative
QT	Quantitative
SanMark	Sanitation Marketing
SDGs	Sustainable Development Goals
SMART	Specific, Measurable, Achievable, Realistic and Timebound
SMS BMS	SMS based Monitoring System
SSR	Secondary Sources Review

STBM	Sanitasi Total Berbasis Masyarakat
SR	Success Rate (ODF)
ToC	Theory of Change
ToR	Terms of Reference
TR	Triggering Rate
UN	United Nations
UNEG	United Nations Evaluation Group
UNICEF	United Nations Children's Fund
USD	United States Dollars
WASH	Water, Sanitation and Hygiene
WB	World Bank
WHO	World Health Organisation
WinS	WASH in Schools
WSP	Water and Sanitation Programme, World Bank

Key Terms

Bupati	Mayor of a district
BAZNAS	The Indonesian Zakat Board
Camat	Head of a sub-district
Dana desa	Village funds
Desa	Village
Dusun	Sub-Village or hamlet (Community)
Kepala desa	the elected head of the village
PKK	Pembinaan Kesejahteraan Keluarga, (The Family Welfare Movement)
Puskesmas	Local health centre at Desa level
RPJMD	District Development Plan
SanMark	Sanitation Marketing
Sanitarian	Puskesmas worker on sanitation

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We wish GOI and UNICEF success with their work for people of Indonesia. We hope this evaluation adds value to the ongoing and future work.

Multiple stakeholders contributed to the evaluation with their experiences and reflections, however the evaluators take full responsibility for the contents of the evaluation report.

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EXECUTIVE SUMMARY

CONTEXT AND BACKGROUND OF THE INTERVENTION (UNICEF SUPPORT TO STBM)

Indonesia is the largest archipelago in the world. With population of 252 million from 360 ethnic groups, Indonesia is the fourth most populous country in the world. Reportedly, the country managed to meet the water related Millennium Development Goals (MDG) targets, however fell short of achieving ones for sanitation[1]. To accelerate access to basic sanitation the Government of Indonesia (GoI) launched a national sanitation programme called *"Sanitasi Total Berbasis Masyarakat"*[2] in 2010 *(henceforth referred to as the STBM programme).*

UNICEF Indonesia Country Office (henceforth, 'UNICEF' refers to the Indonesia Country Office unless otherwise indicated) is one of the key and longstanding partners extending support to the Government of Indonesia (GOI) for water, sanitation, and hygiene (WASH)sector. UNICEF, with assistance from Bill and Melinda Gates Foundation (BMGF) has been implementing a two-country programme i.e. Malawi and Indonesia, named 'Scaling-up and Strengthening Community Approaches to Total Sanitation', since 2013. 'UNICEF-BMGF Sanitation Programme in Indonesia' (also referred to as UNICEF support to STBM) is part of this cross-regional partnership. Initially, the programme was planned for three (03) years i.e. 2013-15, however later extended for two more years i.e. November 30, 2017.

UNICEF-BMGF Sanitation Programme in Indonesia (2013-17) is object of this 'Endline or End of Programme Evaluation'. The readers may note that it is titled as 'Endline Evaluation Survey' in the evaluation TORs, however this remains an 'End of Programme or Ex-post Evaluation'. The report offers an overview of the 'National STBM Programme', which this UNICEF-BMGF programme set out to strengthen and accelerate delivery.

OVERVIEW OF THE NATIONAL STBM PROGRAMME

Indonesia stands as the first country in the region that introduced community approaches i.e. 'Community Led Approaches to Total Sanitation' (CLTS) in 2005. It was Water and Sanitation Programme (WSP) of the World Bank that introduced the approach to help achieve accelerated sanitation results. Later it was included as preferred approach in the 'National Sanitation Strategy (2008)'. The national strategy focuses mainly on three mutually supportive components namely; a) enabling environment; b) demand creation (primarily through CLTS) and c) improvement of supplies (mainly via Sanitation Marketing. The approach was piloted in several provinces before the launch of national programme.

In 2010, the first national rural sanitation programme i.e. STBM, was launched, featuring CLTS. The national STBM programme was initiated with support from 'Office of the President' and designed collaboratively by both the BAPPENAS (Ministry of National Development Planning) and the Ministry of Health (MoH). The two remain key public stakeholders to steer and implement National STBM Programme. The BAPPENAS is mandated to lead sector coordination and provide oversight at both national and sub-national levels. MoH is the lead implementer responsible for planning, field implementation, capacity development, monitoring and reporting. The STBM programme aims to *provide 'universal access to sanitation in the country by 2019'*. The programme outcome is to: *'reduce* the incidence of waterborne and other environmentally linked diseases related to sanitation and hygiene behaviour'. Out of proposed Five (05) Pillars or STBM components, so far efforts of this program were concentrated on Pillar One (01) i.e. Stop open defecation. The technical assistance under UNICEF-BMGF programme focuses on the pillar One.

1. OVERVIEW OF UNICEF-BMGF TECHNICAL ASSISTANCE (OBJECT OF EVALUATION) TO NATIONAL STBM PROGRAMME (2013-17)

This is an 'Endline of End of Programme Evaluation' for the UNICEF-BMGF Sanitation Programme in Indonesia (2013-17).

Purpose and Objectives of the UNICEF-BMGF Programme: The purpose of goal is 'accelerate and strengthen the national rural sanitation programme i.e. STBM, in Indonesia', as to enable achieving 100% ODF status (country-wide) by 2019.

[1] https://everyone.savethechildren.net/sites/everyone.savethechildren.net/files/Indonesias%20progress%20on%20the%202015_July2013.pdf

[2] In English, "Sanitasi Total Berbasis Masyarakat" means 'Community Based Total Sanitation Strategy'

The specific objectives of UNICEF-BMGF assistance as listed in the proposal are:

1. Supplement and expand on-going sanitation programmes in two countries (Indonesia and Malawi) with specific emphasis on learning through innovation;
2. Assess and analyse innovations and implementation strategies in these two countries to distil lessons learned and assess the impact of implementation modalities on progress, and to transmit this learning to other countries in two regions.

The targets included reaching out to accelerate national STBM programme to reach out to **'**80,000 households to have access to new or rehabilitated latrines due to 'direct' interventions' in three provinces. Moreover, an additional 220,000[3] households have access to new or rehabilitated latrines, due to replication by government in Indirect districts. The targets were scaled-down later.

For readers it is pertinent to highlight that UNICEF-BMGF assistance focused on *pillar one of STBM Programme I.e. Stop Open Defecation (OD).*[4]

Focus of UNICEF-BMGF Sanitation Programme – Components and Interventions: UNICEF-BMGF programme prioritised Six (06) key components for the technical assistance. These include a); Improving the enabling environment (for rural sanitation) particularly advocacy for sanitation related policies, regulations and finances; b) Capacity development (public sector agencies in particular) and partnerships; c) Demand creation through improvements in knowledge and awareness among communities; d) Supplies facilitation through innovation and sanitation marketing (SanMark); e) Strengthen the monitoring systems; and f) Knowledge management.

Series of interventions were planned and implemented at all levels i.e. national, sub-national and communities (details in the report).

Outreach of UNICEF-BMGF Programme The UNICEF-BMGF programme has had a series of interventions at national, sub-national, and community levels. At more operational level, the programme extended direct support to provinces and districts to accelerate STBM implementation. The direct assistance was extended to three Eastern Provinces i.e. Papua, South Sulawesi and Nusa Tenggara Timur (NTT). Within three provinces, there are districts which have received direct assistance, hence are referred to as 'Direct' districts. There are Six (06) 'Direct' districts. Besides these, there are Sixteen (16) 'Indirect' districts, receiving provincial level assistance. Remaining are 'Other' districts, which did not receive either direct or indirect assistance.

UNICEF-BMGF Programme Timeline: The global UNICEF-BMGF programme was approved in 2012, however the field implementation in Indonesia commenced in 2013. Planned for three years initially, the implementation was extended by two more years. Overall, it was a 'Five (05)' year programme which was implemented from 2013-17 (ended on November 30, 2017).

Beneficiaries of UNICEF-BMGF Programme: The intended beneficiaries included public agencies, civil society organisation, and eventually the communities i.e. men, women, boys and girls. The key public-sector beneficiaries were the MoH and BAPPENAS including their provincial, district and field level offices. Several NGOs benefitted by getting involved in the programme implementation.

The communities in 'Direct', and 'Indirect' districts are the ultimate beneficiaries of UNICEF-BMGF assistance. UNICEF exceeded the revised targets and were able to support construction of 60,142 and 176,393 new latrines in 'Direct' and 'Indirect' districts respectively. This helped improve the sanitation access to rural Indonesians.

[3] The indicated 220,000 family latrines will be from the three target provinces only.

[4] Because the STBM programme focused on five pillars while UNICEF support to the Government focused only on the first pillar, i.e. Stop Open Defecation (OD), the evaluation did not asses the effectiveness of the overall STBM programme. Since STBM was implemented directly by the GoI through its relevant entities (MoH and others), and UNICEF provided the technical assistance, it was challenging for the Evaluators to assess 'attribution' of UNICEF efforts at the larger scale. Thus, the evaluation scope looked at the Government-UNICEF partnership with a focus on assessing 'UNICEF contributions' to Government's work for STBM by comparing the achievements in Government-plus UNICEF districts, versus Government-only districts.

Financial Resources: BMGF funded USD 7,523,125 for *'Scaling-up and Strengthening Community Approaches to Total Sanitation' for both Malawi and Indonesia.* As per UNICEF Indonesia information (as of July 2017), UNICEF Indonesia received $3.3 million from the total BMGF grant. In addition, UNICEF leveraged funding from other sources to complement the implementation. The other contributors include UNICEF ($ 1.8 million), GoI ($1.7 million – for direct districts only), and communities ($ 5.3 million).

Key Stakeholders & Roles: The key primary stakeholders that remained involved in development and delivery of UNICEF-BMGF assistance to the national STBM Programme includes various public-sector entities such as Ministry of Health (MoH)/STBM Secretariat, Ministry of National Development Planning (BAPPENAS), POKJA AMPL (WASH Working Group), Provincial/District Health Office (PHO), Regional Development Planning Agency (BAPPEDA) and Bill and Melinda Gates Foundation (BMGF), the donor. Other secondary stakeholders involved at different levels include local partners (NGOs/CSOs), media entities, and communities (village level leaders, volunteers, informal/formal forums and the beneficiaries). Refer to Table 1.03.6 for brief description of the role of key stakeholders.

Theory of Change: The BMGF grant document does not include any TOC for the programme. However, during implementation a basic TOC was developed in 2015 and refined further in 2017. The evaluators refer to the latest available version as the current ToC to inform the evaluation design, tools, findings and recommendations.

Evaluation Hypothesis: The hypothesis for the evaluation was embedded in the earlier stated objectives of the evaluation. Hence, leading from that, the hypothesis for the evaluation was:
UNICEF technical assistance to the STBM Programme has contributed in an improved enabling environment, the capacitated governance and the empowered communities that are exhibiting positive attitude and practices for improved WASH behaviours, thereby creating and sustaining a new norm of ODF in targeted provinces.

2. Evaluation Purpose, Scope and Methodology

Evaluation Purpose & Objectives: This is an 'Endline or End of Programme' evaluation. After careful review of the TORs and subsequent discussions with UNICEF WASH team, it was agreed to refer to it as a 'Summative-Formative', to capture fully the stated expectations. It is 'Summative' as being part of the contractual obligations towards BMGF to undertake an end of programme evaluation to generate verifiable evidence of success for accountability purpose. At the same time, it is 'Formative', as both UNICEF and BMGF want to use the evaluation findings in terms of any lessons learnt to inform future programming (see section 2.2.1 for more details).

The overarching objective is to generate evidence of success to assess the effectiveness of UNICEF-BMGF assistance. With that, it's objective is to assess the sustainability of the results, particularly around creation of social norm of latrine use. The evaluation findings and recommendations are expected to inform the scope and scale of UNICEF's future engagement with GOI to facilitate achieving the 'universal access to basic sanitation in Indonesia by 2019. Besides these, the three stated objectives in the TORs.

Significance of the Evaluation; The evaluation is significant as it aims to create evidence and offers an independent view of Programme successes, challenges, and learning for all stakeholders particularly the GoI, UNICEF and BMGF to strengthen and accelerate the achievement of country-wide ODF by 2019. It informs the future collaboration of UNICEF with GoI and BMGF as well for sanitation sector.

Evaluation Criteria: This evaluation followed selected (as desired in TORs) OECD-DAC (Organisation for Economic Cooperation and Development-Development Assistance Committee) criteria. These two criteria are: effectiveness and sustainability. This excluded other three criteria of OCED-DAC i.e. relevance, efficiency, and impact. For UNICEF, the selected criteria are those that were prioritised based on interest of BMGF, the key donor. Moreover, the availability of limited funds played into taking the other criteria out. Besides OCED-DAC, the evaluation included assessment around Non-DAC criteria i.e. equity, gender, human rights based approaches (HRBA).

Evaluation Matrix: This evaluation has been conducted to answer the Key Evaluation-Questions as listed in the UNICEF/Evaluation Reference Group (ERG) approved Evaluation Matrix (EM, see Appendix 2.1 for the full matrix). The EM was formulated based on the ToRs, relevant UNEG/UNICEF

standards for evaluations, discussions with UNICEF/ERG and the Evaluators' understanding of the Programme and the aims of this evaluation.

Evaluation Scope and Coverage: This evaluation covered all interventions and assistance extended under UNICEF-BMGF Sanitation Programme for Indonesia. The scope includes all activities carried out under the programme from January 2013 to November 2017. All these activities relate to 'Pillar One (01)' of STBM except for post KAP assessment around 'Handwashing with Soap (HWWS)', which is 'Pillar Two (02). 'Social Norms' assessment has been carried out for sustained or exclusive latrine use. Norms creation framework however has not been used for assessment of HWWS.

The geographic spread or scope included S*ix (06) 'Direct' and Three (03) 'Other' districts* in three selected provinces i.e. South Sulawesi, Papua, and NTT. The evaluation scope excluded the evaluation of 'Indirect' districts. As per UNICEF WASH team, this decision was made in view of BMGF's interest in having more meaningful comparison and analysis between 'Direct' and 'Other' districts. Moreover, it was done to understand and assess the UNICEF's value addition.

Evaluation Users: The primary users of the evaluation are UNICEF in Indonesia, the GoI, BMGF, and other WASH sector partners in Indonesia. Within the GoI the evaluation is most relevant to the MoH, BAPPENAS, provincial and district governments, and relevant line agencies. The secondary audience consists of other country and regional offices of UNICEF such as UNICEF Country Office Malawi, UNICEF Eastern and Southern Africa Regional Office (ESARO)[5] in Kenya and EAPRO in Bangkok, other UN and donor agencies working in WASH sector such as, the WSP, I/NGOs, and other development partners.

Evaluation Design: The Evaluation uses 'Theory Based Evaluation' design and the 'Quasi-Experimental' research design or approach. The quasi-experimental design is used to assess the programme effectiveness in terms of mapping any incremental change in the 'Direct' districts (experiment group) around improved sanitation access, continuous usage, and allied behavioural changes. To map this change a longitudinal analysis has been undertaken for key programme performance indicators over the period of programme delivery in the 'Direct' districts. The data has been compared against the 'Other' districts, treated as 'control group'. Also, where available, these have been related to national averages to put analysis into perspective e.g. triggering and success rates in districts. The 'longitudinal' and 'comparative' analysis techniques have been used to measure change over time (in Direct districts) and between 'Direct' and 'Other' districts.

Evaluation Methods: The evaluation employed a mixed-method approach by using both quantitative and qualitative methods. A variety of data collection tools such as Desk review, Post-KAP Household Survey (HHS)[6]; Focus Group Discussions (FGDs); and Key Informant Interviews (KIIs) were employed. The HHS also included the physical Observations by enumerators for validation of responses on selected questions about latrine and handwashing facilities. Beside these key methods, unstructured field observations and a transect walk within communities were also conducted to observe the sanitation situation. Additionally, where applicable, a few notable success cases were also documented to highlight examples of key successes and/or weaknesses related to processes implemented, institutional aspects of the UNICEF support and any significant change in WASH-related behaviours observed at household level and at community level.

For quantitative data collection, a post-KAP Household Survey (HHS) was undertaken in all the three provinces under UNICEF's support to STBM. The HHS was undertaken for a pre-determined sample of 3,240 HHs from 36 ODF Villages (desa) in six *'direct'* and three *'other' districts*. The qualitative methods covered a total of *65 KIIs* were conducted at the national, provincial, district and sub-district levels.

Evaluation Key Stakeholders: The key stakeholders consulted for undertaking KIIs includes BAPPENAS (National Agency for Planning and Development); National Ministry of Health, STBM Secretariat; POKJA AMPL Representatives, Field Offices of UNICEF at Provincial level; Provincial Health Offices, District Health Office (DHO); BAPPEDAS (Planning and Development department at district level); Bupati (mayor of a district); Camat (head of a sub-district); Sanitarians (Puskesmas staff);

[5] UNICEF ESARO (East and South Africa Regional Office), Nairobi, Kenya; and UNICEF EAPRO (East Asia and Pacific Regional Office), Bangkok, Thailand

[6] Knowledge, Attitude and Practices (KAP) Household Survey

and Entrepreneur/Mason. Overall, 72 FGDs (i.e. two per community/village) were conducted in 36 villages (Desa) of the six 'direct' and three 'other' districts (four communities per district). The participants (550) of these group discussions included community members (Male and Female), Village Kaders (Volunteers) and other key active members at the community level.

Evaluation Ethics, Quality Assurance and Implementation: The evaluation design and implementation adhered to all applicable UNEG Norms and Standards of Evaluation[7] as stipulated in various UN guidelines and UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis (2015). In line with the stipulation of the TOR and in compliance to the national criteria for research studies in Indonesia, the Evaluators pursued an ethical clearance (904/III/LPPM-PM.10.05/07/2017; dated 24th July is attached as Appendix 7) for approval of the evaluation design, research methods and field data collection protocols, from the well-recognised Atma Jaya Catholic University of Indonesia.

The entire evaluation was conducted in a participatory manner, whereby the 'Evaluation Reference Group' an oversight body comprising government and UNICEF representatives was kept involved on key evaluation processes and deliverables. To carry out field data collection, the international team visited Indonesia from 4th-28th August 2017.

3. Evaluation Findings

The findings and the analysis are structured as such to respond to the evaluation questions and sub-questions, as given in the Evaluation Matrix (refer Appendix 2.1).

Effectiveness

This section responds to the key evaluation question (EQ#1), *"to what extent has UNICEF been successful in enabling the Government of Indonesia (GoI) and sub-national government(s) to develop and implement the processes for achieving the intended outputs and outcomes of the STBM programme?"*

In order to answer evaluation question, the Evaluators assessed the programme interventions and results (including effectiveness of strategies) around strengthening of 'Enabling Environment for Rural Sanitation' (EERS) It begins with giving an overview of the key sanitation results that UNICEF-GOI partnership has produced. These include the key achievements made between 2013-17. However, these are not restricted to UNICEF-BMGF grant only. In subsequent section, a detailed discussion is available around interventions, results, and challenges (including gaps) for assistance provided under UNICEF-BMGF Sanitation Programme, to strengthen the EERS. This however includes assessment for four key elements of UNICEF EE Framework i.e. support for policy and strategy, sector coordination, sector financing, and capacity development.

3.1 UNICEF-GOI Partnership: Key Achievements for Rural Sanitation

This section outlines key sectoral contributions and achievements of UNICEF-GOI partnership between 2013-17. Please note that not all these achievements could be attributed to UNICEF-BMGF Sanitation Programme only. As per UNICEF, two-third (2/3) of the WASH program was from BMGF program; the other one third was spent on water, WASH in schools and health care facilities interventions which are not covered under this evaluation. This evaluation focuses solely on the technical support to the interventions implemented under UNICEF-BMGF Sanitation Programme (2013-17).

- Revision of the ODF verification guidelines;
- Enactment of the Presidential Regulation (#185, 2014) demonstrating highest level of political commitment to achieve Universal Access to Sanitation by 2019;
- Issuance of another national level regulation (#5, 2015) by the Village Ministry to emphasize on the prioritization of rural sanitation as a village development priority;
- Issuance of a Circular by MoH for increasing budget allocation for rural sanitation;
- Finalization of the National STBM Roadmap 2015-19;
- Plan and organize the National Conference on Sanitation (KSAN), held twice in 2015 and 2017;

[7] United Nations Evaluation Group (UNEG), 2016a. Norms and Standards of Evaluation. [.pdf, online] Available at: http://www.unevaluation.org/document/detail/1914 [Accessed: 12 June 2017].

- Development of a 'Fatwa' (religious decree) by MUI (Majelis Ulama Indonesia) for the utilization of 'Zakat'[8] collections for rural sanitation;
- Establishing the baseline for the SDGs targets for water and sanitation;
- Illuminate cross sectoral linkages of rural sanitation, UNICEF WASH and nutrition sections have examined how better to synergise WASH in Schools (WinS) with STBM, while underlining linkages between OD and child stunting;
- the development of provincial WASH profiles by BAPPENAS and WSP, these profiles are accessible on the 'Tinju Tinja' website (a social media campaign to eliminate OD).

3.2 UNCIEF-BMGF SANITATION PROGRAMME: STRENGTHENING OF ENABLING ENVIRONMENT

Overall, the programme appeared to have made significant contributions in improving the EE for rural sanitation. The effectiveness of interventions is evident in terms of accelerated delivery e.g. in terms of triggering coverage in 'Direct' and 'Indirect' districts in selected provinces, improved coordination and information sharing across coordination forums i.e. POKJA, increased finances for rural sanitation (including pilots), and finally increased capacities of frontline staff and communities.

Advocacy for Policy & Planning (Plans, Regulations, and Standards: UNICEF assistance has been instrumental in strengthening the enabling environment at provincial, district and sub-district levels. Most of these efforts relate to advocacy, coordination, capacity development, monitoring, knowledge management and learning. More details of UNICEF assistance and achievements are available in the following sections.

Overall, UNICEF's policy engagement in terms of prioritisation of issues, selection of stakeholders and making inroads (for constructive engagement), strategies and interventions to create receptivity amongst public offices and office holders, has largely been successful. UNICEF advocacy efforts were driven by the need to seek commitment from the Government for the prioritization of rural sanitation at all levels. The objectives were to get firm commitments for enhanced prioritisation and financing by introducing regulations and orders e.g. Bupati Regulations, Circulars and formal letters to different departments. The evaluators believe UNICEF advocacy efforts with strategic and enabling assistance (where required) have bolstered constructive engagement (with stakeholders at all levels) and fostered understanding and ownership of initiatives. For instance, issuance of multiple sanitation related regulations and resultantly the inclusion of STBM targets in District Development Plans i.e. RPJMD, in most of the 'direct' districts. Stakeholders in 'direct' districts appear more aware and sensitised to address the sanitation challenge. In these districts, evidences are available to suggest reasonable increase in sanitation financing from district budgets.

UNICEF support by providing dedicated human resources in terms of 'provincial coordinators' and 'district facilitators', has proven useful in enabling relevant public authorities e.g. the Bupati, BAPPEDA and DHO, etc. to deliver on the STBM agenda. The embedded support in BAPPENAS and STBM Secretariat (at national level) proved enabling also. Both acknowledged the support provided by UNICEF in advancing the rural sanitation. STBM Secretariat benefitted from technical assistance in improving systems and processes, particularly around monitoring, data management, and knowledge management.

Strengthening Coordination: Weak coordination emerged as a key challenge and hence a priority during 'Provincial Bottleneck' undertaken at the start of implementation. To improve coordination, UNICEF focused on strengthening the 'Existing' coordination mechanisms available in the form of national, provincial and district POKJA AMPL. UNICEF has largely been successful in revitalising the POKJAs at the national level and those in the three provinces. Moreover, UNICEF support and lobbying helped to address any duplication of forums (POKJAs) in provinces such as in South Sulawesi. Papua is still operating with two different forums.

Advocacy for Sector Financing: The evaluators received little evidence from UNICEF to ascertain any incremental change in rural sanitation financing at national and provincial levels, particularly for direct districts. UNICEF team shared that they did not track progress on sanitation sector financing during this period. The interaction with the UNICEF Provincial team in Alor (in NTT province) suggests that advocacy with district authorities resulted in issuance of regulations for increased allocations.

[8] Islamic alms to address the fundamental belief that social protection contributions should flow from the well off to the poorest sections of society.

Moreover, the district allocated funds for recruitment of 17 sub-district facilitators for post-triggering monitoring.

UNICEF has been advocating for an increase in sector financing to expedite progress on achieving country-wide ODF. For instance, in Sumba Timur district of NTT province, UNICEF successfully lobbied to have STBM targets included into the district development plan i.e. RPJMD leading to allocation of public funds for STBM implementation. Until 2016, rural sanitation did not have had separate budget line within the 'Village Development Budget'. Until then the Village Heads would make allocations out of interest and commitments. However, in 2016 a new law has been introduced by KEMENDESA (Ministry of Village, Disadvantaged Regions Development and Transmigration), which may contribute to increased rural sanitation financing.

3.3 Capacity Development of Public Agencies and Communities

This section discusses the capacity development interventions under UNICEF's support for public agencies including the sanitarians (front line staff of the local health centre - Puskesmas) and communities.

Public Agencies: Capacity building emerged as a priority need during the 'bottleneck' exercise, which was followed up by offering variety of assistance (at all levels). The focus has been on enhancing capabilities of public sector staff (at all levels) and communities, to strengthen planning and implementation of community lead total sanitation approaches, and improved monitoring and reporting. The evaluators note that capacity development did not follow a particular strategy, nor was one documented, instead it remained 'adaptive', where UNICEF relied on secondary sources to plan and implement training interventions.

The focus has primarily been on training and skill development, at all levels, in 'direct' districts. A series of trainings were organized at different levels, attended by key stakeholders such as public officials from BAPPENAS/BAPEDDA, MoH/DoH and members of POKJA. At ground level, these include the head of the Puskesmas, sanitarians, head of village, local leaders, religious figures, village Kaders, women groups, and masons. Most of these trainings were supported by NGO partners. For some selected districts, learning and exchange visits were organised to inspire and educate sanitarians and other staff.

The major achievements include revision and finalisation of STBM training manuals. These were referred to as key successes that helped in standardisation of training contents and delivery. Additional trainings were organized to support the allied functions of varied tiers of management. These include training in creative writing and documentation, implementation of android based provincial monitoring system in NTT, orientation on the development of a communications campaign for religious leaders, entrepreneurship skills to strengthen sanitation marketing forums/groups.

Capacity development was viewed from system strengthening perspective rather simply an event driven agenda. UNICEF promoted the use of various modalities including the traditional workshops, training events and coordination events were used for executing the overall capacity development approach. Overall, capacity development by the GoI followed a cascade model. The limited engagement of public sector training institutes at any level, appears to be a gap in system-wide capacity development. Moreover, it would have been better had post-training support and follow-up might have been undertaken especially in the mentoring, coaching, on-job support, refreshers, and tracking of how trainees are performing.

Sanitarians: Sanitarians are the key frontline workers responsible for triggering and other activities of for STBM implementation. Most public officials pointed that triggering generally done by sanitarians remains of poor quality. Unfortunately, continued capacity development / on-the-job training of the sanitarians has not been institutionalized within MoH; therefore, MoH relies on organizing training on an ad-hoc basis with support from external agencies like UNICEF and other sector partners. UNICEF needs to further emphasize and actively work with the government to increase investments for the institutionalization of the capacity development of the sanitarians.

Communities: Empowering communities to take the lead in resolving their ODF issues is part and parcel of the STBM / CLTS approach. At the community level, evidence of enhanced capacities (knowledge, action plan, targets, and internalization) varies from region to region, some showing

reasonable progress while others are just taking off. A major area of concern is the adoption of the new social norm of ODF. The implementation of community-agreed sanctions for OD practices is almost non-existent, although people do informally discourage the practice of OD. There is a lack of a defined agenda for post-ODF activities within the government and the communities, in most cases, emanating from varying capacities for Post-ODF activities. Advocating for regular monitoring and documentation through the communities would, in addition to administrative gains, help improve capacity development efforts.

3.4 IMPLEMENTATION

This section discusses in detail the implementation of the Programme, specifically for the partnerships cultivated by UNICEF, communication campaigns and sanitation marketing.

PARTNERSHIPS – ROLE OF THE NGOS / CSOS:

UNICEF pursued partnerships from the national level to the sub-national level, with a variety of different partners including CSOs, NGOs, Academic institutions and Faith based organisation. UNICEF ensured the right selection of the partners considering the local context, penetration into communities, coverage, experience of working in WASH sector and financial stability. The selected partners were properly introduced to the Programme and the goals of the partnership. In a context where the available partners did not have sufficient capacity multiple partnerships within a single district were preferred to minimize the risks involved and leverage the strengths of each partner. Two modalities i.e., PCA & SSFA were employed for contract management. By working through local partners, UNICEF admirably turned the challenge posed by the 2014 fund channelling law, into an opportunity to develop partnerships. UNICEF's partners contributed to the development of knowledge management and communication products. The presence of local partners at the provincial level enabled POKJA to undertake review meetings, monitoring visits and the convening of the training events. At the district level, the local partner worked in close association of the district facilitator resulting in improved work planning and coordination between Puskesmas, sanitarian, camat and the STBM team. In general, the partnerships were mostly successful in producing the required outputs and in providing support to STBM. UNICEF's partnership approach was adaptive to tailor the selection of partners and the work assigned to those partners in each district and province, thereby ensuring context-appropriate support. One limitation in UNICEF's approach was the short duration of the partnerships, that potentially can affect unfavourably the quality of the relationship and future priorities of the two partners. UNICEF's partnerships improved the capacity of the partners to work with government in future with or without UNICEF's presence, is a significant outcome of their work with UNICEF.

COMMUNICATION CAMPAIGNS

The findings in this section highlight UNICEF's contributions in influencing the communication campaigns and approaches being implemented in STBM implementation.

UNICEF's major contribution and achievement is in convincing the government to take a departure from conventional communication approaches and tools to strengthen the 'Behaviour Change Communication (BCC)' strategies, interventions and products. It was for UNICEF's efforts that government bought the idea to introduce and implement 'Post –Triggering Communication' campaigns. This included a developing and implementing a series of interventions to amplify the message shared by the Sanitarian, as part of 'Triggering'. The BCC strategies and interventions were adapted to local context to make these more responsive and effective. UNICEF support helped leveraging and integrating the religious institutions and leaders, as part of BCC campaigning. UNICEF developed a 'Communication Strategy' in 2014, however, was treated as an internal document. Therefore, the extent of its adoption and application by government officials is not much visible.

The use of innovative approaches (off-line use of the social media Tinju Tinja campaign messages/content etc.) used for communication, proved a notable success. UNICEF also involved local networks (local women association, Kaders/volunteers etc.) as means of communication. A formative research about impact assessment of UNICEF's communication approaches would help to guide future communication strategies and as a valuable knowledge management product.

SANITATION MARKETING

The findings in this section covers an overview of the key efforts made, achievements, and areas of improvement around SanMark.

To the evaluators, the SanMark as a concept and interventions has not been prioritised much within STBM. UNICEF assistance did prioritise some aspects of SanMark, however with limited success and documentation. The key achievements are the formation of a SanMark Forum in South Sulawesi; and across all 'direct' districts training of masons to enhance their technical skills for latrine construction and to introduce them with low-cost latrine designs. UNICEF has been able to demonstrate a working model of SanMark with reasonable level of success in NTT. In Papua some efforts have been invested to develop special toilets for the lake-side community. However, the effort is not documented, and no data is available to comment on the degree of success. The monitoring records lack information and analysis around adoption of low cost designs, affordability (for the poor), inclusiveness (disaster resilience and usability across different groups like people with disabilities, older persons and others). Moreover, no evidence is available to suggest success with promoting entrepreneurship (except in NTT) and engagement of private sector in sanitation related services. The evaluation suggests that not much success has been achieved around access to financing for poor beyond effective advocacy for mobilizing the dana desa (village funds) for village level sanitation particularly to help the poor households.

3.5 UNICEF-BMGF Programme Contributions in Changing Knowledge, Attitude and Practices (KAP) of Communities

This section is in response to the key evaluation question, *"to what degree joint GoI and UNICEF efforts succeeded in improving knowledge and attitudes; and adopting and sustaining critical sanitation behaviour (at community and individual levels) in particular ODF (consistent latrine use by all)?"*.

The post-KAP Household Survey (HHS) was conducted by the evaluators as part of the Endline component of this evaluation. The HHS was administered to a total of 3,243 HHS in both 'direct' and 'other' districts of SS, NTT and PP. The Sampling Frame used for the HHS is attached as Appendix 3.2; only ODF communities were included in the survey. Out of the total HHS covered, 67% belong to 'direct' districts while the remaining 33% are from 'other' districts. In both 'direct' and 'other' districts around 50% of respondents are male and 50% are female. The results of the HHS have been analysed disaggregated by various demographic aspects, gender, education and income profile of the survey respondents. The detailed tabulations of HHS results for both categories ('direct' and 'Other') of districts have been annexed as Appendix 14 & 15. Following the standard practice and considering the limitation of Executive summary length (no. of pages), survey results for key selected indicators have been presented in this section.

Overall, the survey results reveal mixed pattern about progress for key indicators related with water, sanitation and hygiene. Survey results clearly indicate the success/value additions of joint implementation by GoI and UNICEF. Out of ten selected key indicators on WASH related knowledge, attitude and practices of communities, progress in 'direct' districts is significantly high than in 'Other' districts where GoI is implementing STBM without any external assistance.

Selected Indicators	'Direct' Districts) (%)	'Other' Districts (%)	Status Comparison
Latrine Existence - Does your house currently have a toilet – Yes	86	85	Marginal difference
Do you share this facility with other families outside of your home? (Yes)	8	8	No difference
Have you improved/upgraded this latrine in last three years? (Yes)	11	10	Marginal difference
When at home, for how many days during last week (7 days), did immediate family members defecate in the open? (some days/most days/every day)	8	14	Significant progress in 'direct' districts
Households reporting participation in meeting about sanitation and during visit of government official regarding construction of a latrine.	33	20	Significant progress in 'direct' districts

Households received sufficient information (awareness messages, supplies, mason etc.) helpful to construct a latrine.	79	81	Marginal difference
Distribution of households able to recall three key messages learned/practice in the participated meeting.	57	36	Significant progress in 'direct' districts
Awareness of any available options to receive any assistance to build a latrine (Have Latrine at Home)	49	17	Significant progress in 'direct' districts
Recipient of any assistance to help you build a latrine (Respondents Have Latrine at Home)	36	26	Significant progress in 'direct' districts
Awareness of any available options to receive any assistance to build a latrine (Respondents without Latrine at Home)	37	5	Significant progress in 'direct' districts

3.6 MONITORING AND KNOWLEDGE MANAGEMENT

The evaluation question on monitoring is "how well did UNICEF monitoring and knowledge management interventions enable the GoI and Communities for programme course correction and advocacy with government?". The findings herein are structured in two subsections; namely Monitoring System and Knowledge Management (KM) to highlight key contributions by UNICEF in improving the STBM monitoring system at national and sub-national levels. The description also encompasses most salient aspects requiring further improvements.

Strengthening of STBM Monitoring: The STBM monitoring system has improved in recent years mainly due to UNICEF's technical assistance. These improvements are visible at the national, provincial and district levels. Major achievements relate to piloting and implementation of SMS based monitoring (SMS BMS) and supporting the MoH at the national level in its efforts to further improve the monitoring system and the associated STBM website. However, a lot of work needs to be done to strengthen post-ODF monitoring at the community level. POKJAs role in the monitoring of STBM implementation at the district level needs more recognition. Simultaneously, the role of the Puskesmas in monitoring the progress of STBM needs to be enhanced through increased earmarked public funding for monitoring.

UNICEF supported the MoH by appointing a dedicated KM expert to look into the significant challenges of the existing SMS BMS. UNICEF supported the STBM training on SMS and Web Based Monitoring System at provincial level to train government staff from BAPPEDA, PHO, DHO, district level operators and the sanitarians. With technical support of UNICEF, in NTT, the Android based Monitoring application has been developed and implemented by government for provincial level monitoring of the STBM programme by the Provincial POKJA. The POKJA can use monitoring information/data to plan, organize and execute its support specific to the needs of each district. Since 2016, UNICEF's technical support to STBM secretariat is focused on improving the feedback system on the monitoring data. Despite significant improvements on various aspects of the monitoring system at all levels, the current system is still facing some issues about data quality, consolidation and reporting. Therefore, the current efforts are also directed to remove such anomalies from the system. In this aspect, UNICEF is working with MoH to introduce the three new indicators to monitor quality of triggering such as success rate, triggering rate and the slippage, each of which can help to identify weaknesses in the implementation of STBM.

Knowledge Management (KM): Under UNICEF-BMGF technical support, the core objective of KM is to contribute to policy influencing, advocacy, better programming and improving the evidence through improved documentation, reporting, review, consolidation of expert viewpoints and monitoring & evaluation. The KM efforts aimed to save efforts of the individual districts from "re-inventing the wheel" when implementing STBM. To achieve these objectives, UNICEF efforts around KM has resulted in varying degree of success for sharing of learning experiences and knowledge management at all levels. UNICEF's KM efforts were guided from a WASH KM strategy that was prepared by UNICEF in 2014[9]. However, the extent to which KM strategy was applied, varied across districts mainly due to varying existing capacities within various tiers of the government.

[9] United Nations Children's Fund (UNICEF), 2014b. KM Workplan WASH 2014.

A noteworthy achievement of UNICEF support around KM is the wider acceptance and recognition of the need for KM component within government system. Though, a lot more needs to be done at government level for integrating KM into the Government's systems, UNICEF is successful in sensitizing and enabling the government to understand the crucial role of KM to accelerate and sustain the STBM accomplishments. In conclusion, where knowledge management did not get the due attention in the early years when the focus was more on Programme implementation, it is firmly on the agenda now. Dedicated, robust efforts are required to compensate for the time lost and to get desired outputs and outcomes. Alongside, the government's capacity of creating knowledge management products is noted at the lowest level.

3.7 UNICEF VALUE ADDITIONS

1. **STBM Acceleration and Scale-up:** The most appreciated value addition of UNICEF's support in 'direct' districts is wider coverage (high triggering rate) and marginally better success rate for ODF achievements. In UNICEF's 'direct' districts in NTT, the triggering rate is 100% and the success rate is 43%; in contrast, the triggering rate in 'other' districts is 72% and the success rate is 41%. The similarity of the success rates, despite significant differences in triggering rates, can plausibly be linked to UNICEF's contributions to the enabling environment at the provincial level (POKJA AMPL, BAPPEDA, PHO), thereby producing positive impacts on government-led implementation in 'other' districts.
2. **System strengthening approach:** UNICEF value additions are evident from improved Government systems for STBM planning and implementation by National STBM Secretariat in the MoH, the POKJA AMPL under BAPPENAS and other Government and sector partners at the national and sub-national levels.
3. **A shift from output to outcome;** UNICEF successfully shifted the focus of the Government from output (latrine construction) to outcome (ODF) by emphasizing the need for high quality triggering - concrete planning or actions for post-ODF agenda, from the Government have not yet materialized however.
4. **Focus on Behaviour Change Communication;** *UNICEF efforts to promote long lasting improved WASH behaviours through creation of 'Social Norm' represents a significant value addition to STBM*. Presently government acknowledges the value of regular multi-channel communication campaigns as part of post-triggering actions at community level.
5. **Partnership Dividends;** *By fostering local partnerships and improved coordination with government, UNICEF has increased the ability of local partners to support government-led implementation of STBM in future.*
6. **KM and Sharing of Lessons Learned;** The collection, documentation and sharing of innovations and lessons learned, between provinces and districts (both 'direct' and 'Other') is a commendable contribution of UNICEF. This *'enabled sharing'* has empowered government to replicate novel interventions across districts within provinces.

SUSTAINABILITY

This section responds to key evaluation question, *"how application of two different approaches (Joint implementation in 'Direct districts'; and Government –only for 'other districts') affected the implementation, results and sustainability of the achievements?"*

UNICEF efforts, have contributed in embedding the STBM ownership within government system, at least in 'direct' districts, is well-demonstrated. However, post-ODF agenda needs further efforts to sustain the ODF achievements. In this regard continued advocacy efforts are required to enact relevant supporting regulations in ensuring that post-ODF activities are planned, provided funds and emphasized by the government system. Frequent changes of leadership within key departments at provincial and district level negatively impact the sustainability of the achieved results, a factor beyond control of UNICEF. With UNICEF's efforts, coordination forums at provincial and district levels have been revived and capacitated with necessary planning, implementation and other technical skills indicating positive signs for sustainability. With UNICEF support the government has worked with local NGOs. The enhanced capacities of the NGO partners in terms of better understanding of the role of government entities in STBM implementation warrants more likelihood of sustainability. Government needs to further harness the strengths of these NGOs in sustaining the ODF achievements and devising the post-ODF agenda. At community level, sensitized local networks (PKK, volunteers/Kaders etc.) have played a pivotal role in implementing ODF activities, but their role is diffusing with time. Continued active engagement of these local networks needs government support for their potential role in post-

ODF monitoring, leading to stabilization of the new social norm. Shared latrine use is common, but in the long term it is not a replacement for having a latrine in each household. Government led STBM implementation needs to help households in moving up the sanitation ladder, not merely focusing on pillar-1 (ODF). The STBM implementation particularly in UNICEF supported 'direct' districts need gradual expansion to include other key pillars of STBM particularly HWWS in priority and then the others as well.

3.8 Social Norm Development

The findings in this section respond to the evaluation question "*to what extent did UNICEF's support to STBM enable the government, households and communities in creating and sustaining a social norm of ODF?*" To respond to this question comprehensively, the Evaluators took note of current STBM implementation model and particularly the communication model and interventions (including those for pre-and-post ODF) vis a vis behavioural transformation to the extent of creating/upgrading social norms of latrine use. To complement that, social norms questions were added to the post-KAP/HHS particularly around beliefs, access and practice, normative and empirical expectations, and existence of sanctions, and analysed accordingly to assess existence of norm of exclusive latrine use.

The review of current STBM pre-and-post ODF interventions indicate that the current STBM implementation does not have any specific interventions to create and sustain social norm of exclusive latrine use. The pre- and post- ODF tasks of sanitarians appear to lack any particular activity/ies aimed to create collective commitment (by all members of the community) to sustain the practice of latrine use, once ODF status is awarded. Moreover, no reference was made to the current programming seeking communities impose (agreed) sanctions on those who may not comply with the agreed behavioural expectations. Informal sanctions exist in the form of public censure, however not in all villages and not formally agreed upon as sanctions for non-compliance. In lieu of the above, it could be argued that the MoH may need to take a considered view of whether it intends to adopt the concept of social norm creation and if it is affirmative, the current programming would require some fine-tuning.
The numbers and analysis for post KAP in terms of personal beliefs, normative and empirical expectations (against the actual prevalence of latrines) and existence of sanctions, all point to 'Unstable Social Norm' of exclusive latrine use.

Moreover, Evaluators may want to impress that norms creation is a long-term process. The expectations to create/upgrade norms in 2-4 years programming cycle appear unrealistic. For the government counterparts the concept is fairly new, as is for UNICEF. UNICEF needs to work closely with government agencies to unbundle the concept and create set of interventions for social norms creation. It may need to set guidance and standards around criteria and pre-condition in which to communities would be considered having achieved 'Stable Social Norms'. The pre-conditions must set some flexibility for open defecation in so called 'Special Circumstances', as this may continue to happen.

Scalability: Using the WHO framework to assess the scalability potential of an intervention, the evaluators' commentary adheres to the qualitative assessment of all elements of the WHO framework. Despite significant improvements in government's capacity for STBM planning and implementation, still there are many weak areas that require dedicated efforts by the government to improve its capacity, such as monitoring system, post-ODF plans and resources, knowledge management, and standardization of planning and implementation processes for successful scalability. Value additions introduced by UNICEF in 'direct' districts have all potential for replication and scalability, so must be considered by the MoH, BAPPENAS and STBM Secretariat for replication; however, there is need to tailor the best practices (learned from 'direct' districts) to the varying diverse contexts in Indonesia for country-wide adoption. Better rationalized prioritization of those districts where STBM has not been initiated yet or is not progressing well must be considered. The sensitization and experience of the provincial governments obtained through UNICEF support needs to be leveraged by the national entities to scale-up STBM in other areas.

3.9 Non-DAC (OECD) - Gender, Equity and Human Rights

The commentary in this section is in response to the key evaluation question, *"what approaches, strategies, and interventions are integrated in STBM to enable improved sanitation coverage for poor, minority, men, women, boys, girls, elderly people and person with disabilities?*".

Gender: Overall, considering that UNICEF's inputs, by design, are limited to technical assistance and support by way of guidance and demonstration, the findings clearly show that the STBM Programme is gender-sensitive; a fact clearly visible at the village and community levels where women and girls are involved in most of the interventions / actions undertaken at community level. However, UNICEF can further influence the government in improving gender norming in the STBM programme. This level of attention can be encouraged by asking for gender-disaggregated data and statistics, and application of monitoring systems, across all types of interventions, particularly for capacity development. UNICEF's intervention in this regard will foster the development of treatment for women and girls that may be different but necessary to ensure equivalency in terms of rights, benefits, obligations and opportunities.

Discussions with female respondents during FGDs have highlighted some key social issues associated with the Programme implementation and achievements, that affects their role in daily life such as shared use of latrine, increased workload in maintaining and cleaning domestic or shared latrines etc. The programme has contributed in greater recognition among communities of the need for continued latrine usage. This has resulted in some form of informal positive sanctions such as issuance of letter of recommendation for couples who want to marry, until the couple ensures that a latrine is constructed in the couple's home.

Equity: By design, CATS implementation discourages the provision of direct subsidies and so the STBM. UNICEF maintained the principles of CATS by not promoting direct subsidies for latrine construction, however equity aspects were addressed by focused advocacy for the utilization of village funds (DANA DESA) and Zakat money for sanitation purpose particularly for helping poor who cannot afford to construct latrine. The selection of deprived regions (provinces and districts) for UNICEF's support reflect equity focus of UNICEF's programming.

Despite visible focus on equity, a few aspects of SanMark needs further efforts to comply for equity aspects such as poor access (30%-50%) in accessing sanitary supplies and weak focus (51%) on facilitating the availability of loans and/or any other financial assistance options as reflected from HHS results. Similarly, limited availability of latrine designs for persons with disabilities and disaster resilient latrine designs are other weak equity aspects of UNICEF's support to TBM. However, few efforts have been made in Papua to develop latrine designs for the lake-side communities, however limited success is noted so far.

HRBA Considerations: By and large, the overall Programme design and implementation of UNICEF's technical assistance corresponds to key aspects of human rights based programming principles. Involvement of relevant government key entities in coordination forums (POKJA) and frequently convened progress review meetings have established some form of accountability within duty bearers. The sensitized communities are now more aware of their water and sanitation rights, however the establishment of a complaint redressal and conflict resolution mechanisms for right-holders remain unaddressed. The commentary below separately elaborates all above highlighted aspects.

4. Lessons, Conclusions and Recommendation

4.1 Conclusions

UNICEF's Technical Assistance to STBM has indeed remained aligned to the ToC pathways and the outcome-level results. Where applied collectively the results are emphatic (e.g. germinated an enabling environment supported by enhanced governance; national, provincial and district levels, creating knowledge-empowered communities that exhibit positive attitude, implementation, and greater ownership and participation) and wherever any aspect of the pathways remained weak, the results too have been affected (e.g. a slowly emerging and unstable new social norm of ODF).

The Evaluators conclude that UNICEF support to STBM has largely been successful in furthering the national ODF momentum, and as a means to increase the coverage and success rate for government implementation. UNICEF has successfully demonstrated the utility of supporting the government led implementation with limited funding, scope and scale, to achieve the wider results. UNICEF support has thus been a cost--efficient model of technical assistance. The success should progress to a scaling up and thereby ensuring a significant contribution towards achieving the national goal for elimination of ODF in Indonesia.

However, a lot more work still needs to be done towards perfecting planning, budgetary analysis, improving the monitoring system (software, hardware, technology integration, use of information), and, in enhancing the government's capacity to vitalise knowledge management and its appropriate utilisation. The involvement of long-term local partners and added focus on meaningful involvement of a variety of influencers (such as Camat, village head, existing local networks, religious/faith-based leaders) will play a vital role in strengthening implementation efforts.

Overall, the concept of 'Social Norms' in rural sanitation i.e. STBM, is not yet fully integrated into implementation processes. There is only limited awareness of 'Social Norms Theory' at all levels. There is need to advocate with government to adopt the 'social norm' concept and integrate it into STBM programming.

Overall, If UNICEF's model of technical assistance is scaled up across Indonesia, particularly where STBM has yet to establish a strong reference and evidence, Indonesia will eventually accelerate progress towards universal ODF status, and thereby laying the foundation for achieving WASH targets of the SDGs.

4.2 LESSONS LEARNED

Find below a list of key lessons learnt (and best practices) drawn from discussions with key stakeholders. These were validated and further distilled during discussions with ERG.

1. Strong and contextually relevant evidence (message) strengthens Advocacy & Lobbying: Moreover, to leverage benefits of advocacy, interventions must be timed to correspond the national and subnational planning cycles and processes, to enable inclusion of relevant interventions and secure commitment for adequate resources into national and sub-national sectoral/development plans.
2. 'Flexible/Adaptive Models' are best suited to address regional diversities: The continuity and scalability of Flexible/Adaptive Models of delivery, is expected to accelerate the successful STBM implementation.
3. BCC leverages faiths and faith leaders as key influencers: The STBM BCC must effort to leverage belief systems and faith leaders as influencers, for successful and sustainable behavioural change.
4. Post-triggering BCC campaigning works to reinforce sanitarian messages: The use of interactive, contextually relevant content and its repetitive dissemination worked well to further strengthen the resolve (post-triggering) to construct latrine (move away from OD).
5. Appropriate timing is critical for success of knowledge management and usability: The KM underpins the relevance and quality of evidence creation, which in turn accelerates and influences the lobbying and advocacy, and consequently the scale-up. Knowledge management and effective dissemination requires timely planning and resources with adequate capacities (at all levels) to enable reflections, documentation, and dissemination.

4.3 RECOMMENDATIONS

This section lists the outline of the strategic and operational recommendations of the Evaluation. The complete matrix entailing Recommendations & Actions, reference to the relevant section of the findings, and Priority & Responsible Stakeholder/s have been presented in the main report. The recommendations have been drawn following 'participatory' and consultative process and were validated involving ERG members particularly the relevant government authorities.

1 - Improved coordination lies at the core of successful and accelerated implementation of STBM Programme. The successes and achievements vis a vis improved coordination shall require a); adequate staffing; b) merger or consolidation of multiple POKJA; c) enhanced capacities of POKJA members and d) dedicated efforts to encourage information exchange through documentation, newsletters, and where possible exchange visits.

2 - Effective communication underpins success of any behavioural change interventions. The STBM communication model or approach requires a complete overhaul or revamping. The overhaul should entail a) increased focus on post-triggering communication; b) leveraging of interactive communication mediums; c) involvement of religious and faith-based institutions and leaders as key influencers; d) 'Adaptive' communication approaches; e) prioritisation of post-ODF behavioural compliance including progression on sanitation ladders; and f) more investments to improving communication capacities of

Sanitarians and other frontline staff; g) leverage the human resources for health promotion/education, particularly those at ground level (in Puskesmas and districts) to share the burden of sanitarians; h) Leverage technical capacities of Public Information and Communication Department at district level to tailor the communication strategies, interventions and products to the respond to the local context.

3 - Sanitation marketing is integral to diversifying technologies, improving affordability and access, and achieving inclusive access. The STBM needs to lay adequate focus on improving access, affordability, quality, and resilience of sanitation technologies in Indonesia. This may require different initiatives such as: a) comprehensive assessment of sanitation market; b) facilitate research and product development to help diversify technologies and make them more affordable; c) encourage private sector engagement; d) encourage inclusive and resilient latrine designs; e) encourage/introduce loans and grants (from social protection and Zakat funds) to help extreme poor have access to latrines.

4 - STBM monitoring system has seen improvements, however there are areas that need further work. The monitoring system needs a systematic and gradual upgradation (to align it to SDGs) which may require a) systemic assessment to identify and prioritize areas for improvement; b) undertake comprehensive human resource capacity assessment; c) set mandatory requirements for use of monitoring data for planning, reviews, and resource allocations at all levels; d) introduce process and outcome/impact monitoring processes into regular monitoring; and e) develop guidelines for data management team, reporting standards and integration of available information with the planning cycle.

5 - Research is integral to knowledge management (KM) and evidence creation. The STBM Programme needs a concerted focus on improving research and knowledge management. This may require: a) clear and well-thought out research and knowledge management strategy and action plan with and adequate resources; b) comprehensive capacity assessment and development plan for KM; c) focus on producing knowledge products and evidences highlighting the best practices; d) enhanced utilization of available evidence and e) encouraging greater engagement of academic and research institutes

6 - STBM Secretariat may need to take a considered position on adoption of concept of ‘Social Norms Creation’ for rural sanitation programme. It will require to focus and prioritization of collective behavioural change, expanding the involvement of local reference networks, and capacity development of key implementers.

1. CONTEXT & OBJECT OF EVALUATION

1.1 Context and Background

Indonesia is the largest archipelago nation in the world. With a population of 252 million from 360 ethnic groups, Indonesia is the fourth most populous country in the world. It stretches 5,150 km between the Australian and Asian continental mainland, and divides the Pacific and Indian Oceans at the Equator. The country comprises five main islands, namely Sumatra, Java, Kalimantan, Sulawesi and Papua. It has a total of 17,508 islands, among which 6,000 are inhabited. The population of Indonesia can be divided into two major groups: in the western region, most from the Malay ethnicity, while in the eastern region there are the Papuans originating from the Melanesian Islands. Minority ethnicities are derived from Chinese, Indian and Arab descendants. Islam is the major religion, followed by 85.2% of the population, which qualifies Indonesia as the largest Muslim country in the world. The remaining population consists of Protestants (8.9%); Catholics (3%); Hindus (1.8%); Buddhists (0.8%) and other religions (0.3%). Indonesia is administratively divided into 34 provinces and 508 districts[10]

Over the past decades, Indonesia has made considerable progress in reducing poverty, including extreme poverty. This has resulted in improved its rankings on human development indices. Despite significant socio-economic achievements, the country lags in achieving universal access to improved sanitation and safe water. Those living in rural areas are relatively more deprived. Reportedly, the country managed to meet water-related MDG (Millennium Development Goals) targets, however fell short of achieving ones for sanitation[11]. By the end of 2015, only 61% of the total population of Indonesia had access to improved sanitation. 20% were reported to be practicing open defecation.[12]

At all levels, there is appreciation that together poor sanitation and related hygiene behaviours, are impacting both health and the economy. Water and Sanitation Programme (WSP), a World Bank (WB) initiative, reported that 'in 2006 alone, Indonesia lost an estimated IDR 56 trillion (USD 6.3 billion) due to poor sanitation and hygiene, equalling 2.3% of the country's gross domestic product (GDP)'.[13] The Ministry of Health (MoH) estimates that in 2012 'the number of diarrhoea patients in health facilities amounted to 5,097,247 people' and records 192 outbreaks of diarrhoea between 2008 and 2015, which resulted in 515 fatalities.[14] Another study reports that 'the combination of unimproved latrines and untreated drinking water was associated with increased odds of stunting in three districts of Indonesia'[15]. As per the MoH report (2013), 18% of children under 5 were severely stunted and 19.2% were stunted.[16]

[10] Organisation of Economic Cooperation and Development (OECD), 2016. Country Profile – Indonesia. Available at: http://www.oecd.org/regional/regional-policy/profile-Indonesia.pdf [Accessed: 23 June 2017]. Note that the number of districts (regencies and cities) in Indonesia has increased over time; the number mentioned is based on information from 2016.

[11] https://everyone.savethechildren.net/sites/everyone.savethechildren.net/files/Indonesias%20progress%20on%20the%202015_July2013.pdf

[12] https://www.wssinfo.org/documents/?tx_displaycontroller[type]=country_files

[13] Water and Sanitation Programme (WSP), 2008a. Economic Impacts of Sanitation in Indonesia. [.pdf, online] Available at: https://www.wsp.org/sites/wsp.org/files/publications/esi_indonesia.pdf [Accessed: 5 June 2017.

[14] Ministry of Health (MoH), 2015. 2015 Indonesia Health Profile. [.pdf, online] Available at: http://www.depkes.go.id/resources/download/pusdatin/profil-kesehatan-indonesia/indonesian%20health%20profile%202015.pdf [Accessed: 8 December 2017].

[15] Torlesse, H., Cronin, A.A., Sebayang, S.K., Nandy, R. (2016) Determinants of stunting in Indonesian children: evidence from a cross-sectional survey indicate a prominent role for the water, sanitation and hygiene sector in stunting reduction. *BMC Public Health*, 16:669; DOI 10.1186/s12889-016-3339-8; https://www.ncbi.nlm.nih.gov/pubmed/27472935

16 Ministry of Health (MoH), 2013. Indonesia Health Profile 2013. [.pdf, online] Available at: http://www.depkes.go.id/resources/download/pusdatin/profil-kesehatan-indonesia/Indonesia%20Health%20Profile%202013%20-%20v2%20untuk%20web.pdf [Accessed: 25 November 2017].

Globally, evidence suggests that, 'Water, Sanitation and Hygiene (WASH) investments can have significant health, economic and development benefits and provide excellent value for money' in many contexts. World Health Organisation (WHO) estimates suggest that 'for every $1 invested in water and sanitation, an average of at least $4 is returned in increased productivity. Hygiene promotion is the most cost-effective health intervention.'[17] [18] Over 40% of infant deaths in Indonesia are caused by diarrhoea and pneumonia, both of which are waterborne diseases.[19] Research indicates that the improvement of the water quality can reduce diarrhoea incidence by up to 30% in the country.[20]

World Health Organisation estimates that 'For every 1 USD invested in water and sanitation, the economic return is at least 4 USD because of improved health and increased productivity'.

Realising the challenge and consequent impact, the GoI took different initiatives to improve access to and the quality of water, sanitation and hygiene promotion initiatives. For rural areas in particular, the focus shifted to community-led and government-supported services. For rural sanitation, 2005 saw the introduction of the 'Community-led Total Sanitation' (CLTS) approach by the World Bank's Water and Sanitation Programme. UNICEF's equivalent effort is known as the 'Community Approaches to Total Sanitation' (CATS), which is an umbrella[21] term that embodies multiple approaches, which can be applied through a range of methods. These include engaging with the Government and strengthening its ability to deliver on sanitation, CLTS, School-Led Total Sanitation (SLTS), Total Sanitation Campaigns (TSC) and other approaches, including community meetings, sanitation marketing etc.[22] CLTS focuses on triggering behaviour change in communities to stop Open Defecation (OD) and thus, to achieve Open Defecation Free (ODF) status.

To expedite progress towards sanitation MDGs, the Government of Indonesia launched a national sanitation programme called *'Sanitasi Total Berbasis Masyarakat'*[23] in 2010 (henceforth referred to as the STBM programme). The STBM Programme was developed jointly by the 'Office of the President' and the MoH. To oversee the programme roll out, a dedicated STBM Secretariat was established in the same year (2010).[24] Different sector partners contributed to setting up the Secretariat, including UNICEF.

Improved access to sanitation continued to remain a public policy priority in Indonesia. In recent decades, it has gained more prominence. In 2014 the President of Indonesia[25] issued a presidential decree declaring rural sanitation a national priority. The decree sets the target of achieving universal access to sanitation by 2019, illustrating political commitment to addressing the challenge of sanitation at the highest level.

The UNICEF Indonesia Country Office *(henceforth, 'UNICEF' refers to the Indonesia Country Office unless otherwise indicated)* is a key sector partners, and has been assisting the GoI to

17 United Nations Children's Fund (UNICEF), 2015. Water, Sanitation and Hygiene – The Case for Support. [.pdf, online] Available at: https://www.unicef.org/publicpartnerships/files/WASHTheCaseForSupport.pdf [Accessed: 8 December 2017].
18 http://water.jhu.edu/index.php/magazine/climate-change-and-health-why-the-link-to-water-is-critical/
19 http://unicefindonesia.blogspot.com/search?q=SANITATION
20 Yogyakarta survey reveals challenges and opportunities for ensuring access to clean water and sanitation. Posted by UNICEF Indonesia, By Aidan Cronin, Chief of WASH, Mitsunori Odagiri, UNICEF WASH Officer, and Bheta Aryad, Social Policy Specialist, UNICEF Indonesia. January 5, 2017. http://unicefindonesia.blogspot.com/search?q=SANITATION
21 Monitoring Community Approaches to Total Sanitation (CATS). http://www.sanitationmonitoringtoolkit.com/sanitation-monitoring-toolkit/monitoring-community-approaches-to-total-sanitation-cats
22 UNICEF: Global evaluation of CATS Sector Strategy – Final report – March 2014. https://www.unicef.org/evaluation/files/Evaluation_of_the_WASH_Sector_Strategy_FINAL_VERSION_March_2014.pdf
23 In English, 'Sanitasi Total Berbasis Masyarakat' means 'Community Based Total Sanitation Strategy'
24 http://www.stbm-indonesia.org/
25 http://documents.worldbank.org/curated/en/326971467995102174/pdf/100891-WSP-P131116-AUTHOR-Susanna-Smets-Box393244B-PUBLIC-WSP-SERIES-WSP-Indonesia-WSS-Turning-Finance-into-Service-for-the-Future.pdf

help improve access to sanitation, particularly in rural areas. In 2012, with assistance from the Bill and Melinda Gates Foundation (BMGF), UNICEF developed a three-year programme (2012-15) named *'Scaling-up and Strengthening Community Approaches to Total Sanitation' (henceforth referred to as UNICEF support to STBM or simply the Programme)*. It is pertinent to note that the actual field implementation in Indonesia however started in 2013. Under this programme, technical assistance was extended to the Government of Indonesia (hereafter referred to as GoI and the Government) lead national STBM programme to both accelerate and strengthening its implementation.

The technical assistance for national STBM in Indonesia is part of wider organisation partnership between UNICEF and BMGF. Under this partnership BMGF provided financial assistance to the UNICEF Headquarters and two Regional Offices. The global partnership funded assistance to the Government of Malawi also. Although planned for three years initially, this programme was extended until the end of 2017 (in Indonesia).

As part of the contractual obligations UNICEF commissioned and 'Endline Evaluation' for UNICEF-BMGF Sanitation Programme in Indonesia. The Evaluators' may want to put on record that this is a complete 'Endline or Ex-Post Evaluation', however the TORs (Appendix 1) refer to it as 'Endline Evaluation Survey'. However, after discussions with UNICEF Indonesia Office, this report is titled as 'Endline Evaluation'.

1.2 Overview of the National STBM Programme

This section describes briefly the national rural sanitation programme called STBM, to which UNICEF extended technical support under UNICEF-BMGF Sanitation Programme. The overview includes STBM aims and objectives, approaches, components and interventions.

In 2005, it was Water and Sanitation Program of the World Bank P that introduced 'Community-led Approaches to Total Sanitation' (CLTS) in Indonesia. From 2005-08, this approach was piloted in several provinces to assess how it works in rural Indonesia. The pilot implementation proved successful. Recognising the demonstrated success of CLTS in accelerating sanitation results, the GoI included it as a preferred approach in the 'National Sanitation Strategy - Indonesia' in 2008. As explained above, the first national rural sanitation programme i.e. STBM, was launched in 2010 featuring CLTS implementation at scale. Reportedly (as per MoH) by 2015, STBM was being implemented in 492 out of 514 rural and urban districts, in all 34 provinces. This indicates its nation-wide coverage or CLTS implementation at scale.

The national STBM programme was designed collaboratively by both the BAPPENAS (Ministry of National Development Planning) and the MoH. The BAPPENAS is mandated to lead the 'Sector Coordination' and is involved in STBM oversight at national and sub-national levels. MoH is the 'Lead Implementer' at all levels and role entails periodic planning, field implementation, training, and monitoring and reporting.

1.2.1 STBM Results, Components, and Approaches

The national STBM programme has varied levels of results, however the overarching goal is to: 'provide 'universal access to sanitation in the country by 2019'.

At lower level in the results hierarchy the programme intends to achieve the outcome of: 'reduce the incidence of waterborne and other environmentally linked diseases related to sanitation and hygiene behaviour'.

The programme delivery strategy or approach is 'Community-led' i.e. CLTS, to achieve the goal and outcome The STBM website[26] while explaining the programme and approach states that: 'STBM is an approach to change hygiene behaviours and a poor sanitation situation through community empowerment with triggering methods.'

Components/Pillars of STBM Programme

The STBM programme has multiple components. There are 'Five (05) programmatic components, referred to as STBM 'Pillars' (see Visual 1.01). These are:

1. Stop open defecation;
2. Handwashing with soap and running water;
3. Drinking water and food management;
4. Domestic solid waste management;
5. Domestic liquid waste water management.

For more details please refer Appendix 8.

Visual 1.01: Five Pillars of the STBM

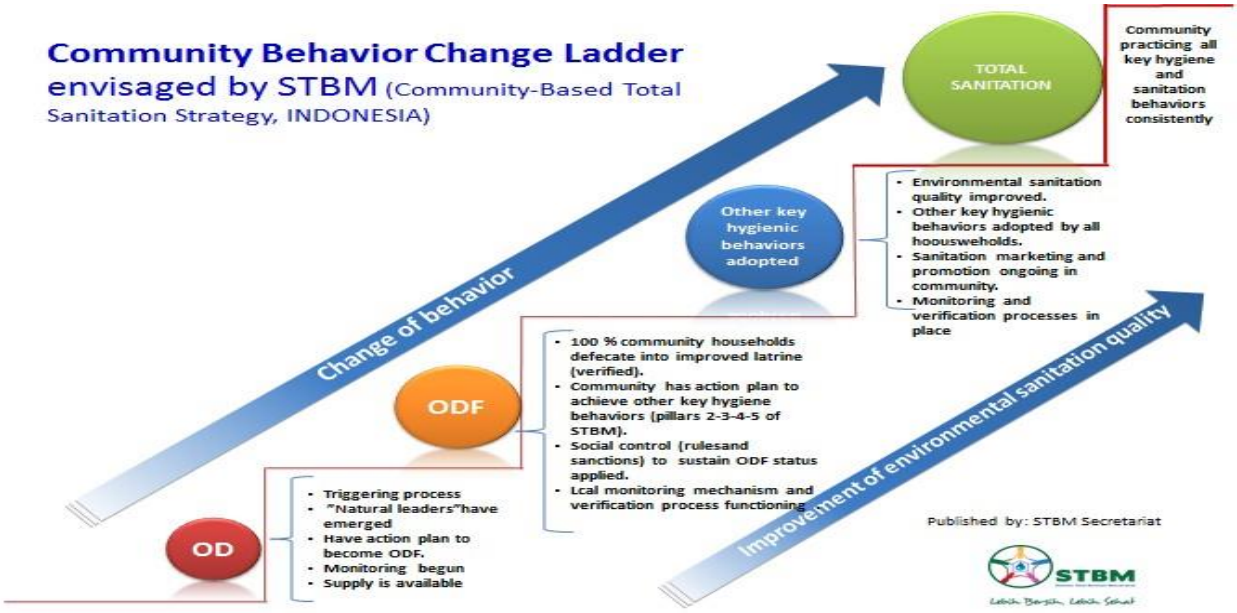
Approach/es of STBM Programme

The national STBM programme is designed and being implemented using the 'Community-led Approaches'. The approach being used is CLTS, however UNICEF has been advocating and supporting the GOI to adopt the broader approach i.e. CATS (Community Approach to Total Sanitation). This approach features amongst the five pillars of the 'National Sanitation Strategy of Indonesia (2008)'. Doing so, Indonesia became the first country in the South East Asian region that adopted the 'Community led Approaches' i.e. CLTS and CATS, as a part National Sanitation Strategy.[27]The national strategy focuses mainly on three mutually supportive components, namely; a) enabling environment, b) demand creation (primarily through CLTS), and c) improvement of supplies (mainly by applying Sanitation Marketing i.e. SanMark). The Visual 1.02, sums up the progressive behavioural change approach that this model embodies.

26 Ministry of Health of the Republic of Indonesia (MoH), 2017c. Overview of STBM. [webpage, online] Available at: http://stbm-indonesia.org/dkconten.php?id=2 [Accessed: 7 June 2017].

27 United Nations Children's Fund (UNICEF), 2013b. First Progress Report. [.docx, stored document] Received on 19 May 2017 in batch 2. Stored by AAN Associates. Filename: BMGF 1st progress report Final 30Nov2013.

Visual 1.02: Community Behaviour Change Ladder



1.3 Overview UNICEF-BMGF Sanitation Programme Indonesia 2013-17 (Object of Evaluation)

The programme evaluated is the; 'UNICEF-BMGF Sanitation Programme in Indonesia', implemented as technical assistance programme from 2013-17. The programme was designed and implemented to support the national rural sanitation programme i.e. STBM.

This section offers an overview of the UNICEF-BMGF Sanitation Programme. It describes briefly the nature, scale, and scope of technical assistance extended to the national STBM Programme. It lists the objectives and targets of technical assistance (results), components, interventions, and achievements, locations, beneficiaries, timelines, budget, key stakeholders, and the 'Theory of Change' (ToC).

1.3.1 Overarching Goal & Objectives of UNICEF-BMGF Sanitation Programme

The UNICEF-BMGF Programme was designed and implemented to support the national programme to achieve the stated target of universal access to sanitation by 2019. It was a support programme that meant to; 'accelerate and strengthen the national rural sanitation programme i.e. STBM, in Indonesia'. It prioritised bolstering the national efforts by providing strategic and quality inputs to enable it to achieve country-wide ODF status by 2019.

Within the overarching goal the programme had several specific objectives. These include (as per the proposal):

1. Supplement and expand on-going sanitation programmes in two countries (Indonesia and Malawi) with specific emphasis on learning through innovation;
2. Assess and analyse innovations and implementation strategies in these two countries to distil lessons learned and assess the impact of implementation modalities on progress, and to transmit this learning to other countries in two regions.

Its targets included increasing access to latrines by working through the national STBM in selected provinces (details given below). The first target was that by the end of programme at least '80,000 households would have access to new or rehabilitated latrines due to 'direct'

interventions'. The other target was that by the end of the programme: 'additional 220,000[28] households have access to new or rehabilitated latrines, due to replication by government (indirect latrines)'. These targets however were modified later on and have been elaborated further in the sub-section on beneficiaries.

It is pertinent to highlight that UNICEF-BMGF assistance focused on 'Pillar One (01)', of the national STBM programme *i.e. Stop Open Defecation (OD).*[29]

For BMGF, however, this assistance was meant to leverage both the implementation and learnings acquired through (upscaling of CLTS/CATS within national programmes in Indonesia and Malawi) to inform the planned expansion of BMGF sanitation assistance to over twenty (20) countries across the globe.

1.3.2 UNICEF-BMGF Sanitation Programme – Components and Interventions

The technical assistance meant for national STBM programme prioritised multiple areas to strengthen implementation and documentation. There are six (06) listed priorities that UNICEF-BMGF Sanitation Programme focused on. These include:

1. Improving the enabling environment (for rural sanitation);
2. Demand creation through knowledge and awareness;
3. Supplies facilitation through innovation and sanitation marketing;
4. Capacity development (public sector agencies in particular);
5. Strengthen monitoring systems; and
6. Knowledge management.

BOX 1.01: PRIORITY AREAS OF ASSISTANCE

- The creation of a conducive environment *(enabling environment*)
- Improved sanitation needs *(demand creation)*
- The increase in the provision of access to sanitation *(supply improvement)*
- Enhancing Government's Capacity
- *Knowledge Management*
- *Strengthening Monitoring Systems*

It is important to note that where the UNICEF-BMGF assistance worked to strengthen the field implementation, it simultaneously focused on upstreaming work to advocate for policy reforms to accelerate replication.

UNICEF-BMGF technical assistance applied the 'Enabling Environment for WASH (EE)' (refer Visual 1.03), developed in 2016. Within UNICEF, the assistance to the 'Enabling Environment for WASH[30]' implies creating (or contributing to) the conditions for a country to have sustainable, at-scale WASH services to facilitate achieving SDG (Sustainable Development Goal) 6.

The EE assistance consolidates the range of different interventions planned and implemented. This included support for sector policy and strategy, institutional arrangements, sector financing, planning, monitoring and knowledge management, and capacity development. The whole model focused on strengthening the current public-sector delivery by streamlining planning, coordination, financing, monitoring and knowledge management, and building

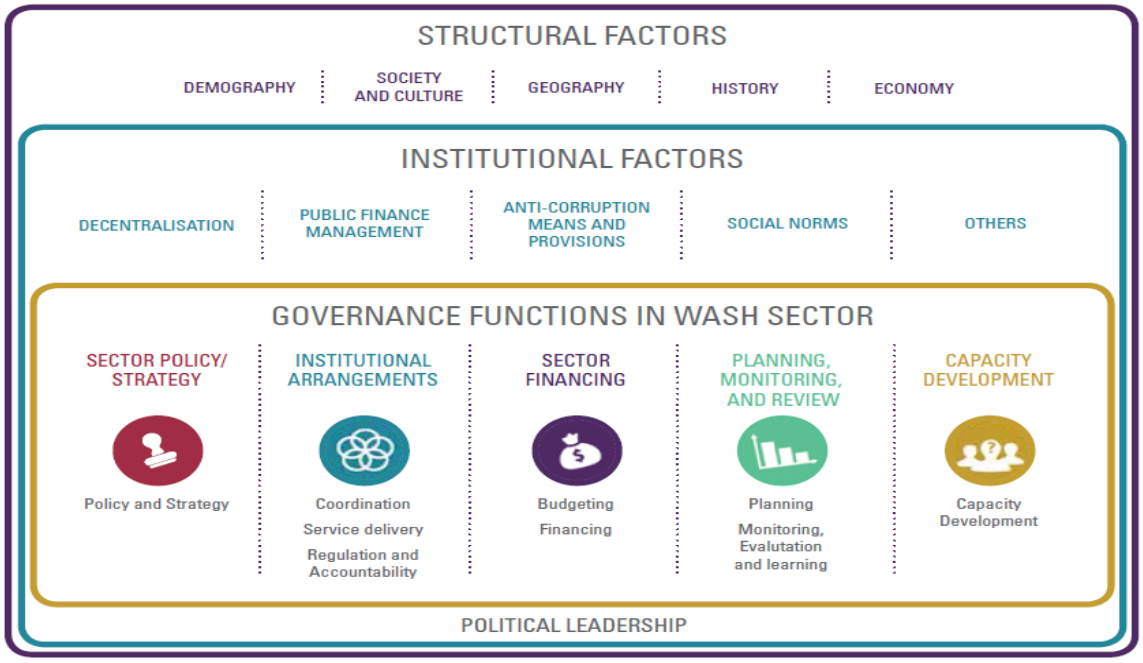
28 The indicated 220,000 family latrines will be from the three target provinces only.

29 Because the STBM programme focused on five pillars while UNICEF support to the Government focused only on the first pillar, i.e. Stop Open Defecation (OD), the evaluation did not asses the effectiveness of the overall STBM programme. Since STBM was implemented directly by the GoI through its relevant entities (MoH and others), and UNICEF provided the technical assistance, it was challenging for the Evaluators to assess 'attribution' of UNICEF efforts at the larger scale. Thus, the evaluation scope looked at the Government-UNICEF partnership with a focus on assessing 'UNICEF contributions' to Government's work for STBM by comparing the achievements in Government-plus UNICEF districts, versus Government-only districts.

30 Programme Document: Presentation Field Trips; UNICEF Indonesia 120916. (Source: UNICEF 2016: Strengthening Enabling Environment for Water, Sanitation and Hygiene (WASH) Guidance Note)

capacities across different hierarchal levels, for accelerated delivery and creating sustainable results.

Visual 1.03: Framework for Strengthening the WASH Sector Enabling Environment



UNICEF assistance focused on standardising and improving the quality of CLTS implementation, as part of larger CATS approach (refer Appendix 9 for details of CLTS and CATS).

The key interventions and achievements under EE include review and finalisation of 'ODF Declaration Guidelines' (refer to Appendix 10). Assistance was provided to improve sector coordination at national and sub-national levels. The provincial and district authorities were advocated to issue requisite regulations and financing for rural sanitation. A Fatwa was secured to fund rural sanitation by using Zakat funds (more details below). Support was provided to strengthen the monitoring system and using monitoring data to inform planning and resources allocation. A range of knowledge products have been developed and disseminated for sharing and replication. Moreover, range of trainings organized for frontline staff of MoH/DOH, members of coordination forum (at all levels), and training manuals were updated. Furthermore, Non-Governmental Organisations (NGOs) partners were engaged to work closely with government (at provincial and district levels) to build technical and administrative capacities of public agencies. In due course, the capacities of these NGO partners have improved, and now these are available to assist the governments. More details are available in the section on findings.

1.3.3 Outreach of UNICEF-BMGF Programme

As highlighted earlier, the national STBM Programme is being implement across all 34 provinces. The fact that the 'UNICEF-BMGF Sanitation Programme' is geared to strengthen STBM implementation, hence on that count it could be argued to have a national outreach.

The UNICEF-BMGF programme has had a series of interventions at national, sub-national, and community levels. At more operational level, the programme extended direct support to provinces and districts to accelerate STBM implementation. The direct assistance was

extended to three Eastern Provinces i.e. Papua, South Sulawesi and Nusa Tenggara Timur (NTT). These provinces are highlighted in the Visual 1.04.[31]

Visual 1.04: UNICEF support to STBM Target Provinces

Within three provinces, there are districts which have received direct assistance, hence are referred to as 'Direct' districts. There are Six (06) 'Direct' districts. Besides these, there are Sixteen (16) 'Indirect' districts, receiving provincial level assistance. Remaining are 'Other' districts, which did not receive either direct or indirect assistance. Table 1.03 explains the differences between these three different groups of districts.

Table 1.03.1: District Types

District Type	Description
Direct Districts	UNICEF is supporting STBM programme implementation at all levels i.e. provincial, district, sub-district, desa (village) and dusun (community) level. There are 6 direct districts.
Indirect Districts	UNICEF is supporting STBM implementation but only through provincial level support i.e. placement of facilitators. The numbers increased to 16 from originally planned 12 districts. **Please note:** that these 'indirect' districts are not within the scope of this evaluation.
Other Districts	All remaining districts where government is implementing the STBM programme. No direct support was extended to these districts by UNICEF at any level.

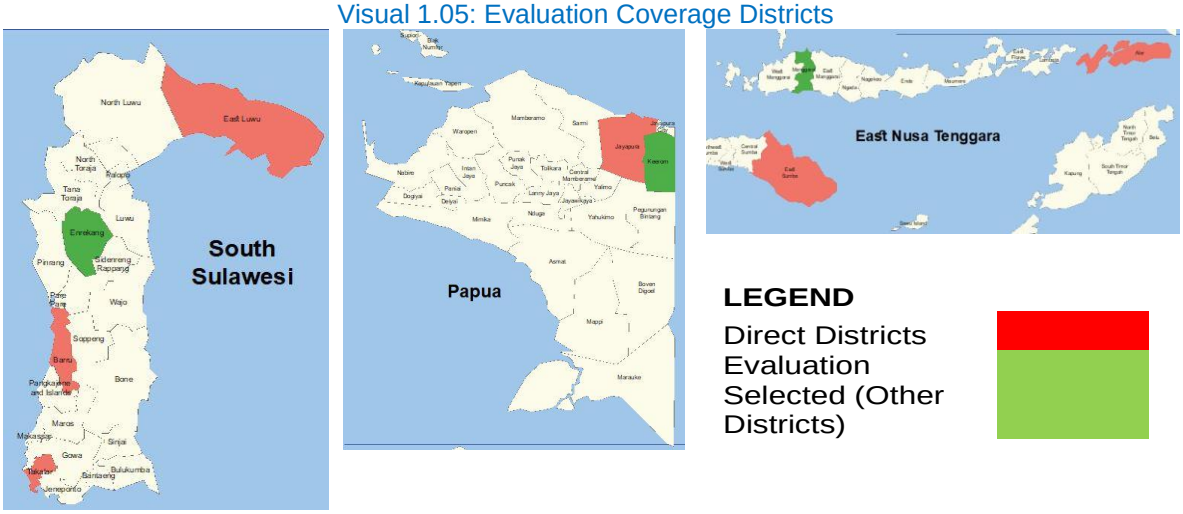
Table 1.03.2 lists the 'Direct' districts in each of the three provinces[32]. Table 1.03.3 lists the number of households and sub-villages planned to be covered in these districts. Visual 1.05 shows the location of the direct districts (red) within the selected target provinces. Please note that the districts coloured green are 'Other' districts, where data collection was carried out as part of the evaluation.

[31] United Nations Children's Fund Indonesia Country Office (UNICEF ICO), 2013. First Progress Report.

Table 1.03.2: Direct Districts

Province	District
South Sulawesi	Takalar
	Barru
	Luwu Utara
Papua	Jayapura District
Nusa Tenggara Timur (NTT)	Alor
	Sumba Timur

Visual 1.05: Evaluation Coverage Districts



UNICEF-BMGF Programme Timeline

The global UNICEF-BMGF programme was approved in 2012, however the field implementation in Indonesia commenced in 2013. Planned for three years initially, the implementation was extended by two more years. Overall, it was a 'Five (05)' year programme which was implemented from 2013-17 (ended on November 30, 2017).

1.3.4 Beneficiaries (Institutions and Communities)

This programme was planned to assist a range of stakeholders comprising public agencies, civil society organisation, and eventually the communities i.e. men, women, boys and girls.

Within the GOI, the MoH and BAPPENAS including their provincial, district and field level offices are the primary beneficiaries. With those several NGOs benefitted by getting involved in the programme implementation.

The communities in 'Direct' and 'Indirect' districts are the ultimate beneficiaries of UNICEF-BMGF assistance. Communities benefitted in variety of ways such as accelerated triggering and achieving ODF status. This in turn increased the access to basic sanitation in triggered and ODF communities, where more people constructed/upgraded their latrines. Find below the tables that present the overall coverage of the programme and the results its produced in term so triggered, ODF communities, and construction of new latrines.

Table 1.03.3 lists the number of targeted households per district, as reported in the first progress report (2013) of the Programme.[33] It includes details of dusun (communities) covered including number of households in each dusun (community).

Table 1.03.3: UNICEF Support to STBM Initial Targets

Province	District	Target	
		# HHs	# Sub villages (Dusun)
South Sulawesi	Takalar	22,197	283
	Barru	10,960	114
	Luwu Utara	26,615	488
Papua	Jayapura District	13,877	137
Nusa Tenggara Timur (NTT)	Alor	11,241	388
	Sumba Timur	21,361	391
	Totals	**106,251**	**1,801**

The following two tables list the number of households and villages that benefitted from the programme. Table 1.03.4:[34] lists the yearly results for Triggered and ODF villages including number of HHs that benefitted. The Table 1.03.5 lists the number of new latrines built in 'Direct' and 'Indirect' districts.

Table 1.03.4: STBM Outputs by Year

Year	Start Date	End Date	HHs (Cumulative)	ODF villages (claimed) (Cumulative)	Triggered communities (Cumulative)
Y2	01-11-2013	31-10-2014	47,652	N/A	780
Y3	01-11-2014	31-10-2015	87,465	1223	3492
Y4	01-12-2015	30-11-2016	124,585	2547	4937

Table 1.03.5: STBM Latrines Results (overall numbers against best agreed targets)

Description	Achieved (UNICEF Reported)	Target	Comments
Number of Latrines built in 'Direct' districts	60,142	43,350	Exceeded the best agreed target.
Number of latrine built in 'Indirect' districts	176,393	87,465	Exceeded the best agreed target

[33] United Nations Children's Fund Indonesia Country Office (UNICEF ICO), 2013. First Progress Report.

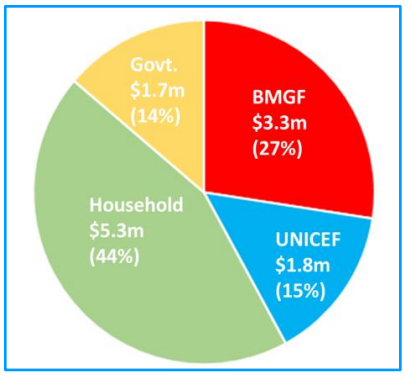
[34] United Nations Children's Fund (UNICEF), 2016. *Year 4 Progress Report.*

1.3.5 Financial Resources

The total BMGF grant amounts to $7,523,125 (in words - seven million, five hundred and twenty-three thousand, one hundred and twenty-five United States Dollars), for the whole programme implemented in two countries i.e. Malawi and Indonesia.

As per UNICEF Indonesia information (as of July 2017), UNICEF Indonesia received $3.3 million from the total BMGF grant. In addition, UNICEF leveraged funding from other sources to complement the implementation. The other sources are of UNICEF herself, GOI, and the communities (only for 'Direct' districts). The Visual 1.06, illustrates the contributions from different stakeholders.

Visual 1.06: Funding Contributions from Different Stakeholders



1.3.6 Key Stakeholders & Roles

A range of public and non-public stakeholders contributed to this programme in varying roles. These include public sector entities, public/elected office holders at different levels, non-profit partners, private organisations, businesses, media organisations, and communities. Find below the list i.e. Table 1.03.6, of most significant stakeholders and their roles/contributions to the programme.

Table 1.03.6: Key Stakeholders

Legal Name	Type	Level	Description/Role
Ministry of Health (MoH)	Government, Primary Duty Bearer	National	The ministry is responsible for health services planning and delivery across Indonesia. MoH is prime implementer of national STBM programme. The role involves overall planning, STBM secretariat management, funds management, implementation through provincial, district and local level health establishments. It implements the planned interventions through networks of sanitarians (health workers) stationed at local health centres called Puskesmas. The MoH/DHO and field teams are key partners for UNICEF-BMGF assistance, and have benefitted from range of interventions such as capacity building, knowledge management, advocacy, and others.
Ministry of National Development Planning (BAPPENAS)	Government Primary Duty Bearer	National	BAPPENAS remains the key public agency involved in design of national STBM Programme, and have been supporting with coordination and oversight. It leads the national, provincial and district level POKJAs and benefitted from range of UNICEF-BMGF interventions.
POKJA AMPL (WASH Working Group)	Government Primary Duty Bearer	National, Provincial, and district	These are public sector coordination forums available national, provincial and district levels. These include key WASH sector public agencies such as MoH/DHO, BAPPENAS/BAPPEDA, and others. These forums oversee the planning and implementation of the STBM programme and contribute to advocacy and knowledge sharing. The members of these forums at national level and those in direct provinces and districts benefitted directly from range of interventions under UNICEF-BMGF technical assistance.
Bill and Melinda Gates	Donor Primary	Internation al	BMGF is the leading donor of the UNICEF technical assistance to GOI. It is involved in

Table 1.03.6: Key Stakeholders

Legal Name	Type	Level	Description/Role
Foundation (BMGF)	International Funding Agency		reviewing the progress of UNICEF technical assistance, and intends to use the learning for scale-up into 20 countries. BMGF contributed $ 3.3 million to the programme in Indonesia.
UNICEF	UN System Organization Primary Technical Partner/Facilitator	National/ International	The primary stakeholder involved in providing support to STBM. UNICEF has worked with the GoI to design, fund and support the technical assistance to enable acceleration and strengthening of national STBM Programme. UNICEF is involved in upstreaming work i.e. advocacy and oversight. UNICEF Indonesia contributed $ 1.8 million to the programme.
Provincial/District Health Office (PHO/DHO)	Government Primary Duty Bearer	Provincial and district	These are provincial/district health offices, responsible for provincial/district level health services planning and delivery. These are represented on coordination forum and leading field implementation of STBM Programme.
Regional Development Planning Agency (BAPPEDA)	Government Primary Duty Bearer	Provincial and district	This is provincial/district level development planning agencies. The offices are supporting with oversight, coordination and advocacy efforts of STBM Programme. These offices have benefitted from training and coordination support extended under UNICEF-BMGF assistance.
District Administration	Government Secondary Duty Bearer	District	Led by the bupati (an elected official), the district government plays a central role in determining development priorities and allocating resources. At the sub-district level, the camat (an appointed official) acts as a bridge between village authorities and the district government. The camat plays a key role in coordinating the implementation of STBM. Various local authority figures, including village heads, religious leaders and others commanding the respect of the community. To provide local support with implementation. District administrations contributed $ 1.7 million (in Direct districts only).
Puskesmas (Local Health Centre)	Government Primary Duty Bearer	Local	Health centres at the local level; usually one per cluster of villages. Operate under the MoH. These represent the lowest unit of DHO directly involved in STBM implementation. The staff of Puskesmas benefitted from range of training and support interventions under UNICEF-BMGF assistance.
Sanitarian	Government Primary Duty Bearer	Local	Sanitarians are based in Puskesmas (local health centre). These are the key field implementers and the roles involves triggering, post triggering follow-up, post ODF communication, monitoring and reporting. The Sanitarians benefited from range of capacity development and support interventions under UNICEF-BMGF.
Community Members	Community Primary Right Holders	Local	Under the CLTS approach, the community itself is ultimately responsible for bringing about the change to ODF status. Community volunteers, called Kaders, participate in the implementation of a number of development efforts, not only STBM. Natural leaders who emerge from the community during the triggering process act to promote and monitor ODF in the village.

Table 1.03.6: Key Stakeholders

Legal Name	Type	Level	Description/Role
			Communities contributed $ 5.3 to the programme.
Local Sanitation Business owners	Private sector organisation Secondary Business	Local	Individuals operating businesses relating to sanitation. To sell services/goods to programme staff and beneficiaries.
BABINSA (local army)	Government Secondary	Local	Local army. To provide local support with implementation, specifically in CLTS triggering and post-triggering monitoring. Also, to provide subsidies for latrine construction.

1.3.7 Theory of Change (ToC)

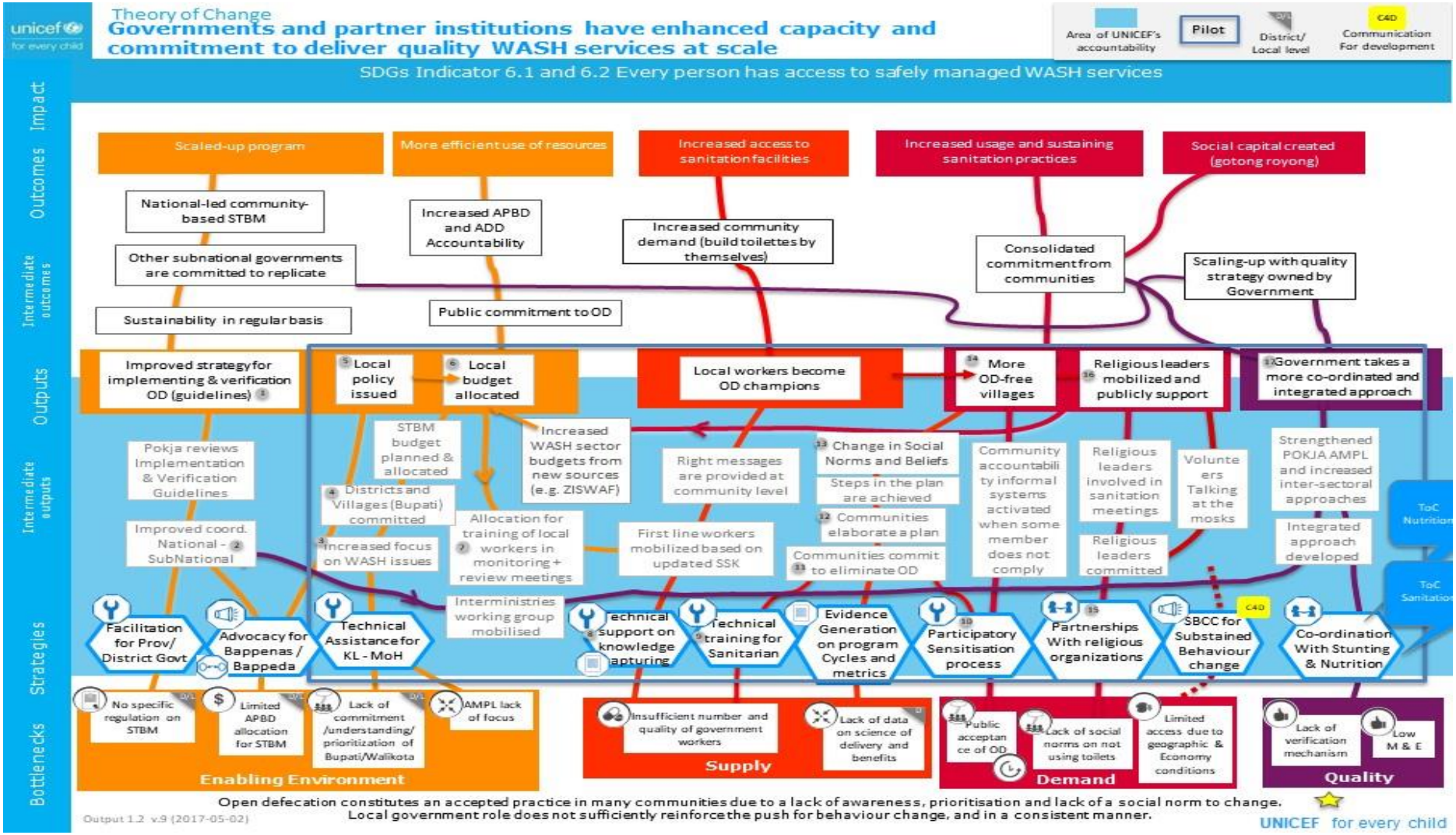
The BMGF grant document does not include any TOC for the programme. However, during implementation a basic TOC was developed in 2015 and refined further in 2017. The Evaluators have used 2017 version as the final TOC for this evaluation.

The TOC embodies all the key elements that are required to define the causal pathways. It starts with listing the bottlenecks at the bottom and moves upwards while listing corresponding strategy/ies (for each bottleneck), inputs, outputs, immediate outcomes, outcomes and impact. The risks and assumptions are missing. To the Evaluators, the composition and structure of the TOC provides basis to assess the programme logic and hence comment on its effectiveness (one of the key evaluation criteria).

1.3.8 Evaluation Hypothesis

The evaluation is guided by a hypothesis that states: *UNICEF contributions to the STBM Programme has germinated an enabling environment, supported by enhanced governance, for knowledge-empowered communities, exhibiting positive attitudes and practices with greater ownership and participation, and creating and sustaining a new norm of ODF.*

Visual 1.07: Theory of Change



2. EVALUATION PURPOSE, SCOPE AND METHODOLOGY

This section encompasses the description of the evaluation purpose and scope, and the evaluation methodology and approach. The first part covers evaluation purpose, objectives, significance, scope and coverage, and on the potential evaluation users. The second part describes the evaluation methodology, design, approach and compliance to applicable ethical standards.

2.1 EVALUATION PURPOSE, OBJECTIVES AND SCOPE

2.1.1 Evaluation Purpose

This is an 'Endline or End of Programme' evaluation. After careful review of the TORs and subsequent discussions with UNICEF WASH team, it was agreed to refer to it as a 'Summative-Formative', to do justice to the expectations. It is 'Summative' as being part of the contractual obligations towards BMGF to undertake an end of programme evaluation to generate verifiable evidence of success for accountability purpose. At the same time, it is 'Formative', as both UNICEF and BMGF want to use the evaluation findings in terms of any lessons learnt to inform future programming (see section 2.2.1 for more details).

The Evaluators reiterate that is essentially a complete 'End of Programme Evaluation', and should not be confused with 'WASH STBM Endline Evaluation Survey', which it is titled as in the TORs. This evaluation has been designed and implemented as a 'Summative-Formative Evaluation'. The evaluation design includes extensive qualitative data collection and triangulation, besides the Endline KAP survey.

2.1.2 Significance of the Evaluation

This evaluation is significant for GOI, UNICEF, and BMGF in variety of ways. Based on discussions with GOI and UNICEF, the Evaluators have outlined following as the elements of significance of this evaluation. These are:

- First and foremost, the evaluation is significant for evidence creation around success of the UNICEF-BMGF assistance, by independent evaluators. It is expected to generate evidence of success while using systematic and rigorous research methods. It would generate evidence as to how UNICEF-BMGF assistance changed the EE for WASH particularly around policies and systems, sector financing, sector coordination, monitoring and knowledge documentation, and all-round capacities (to design and implement STBM better), and it impact on accelerated delivery of STBM in selected provinces, particularly 'Direct' and 'Indirect' districts.
- It is significant for being the first study to systematically assess creation of 'Social Norm' of latrine use. The evaluation is to provide evidence of if STBM programme has been able to create 'Social Norm' of latrine use, as part of the overall sustainability assessment. The recommendations may guide re-alignment of current STBM implementation, to enable it to work for creation of relevant 'Social Norms'.
- The evaluation is significant for its formative value, as the learning to inform the scope and scale of future UNICEF technical assistance to the GOI for achieving the target of universal sanitation access (by 2019) and safely managed latrines by 2030. The lessons learnt shall contribute to and inform the global and regional discourse within UNICEF and for others involved in sanitation programming.
- The evaluation holds its significance for BMGF as it would provide them with an independent view of the successes, challenges, and learning around public sector led sanitation programme in the region. Also, this shall inform the shape of the future collaboration between UNICEF and BMGF, and also the BMGF planned sanitation assistance/programming expansion to the 20 odd countries.

2.1.3 Evaluation Objectives

This is to reiterate that this is a hybrid evaluation, that has both the summative and formative purposes. The overarching objective is to generate evidence of success to assess the effectiveness of UNICEF-BMGF assistance. With that, it's objective is to assess the sustainability of the results, particularly around creation of social norm of latrine use. The evaluation findings and recommendations are expected to inform the scope and scale of UNICEF's future engagement with GOI to facilitate achieving the 'universal access to basic sanitation in Indonesia by 2019. Besides these, the three stated objectives in the TORs as below (rephrased):

1. **At the community level:** to understand and assess the phenomena and extent of slippage and creation of social norm in both intervened and non-intervened communities through mixed method approach comprising HHS, FGDs and Key Informant Interviews (KIIs).
2. **At the household level:** to understand and assess the knowledge, attitudes and practices (by using KAP questions), social norms (particularly beliefs, expectations, and existence of sanctions) as well as the key drivers and barriers to sanitation in ODF communities and its sustainability.
3. **Comparison:** to draw comparative analysis for 'Direct' districts (where STBM is implemented by the Government and supported by UNICEF) and 'Other' districts (GoI only) ODF certified communities as to examine effectiveness of UNICEF-BMGF assistance around accelerated achievements, ODF sustainability, strength of the new social norms and other critical KAP results.

Besides that, Evaluators were asked to look into how responsive was the programme design and implementation to the 'Highly Decentralised Governance' context in Indonesia. Moreover, to generate evidence around understand and assess the extent and causes of slippage in ODF villages (implying if and to what extent OD is practised in ODF certified villages). Furthermore, dig deeper to understand the barriers and drivers for communities to achieve and sustain ODF.

2.1.4 Evaluation Criteria and Key Questions

This evaluation followed selected (as desired in TORs) OECD-DAC (Organisation for Economic Cooperation and Development-Development Assistance Committee) criteria. These two criteria are: effectiveness and sustainability. This excluded other three criteria of OCED-DAC i.e. relevance, efficiency, and impact. For UNICEF, the selected criteria are those that were prioritised based on interest of BMGF, the key donor. Moreover, the availability of limited funds played into taking the other criteria out. Besides OCED-DAC, the evaluation included assessment around Non-DAC criteria i.e. equity, gender, human rights based approaches (HRBA).

The Evaluators, together with the 'Evaluation Reference Group' (the forum formed to provide evaluation oversight) particularly the UNICEF Indonesia team, reviewed and refined the evaluation questions to draft the Evaluation Matrix (see Appendix 2.1). This helped to align the evaluation questions to the expectations, and also add focus and sharpness. Moreover, it facilitated adding realism to the evaluation expectations. In the same process, the evaluation questioned were then un-packed into sub-questions and corresponding indicators. Furthermore, the indicators while working as areas of enquiry enabled identifying the relevant stakeholders (to seek information from) and selecting the most appropriate research methods to primary information. It was during this phase the decisions were made around breadth and depth of application of these methods and tools.

The evaluation questions that this evaluation set out to respond to are as below:

Table 2.01.1: Key Evaluation Questions and Sub-Questions

Question Number	Key Question
OECD-DAC Evaluation Criteria: Effectiveness	
EQ-1	To what extent has UNICEF been successful in enabling Government of Indonesia (GoI) and sub-national Government(s) to develop and implement the processes for achieving the intended outputs and outcomes of the STBM programme.
EQ-2	KAP & Changing Social Norms: To what degree joint GoI and UNICEF efforts succeeded in improving knowledge and attitudes; and adopting and sustaining critical sanitation behaviour (at community and individual levels) in particular ODF (consistent latrine use by all)?
OECD-DAC Evaluation Criteria: Sustainability	
EQ-3	How application of two different approaches (Joint implementation in 'Direct districts'; and Government –only for 'other districts') affected the implementation, results and sustainability of the achievements?
Non-DAC Evaluation Criteria (Equity, Gender, HRBA)	
EQ-4	What approaches, strategies, and interventions are integrated in STBM to enable improved sanitation coverage for poor, minority, men, women, boys, girls, elderly people and person with disabilities?

2.1.5 Evaluation Scope and Coverage

This evaluation covered all interventions and assistance extended under UNICEF-BMGF Sanitation Programme for Indonesia. The scope includes all activities carried out under the programme from January 2013 to November 2017. All these activities relate to 'Pillar One (01)' of STBM except for post KAP assessment around 'Handwashing with Soap (HWWS)', which is 'Pillar Two (02). 'Social Norms' assessment has been carried out for sustained or exclusive latrine use. Norms creation framework however has not been used for assessment of HWWS.

The geographic spread or scope included S*ix (06) 'Direct' and Three (03) 'Other' districts* in three selected provinces i.e. South Sulawesi, Papua, and NTT. Table 2.01.2 lists the districts covered in the evaluation. The evaluation scope excluded the evaluation of 'Indirect' districts. As per UNICEF WASH team, this decision was made in view of BMGF's interest in having more meaningful comparison and analysis between 'Direct' and 'Other' districts. Moreover, it was done to understand and assess the UNICEF's value addition.

Table 2.01.2: Districts Covered by the Evaluation

Province	'Direct' Districts	'Other' Districts
South Sulawesi	Takalar	Enrekang
	Barru	
	Luwu Utara	
Papua	Jayapura District	Keerom
Nusa Tenggara Timur (NTT)	Alor	Manggarai
	East Sumba	

2.1.6 Evaluation Users and Uses

There are multiple evaluation users with varied interests and expectations. These have been grouped as primary and secondary audiences based on proximity and extent of (possible) use/s of the evaluation. A short note added as to how GOI and UNICEF plan to disseminate the evaluation results.

Primary Audience/Users
GoI, UNICEF, and BMGF, have been included amongst the primary audiences.

Within the GoI, there are two public agencies i.e. MoH and BAPPENAS, with provincial, district and field level offices, who are directly linked to the evaluation. With these, there are provincial and district governments in selected/Direct provinces and districts that have interest in the evaluation. This evaluation would give an independent and objective assessment of the STBM successes and achievements to these public stakeholders. Moreover, it would give an assessment of effectiveness of (UNICEF supported) new approaches and interventions for accelerated and sustainable sanitation results. For them it is important that it would systematic approach to generate evidence of the existence and extent of slippage (of ODF communities) and social norms creation of sustained latrine use. The evaluation is set to provide insights into strengths, and challenges of current STBM programme and implementation approaches, to inform future planning, replication and scale-up. It may highlight where and how WASH partners could add value in strengthening the current programming.

UNICEF is primary audience also. Where it may benefit from what is listed above, it expects the evaluation to make an assessment of UNICEF value add to the programme. The description of successes, challenges, and lessons learnt are set to guide the scope and scale of future assistance to the national STBM programme. Moreover, it shall feed into the 'BMGF Programme Completion Report. The evaluation shall stimulate the internal discussions and reflections on future shape and scale of sanitation assistance in mid-income countries.

For BMGF, the evaluation produces evidence of success for the resources invested. Moreover, the learning informs the BMGF global and regional sanitation strategies, and guides prioritisation of future investments. Furthermore, the assessment contributes to defining the scope and scale of future assistance for Indonesia and other regional countries where BMGF is either working already or plans to expand.

Secondary Audience/Users
The secondary audience or users comprise other bilateral and multilateral donors such as the World Bank, the Asian Development Bank, DFID, USAID, DFAT, DANIDA, and others, who may use the evaluation findings and results to inform their sanitation specific assistance and programming. Similarly, the other group of secondary users are the United Nations (UN) agencies, INGOs (International Non-Governmental Organisation) with interest and investments in sanitation results, to use evaluation findings and results to inform their programming and operations.

2.1.7 Evaluation Dissemination

UNICEF Indonesia shared the evaluation findings and results regionally (in the WASH Regional Workshop held in Bangkok, October 2017) and at the annual BMGF Global Sanitation Grantee meeting held in Patna, India (6-10 November 2017). Moreover, a presentation was made on December 7, 2017 to key decision makers of BAPPENAS and MoH (Directors and other key staff) – members of 'Evaluation Reference Group (ERG)', to take the relevant public and external stakeholders on board on the results and recommendations of the evaluation. BAPPENAS conveyed that they would convene a meeting of national stakeholders and would invite UNICEF to make presentation there to share the findings and recommendations to wider audience.

2.2 Evaluation Methodology, Conceptual Framework, Limitations and Ethics

This is a 'Mixed Method' and 'Participatory' evaluation. The evaluation used the multiple methods, both qualitative and qualitative. The selection of methods leverages the strengths of different social research methods, and parallel and complementary application helped overcome the method specific limitations and gaps. Data triangulation techniques have been applied to leverage complementarities of gathered data.

The evaluation applied the principle of 'participation', whereby all key stakeholders were represented on the ERG an oversight body comprising both government and UNICEF representatives was formed at the start and remained engaged through all stages of the evaluation. Moreover, the evaluation process entailed extensive discussions and engagement with all key stakeholders including the Government, UN, civil society partners, donors, communities – women, men, girls and boys. A total of over 3500 individuals were consulted (over 3300 from communities comprising women, men, girls and boys), which amplifies the participatory nature of the evaluation.

The evaluators' sought the requisite 'Ethical Clearance' (904/III/LPPM-PM.10.05/07/2017; dated 24th July) from Atma Jaya Catholic University of Indonesia; as needed to operate in Indonesia. This was in a way an endorsement that the evaluation is compliant with best industry practices particularly UNICEF adopted UNEG (United Nations Evaluation Group) norms, standards and ethical guidelines[35], and reporting standards[36] for evaluation reports.

2.2.1 Evaluation Framework and Conceptual Design

This is a 'Summative-Formative' evaluation. *In line with the ToR, the Evaluation applied the selected evaluation criteria of 'effectiveness' and 'sustainability' from the listed OECD-DAC criteria.[37] Furthermore, the evaluation focused on the non-DAC standard evaluation criteria, of Equity, Gender and HRBA Principles.* The other criteria elements such as assessment of relevance, efficiency and impact are not in the scope of the evaluation as per the ToR.

The Evaluation uses 'Theory Based Evaluation'[38] design and the 'Quasi-Experimental' research design or approach. Like experimental designs, quasi-experimental designs test causal hypotheses, however quasi-experimental designs, by definition, lack random assignment. Quasi-experimental designs identify a comparison group that is as similar as possible to the treatment group in terms of baseline (pre-intervention) characteristics. Quasi-experimental methods are applied in situations where it is not possible to randomize individuals or groups to treatment and control groups.

The quasi-experimental design is used to assess the programme effectiveness in terms of mapping any incremental change in the 'Direct' districts (experiment group) around improved sanitation access, continuous usage, and allied behavioural changes. To map the change a longitudinal analysis has been undertaken for key programme performance indicators over

[35] United Nations Evaluation Group (UNEG), 2016a. Norms and Standards of Evaluation. [.pdf, online] Available at: http://www.unevaluation.org/document/detail/1914 [Accessed: 12 June 2017].

[36] United Nations Children's Fund (UNICEF), 2010a. UNICEF-Adapted UNEG Evaluation Report Standards. [.pdf, online] Available at: https://www.unicef.org/evaluation/files/UNEG_UNICEF_Eval_Report_Standards.pdf [Accessed: 9 June 2017].

[37] Organisation for Economic Cooperation and Development (OECD) Development Assistance Committee (DAC) criteria for evaluations.

[38] 'A theory-based approach to impact evaluation [is] one that maps out the causal chain from inputs to outcomes and impacts and tests the underlying assumptions [which] will shed light on the why question'. International Initiative for Impact Evaluation (3IE), 2009. *Theory-Based Impact Evaluation: Principles and Practice.* [.pdf, online] Available at: http://www.3ieimpact.org/media/filer_public/2012/05/07/Working_Paper_3.pdf [Accessed: 19 June 2017].

the period of programme delivery in the 'Direct' districts. The data has been compared against the 'Other' districts, treated as 'control group'. Also, where available, these have been related to national averages to put analysis into perspective e.g. triggering and success rates in districts. The 'longitudinal' and 'comparative' analysis techniques have been used to measure change over time (in Direct districts) and between 'Direct' and 'Other' districts. Both quantitative and qualitative data (gathered as part of the evaluation) was used to ascertain and analyse the extent of change and determinants/contributors of change. This enable distillation of UNICEF value addition in terms of unlocking the 'Bottlenecks' to accelerate sanitation access.

To asses UNICEF contribution or attribution to the results, the technique of 'Contribution Analysis' is used. It is based on the principle of analysing a given situation, marked with presence of one intervention but in absence of other intervention, and comparing the results to measure the effect of the 'combined effect' of the two interventions. For this evaluation, the comparative analysis is done between 'Direct' and 'Other' district to demonstrate the element of 'Contribution'.

To map sustainability particularly the sustainability of behaviours, the evaluation has used the 'Social Norms Theory' framework. Social norms can be defined as 'what people in some group believe to be normal in the group, that is, believed to be a typical action, an appropriate action, or both.[39] Social Norms Theory is concerned with the identification and measurement of social norms to understand human practices and design remedial interventions[40]. The Appendix 2.3 details the framework used for assessment of the social norm creation and sustainability aspects of the Programme. It lists parameters used for assessment of Equity, Gender and HRBA dimensions of UNICEF support to STBM.

2.2.2 Evaluation Methods

The evaluation used both quantitative and qualitative data collection methods. The selection of methods and techniques relates to the indicators framed to address each sub-question. Find below the list methods and tools used for data collection:

1. Document review
2. Quantitative methods:
   (a) Post-KAP Household Survey (HHS);
   (b) Physical Observation by the data collector (Interviewer) as part of interview for HHS to observe any signs of the latrine use, hygienic conditions of the latrine, safe distance to the sanitation facility, and the sanitation situation overall.
3. Qualitative methods:
   (a) Focus Group Discussions (FGDs);
   (b) Key Informant/Semi-structured Interviews/ (KIIs);
   (c) Field Observations – Transect walk, and;
   (d) Case studies (Optional) to document key successes related to processes implemented, institutional aspect and significant changes in WASH behaviours observed at household and at community level.

The post-KAP HHS was performed to map the extent of change in sanitation access including changes in the communities' understanding, commitment and adoption of behaviours. The survey results were also used for the assessment of 'norm creation' for latrine use. The HHS included observation questions and a 'transect walk' (by the enumerators) to look for evidence of open defecation. Qualitative discussions such as KIIs and FGDs not only worked to

[39] Mackie, G.; Moneti, F.; Shakya, H. and Denny, E., 2015. What are Social Norms? How are they Measured? [.pdf, online] Available at: https://www.unicef.org/protection/files/4_09_30_Whole_What_are_Social_Norms.pdf [Accessed: 9 December 2017].
[40] IBID

complement and enrich the HHS information, they provided insights into the experiences and reflections of participants. Moreover, KIIs and FGDs helped to document the lessons learnt and suggestions for improving of the programme. Where applicable, the information from different sources was corroborated for clarity and validation, and triangulated to respond to the evaluation questions.

2.2.3 Document Review

The Evaluators received over 100 documents from UNICEF, which included the baseline and midline survey reports and questionnaires, yearly reports to the BMGF, SMS monitoring data analyses, monitoring and evaluation templates, planning documents and articles. In addition to these sources, GoI documents, research papers, CATS and CLTS guidelines and other relevant documents were used. The literature review facilitated understanding the programme better by offering insights into nature and extent of assistance, progress made over time, challenges and learning, and partnerships arrangements with range of stakeholders. It also helped with understanding the evolution in the national STBM programme and global discourse on implementation of CLTS and CATs approaches. The relevant pieces from the literature review are added and referenced appropriately, in drafting the report and complement the primary information. Appendix 13 lists the documents reviewed by the evaluators.

2.2.4 Quantitative Methods

For quantitative data collection, a post-KAP Household Survey (HHS) was undertaken in all three provinces under UNICEF's support to STBM. The HHS was undertaken for a pre-determined sample of 3,240 HHs from 36 Villages (desa) in six *'direct'* and three *'other' districts;* 27 ODF villages were selected, along with 9 non-ODF villages. The HH payload of each village was evenly distributed among its dusun (community). A random number was drawn between 1 and 10 to be used as 'n' for the interval. The coordinator then picked the first HH from the right facing north, and used the interval for selection of the next closest HH. The process was repeated until the required number of HHs was surveyed. Key aspects of the HHS, including the brief on the rationale and methods employed for selection of districts, the sampling frame, methodological limitation, procedure adopted for selection of households for the face-to-face interview and measures taken to minimize possible response biases, are described in Appendix 3.1. Table 2.02.1 shows the distribution of desa/villages and HHs by each of the administrative units, while Table 2.02.2 outlines the geographic scope of the HHS.

Table 2.02.1: Overall Sample Distribution by Districts and Villages

Units	'Direct' districts	'Other' districts	Total
Districts	6	3	9
Desa (villages)	25	11	36
HHs	2,160	1,080	3,240

Table 2.02.2: Geographic Scope of the Post-KAP Survey

Province	'Direct' Districts	'Other' Districts
Nusa Tenggara Timur	Alor	Manggarai
	Sumba Timur	
Sulawesi Selatan	Barru	Enrekang
	Luwu Utara	

Table 2.02.2: Geographic Scope of the Post-KAP Survey

Province	'Direct' Districts	'Other' Districts
	Takalar	
Papua	Jayapura	Keerom

The post-KAP questionnaire used for the HHS (Appendix 3.3) was adapted from the questionnaires employed for baseline/midline KAP, to the extent necessary, with a focus on analysing key individual and communal behaviours for the purpose to reflect on changing of social norms.

Table 2.02.3: Distribution of Households by Province and Respondents Gender

Gender		Direct			
		NTT	SS	PP	Total
Respondents	Male	495	678	338	1511
	Female	520	674	336	1530
	Total	1015	1352	674	3041

2.2.5 Qualitative Methods

The qualitative data collection methods that were used in the evaluation are described below. The guides for KIIs and FGDs used for qualitative data collection are attached in Appendices 4 and 5.

Key Informant Interviews

A total of *65 KIIs* were (Appendix 4.4) conducted at the national level, provincial level, and district/sub-district level. The actual number of KIIs was extended than the originally planned number (30) of KIIs at inception stage. The extension in scope was sought to ensure diversity of opinions from key stakeholders from different regions. The International team conducted KIIs at provincial and district level in two provinces namely South Sulawesi and NTT, covering the Barru, Takalar and Alor districts. The KIIs in other locations were conducted by the experienced staff of the national partner. The Table 2.02.4 lists the key stakeholders at all levels that were interviewed during evaluation. Purposive sampling was applied, and efforts were made to ensure that this distribution sufficiently addressed geographic coverage and diversity, with respect to the involvement of the most relevant stakeholders in the evaluation at all levels. This approach guaranteed that required information was collected up to saturation point, a gold standard for qualitative data collection.

Table 2.02.4: KII Distribution

Level	Stakeholder / Respondents
National	UNICEF (Group Interview); Chief of WASH, WASH Specialist, Chief of PME (Programme Monitoring and Evaluation); MoH/STBM Secretariat; BAPPENAS/POKJA AMPL Representative
Provincial	STBM Secretariat; POKJA AMPL Representative; Field Office UNICEF at Provincial level; 03 Provincial Health Offices
'Direct' Districts	District Health Office (DHO); BAPPEDAS (Planning and Development department at district level); bupati (mayor of a district); camat (head of a sub-district); Puskesmas (local health centre)-Sanitarians (Puskesmas workers); Entrepreneur/Mason
'Other' District	DHO; BAPPEDAS (Planning and Development department at district level); bupati (mayor of a district); Puskesmas (local health centre)-Sanitarians (Puskesmas workers);

For more details on the distribution of KIIs at each level (provincial, district and sub-district), and the basis for selection of districts for KIIs is presented in Appendix 4.5.

Focus Group Discussions

A total of 72 FGDs (Appendix 5.2) were conducted. Two FGDs were organised in each of the selected 36 villages (Desa) of the six 'direct' and three 'other' districts (four communities per district). Purposive sampling was employed to undertake FGDs to ensure widespread geographic coverage as well as diversity of views from a range of respondents/beneficiaries at the community level. For this purpose, separate group discussions with male and female respondents were planned to address gender-related challenges and to ensure access to female respondents in an environment where they can freely express their views. Various HH and community level actors were invited to participate in the group discussions while maintaining a balance for the total number of participants (8-12) in any group discussions. The list of the participants for the FGDs included:

- Kepala desa (the elected head of the village) or other key people of village authority (in the absence of Village head)
- Female heads of HHs/mothers of young kids
- Village Kader (both male and female volunteer workers at community level)
- Members of HHs with and without latrines (at least 2 members from each group)
- Sanitarians
- Religious leader (if available in the community at the time of FGD)
- Community mobilizer/teacher/champions of sanitation
- Male heads of HHs

To the extent possible and with complete informed consent, the poor, elderly and people with disabilities were included in the group discussions. The village leader played a pivotal role in this regard through identification, facilitation and access to such persons. Furthermore, convenience, security and other aspects of human rights such as respect, dignity and their active participation in discussions were ensured. FGDs were conducted in each of the nine districts of the three provinces. The FGDs were conducted in communities where HHS was completed. This approach enabled the Evaluators to better triangulate findings and draw inferences. The distribution of the FGDs is presented in Table 2.02.5 below. The sampling strategy for the FGDs is attached as Appendix 5.3.

Table 2.02.5: Distribution of FGDs by ODF Community and District Types

S#	Type of District	ODF community	Non-ODF Community	Total Communities in each District Type
1	Direct	18	6	24
2	Other	9	3	12
	Total communities	27	9	36
	Total FDGs	54	18	72

Transect Walk

Transect walks were done by field staff involved in undertaking HHS and FGDs. This activity aimed to observe signs of OD and the general sanitation situation by taking photographs of the places where OD was noted. ODF status requires an OD-free physical environment within an ODF community.

2.2.6 Ethical Approvals for Fieldwork

In line with the stipulation of the ToR and in compliance to the national criteria, the Evaluators pursued ethical clearance for the evaluation design, research methods and field data collection protocols, from the well-recognised *Atma Jaya Catholic University of Indonesia*. The approval letter (reference# 904/III/LPPM-PM.10.05/07/2017; dated 24th July) for the ethical clearance is attached as Appendix 7. UNICEF provided the requisite guidance and follow-up by the local partner to seek the necessary approval.

2.2.7 Field Staff Training, Pre-testing and Translation of the Finalized Tools

The collection of primary data from the field commenced after approval of the Inception Report including the data collection tools and detailed field plan. The core team (International Evaluators) was joined by National staff (National Consultant, the interpreters, and support staff to conduct FGDs, etc.) and the local partner. All field data collection (complete HHS and part of FGDs and KIIs) was done through the local staff under the direct control and supervision of the local partner. The international team undertook most of the KIIs at the national, provincial and district levels, along with FGDs in selected communities. The international team visited two of the three provinces for selected districts of the 'direct' districts.

Since, the questionnaire for the Endline survey was adapted using the baseline tool (already tested and applied for actual data collection), it did not require additional pre-testing. However, the tools were tested for reassurance during the training of field staff (data collectors, interpreters and other staff to be involved in survey monitoring and quality assurance of the data collection processes) through mock exercises. The HHS questionnaire was modified to incorporate the feedback received during training event for the field survey team. The finalized tools were shared with UNICEF. The finalized tools were translated in local language before application in field. The training event was also attended by a member of UNICEF WASH team.

The field data collection phase started with the training of enumerators and data entry operators. The field enumerators were rigorously trained. A comprehensive training plan was developed, containing information on all aspects of the survey, including evaluation purpose, methodology, questions, survey protocols, role of the field (district) supervisors, separate staff for quality assurance of the data collection processes, and field security protocols. The field training focused on comprehension of all sections by the entire field staff; with added focus on understanding and how to ask questions related to social norms.

The field data collection process, particularly the field survey, included quality assurance mechanisms such as formation of tele-sheets to validate key questions, spot checks, and telephonic validations from respondents who have shared their mobile numbers. Daily data editing was done to a keep check on quality and completeness of data collected from the field.

2.2.8 Data Processing and Consolidation

Data processing of the quantitative data (filled questionnaire) commenced immediately at the end of actual data collection. All the questionnaires were manually screened for consistency and quality at two stages – once in the field, upon completion of daily activity (by the enumerator and/or district supervisor), and a second time when questionnaires were handed over to the quality assurance staff on daily basis, for 100% editing/coding to ensure data accuracy and completeness. Once cleared from the field quality assurance staff, all filled forms were dispatched to the central data entry point. The data entry was carried out using specialized software, i.e. Census and Survey Processing System (CSPro). Post-data entry, editing and cleaning, and statistical analysis were done using interactive data analysis techniques, the Statistical Package for the Social Sciences (SPSS) and MS Excel.

2.2.9 Data Analysis Approaches

Quantitative data: All tabulations of the HHS were based on a variety of stratifications, i.e. disaggregation by sex, gender, ethnicity, income levels, administrative parameters (region, province, and district), period of ODF declaration, etc., for all key elements of the investigation, like OD practice, latrine use, supply side elements, etc. These tabulations were produced using statistical techniques such as frequency tables, and cross tabulations.

Qualitative Data: the qualitative findings were scrutinized and examined by core team members to identify key themes and trends occurring in the responses from KIIs/FGDs. The qualitative data from the IDIs, FGDs and Field Observation were analysed manually by going through transcripts developed from notes taken during the KII/ FGD/Observation sessions. Afterwards; data was summarized, coded and categorized into themes (data reduction). Continuous iterative revision of texts was carried out to identify and code the main patterns and categories in the data. Matrices were used to organise the data and interpret and synthesize it into conclusions (data display). Conclusions were then verified by going back to the transcripts (conclusion drawing and verification). The process yielded some specific success stories or case studies (see boxed text in 'Findings') on Programme achievements, to further enrich the analysis on outcome level and other significant change/s on the '*Social Norm*'.

2.3 Evaluation Limitations and Mitigation Measures

This section lists the limitations faced and managed during fieldwork in Indonesia. The Evaluators prepared a Field Team Preparedness document and used that to train field teams for both international and national teams. During training and later during the fieldwork, team supervisors remained vigilant and keenly aware of the many risks and limitations that could potentially derail the evaluation. Every effort was made, particularly timely communication and coordination to anticipate and account for external factors and dangers. Some of the key limitations and the associated mitigation measures are delineated in Table 2.03.1.

Table 2.03.1: Evaluation Limitations and Mitigation Measures

Limitations	Management and Mitigation Measures
Different time zones posed a challenge in coordination and communication.	A communication protocol was formulated (e-mail, cloud-based document sharing, Skype meetings, etc.) and agreed upon and to the extent possible it was followed to manage the flow of information and mitigate lost opportunities for discussions.
Unfavourable / unusual weather caused some setbacks in travel and accessibility to target locations or timing of planned events.	Team ensured regular communication between teams and central coordination (UNICEF, National Partner HO) and thus mitigated any lost time or data collection events. Field Plans were rapidly adjusted and acted upon.
Unavailability of or insufficient time with some stakeholders for detailed discussions was noted as a constraint.	Additional meetings with the same respondents were convened for a few stakeholders to ensure complete discussion on all aspects mentioned in the tools.
Accessibility of communities in remote lake-side locations was a challenge faced during the household KAP survey	Fields teams used available means of transport, including boats. Extent of fieldwork was not affected, however some delays were faced and dealt with.
The probability of missing out on important comments due to local dialect or use of colloquial phrases during discussions.	Teams included experienced national consultants, and translators and note-takers wherever necessary to avoid the loss of information during FGDs and KIIs.
Unforeseen / unexpected change in locations for qualitative data collection were experienced, particularly in the case of NTT.	Team maintained a flexible approach and managed such changes through meticulous coordination and plan adjustments.

Table 2.03.1: Evaluation Limitations and Mitigation Measures

Limitations	Management and Mitigation Measures
Few stakeholders did not allow the recording of the discussion; consequently, Transcriptions for such discussions were not available at data analysis stage.	Extra care and attention was given in such occasions to take meeting notes on paper; these field notes were compiled during data consolidation phase. Resultantly, this phase consumed more time than expected.
The slow and at times delayed transmission of information from stakeholders, such as government agencies, UNICEF and partners, including feedback on deliverables, caused delays in assignment completion.	The evaluation team setup a cloud-based document sharing system and facilitated the document sharing processes by preparing a comprehensive list of documents and proactively managed the process up through frequent follow-ups and discussions. All key stakeholders used the system. However, certain documents could not be received in time. The team however, used alternate document scoping paths and mitigated any delays in data analysis.

2.4 Compliance with UNEG/UNICEF Evaluation Norms, Standards and Ethics

The evaluation design and implementation adhered to all applicable UNEG Norms and Standards of Evaluation[41] as stipulated in various UN guidelines for all evaluations, such as the UNEG Norms and Standards of Evaluation (2016), UNICEF adopted UNEG quality standards for evaluation reports (2017) and UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis (2015). It should be noted however that the scope of this evaluation is focused on effectiveness and sustainability, the OECD DAC criteria elements as specified in the ToR. Table 2.04.1 describes some of the ways in which evaluation norms, standards and ethics have been integrated into this evaluation.

Table 2.04.1: Evaluation Norms

Evaluation Utility	The Evaluators approach to the evaluation aims to produce analysis, conclusions and recommendations that can be used confidently to improve organisational learning, inform decision-making and create accountability. Therefore, the context and goals of the object of the evaluation are thoroughly understood to the Evaluators, so that a practical, specific and realistic evaluation can be developed.
Credibility	The Evaluators have ensured that any issues or concerns that relate to the credibility of the evaluation are discussed and resolved at every step. If necessary, issues or concerns are communicated clearly to the appropriate authority.
Independence	Maintaining the independence of the evaluation is the responsibility of both the Evaluators and program management. Both organisational independence and behavioural independence are accounted for by the Evaluators; the former through diligent discussion and reporting of any issues and the latter through an organisational culture that perceives and addresses any undue pressure or limitation.
Impartiality	Awareness of the need to avoid any sort of bias is built into both the systems and culture of the Evaluators. Any potential conflicts of interest are investigated and addressed both when forming the core team and when training and selecting field team members. The data collection methodology is designed with the need to avoid biased sampling, tools etc. This vigilance extends into the data analysis and report-writing phases, as various pitfalls exist at both points in the evaluation that can undermine the impartiality of the process.
Ethics	The evaluation has been designed and conducted with UNICEF ethical guidelines in mind. The UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis' [42] is a part of the Consultant's standard process for conducting

[41] United Nations Evaluation Group (UNEG), 2016a. Norms and Standards of Evaluation. [.pdf, online] Available at: http://www.unevaluation.org/document/detail/1914 [Accessed: 12 June 2017].

[42] United Nations Children's Fund (UNICEF), 2015a. UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis. [.pdf, online] Available at: https://www.unicef.org/supply/files/ATTACHMENT_IV-UNICEF_Procedure_for_Ethical_Standards.PDF [Accessed: 9 June 2017].

Table 2.04.1: Evaluation Norms

	UNICEF evaluations. Thus, the principles of respect, beneficence, non-maleficence and justice; the core procedures relating to the issues of harms and benefits, informed consent, privacy and confidentiality; and UNICEF's position on conflicts of interest and ethical funding are integrated into all phases of this evaluation.
Confidentiality	The Evaluators exhibit an absolute commitment to ensuring complete confidentiality of the respondents, during fieldwork, data entry and cleaning. Personal information is kept physically separate as much as possible and consolidated data is handled by a single individual to reduce potential points of failure.
Transparency	All products of the evaluation are made available to the public.
Human Rights and Gender Equality	The need to respect human rights will be considered in various ways, including through the organisation's culture, in the training provided to field teams and in the evaluation design. Both the core and field teams are chosen with a view towards gender equality and this element is considered in the design and execution of data collection efforts.

Quality Assurance of the Evaluation Processes
The following key measures were used to ensure quality assurance of all processes that were implemented during evaluation, particularly the field data collection.

- **Continued support and supervision:** The Evaluators (both international and national), with support from the local partner, provided technical support and supervision to our local data collection teams in the field whenever necessary.
- **Ethical clearance** from *Atma Jaya Catholic University of Indonesia* (see section 2.2, 'Ethical Approvals for Fieldwork' for further details) was sought prior to the start of data collection, through the local partner. Where required, UNICEF support was sought to facilitate the approval process.
- **Experienced staff** was engaged for field data collection.
- **Comprehensive training** of all the field staff was ensured. The core team trained the master trainers at the provincial level, who, in turn, trained the other staff
- **Gender balanced** staff was deployed. Most of the field staff were women.
- **Where permission** was awarded, audio recording of the KIIs and FGD was done to ensure that complete data/information was available during data consolidation and analysis phase. Informed consent was a critical pre-requisite for HH level interviews.
- **Evidence** (photographs of the key locations and events) was collected with prior permission from the concerned community members or the respondents/participants of the KIIs and FGDs.
- **Transcriptions:** Along with the field notes, the transcriptions of KII's, meetings and FGDs were made.
- **Confidentiality and anonymity** of the data was ensured by a) separating the respondents' identity from the actual data, b) erasing the identifiable information immediately after completion of data cleaning, and d) making sure only designated and authorized manager/s were granted access to datasets during data processing and analysis.

Quality Assurance of the Household Survey was ensured by complying to following processes and mechanisms:

- Questionnaires were tracked and accounted for through identification numbers.
- Interview log sheets, which record successfully completed questionnaires and rescheduled appointments, were submitted by enumerators on a daily basis and verified by the supervisor.
- Supervisors collected and checked completed questionnaires at the end of each day.
- Mistakes, lessons and corrective measures were discussed by each field team in daily evening meetings.

- All team members remained in contact to ensure a shared understanding of approaches, data collection processes, challenges and mitigation measures.
- Data entry began immediately after the questionnaires were received, which helped to identify errors and mistakes that the supervisors may have missed.
- 10% of the data entry was cross-verified by comparing the soft data with the actual forms during data entry process.
- Double data entry for 10% of the forms was ensured to guarantee complete and correct data entry.

The evaluators, through the local partner, provided a team of independent field monitors, who carried out the following activities:

- **Spot-checking:** the survey supervisors visited a random selection of enumeration areas to re-administer randomly selected questions to three or four respondents in order to permit a consistency check. A total of 5% HHS forms were inspected as part of quality assurance through spot-check visits.
- **Interview observation:** The monitoring team, through its local partner, observed all the enumeration teams, particularly in the early stages of the data collection process. This was to check that the asking of questions, the recording of responses and the treatment of respondents was carried out correctly.

Protocol observation: the survey supervisors observed fieldwork protocols to ensure that respondents were selected appropriately, and that the replacement procedure was carried out according to guidelines.

2.5 Evaluation Implementation, Management, & Team Composition

The execution of the evaluation was divided into five phases; each phase comprised of series of activities contributing directly and/or indirectly to a particular transit or contractual deliverable or a set of deliverables. Table 2.05.1 contains details of the phases of the evaluation, the main activities within each phase and the corresponding Outputs (transit deliverables) or the contractual deliverables.

Table 2.05.1: Phases of Work

#	Phase Title	Activities	Outputs/Deliverables
1	Pre-Inception Phase (Evaluation Toolkit Design & Inception Report) (May-June 2017)	Four initial Skype meetings were held with UNICEF on (May 16, 19, 24 and 2 June 2017) to clarify the scope of the evaluation and discuss the programme itself. A literature review of programme documents was carried out; queries and requests for required documents and data were generated. The Endline Evaluation Matrix (EEM) was developed and submitted to UNICEF for approval and feedback. A brief on the evaluation methods was produced and shared with UNICEF. The EEM was finalized, and the process to lock the scope, methodology, sampling frame and data collection tools of the evaluation begun. The draft inception report was developed and shared with UNICEF for review and feedback.	• EEM developed and shared with UNICEF • Brief on Evaluation Methods document produced and shared with UNICEF • Development of data collection tools started. • Draft Inception Report prepared and shared with UNICEF for feedback
2	Inception Phase (July-August 2017)	The literature review process continued and the scope, methodology, sampling frame and data collection tools of the evaluation were finalized. The inception report was finalized and submitted after UNICEF inputs were incorporated. The process of obtaining ethical clearance was begun through the	• Inception Report finalized and shared with UNICEF. • scope, methodology, sampling frame and data collection tools of the evaluation finalized.

Table 2.05.1: Phases of Work

#	Phase Title	Activities	Outputs/Deliverables
		local partner. Reference letters from UNICEF were requested to facilitate visa processing.	• Application given for local ethical clearance
3	Field Data Collection (August - September 2017)	Ethical clearance was received, and planning for fieldwork was completed in cooperation with the local partner and with assistance from UNICEF. It took longer than expected to finalize the inception report and to obtain visas for the field team. As a result, the data collection process was pushed from July to August. Master trainers were trained, who in turn trained the field team. The data collection tools were translated and pre-tested. The international team, with support from Instrat, undertook the KIIs and FGDs. The collection, processing and preliminary analysis of data was carried out, and a field debriefing was produced and delivered by the AAN team. A 2-page brief on key field impressions was written and shared.	• Local ethical clearance granted • Data collection completed • Field debrief by AAN team prepared and delivered to UNICEF • 2-page brief on key field impressions produced and shared with UNICEF
4	Data Processing, collation, consolidation and Analysis (October 2017)	After the field mission, consolidation of the primary data (field notes, audio-recordings, transcripts) collected, was started on an immediate basis. Data entry, editing, coding and cleaning of the quantitative data was done in parallel during this phase. Data analysis was done, and the literature review of relevant documents continued. An Evaluation Highlights documents summarizing headline results and raw data was developed and shared with UNICEF.	• Evaluation Highlights document developed and shared with UNICEF
5	Reporting and Dissemination (November-December 2017)	During this phase the Draft Evaluation Report was prepared and shared with UNICEF for feedback. The report was finalised based on feedback received. Later, a Bahasa version of the report was produced and shared. A presentation was made to key decisions makers from both BAPPENAS and MoH (members of the ERG) on December 07, 2017 in Jakarta. The session was aimed to serve both validation and dissemination purposes. A four-page evaluation brief sent afterwards to conclude the contract.	• Evaluation Report produced, finalized, translated into Bahasa Indonesia and shared with UNICEF • Closing PowerPoint Presentation to be developed, delivered to the ERG and translated into Bahasa Indonesia • Four-page summary 'evaluation brief' developed and shared with UNICEF in agreed format.

2.6 Evaluation Management, Team Composition, and Timeline

The overall evaluation was supervised by the WASH section of UNICEF. The chief of the WASH section, along with his team provided technical inputs at various stages of the evaluation. The Chief of the Planning, Monitoring, Evaluation, and Research (PMER) section monitored and provided inputs to the evaluation by participating in meeting as and when needed.

The entire evaluation was conducted in a participatory manner, whereby the ERG comprising representatives from BAPPENAS, MoH (including STBM Secretariat), and UNICEF WASH, Child Survival and Development (CSD), and PMER were consulted during all key stages of

the evaluation and approved the deliverables. A final presentation was organised on December 07, 2017, to present evaluation findings, validate, and seek inputs on the evaluation recommendations, before approval of the report.

The evaluation was undertaken by a team of international and national experts with demonstrated experience in evaluations and coupled with demonstrated knowledge of the WASH sector including the application of social norm theory for WASH evaluations in varied contexts. The roles of the evaluation team members are described in Appendix 12.

A local partner i.e. Instrat, one of the leading Market Research Firms in Indonesia, was taken on board for the field data collection and local coordination.

This evaluation was implemented from May – December 2017. The field work was carried out in the period 4th to 28th August 2017.

3. EVALUATION FINDINGS

This section consolidates the evaluation findings and analysis. The commentary follows the flow of evaluation matrix, whereby each question and sub-question is responded to, for the corresponding indicators. The discussion is guided by the nature and scope of technical assistance rendered to the national STBM programme. A separate section entails commentary and analysis for cross cutting priorities such as equity, gender and HRBA.

The findings and analysis are informed of the data gathered while applying both the qualitative and quantitative methods and tools. These include a representative household survey, and series of discussions with range of public and non-public stakeholders including communities at all levels. Overall, 72 FGDs in 36 ODF communities of six direct districts in three provinces were conducted. During these consultations 550 community members were consulted both men and women. Moreover, 65 KIIs were conducted at national, provincial, district and community levels.

EFFECTIVENESS

This section responds to the key evaluation question (EQ#1), *'to what extent has UNICEF been successful in enabling the Government of Indonesia (GoI) and sub-national government(s) to develop and implement the processes for achieving the intended outputs and outcomes of the STBM programme?'*

This question has been responded to by taking stock of programme interventions and results (including effectiveness of strategies) around strengthening of 'Enabling Environment for Rural Sanitation' (EERS). It begins with giving an overview of the key sanitation results that UNICEF-GOI partnership has produced. These include the key achievements made between 2013-17. However, these are not restricted to UNICEF-BMGF grant only. In subsequent section, a detailed discussion is available around interventions, results, and challenges (including gaps) for assistance provided under UNICEF-BMGF Sanitation Programme, to strengthen the EERS. This however includes assessment for four key elements of UNICEF EE Framework i.e. support for policy and strategy, sector coordination, sector financing, and capacity development. The contributions and achievements to strengthening the monitoring system and knowledge management, are described separately, as part of response to a separate evaluation question. The implementation arrangements and their effectiveness has been addressed while responding to the EQ # 1.

3.1 UNICEF-GOI PARTNERSHIP: KEY ACHIEVEMENTS FOR RURAL SANITATION SECTOR

This section outlines key sectoral contributions and achievements of UNICEF-GOI partnership between 2013-17. Please note that not all these achievements could be attributed to UNICEF-BMGF Sanitation Programme. As per UNICEF, two-third (2/3) of these achievements could be related to the technical support interventions implemented under UNICEF-BMGF Sanitation Programme (2013-17).

- **Policy Advocacy & Achievements:** The revision and approval of the 'ODF Verification Guidelines/Standard' is one major policy achievements, as this enabled uniform application of rural sanitation standards/practices around ODF certification. It was UNICEF that highlighted the need and then extended assistance to STBM Secretariat to review, finalise, and issue revised guidelines for uniform application.
- **Presidential Regulation:** UNICEF successfully lobbied alongside other sector partners, which contributed to the issuance of Presidential Regulation (#185, 2014). This regulation demonstrates the highest level of political commitment to accelerate access to drinking water and sanitation in the public agenda in Indonesia. It aims to

achieve Universal Access to Sanitation by 2019. This apparently provided traction to another national level regulation (#5, 2015), by the Ministry of Villages, Underdeveloped Regions and Transmigration (KEMENDESA). The regulation advocates and encourages the local governments to prioritize sanitation as part of village development planning.

- **MoH Circular on Sanitation Financing:** The policy advocacy with MoH contributed to the issuance of a 'circular' to all heads of provincial and district governments, and, an advocacy letter to all heads of villages on increasing budget allocation for rural WASH.
- **National STBM Roadmap:** UNICEF has been a key contributor to the preparation and finalization of the National STBM Roadmap 2015-19. The Roadmap is a strategic document with MoH as custodian. It emphasizes the role of other ministries and departments, and sets targets for sub-national governments to mobilize resources to accelerate the STBM implementation.
- **National Sanitation Conferences:** UNICEF supports the government in organising 'National Conference on Sanitation (KSAN)' a sector event organised after every two years. These were organised in 2015 and in 2017. A prominent contribution of UNICEF in collaboration with POKJA AMPL was the dissemination of key experiences gained through up-scaling of STBM.
- **Financing for WASH:** To improve sector financing and demand, UNICEF partnered with key Islamic institutions on the importance of WASH for development and its central role in Islamic spiritual guidance. This led to a 'Fatwa' (religious decree) from the MUI, the Majelis Ulama Indonesia/Indonesian Council of Islamic Scholars, for the utilization of 'Zakat'[43] collections for rural sanitation. This Fatwa was secured in 2015 and it requires active involvement of the Dai Sanitasi (Mosque volunteers). UNICEF has supported a pilot rollout to test its real-life application in the district of Wonogiri in Central Jawa. UNICEF continues to work with MUI to operationalise and articulate the disbursement of Zakat funds. A PCA was developed between UNICEF and the MUI with this objective. Furthermore, a Memorandum of Understanding between BAPPENAS and the MUI was signed around the implementation and upscaling of this model. UNICEF maintains technical assistance to both entities to develop the mechanisms for training of the Dai Sanitasi.
- **Baseline for WASH SDGs:** As part of enabling environment support UNICEF, together with other sector partners, assisted the government to establish the baseline for the SDGs targets for water and sanitation. The assistance shall guide SDG specific planning and tracking of results.
- **Advocating WASH Prioritisation for Inter-Sectoral Significance:** To illuminate cross sectoral linkages of rural sanitation, UNICEF WASH and nutrition sections have examined how better to synergise WASH in Schools (WinS) with STBM, while underlining linkages between OD and child stunting. The integration assists UNICEF in impressing upon the Government on the need to prioritise cross sectoral work.
- **Social Media Campaigns:** UNICEF in partnership with BAPPENAS and WSP developed provincial WASH profiles, accessible on the 'Tinju Tinja' website (a social media campaign to eliminate OD).

3.2 UNICEF-BMGF Sanitation Programme: Strengthening of Enabling Environment

This section offers assessment of UNICEF-BMGF partnership for strengthening the enabling environment for rural sanitation in Indonesia. This section covers only four (out of five) elements of EE, which are: i) Advocacy for strategy and policy (plans, regulations, and standards); ii) Improved coordination; iii) Sector Financing; and iv) capacity development. The

[43] Islamic alms to address the fundamental belief that social protection contributions should flow from the well off to the poorest sections of society.

commentary includes key findings in terms on interventions, results, and successes, challenges, and gaps. This is followed-up by a section on effectiveness vis a vis implementation approaches and arrangements.

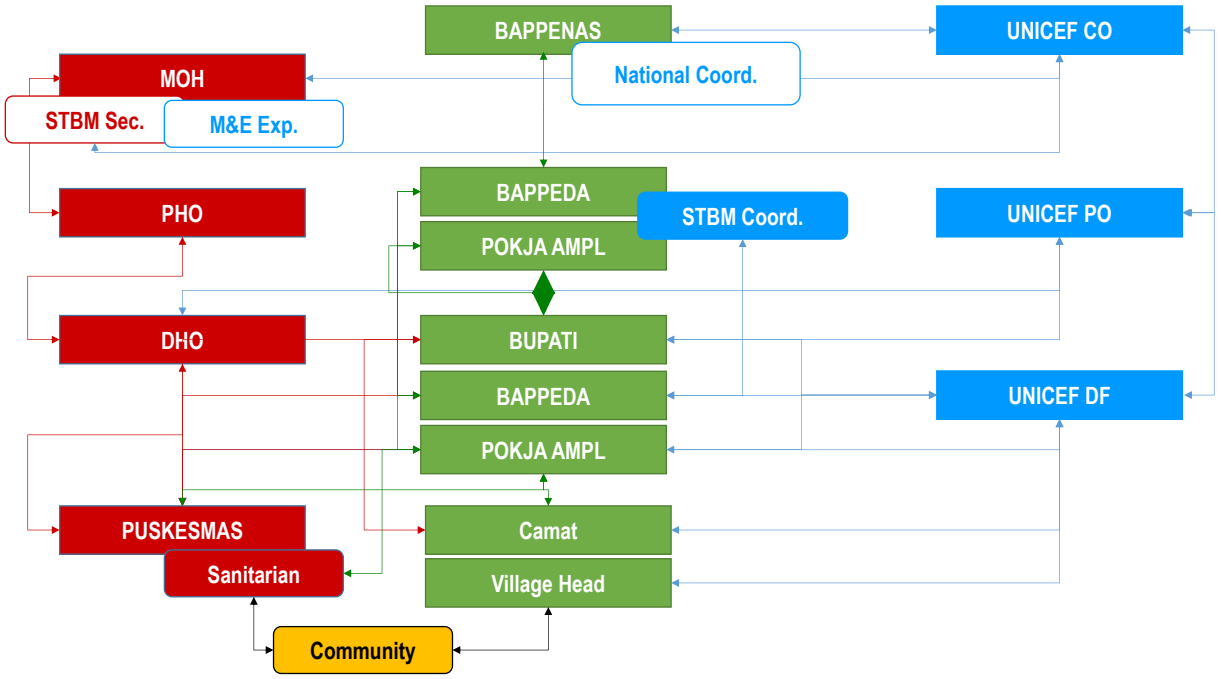
Overall, the programme appeared to have made significant contributions in improving the EE for rural sanitation. The effectiveness of interventions is evident in terms of accelerated delivery e.g. in terms of triggering coverage in 'Direct' and 'Indirect' districts in selected provinces, improved coordination and information sharing across coordination forums i.e. POKJA, increased finances for rural sanitation (including pilots), and finally increased capacities of frontline staff and communities.

3.2.1 Advocacy for Policy & Planning (Plans, Regulations, and Standards)

The national STBM Programme was initiated in 2008 with support from World Bank's 'Water and Sanitation Programme'. UNICEF, as a key WASH stakeholder continued assisting the government in strengthening the policies, systems and processes of STBM programme.

Visual 3.01 illustrates UNICEF's engagement with different stakeholders at varied governance tiers in Indonesia. The evaluators did take note of a highly decentralized governance system in Indonesia, while assessing and commenting on the interventions and successes around UNICEF's policy advocacy work.

Visual 3.01: System of Decentralized Government in Indonesia



Overall, UNICEF's policy engagement in terms of prioritisation of issues, selection of stakeholders and making inroads (for constructive engagement), strategies and interventions to create receptivity amongst public offices and office holders, has largely been successful. The multi-layered and adaptive engagement with key influencers and tools used to get engaged with varied tiers of governances i.e. national, provincial, and districts, appear appropriate in a highly-decentralised context such as Indonesia. The key influencers that UNICEF targeted for policy engagement at different levels include:

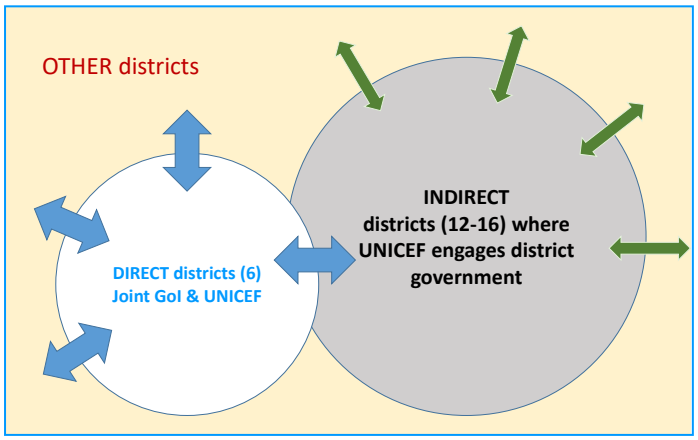
- National level: Line ministries e.g. BAPPENAS, MoH, and President's Office;

- Provincial level: BAPPEDA, PHO, Office of Provincial Governor, and;
- District level: Bupati – elected head of the district government, and the DHO.

UNICEF advocacy efforts were driven by the need to seek commitment from the Government for the prioritization of rural sanitation at all levels. The objectives were to get firm commitments for enhanced prioritisation and financing by introducing regulations and orders e.g. Bupati regulations, circulars and formal letters to different departments.

The evaluators are of the opinion that UNICEF advocacy efforts with strategic and enabling assistance (where required) bolstered constructive engagement (with stakeholders at all levels) and fostered understanding and ownership of initiatives. For instance, the inclusion of STBM targets in District Development Plans i.e. RPJMD, in 'direct' districts. Stakeholders in 'direct' districts appear more aware and sensitised to address the sanitation challenge. In these districts, evidences are available to suggest reasonable increase in sanitation financing from district budgets.

As part of support to improve the enabling environment, UNICEF worked closely with the three provincial governments in its target provinces. UNICEF approached the provinces with clear objectives to strengthen the existing systems. The premise was that each province is unique, hence UNICEF assistance must follow an 'Adaptive Approach', to be able to understand special needs and hence package assistance accordingly. The systems strengthening work began with 'Provincial Bottleneck Analysis', in each of the selected provinces. The exercises were carried out jointly with key provincial stakeholders as represented by Provincial POKJA – AMPL. The exercises helped with identification of bottlenecks and prioritisation of issues for assistance. The issues were, more or less similar, for instance absence of 'provincial regulations' for STBM implementation, weak institutional coordination mechanisms, limited funding, and limited capacities at provincial and district levels. By conducting a bottleneck analysis, UNICEF enabled the government and itself to better direct its efforts and set the agenda for the *following year in each province and district.*



Visual 3.02: Outreach of UNICEF's Efforts

UNICEF's 'Adaptive Approach' remains a hallmark of this programme, which allowed it to tailor its assistance to the local context. The commitment to this understanding or premise of UNICEF assistance is noted across all tiers. This gets further reinforced by the words of one provincial team members who shared: 'The aim of this project is to strengthen the government programme. We do not want to make this 'our project' with the government following. From the beginning we tried to use their terminology, their systems, developed their capacities and built on their achievements.'

The field interaction suggests that provinces or provincial governments have had limited role to play for STBM implementation, except policy and coordination work (to act as bridge between fairly independent districts and the national government). Nevertheless, UNICEF was able to leverage provinces strategically to garner support for STBM from districts, in the form of the issuance of requisite regulations and circulars (such as those from PHO to DHOs) to expedite STBM delivery. Moreover, the active Provincial POKJA APML, played an active role in facilitating districts and disseminating the achievements and best practices across 'direct' and 'indirect' districts.

The level of ownership of STBM implementation varies across provinces. The findings (mostly qualitative) suggest that UNICEF has been able to cultivate a much stronger, deeper and meaningful relationship with provincial and districts governments of NTT province. However, on the contrary the depth of engagement and resultant ownership of provincial and district government is relatively weak/low in Papua. South Sulawesi province offers a mixed picture, where apparently, some districts performed better than others. This opinion is drawn on qualitative assessment (in terms of interaction with provincial and district authorities and number and range of regulations and orders passed at both provincial and district levels), hence must not be tied to post KAP results.

Similarly, the provincial and district POKJA in NTT come up as relatively more engaged and active, which could be linked to the replication of good practices in 'other' districts in the province. The district POKJA worked to share challenges, learning and best practices across provinces. For instance, the allocation of certain % from village development fund was first applied in NTT and later was adopted in other provinces.

For UNICEF limited success in Papua is for multiple reasons. Firstly, the development context of the province, as it is ranked amongst under-developed provinces of Indonesia due to various socio-economic indicators[44]. Secondly, the lower prioritisation of rural sanitation in view of bigger development challenges in terms of creating livelihood opportunities, provision of quality education, and health. The authorities were frank to admit that in view of competing priorities, rural sanitation is lower on priority list for them. Thirdly, so far, the district government did not allocate additional resources, nor did they issue requisite directives for the prioritisation of rural sanitation.

The evaluators are of the view that in the decentralised context of Indonesia, UNICEF made the right choice by laying adequate focus on cultivating trust and constructive partnerships with districts. Again, it featured 'Adaptive Approach', which enabled working constructively with bupatis i.e. district head or governor. The district represents an administrative tier that operates with significant level of autonomy. The bupati office makes decisions quite independently in terms of setting development priorities for the district and allocation of resources. The field discussions and review of district level orders and circulars, suggest that UNICEF has leveraged the partnerships quite effectively to have rural sanitation on the district development agenda. The level of ownership and achievements varies across districts. In districts, where the bupati was more pro-active and approachable (to UNICEF) and have had support available from DHO, it was possible to achieve much more compared to districts with unsupportive bupatis.

BOX 3.01: ADVOCACY IN NTT

The timing of the advocacy could be a key to success for STBM implementation. Luckily for NTT, it has favoured the UNICEF efforts, and so sanitation was prioritized in RPJMD when UNICEF support to STBM was kicking off in NTT. This resulted in sanitation/STBM budget to be allocated in APBD-II 2014. Where as in Papua, the case was not so, and UNICEF struggled throughout the BMGF support duration to convince Bupati to incorporate STBM budget in the RPJMD.

In NTT UNICEF was successful in timing the advocacy efforts (with bupati) with district planning cycle with the intent to have STBM targets incorporated into 'Medium Term District Development Plans i.e. RPJMD. The team was convinced that this is one of the most critical vehicles to mobilise financing at district level. This however could not be across districts.

[44] Papuans also comprise the poorest sector of Indonesian society despite having a higher regional income than the national average. Papua province has a poverty rate (rural and urban) of 30.66% in 2012, the highest in Indonesia and far above the national average of 11.66%. Literacy is also very poor – the worst in Indonesia. In the 15-44 years age group Papua province had an illiteracy rate of 34.83% in 2011, the latest figures available. This is against a national average of just 2.30%. Health statistics are likewise grim. Papuan people suffer conditions far worse that the average Indonesian, and worse even than their counterparts in PNG (Papua New Guinea). They are poorer, less educated and deprived of even the most basic health services, leading to structural discrimination and further marginalisation. http://pacificpolicy.org/2013/06/economic-and-social-indicators-in-west-papua/ [accessed on Dec 16, 2017]

Nonetheless, this has emerged as good practice which should be prioritised for future assistance.

Within the district governance, the camat (Head of sub-district), appointed by bupati, wields considerable influence, and UNICEF did well to engage with the camat. The engagement appears both useful and effective in advancing sanitation agenda. In most districts, the camat would was found to be instrumental in coordinating the delivery of STBM. The role involved coordination with head of the Puskesmas (health centre), village heads, and most active ones were reported to be attending district POKJA AMPL meetings. These were instrumental in winning over the village heads, who in turn had an important role to play in achieving and sustaining ODF.

The evaluators' noted that both the personal commitment and interest of the DHO and the head of the Puskesmas (health centre), was critical, and they appear to be key 'enablers' to achieve STBM. Where these were committed, the districts were able to demonstrate better results. They efforts catalysed the implementation, accelerated ODF achievement, and enabled district wide scale-up. Realising this, the delivery strategy of *UNICEF prioritised working with DHOs and Head of Puskesmas, to foster commitment and ownership. In direct districts, the Heads of Puskesmas were invited to district meetings and events, to help others understand their challenges and encouraged their involvement in finding solutions.*

UNICEF support in terms of dedicated human resources by appointing 'provincial coordinators' and 'district facilitators', has proven useful in enabling relevant public authorities e.g. the bupati, BAPPEDA and DHO, etc. to deliver on the STBM agenda. The team as a whole enabled better planning and coordination at the provincial and district levels. Together extended the much needed 'Secretariat support' to enable the 'provincial and district POKJA AMPL' to deliver on the promise of improved coordination. The 'Facilitators' provided an opportunity to the health workers at Puskesmas and communities to have their voices heard at district and provincial levels.

The embedded support in BAPPENAS and STBM Secretariat (at national level) proved enabling also. Both acknowledged the support provided by UNICEF in advancing the rural sanitation. STBM Secretariat benefitted from technical assistance in improving systems and processes, particularly around monitoring, data management, and knowledge management.

In terms of limitation, the teams across provinces did refer to unavailability of evidences (research reports and documents) to effectively put up the case for prioritisation of rural sanitation to both provincial and district authorities. Apparently, it improved as programme progressed as news researches and materials were produced. For everyone involved (within UNICEF) this comes across as a lesson learnt to prioritise the evidence creation as a tool to enable effective advocacy and lobbying.

Table 3.01.1 lists the district level regulations and instructions achieved in three provinces. There is only one for Papua, which corresponds to the qualitative assessment around weaker performance.

Table 3.01.1: Achievements Advocacy on Regulation

Province	District	Type of Instrument	Description	Dated
NTT	Sumba Timur	Bupati instruction on STBM issued	Bupati instruction on STBM issued. This circular letter issued by bupati to encourage the STBM implementation in village and sub-district and also district	02-Oct-13
NTT	Sumba Timur	Bupati regulation on STBM signed	The POKJA member developed the regulation draft and the draft consulted with stakeholders in Dec 2013. Signed by bupati on 15 Jan 14;	11-Jan-14
NTT	Sumba Timur	Bupati regulation	Socialization of bupati regulation to district and sub-districts stakeholders - The socialization was conducted by bupati and attended by district and Kecamatan participants include camat and Puskesmas;	21-Feb-14
NTT	Alor	Bupati decree	Alor bupati decree on STBM for camat to facilitate the villages to implement STBM	25-Apr-14
NTT	Province	Instruction letter of governor for STBM. launched. Strategy to achieve universal access	Province POKJA AMPL coordination meeting combined with Tinju Tinja Campaign - Provincial POKJA AMPL coordination meeting involved all 22 districts with sharing budget UNICEF, PPSP and PHO. This meeting was attended by National (BAPPENAS & MoH), parliament chairman, vice governor, head of related Dinas,	16-Jun-15
NTT	Alor	DHO instruction to Puskesmas	Head of DHO Alor issued instruction to Puskesmas to optimize the utilization of BOK 2017 to accelerate ODF district;	31-May-17
NTT	Alor	Bupati instruction to camat and village government	Bupati of Alor issued an instruction to camat & village government to accelerate the ODF and allocate Dana Desa for STBM	16-Jun-17
Papua	Jayapura	Commitment for issuance of Bupati circular letter	POKJA AMPL Jayapura will prepare Bupati circular letter.	13-Apr-15
SS	Provincial	Circular letter for STBM is developed	Assisted Provincial POKJA AMPL to publish the 1st edition of provincial news letter	01-Nov-14
SS	Luwu Utara	Bupati regulation	Bupati Luwu Utara Regulation no 43/2014 on Healthy Village was issued; Allocation of 10% from Village Fund for Health purpose, including STBM	30-Dec-14
SS	Takalar	Bupati regulation	Bupati Takalar issued a Regulation on Healthy Village; Bupati Regulation no. 6/2017 is on Mechanism and Allocation of Village Fund Budgeting, and was issued on 5 April 2017. An allocation of 10% from Village Fund for Health purpose that also include budget for STBM implementation has been committed through this regulation.	30-Dec-14 5-April-17
SS	Provincial	Governor circular letter	SS governor circular letter on STBM acceleration was issued; SS governor letter was circulated to all bupati in SS;	27-Feb-15
SS	Luwu Utara	Bupati decree	Advocacy Meeting with new Bupati Luwu Utara; Technical guidance for Village fund utilisation for STBM as follow up of bupati decree, commitment strengthening on acceleration of UAS 2019	09-Feb-17

3.2.2 Strengthening Coordination

Weak coordination emerged as a key challenge and hence a priority during 'Provincial Bottleneck' undertaken at the start of implementation. To improve coordination, UNICEF focused on strengthening the 'Existing' coordination mechanisms available in the form of national, provincial and district POKJA AMPL. In most provinces these POKJA were formed after 2007-8, as precondition to join the national Program Pembangunan Sanitasi Permukiman (PPSP)/ the Settlement Sanitation Development Program. These however have had become inactive over the years in most of the provinces.

UNICEF has largely been successful in supporting the POKJAs at the national level and revitalising those in the three provinces. Moreover, UNICEF support and lobbying helped to address any duplication of forums (POKJAs) in provinces such as in South Sulawesi. Jayapura district in Papua is still operating with two different forums i.e. POKJA AMPL and POKJA Sanitasi.

UNICEF support helped in cultivating ownership of these forums. National and sub-national authorities acknowledged and appreciated the 'secretariat support' made available to these forums by UNICEF. The re-activation of these forums added to the seriousness attached to rural sanitation. The participation (by all key stakeholders) and regularity (of holding events) helped improved the interaction between key public stakeholders. The planning, review and

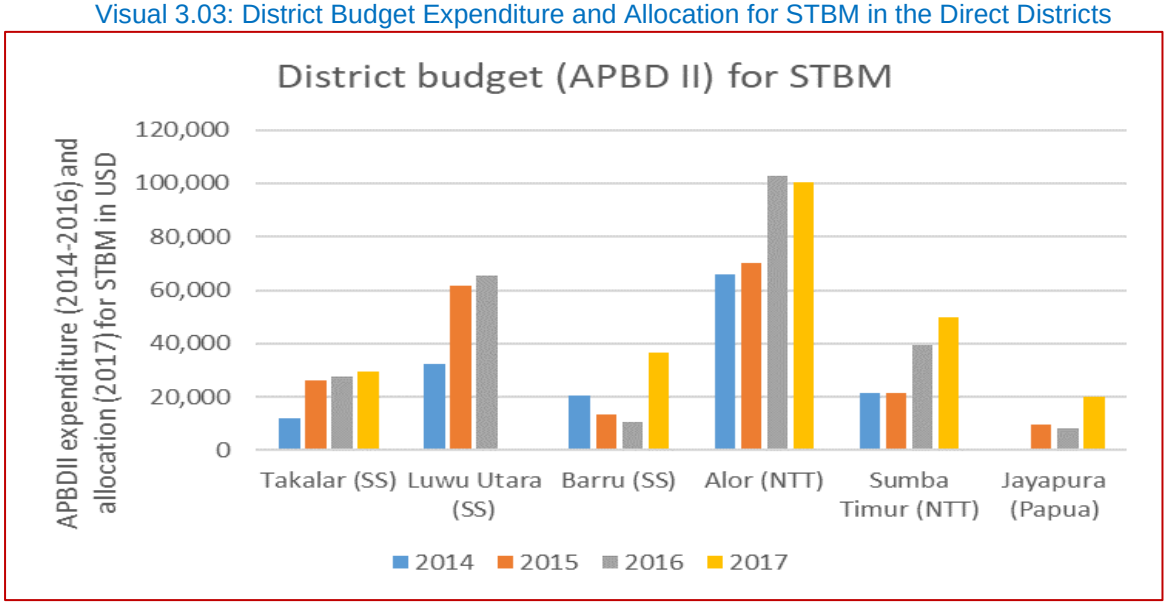
reporting on STBM became more organised and consistent. These forums provided opportunities to exchange ideas and learning, which is evident from the replication of good practices across provinces and districts. District POKJAs helped with lobbying and advocacy with bupatis also. The knowledge management and information exchanges through the production of 'newsletters' proved useful in disseminating best practices. Moreover, the successes and practices were disseminated through 'exchange visits' to 'other' districts. This however has not been systematically documented especially with respect to how did it affect the STBM implementation in these districts. The participants from sub-national POKJAs attended national events and shared their experiences with national stakeholders.

Where the forums have largely worked effectively, these to a degree have triggered 'turf' related tensions between two key players i.e. PHO and BAPEDDA. These were noted in one of the provinces visited by the evaluators, where the PHO shared that despite being the 'prime implementer', their department does not get due credit. To them the BAPPEDA, being responsible for convening the POKJA, takes all the lime-light for rural sanitation related achievements. (See recommendation #1).

3.2.3 Advocacy for Sector Financing

The evaluators received little evidence from UNICEF to ascertain the any incremental change in rural sanitation financing at national and provincial levels, particularly for direct districts. UNICEF team shared that they did not track progress on sector financing during this period. UNICEF evidences shared were found to be incomplete, hence of limited use to ascertain if and to what extent the sector financing (for rural sanitation) has increased over these years because of increases in the overall public-sector development financing, and the relative increase in relation to other development priorities such as education, health etc. In view of the above, the evaluators are unable to comment on the effectiveness of UNICEF assistance in terms of increased public-sector financing of rural sanitation. Nevertheless, this section offers a roundup of UNICEF supported initiatives and achievements made with respect to sector financing in Indonesia. These include both the efforts at national level and those at district levels i.e. 'direct' districts.

Visual 3.03: District Budget Expenditure and Allocation for STBM in the Direct Districts



Visual 3.03 is self-explanatory in terms of progress made in different districts. The interaction with the UNICEF Provincial team in Alor (in NTT province) suggests that advocacy with district authorities resulted in issuance of regulations for increased allocations. Reference was made to issuance of instructions by DHO Alor to relevant Puskesmas to optimize the utilization of

BOK 2017 (operational fund) to accelerate district-wide implementation of ODF status. The Community Empowerment Department (CED)has made commitment to allocate 'Special Fund' for all villages to accelerate ODF achievement. Moreover, the district allocated funds for recruitment of 17 sub-district facilitators for post-triggering monitoring.

Indonesia being a highly-decentralised country features a relatively complex system of public financing. Funds are allocated to national public entities and programmes. With that there are direct funds available to provinces and districts. Rural sanitation in Indonesia apparently is funded out of multiple streams. These include financing by MoH to the STBM Secretariat for country-wide implementation of STBM. Then there are funds made available to provinces and districts, which they spend as per local priorities. Lately, a new initiative public initiative for rural development has taken shape in the form of 'One Billion Rupia Village Fund', allocated annually to each village.

UNICEF has been advocating for an increase in sector financing to expedite progress on achieving country-wide ODF. This includes efforts both at the national, provincial and district levels. Find below examples and successes of UNICEF advocacy for increased sector financing.

At highlighted earlier, UNICEF has contributed to seeking a 'Fatwa' (religious decree) from the MUI, the Majelis Ulama Indonesia (MUI)/Indonesian Council of Islamic Scholars, for the utilization of 'Zakat' collections for rural sanitation. UNICEF has supported a pilot rollout to test its real-life application in the field. UNICEF continues to work with the MUI to operationalise and articulate the disbursement of Zakat funds. A PCA was developed between UNICEF and the MUI with this objective. A pilot has been rolled-out in district Wonogiri of Central Jawa Province. Furthermore, a Memorandum of Understanding between BAPPENAS and the MUI was signed around the implementation and upscaling of this model. UNICEF maintains technical assistance to both entities to develop the mechanisms for training of the Dai Sanitasi at the national level. As this has not been scaled yet, however this could contribute to the achievement of country-wide ODF.

In direct districts, UNICEF has been advocating with bupati to seek additional financing for rural sanitation. In some districts, UNICEF has been more successful in realising additional financing for STBM, than others. For instance, in Sumba Timur district of NTT province, UNICEF successfully lobbied to have STBM targets included into the district development plan i.e. RPJMD. The Evaluators however did not see any evidence on whether, and to what extent, has this been replicated in other 'direct' and/or 'other' districts'.

Until 2016, rural sanitation did not have had separate budget line within the 'Village Development Budget'. Until then the Village Heads would make allocations out of interest and commitments. However, in 2016 a new law has been introduced by KEMENDESA, which may contribute to increased rural sanitation financing. This law seeks to impress upon the village authorities to prioritise allocations for rural sanitation out of new stream of funds i.e. Dana Desa (Village Funds). The bupati can direct the Village Head to earmark funds for rural sanitation from this fund. Some districts have already made progress on this. For instance, in Luwu Utara (district of South Sulawesi province), the bupati has issued the Regulation no 43/2014 on Healthy Village, allowing allocation of 10% of the funds from Dana Desa for health and sanitation including STBM. The other districts have followed suit such as Takalar by issuing relevant regulations i.e. Regulation Perbup 6/2017. These are new developments and likely to have impact on rural sanitation financing, but in the future. Find below the list of relevant regulations issued in 'Direct' districts.

Table 3.01.2: Finance Related Regulations

District	Legal instrument	Title	Actor	Purpose	Dated
Luwu Utara	Bupati regulation	Bupati Luwu Utara Regulation no 43/2014	POKJA AMPL Bupati	Regulation on Healthy Village was issued.	30-Dec-14
Luwu Utara	Bupati decree	Advocacy Meeting with new Bupati Luwu Utara	Bupati (Indah Putri Indriyani)	Technical guidance for Village fund utilisation for STBM as follow up of Bupati Decree, commitment strengthening on acceleration of UAS 2019.	09-Feb-17
Luwu Utara	Bupati regulation	Mechanism of Allocating Village Fund budget	Bupati POKJA AMPL	Allocation of 10% budget from Village Fund for Health purpose, including STBM implementation	5-April-2017
Takalar	Bupati regulation	Perbup 6/2017	Bupati POKJA AMPL	Allocation of 10% budget from Village Fund for Health purpose, including STBM implementation	2017

The Evaluators are of the view that sector financing needs to be tracked to enable an informed analysis. UNICEF Indonesia shared that they have already commissioned (in 2015) a 'WASH Sector Public Spending Review' to map the sector financing, and have been working in parallel with the evaluation process to track how financing for WASH evolved as part of this programme – UNICEF will track in 2018 with the start of the new RPJMN drafting process on how this is likely to evolve.

3.3 Capacity Development of Public Agencies and Communities

This section discusses the capacity development interventions under UNICEF's support for public agencies including the sanitarians (front line staff of the local health centre - Puskesmas) and communities.

Overview: Capacity building emerged as a priority need during the 'bottleneck' exercise, which was followed up by offering variety of assistance (at all levels). The focus has been on enhancing capabilities of public sector staff (at all levels) and communities, to strengthen planning and implementation of community lead total sanitation approaches, and improved monitoring and reporting. The evaluators note that capacity development did not follow a particular strategy, nor was one documented, instead it remained 'adaptive', where UNICEF relied on secondary sources to plan and implement training interventions.

The focus has primarily been on training and skill development, at all levels, both in direct and indirect districts. A series of trainings were organised at different levels, attended by key stakeholders such as public officials from BAPPENAS/BAPEDDA, MoH/DHO and members of POKJA. At ground level, these include the head of the Puskesmas, sanitarians, head of village, local leaders, religious figures, village Kaders, women groups, and masons. Most of these trainings were supported by NGO partners. The major achievements include revision and finalisation of STBM training manuals. These were referred to as key successes that helped in standardisation of training contents and delivery. The limited engagement of public sector training institutes at any level, appears to be a gap in system-wide capacity development. Moreover, it would have been better had post-training support and follow-up might have been undertaken especially in the mentoring, coaching, on-job support, refreshers, and tracking of how trainees are performing.

Find below key findings and analysis around capacity development approach and stakeholders' views on capacity development and its contributions to accelerated/improved STBM delivery.

3.3.1 Public Agencies

The capacity development focused on training of provincial, district and sub-district level public officials and communities in social mobilization and STBM concepts / skills, knowledge management, monitoring, data entry, reporting and effective advocacy. For some special districts, learning and exchange visits were organised to inspire and educate POKJA members and frontline workers i.e. sanitarians. Two learning visits were organized. In Papua, provincial POKJA AMPL visited an ODF district (Pacitan) in East Java and sanitarians from district Jayapura visited Sumedang district in West Java, where ODF had been successfully implemented.

In 2014, UNICEF contributed to the revision and finalization of STBM Training Modules and Curriculum with the MoH. This enabled the standardization of training contents and materials for facilitators, sanitation marketing, university lecturers and master trainers. These modules have been accredited by the 'Agency for Human Resources Development & Empowerment (MoH)[45]. The evaluators did take note of absence of training module for masons. UNICEF supported training used a separate module for masons' training, this however is not part of MoH approved training kit.

Additional training was organised to support the allied functions of varied tiers of management. These include training in creative writing and documentation, implementation of Android based provincial monitoring system in NTT, orientation on the development of a communications campaign for religious leaders, entrepreneurship skills to strengthen sanitation marketing forums/groups.

With the aim to integrate capacity development within government system, UNICEF promoted the use of various modalities including the traditional workshops and training events, for executing the overall capacity development approach. The other settings that were used for enhancing the capacities of relevant stakeholders include various type of meetings at provincial, district and sub-district levels. For example, providing the technical support to POKJA members on a range of issues was a regular agenda of the coordination meetings. The technical guidance and counselling to sanitarians and other staff of Puskesmas was provided during regular meetings convened for progress review and monitoring purposes. Similarly, field visits and exchange learning events were also considered an opportunity to discuss and resolve implementation issues faced to local government, sanitarians and communities. Thus, capacity development was viewed from system strengthening perspective rather simply an event driven agenda.

STBM related capacity development by the GoI operates on a cascade model. At the national level, prior to UNICEF's support, the MoH was already conducting training for key government officials and continued to do so throughout implementation as well. These trained staff members at the national level then provide training to the provincial level and in some cases to the district level as well. At the district level, the available trained government staff usually conduct trainings for the STBM teams at various levels including the DHO, the heads of the Puskesmas and the sanitarians. At community level, the sanitarians train the Kaders which help the sanitarians in conducting triggering and post-triggering activities. UNICEF's role was to keep the relevant government staff and departments active and involved in planning and executing of training events. Where necessary, UNICEF provided financial, technical and logistics support for such events. The role of UNICEF-supported staff, two positions - one each at provincial (STBM coordinator) and district level (STBM facilitator), is very crucial in mobilizing government resources through POKJA for these events.

45 United Nations Children's Fund (UNICEF), 2014a. Second Progress Report.

The evaluators came across different and at times conflicting views as to the capacity development. For instance, the sanitarians at all locations reflected positively on trainings provided for improved 'Social Mobilization'. In general, government stakeholders noted the gaps in the institutionalization of capacity development activities, the limited tracking of training and the assessment of the contributions of training to performance. The government officials also highlighted the insufficient number of available training facilities / institutes and master trainers in the MoH.

3.3.2 Sanitarians

All professional staff related with primary health care services received technical training from public health training institutions before their entry into the public health system. Such trainings are usually focused on building technical knowledge and skills in the respective fields. Unfortunately, continued capacity development / on-the-job training of the sanitarians has not been institutionalized within MoH; therefore, MoH relies on organising training on an ad-hoc basis with support from external agencies like UNICEF and other sector partners.

CLTS implementation through triggering requires a mix of special skills on mobilization, counselling and guidance that is usually developed/built *through frequent trainings on behaviour change communication, self-learning through persistent application of the acquired skills, and above all, the level of personal commitment and motivation*.

The key aspect of the sanitarian's role, while performing their other duties under the Puskesmas is mainly health promotion by delivering key messages on health, nutrition and many other aspects. The skills developed through this role, even with years of experience, does not guarantee that they have acquired the skill-set that is specifically required to do an effective triggering. *Therefore, triggering generally done by sanitarians remains of poor quality*. Once a community is sensitized through poor-quality triggering, it becomes very hard to get the desired level of collective commitment by the community to adopt new behaviour. *The situation leads to prolonged intervention durations to achieve ODF in such communities*; such is the case for most of the communities in Papua. Hence, UNICEF adopted other complementary approaches such as 'door to door' triggering. Where such proactive approaches are appreciated, these cannot be considered a long-term solution to achieving ODF status at sub-district and district levels. UNICEF thus needs to further emphasize and actively work with the government to increase investments for the institutionalization of the capacity development of the sanitarians.

3.3.3 Communities

At the community level, evidence of enhanced capacities (knowledge, action plan, targets, and internalization) varies from region to region, some showing reasonable progress while others are just taking off. A major area of concern is the adoption of the new social norm of ODF. There is a lack of a defined agenda for post-ODF activities within the government and the communities, in most cases, emanating from varying capacities for Post-ODF activities. The subsequent paragraphs explicate these findings.

Empowering communities to take the lead in resolving their ODF issues is part and parcel of the STBM/CLTS approach. UNICEF has worked along these lines for strengthening the activities during post-triggering phase to sensitize communities on the benefits associated with improved sanitation. For this purpose, village based Posyandu Kaders (community volunteers mostly associated with village health post) were involved and provided STBM training. Kaders then supported the sanitarians in monitoring and carrying out other follow-up actions in helping the community reach ODF status. However, it must be noted that the presence and visibility of these Kaders varied and was observed at a minimum in most cases where the Evaluation Team visited the ODF communities. Beside Kaders, members of other local network such as local women associations, existed and were actively involved in dissemination of STBM

messages at household level. A lot more can be done to engage and build the capacity of the potential reference networks (village level volunteers involved in education related work, village development work and other social work, and self-motivated people regardless of their occupation who have high social acceptability and persuasion power within communities) to fully leverage their potential in STBM implementation.

Although STBM teams were established at the village level, these teams could not take the form of an organised or formal sanitation committee with a defined composition, designated roles and clear responsibilities. This incapability has resulted in the limited availability of formal village sanitation plans for the post-ODF phase. Consequently, formal agendas for the meetings of the STBM team were not prepared and no documentation exists to record the key happenings and decisions made during meetings (such as meeting minutes, weekly/monthly activity register or another form of documentation etc.); such a situation indicates a missed opportunity to document the key learnings as part of UNICEF's KM (Knowledge Management) efforts. On the other hand, some of the heads of the villages claimed that such action plans were discussed and implemented by the STBM team during planning, triggering and post-triggering phase until the village achieved ODF status.

The implementation of community-agreed sanctions for OD practices is almost non-existent, although people do informally discourage the practice of OD. Currently, there is no post-ODF monitoring. Advocating for regular monitoring and documentation through the communities would, in addition to administrative gains, help improve capacity development efforts.

3.3.4 Gaps and Opportunities for Capacity Development

On the whole there are visible achievements in terms of enhancing the capacities at various levels. However, much work remains to be accomplished. Major achievements relate with delivering training to national ministries, provincial authorities, the DHO and the sanitarians in their understanding on the CLTS implementation approaches. However, the lack of a structured approach in conducting the capacity gap assessment was noted as a costly lapse. The weaknesses in the technical capacity of the sanitarians is the most cited issue by all stakeholders. A key area of improvement is the monitoring system by implementing the SMS based monitoring system and its linkages with the STBM website, and the use of such data tracking coordination and development.

Training was provided mainly on a demand basis through discussions with the relevant department or ministry. The overall capacity development approach did not provide a sufficient guarantee that the appropriate and timely training was provided. Inappropriate attention to these two key ingredients of development resulted in visible deficiencies in the capacity of sanitarians, albeit at varying levels across districts. A related issue, reported by POKJA members, is that in some cases, there was a repetition of training on similar topics and themes. On occasion, repeated training on challenging topics may be warranted, but in that case the repetition should be built into the planning stage.

UNICEF's capacity development approach lacked sufficient focus on developing linkages with government training institutes and academic institutes for systematic CD approach. Sanitarians receive pre-service training from public health education academic institutes; thus, developing linkages with these institutes is helpful in the integration of STBM modules into regular training curricula of theses institutes. Though, UNICEF partnered with Public Health Faculty of an academic institute (The University of Cenderawasih) in Jayapura (Papua) for their willingness to work on community development through UNICEF supported CLTS implementation (hygiene promotion, triggering, post-triggering follow-ups etc.) and STBM module was part of the pre-service curriculum of the involved faculty. However, a long-term partnership could not be fostered due to changing priorities of the faculty staff, and that is plausibly linked to limited time availability for performing the required tasks. Similarly, in NTT,

a local university is made part of POKJA AMPL, and UNICEF has collaborated with the university as POKJA member, to work on SanMark promotion. Despite these two examples, no evidence is available to indicate long-term partnerships with public sector training institutes for overall CD initiatives. Instead, UNICEF CD approach followed supply-driven agenda that was more focused on capacity development of NGOs, and religious entities/leaders apart from public officials.

A significant gap noted is the limited availability of exclusively trained and experienced trainers for conducting triggering and other CLTS / STBM activities. Since the sanitarians are the actual delivery arm of STBM, the quality of the training they receive through the above capacity development model is not sufficient to impart the needed triggering skills. Furthermore, notably, there are a few sanitarians that have not received any form of training (they joined after the training session at the district level) but are still involved in triggering.

The tracking of the capacity development component lacks a comprehensive database from which valuable learning can be derived; two examples of such gaps are:

- Though records of training events exist at the province level, the structure of the data is not uniform and in most cases the record was centrally compiled. Gaps in capturing all key data (e.g. name, sex, age and education level of the trainee/participant) and STBM related information such as the role in STBM implementation. The existence and hence availability of such a data is always useful to assess the effectiveness of capacity development approach vis-à-vis the achieved results, and;
- While pre-event and post-event checklists were used to assess performance of the participants during the training, the assessment of outcomes of the training in terms of improved performance remains a missing link.

(See recommendation #2).

3.4 IMPLEMENTATION

3.4.1 Partnerships – Role of the NGOs / CSOs

The findings in this section cover the nature of the partnerships, the work undertaken by UNICEF's local partners; role of partners in knowledge management, training and coordination; challenges posed by the 2014 fund channelling law; key outputs/outcome and of UNICEF's partnerships and description of specific partnerships in each of the target provinces.

UNICEF worked with all tiers of the government ranging from National to sub-national level. Doing so, various partnerships were developed with different types of entities including CSOs, NGOs, Academic institutions and Faith based organisation. Working with local partners has enabled UNICEF to leverage the strengths of a diverse range of actors at district level while coordinating with government at one end and communities on the other hand.

UNICEF undertook assessments for the selection of local entities to establish partnerships while following the standard procurement rules of UNICEF. The key considerations made for selection of partners were their awareness of the local context, penetration into communities, coverage, experience of working in WASH sector and financial stability. Where required, briefing sessions were convened to help the potential local partners in understanding the overall purpose and objectives of the partnership. This enabling approach demonstrates UNICEF's commitment to building a sustainable partnership base, right from the beginning.

Following the standard procurement rules of the UNICEF, two key approaches i.e. signing of the Programme Cooperation Agreement (PCA) and Short Services Agreement (SSFA) were used to formulize the engagement. A specific reason for signing the SSFA was to minimize and distribute the risk, considering the relatively low capacity (technical, financial and WASH

experience) of the available potential partners at the time of selection; for example, in Jayapura district of Papua province, two partners (Yayasan Papua, Yayasan Noken Papua) were involved at the same time to support UNICEF at district level because no partner with very strong WASH experience and better technical and financial capacity, was available. Therefore, UNICEF decided to take more than one local partner to minimize the risk of working with single partner with less experience. The two-partner approach worked well and demonstrated the expected positive results – a development that warrants a case study.

The presence of local partners at the provincial level, enabled POKJA to undertake review meetings, monitoring visits and the convening of the provincial level training events. At the district level, the local partner worked in close association of the district facilitator resulting in improved work planning and coordination between Puskesmas, sanitarian, camat and the STBM team. This level of coordination facilitated the organisation of triggering sessions, post-triggering monitoring and other district-level events.

A significant role of these local partners was to work closely to support local government, POKJA and UNICEF in preparing the knowledge management products. Some notable examples include the publication of a pocket size booklet on 'Islamic Teachings and Sanitation' and 'Sanitarian's Smart Practice Compilation Book', jointly produced by district BAPPEDA, DHO, Sanitarians, POKJA, UNICEF and Lemina (the local partner in Takalar and Barru districts in South Sulawesi). Similarly, periodic publication of 'WASH News Letter' in Takalar and Barru with support from Lemina and in Luwu Utara with Madani's support, are commendable accomplishments.

It must be noted that at the provincial level and the district level, partners supported trainings but did not conduct the trainings; trainers were either from UNICEF or experts selected by UNICEF and Government.

The design of the UNICEF support to STBM was based on a principal to 'widen and deepen partnerships with NGOs, CBOs including faith based organisations, training institutions and international agencies'[46]. However, during the initial stages of the Programme, the need to engage the local partners was less emphasized. In 2014 a law on channelling of funds was promulgated. This law prohibited direct cash transfers from international entities to sub-national governments. It thus became necessary for UNICEF to 'find innovative ways of creating tripartite partnerships'[47]. UNICEF admirably turned the challenge posed by the new law, into an opportunity to develop partnerships; resultantly, the first few partnerships were formalized in mid of the 2014.

Review of the partnership closure reports made available to the Evaluators and interactions with relevant personnel, indicate that broadly all targets/outputs were achieved; however, some delays attributable to misalignment with the work plan of local government, were noted. Generally, the government officials and UNICEF staff met during evaluation are appreciative of the facilitation and coordination role of local partners. The interaction with representative of Circle of Imagined Society (CIS Timur), a local partner in Kupang, indicated that 'it was a different kind of experience to work with UNICEF and government on an agenda of advocacy, capacity development and knowledge management. The scope of work was quite different than what we do normally, as an NGO'.

In NTT, UNICEF partnered with two NGOs to account for the different contexts in its two direct districts. Sumba Timur is a mostly Christian district, and accordingly UNICEF established a partnership with Synod GKS, the largest Christian Synod working in the district. UNICEF

46 U.S. Fund for UNICEF (USF), 2012. Scaling-up and Strengthening Community Approaches to Total Sanitation. [.docx, stored document] Received on 19 May 2017. Stored by AAN Associated. Filename: USF Proposal to BMGF_UNICEF WASH Project.
47 United Nations Children's Fund (UNICEF), 2015. Third Progress Report.

conducted an introductory workshop with GKS to introduce the concept of STBM and triggering, and to produce a communication plan for implementation to promote STBM.

In Papua[48], UNICEF initially (around 2014) partnered with a local NGO (SBH) at the provincial level through a PCA. At the district level, a University was engaged via SSFA, while two local NGOs (Runsram in Biak and LPMAK in Mimika) were involved, although without any cash assistance. At each level, the NGOs support the government on STBM implementation and arranged various capacity building trainings and meetings.

It is important to note that multiple agreements (PCAs/SSFAs) were signed with a single entity on a similar scope of work within same province or district. For example, at least two-three agreements were signed with CIS in NTT/Alor, Yayasan Pahadang Manjoru (YPM) in Sumba Timur, Yayasan Noken Papua (Yakenpa) in Jayapura (Papua), Lemina, Bakti and Madni (local partners) in South Sulawesi. The average duration of an agreement ranges between 8-9 months[49] whereas the duration for few partnerships was only for 5-6 months as indicated in the Table 3.03.1. The NGO partners showed their concern over the short duration of the partnerships since it causes an extra hassle to follow the complete cycle of proper documentation for the previous and new agreement. Furthermore, the uncertainty about the probability of award/renewal of new contract potentially unfavourably affects the quality of relationship with the UNICEF and government on one hand, and the motivation/prioritization to work for short-term projects.

Table 3.03.1: Short-Duration Partnerships

Province	District / Level	Partner Name	Type of Partnership	Start date	End Date	Duration (Months)
NTT	Sumba Timur	YPM	PCA	07-Aug-15	30-Dec-15	5
Papua	Jayapura	PHF	SSFA	16-Jun-14	30-Oct-14	5
SS	Luwu Utara	Madani	PCA	01-Jun-2016	01-May-2017	11
SS	Province	Bakti	PCA	10-Jul-15	31-Dec-15	6
SS	Takalar, Barru	Lemina	PCA	25-Jun-15	31-Dec-15	6

YPM: Yayasan Pahadang Manjoru; PHF: Papua Health Foundation; Madani: Lembaga Mitra Swadaya Madiri; Bakti: Yayasan Bursa Pengetahuan Kawasan Timur Indonesia Foundation; Lemina: Lembaga Mitra Ibu dan Anak

The fact that local partners are now more empowered with better advocacy skills and have reasonable exposure on how government system work, is a significant outcome of their work with UNICEF; this development provides the opportunity for local partners to work with government in implementation of STBM without any long-term nurturing from UNICEF. It is also noteworthy that Programme documents indicate that UNICEF established partnerships in the private sector as well, e.g. with UNILEVER, Indomaret, Matahari, and others. However, scope and modalities of engagement remains unclear and even looking forward, the intent to engage the private sector is not easily apparent at this stage.

3.4.2 Communication Campaigns

The findings in this section includes the need for prioritization of communication, UNICEF advocacy strategy and efforts to develop and implement communication campaigns, contextual adaptations of the communication channels, innovations introduced by UNICEF; role of local networks (PKK, volunteers/Kaders etc.) and involvement of religious leaders and organisations and the use of social media-based Tinju Tinja campaign.

Realising that behavioural change would require some strong behavioural communication, UNICEF prioritised assisting government at all levels, to strengthen the ‘Behaviour Change

[48] United Nations Children’s Fund (UNICEF), 2014a. BMGF-UNICEF Partnership Programme on Sanitation in Indonesia – Papua Province. [.ppt].
[49] Calculated based on the review of timeline (start and end date) for 22 agreements (PCAs/SSFAs).

Communication (BCC)' strategies, interventions and products. UNICEF's major contribution and achievement is convincing government to take a departure from conventional communication approaches and tools. Moreover, it was for UNICEF's efforts that government bought the idea to introduce and implement 'Post –Triggering Communication'. This included a developing and implementing a series of interventions to amplify the message shared by the Sanitarian, as part of 'Triggering'. The BCC strategies and interventions were adapted to local context to make them responsive. The NGO partners worked closely with public sector apparatus in design and delivery of these BCC campaigns. UNICEF support helped leveraging and integrating the religious institutions and leaders, as part of BCC campaigning.

Prior to UNICEF support to STBM, the government did not focus on communication as a tool to support STBM; at that stage the focus was on the provision of 'latrines' with low emphasis on behaviour change and triggering alone was considered sufficient. As such, UNICEF efforts to promote behaviour change communication represents a significant value addition to STBM.

UNICEF supported local government to develop and implement communication campaigns with support from local partners of UNICEF. Such communication campaigns aimed to reach out to communities through various means in order to reinforce the STBM messages to influence knowledge, attitude and practices of communities to achieve ODF status. These campaigns are part of UNICEF's efforts to improve post-triggering activities. The intended audience includes those who do not have latrines (to encourage latrine construction) and the general population (to raise awareness of sanitation issues).

Communication activities evolved with time and varied across and within districts; for example, radio messages are aired in Barru but not in Takalar, even though both are part of the same province. Similarly, UNICEF's partner in Papua, Hirosi, used local radio channels to disseminate STBM success stories in Jayapura via talk shows. Radios are available in many households, including those that do not have access to the internet.

In order to strengthen the communication strategies of STBM implementation, UNICEF developed a 'Communication Strategy' in 2014. The communication strategy is built on UNICEF's Communication for Development (C4D) framework of Strategies. The C4D framework highlight three key guiding principles namely a) advocacy for policies and resource mobilization, social mobilization by involvement and capacity building of a range of actors/entities (CBOs/NGOs, media etc.); and c) emphasis on behaviour and social change by involving children, women and other family members at household and community level. The strategy provided an overall guidance to help choose the most appropriate option (communication means) considering the local context. However, the extent of dissemination for adoption and application of newly developed communication strategy by government officials is not much visible; a few government officials met during evaluation were even unaware of its existence. UNICEF team shared that the strategy was not intended to become a government document but was meant for internal use by UNICEF provincial offices to guide Government.

Messages in support of STBM were delivered through multiple channels, such as via banners, radio spots, socialization events, formal/informal gatherings and social media etc. Different approaches were followed in different contexts. It must be noted that POKJA and the local government need to be consulted and taken on-board to design and disseminate behaviour change communication content.

One UNICEF innovation is the conversion of written commitments to pursue ODF (produced as a result of meetings and workshops) to banners. These banners have been used in other meetings and events, where they act as a reminder of the commitment made by persons in positions of authority to the cause of ODF.

UNICEF conducted roadshows in various districts and provinces, for example in 2014 in Sumba Timur, STBM roadshows were conducted in 12 sub-districts, organised by the local POKJA AMPL and an NGO (YPM). These public events demonstrate to the wider community the conviction and dedication of the participants to STBM / stopping OD.

UNICEF made use of its social media based 'Aksi Nasional Tinju Tinja' campaign, which is focused on sharing messages on ending OD through volunteers. Although developed and disseminated by UNICEF through non-BMGF resources, the campaign continues to act in support of various programmes concerned with tackling OD, including STBM[50].

BOX 3.02: SUCCESS CASE: NTT ALOR

UNICEF introduced Tinju Tinja (TT) Campaign in late 2014. It is a social media campaign aimed to raise awareness about sanitation, health, nutrition and its impact on health. It aimed to seek commitment from communities to adopt hygiene practices. The local UNICEF staff shared that the 'concept of TT Campaign Ambassadors was introduced who were later invited to attend POKJA AMPL meeting in Alor. As part of campaign, Provincial Coordination Meeting was organised and attended by NTT governor, other provincial stakeholders and government officials from all 22 districts. The TT Ambassadors (celebrities involved in Tinju Tinja Campaign) were invited to highlight the campaign messages. Commitment was sought by signatures drive on banner of the 'Tinju Tinja Campaign' stating that 'we need to eliminate OD in NTT by 2019''. Those not following social media were shown YouTube videos available online. *The Adaptive Approach worked well in terms of putting moral and social pressure to the decision-makers for their greater commitment and actions to support STBM implementation, the official noted.* The success made us to replicate in districts, where bupati, camat and village heads from all districts were invited. The same banner was displayed in 39 sub-districts (in two direct districts), where all potential champions for the STBM were asked to give their commitment by signing it. Further, the banner was displayed again during ODF declaration ceremonies at district level to remind and reinforce the message. To the official, the approach had two objectives: one; to acknowledge the efforts of high achievers/motivators, and two; to encourage others to follow the suit. To him, this approach helped taking the STBM implementation to other districts also.

In NTT province, with little modifications, UNICEF has promoted the Tinju Tinja campaign as an advocacy tool to reach out to the bupati, POKJA AMPL and local leadership at sub-district and village level. The reason behind this innovative approach was the fact that use of social media is not equally popular amongst all groups particularly the senior government officials; and thus, government officials there are unlikely to encounter the Tinju Tinja Campaign messages. Such government officials still prefer to use old cell phones instead of smartphones. Thus, in order to make use of Tinju Tinja campaign's influence, the content, theme and resources of the Tinju Tinja Campaign were produced on other mediums (Banners and posters) and were displayed during the meetings with bupati, POKJA AMPL and local leadership at sub-district and village level. *This innovative approach proved a great success in achieving strong commitment at various levels and in spreading the STBM messages particularly the elimination of OD*. The offline use of TT campaign is also reported in Papua, however, degree of success in Papua remains unnoticeable.

Recognizing the influence of religious, leaders and institutions, in communicating with the public, UNICEF's local partners developed sermons for use in churches and mosques and has conducted workshops with religious groups to this effect. Religious partner organisations, such as Synod GKS in NTT, assisted in the design of the materials as well. The materials aim to highlight the importance of sanitation in religion, thereby promoting the elimination of OD and improved hygiene practices. UNICEF's local partner in Sumba Timur also conducted hygiene promotion sessions in Sunday Schools; for example, in 2014, a School Sunday Festival was organised to promote, hygiene education (particularly HWWS) among students and parents.

In Papua, UNICEF screened videos that combine humour with a message on stopping OD produced by YouTube personalities popular in the province. To show the videos, a screen and projector is transported to target villages; a generator is provided in villages that do not have

[50] United Nations Children's Fund (UNICEF), 2017. *About – Aksi Nasional Tinju Tinja*. [webpage] Available at: http://www.tinjutinja.com/aksi-nasional-tinju-tinja [Accessed: 9 October 2017].

a supply of electricity. Once the film ends, an NGO facilitator or sanitarian leads a discussion on the content of the video with the community. The use of *YouTube videos* served as an alternate approach to reaching out to poorly triggered communities. It has proved to be a *cost-efficient approach and is well-liked by villagers; as such, this approach should be explored in other provinces as well*.

UNICEF has involved local networks in communication, for example the PKK in various villages has conducted door to door visits and corner meetings to promote ODF.

It is also noted that an assessment of the impacts of the deployed communication approaches was not considered, and consequently no evidence is available to measure the degree of success of apparently successful approaches; a formative research on the impact of communication approaches in a diverse cultural and development context should be useful in designing a sustainable scale-up programme. (See recommendation #2).

3.4.3 Sanitation Marketing

The findings in this section covers an overview of the key efforts made, achievements, and weaknesses around SanMark.

Sanitation marketing is a concept that entails supply side interventions for availability, accessibility, affordability, quality, inclusiveness, and resilience of latrine materials and services to construct, repair, maintain or improve the latrines. To the evaluators, the SanMark as a concept and interventions has not been prioritised much within STBM. UNICEF assistance did prioritise SanMark, however with limited success and documentation. The key achievements creation of SanMark Group or Forum in South Sulawesi, however its activities and resultant impact has not been tracked systematically. The UNICEF supported training in provinces and districts did have low-cost latrine designs module, however it is not part of the national STBM Training Manual. UNICEF has been able to demonstrate a working model of SanMark with reasonable level of success in NTT (more details in Box 3.03). This however has not been documented systematically nor its impact is tracked. The evaluators have not seen if all or parts of it been replicated in other provinces. The monitoring records lack information and analysis around adoption of low cost designs, affordability (for the poor), inclusiveness (disaster resilience and usability across different groups like disabled, older person and others). Moreover, no evidence is available to suggest success with promoting entrepreneurship and engagement of private sector in sanitation related services. The

BOX 3.03: SUCCESS CASE: NTT

Capacitated Masons

Districts in NTT have implemented SanMark-related interventions with vigour. Mason training was conducted at the district level. Masons were selected through sanitarians' involvement, *each sanitarian introduced two masons for the training*. The training quality was considered reasonable because it went beyond just the theoretical aspects of STBM and latrine construction. The training also included the construction of *sample toilets under the supervision of SanMark experts* to demonstrate an enhancement of the quality of their workmanship. Later, a SanMark group was established with one sanitarian and the two trained masons. UNICEF with support, involvement and guidance of local government and POKJA provided two sets of fiberglass moulds in Puskesmas custodianship. These moulds are used by established SanMark groups for construction of toilet (WC) within their communities for families who want to construct low-cost toilets.

Product Quality and Appeal

While the standard cheap model of the toilet is durable it just lacks the finish and appeal of the commercially available models; however, this is not of concern for *most villagers convinced of the need to achieve ODF status, as they are interested in obtaining a toilet as cheaply as possible*. On the other hand, there are some *masons who were interested in competing with commercial models of toilets*, have invested money to buy and install a compression press. These masons are *producing market-compatible toilets* using the UNICEF-provided moulds but with better finishing and colouring of the final product and at more competitive prices.

Market-acceptable Pricing

Some of the trained masons in these SanMark group are particularly motivated to the extent that started constructing latrines at no-profit basis or even for free to poor households, out of a desire to make a positive impact on their communities. The toilets constructed by the trained masons are produced using local materials and are significantly cheaper to produce than the available commercial models, and consequently at a much cheaper price. Furthermore, the *market-compatible toilets* constructed by some masons are *still cheaper than the commercial products* and were appreciated by the well-off community members as well.

evaluation suggests that not much success been achieved around access to financing for poor.
The commentary below elaborates the above aspects.

At design level, the UNICEF support have a clear focus on promotion of the SanMark, but government-led implementation of STBM does not have any clear agenda to promote SanMark. Masons were trained to enhance their technical skills of latrine construction across the programme districts. The masons training also included guidance on basic knowledge of how to establish a small sanitary business. The most significant achievement is the formation of 'Sanitary Marketing Forum' in NTT that proved a great success (see Box 3.04), however such success could not be replicated in other districts.

It is important to that the UNICEF programme did not contribute to any of above stated situation related to availability, price and quality of sanitary materials. The on-ground situation is driven by market forces and the UNICEF as well as the government do not prioritize any support mechanisms to regulate these aspects of the SanMark.

Qualitative findings indicate that sanitary materials are, in general *available* to most of the communities either *within village or at sub-district level*, approximately within a range of *5 - 10KM*. Community members are generally satisfied with the quality of the available products. However, people were mostly concerned about the affordability of the preferred sanitary item for their homes. Skilled masons and labour are easily available for the construction, repair and maintenance or an upgrade the toilets.

A common trend observed in communities is the construction and repair of the toilets on self-help basis without involving a skilled labour to save money. However, FGD participants identified a gap in skills and services related to the repair and maintenance of *domestic septic tanks*. People pointed to the unavailability of appropriate tools and the lack of proper skills for *emptying and/or repairing domestic septic tanks; a commonly occurring problem*.

Where commonly-used latrines are readily available or can be easily constructed, there is no effort to promote the need for design improvements especially *for* use by the *physically challenged people and children*. In Papua some efforts have been invested to develop special toilets for the lake-side community. However, the effort is not documented, and no data is available to comment on the degree of success. (See recommendation #3).

3.5 UNICEF-BMGF Programme Contributions in Changing in Knowledge, Attitudes and Practices of Communities

This section responds to the key evaluation question (EQ#2), *'to what degree joint GoI and UNICEF efforts succeeded in improving knowledge and attitudes; and adopting and sustaining critical sanitation behaviour (at community and individual levels) in particular ODF (consistent latrine use by all)?'*.

The commentary looks at the joint GoI and UNICEF efforts in improving knowledge and attitudes. It presents the review of key aspects seen in adopting and sustaining, or lack thereof, sanitation behaviour at the community and household levels.

The KAP HHS conducted by the evaluators as part of the Endline component of this evaluation was administered to a total of 3,243 HHS in both 'direct' and 'other' districts of SS, NTT and PP. The Sampling methods and distribution applied for the HHS is attached as Appendix 3.1 & 3.2; only ODF communities were initially planned for inclusion in the survey. However, during sampling stage, due to insufficient number of required ODF villages (fulfilling the required criteria) in each district as per the available data, overall seven (07) non-ODF villages (one from each district) was included in HHS sample (Appendix 3.1). Out of the total HHS covered,

67% belong to 'direct' districts while the remaining 33% are from 'other' districts. In both 'direct' and 'other' districts around 50% of respondents are male and 50% are female. Note that in the following discussion, the figures quoted relate to 'direct' districts only unless otherwise stated. The analysis of HHS results is done separately for both 'direct' and 'other' districts.

Overall: UNICEF has prioritized upstream activities throughout its support to STBM. Qualitative interactions indicate that communities have demonstrated reasonable improvement in their knowledge, attitude and practices, albeit with circumstantial variation around OD and other sanitation issues. This has resulted in an increasing trend of constructing new latrines and upgrading existing ones. However, there are areas where water scarcity and geography are noted as some of the barriers to further progress in this regard. The practice of using *shared latrines* is common amongst those who do not have their own toilets. Although the practice of shared latrines contributes to reducing the incidence of OD, it *does not guarantee ODF*; refusal by the owner is always possible, for both predictable and unpredictable reasons. *Therefore, the practice of shared latrine usage needs to be gradually replaced by one toilet per household*. In NTT context, another reason of high use of latrine on sharing basis is multiple families living in a single house.

Access to Sanitation

UNICEF efforts have contributed in enhancing the demand for sanitation leading to an increase in overall latrine existence. The HHS results indicate latrine existence at 86%, (Table 3.05-1) showing an increase of 17% percentage points than the baseline values conducted in late 2014 in same six districts of the three provinces. The Endline survey results are better than the national values as indicated by latest data of the UNICEF/WHO Joint Monitoring Programme[51] report 2017. The comparative results for 'direct' and 'other' districts present almost similar picture, a fact undermining the value of UNICEF's TA in 'direct' districts.

Table 3.05.1: Percentage Distribution of Households' Access to Sanitation Endline ('Direct' and 'Other' Districts)

Indicator	Baseline	Midline	Endline	
			Overall (Direct Districts) (%)	Overall Other Districts (%)
Latrine Existence	68	55	86	85
Sharing of Toilet facility	11		8	8
Latrine Upgraded in 3 last years	-	-	11	10
Open Defecation when at home	-	-	8	14

* Does your house currently have a toilet – Yes
** Do you share this facility with other families outside of your home (Yes)
*** Have you improved/upgraded this latrine in last THREE years - (Yes)
**** When at home, for how many days during last week (7 days), did immediate family members defecate in the open? (some days/most days/every day)

Year	National				Rural			
	At least basic	Limited (shared)	Unimproved	Open defecation	At least basic	Limited (shared)	Unimproved	Open defecation
2000	44	9	14	32	28	7	19	45
2015	68	15	5	12	57	14	8	21

Despite appreciable progress in latrine existence, it is still not encouraging sign that a sizeable proportion (14%) do not have latrine, although the surveyed communities are ODF certified communities.

As indicated in the Table 3.05.1 above, the survey results for 'sharing of toilet facility' and 'Upgradation/improvements in Latrine in last three years' are similar for 'direct' and 'other' districts. Out of those who have toilet at home, 7% of HHs reported that they share their toilets. The incidence of shared toilets is highest in NTT, at 12% and lowest in SS, at 4%; this is likely

[51] https://data.unicef.org/topic/water-and-sanitation/drinking-water/

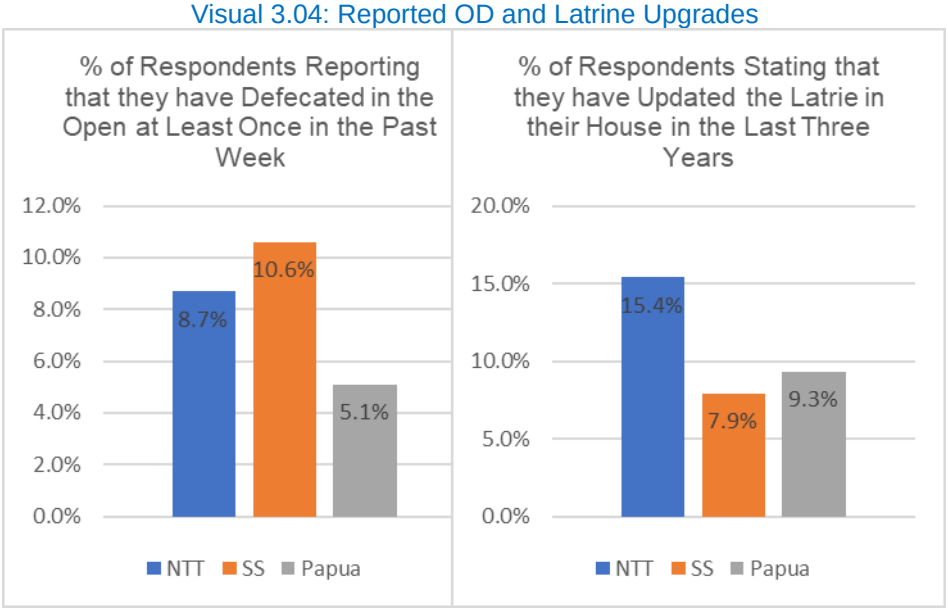
linked to the increased level of development of SS compared to NTT. Interestingly, the rate of sharing in Papua (7%) is lower than in NTT although it has the lowest rate of development compared to the other two provinces (See Table 3.05.2).

Table 3.05.2: Percent Distribution of Households that Share Toilet Facility with Others by District Type ('Direct' and 'Other'), Province and District

Share Toilet Facility with Others	Direct										Others			
	Province			Total	Province						Province			Total
	NTT	SS	PP		NTT		SS			PP	NTT	SS	PP	
					District						District			
					Alor	S. Timur	L.Utara	Takalar	Barru	J.pura	M.Garai	E.kang	Keerom	
No	88	96	93	93	90	85	98	93	96	93	75	98	98	92
Yes	12	4	7	7	10	15	2	7	4	7	25	2	2	8
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100

Of the respondents who have latrine at home, 10.5% of respondents stated that they had improved or upgraded the latrine in their house in the last three years; the highest rate of improvement was in NTT at 15.4%, with Papua following up at 9.3%, the rate in SS was the lowest at 7.9% - most likely a reflection of the high rate of progress towards ODF in NTT and the low requirement for improvement or upgrades in relatively developed SS.

Visual 3.04: Reported OD and Latrine Upgrades



In HHs with toilets, respondents in all three provinces reported that they OD at least once in the past 7 days when at home. In NTT, the rate was 9%, in SS it was 11% and in Papua it was 5%. The fact that reported rates of OD in verified ODF communities remains so high is a point of concern for the sustainability of the achievements of the Programme.

On average the proportion of respondents with latrine at home but still defecating in open is comparatively low in 'direct' districts (8%) than in 'other' districts (14%). This aspect highlights relatively better results of communication approaches under joint efforts of Government and UNICEF's support (refer to Table 3.05.3).

About quality of construction of latrines, 5% of respondents across all three provinces, stated that they are 'very satisfied' and 73% reported that they are 'satisfied' with their toilet facility as a place to defecate, while 21% indicated their dissatisfaction. It is important that the Programme take steps to address the factors contributing to dissatisfaction (maintenance,

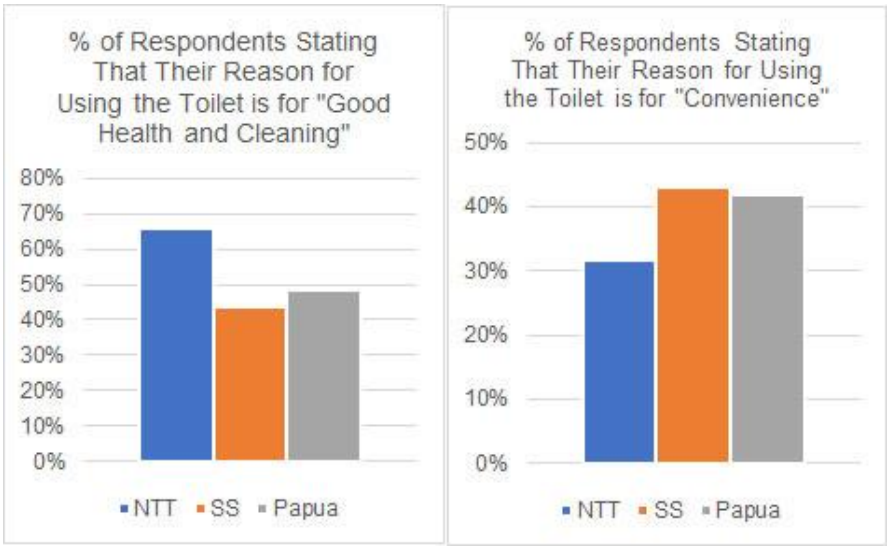
design, smell etc.), for promotion of context specific latrine designs through effective SanMark interventions.

Table 3.05.3: Percent Distribution of Respondents Reporting their Satisfaction with the Toilet Facility as a Place to Defecate by District Type ('Direct' and 'Other') and Province

Degree of Satisfaction	Direct				Others			
	Province			Total	Province			Total
	NTT	SS	PP		NTT	SS	PP	
					District			
Very satisfied	9	2	10	5	2	2	7	4
Satisfied	65	76	79	73	42	95	59	68
Dissatisfied	26	21	11	21	48	2	29	25
Very dissatisfied	1	1	0	1	9	0	5	4
Total	100	100	100	100	100	100	100	100

Of those respondents who reported having a toilet in the home, NTT had the largest percentage of people reporting that their reason for using the toilet was for 'good health and cleaning' at 66%, a significantly higher rate than the other provinces (44% in SS and 48% in Papua). The second most common reason given was 'convenience', at 32% in NTT, 43% in SS and 42% in Papua. Thus, the level of awareness in triggered communities of the benefits of using toilets is high across all three provinces.

Visual 3.05: Reasons for Toiled Use



Awareness on ways to protect young children against diarrhoea.

In terms of understanding the link between diarrhoea and latrine use, only 16% of respondents in direct districts reported that they 'use latrines / dispose faeces of children in latrines' in order to protect their children from diarrhoea. The most common response (27%) was that respondents boil or treat water (refer to table 3.05.4).

Table 3.05.4: Percent Distribution of Respondents Reporting the Ways to Protect their Children Against Diarrhoea District Type ('Direct' and 'Other') and Province

Ways Adopted to Protect Young Children	Direct Districts				Other Districts			
	Province				Province			
	NTT	SS	Papua	Total	NTT	SS	Papua	Total
					District			
Boil or treat your water	26	27	28	27	22	30	29	26
Use latrines to dispose-off faeces of children	19	15	16	16	28	24	16	23
Wash hands with soap and water	25	18	22	21	26	28	21	25
All other options	30	41	34	37	25	18	35	26
Total	100	100	100	100	100	100	100	100

At the time of the survey, 9% of respondents reported that their children under the age of 5 were victims of diarrhoea in the last 24 hours before the survey (See Table 3.05.5) – this is half the national average of 18% (RISKESDAS, 2013). These numbers suggest at least a small portion of the community is aware of the link between latrine use and protection from diarrhoea.

Table 3.05.5: Percent Distribution of Respondents Reporting that their Children Under Age of Five were Victims of Diarrhoea (3 or More Watery Stools Within 24 Hours or same day) by District Type ('Direct' and 'Other') and Province

Children Under Age 5 had Diarrhoea	Direct Districts				Other Districts			
	Province				Province			
	NTT	SS	Papua	Total	NTT	SS	Papua	Total
					District			
Yes	11	10	4	9	15	9	8	12
No	89	88	93	89	84	89	91	87
Don't know	0	2	3	2	1	2	1	1
Total	100	100	100	100	100	100	100	100

Community Participation and Follow-up

Post-triggering activities, such as follow-up visits to households, village level progress review meetings and behaviour change communication are important for achieving ODF status and for establishment and sustainability of norms. The HHS results reflects a slight improvement (5% percentage points) than the baseline values for participation level in sanitation related meetings and during visits of government officials to the village. However, the participation level of community members in 'direct' districts (33%) presents a better situation than in 'other' districts (20%) (See Table 3.05.8). Overall results are not encouraging since greater community participation is a key determinant of the ODF achievements and is fundamental to sustain the achievements. Such a low level (one third) of community participation strongly corresponds to the 'poor quality triggering', the most commonly cited challenge by respondents of the KIIs at provincial and district level.

Table 3.05.6: Percentage Distribution of Households - Post-Triggering Activities by Baseline, Midline and Endline ('Direct' and 'Other' Districts)

Indicator	Baseline	Endline	
		Overall (Direct Districts)	Overall Other Districts
Percent distribution of households reporting participation in meeting about sanitation and during visit of government official regarding construction of a latrine.	28	33	20
Percent distribution of households received sufficient information (awareness messages, supplies, mason etc.) helpful to construct a latrine by province.		79	81
Distribution of households able to recall three key messages learned/practice in the participated meeting.		57	36

When asked about 79% of respondents in 'direct' districts and 81% in 'other' districts are of the view that they have received sufficient information to construct a latrine (See Table 3.05.7). This supports the view of some of the officials interviewed by the evaluators that most people have access to the required information and skills to construct latrines. The same views were also shared by some participants of FGDs that When constructing a latrine, many community members choose to construct the latrine by themselves without the help of a professional mason.

Of those who did participate in meetings, 57% reported that they are able to recall the key messages of the meetings attended by them. The situation is much better in 'direct' districts than 'other' districts (36%).

Communication Channels

The HHS results reflect some behavioural change shift regarding their preferences and trust to the sources of information. A visible shift is noted for means of information sources from electronic medium and family or neighbours to some local authority (head of village or some other authority of the village office etc.) or Government health workers (sanitarians, midwives, cadres/volunteers, etc.). For example, before programme implementation, people were more inclined to get sanitation related information from Television (34%) and/or some other person close to them (17%). However, due to programme activities such as communication campaigns etc., now they are getting more information from programme related staff or other officials (50%). The pattern is almost same in both 'direct' and 'other' districts. These trusted sources should be continuously emphasized in design and execution of behaviour change communication campaigns.

Table 3.05.7: Percentage Distribution of Respondents Regarding their Preferences and Trust to the Sources of Information About Hygiene and Toilets by Baseline, Midline and Endline ('Direct' and 'Other' Districts)

What Are the Sources of Information Through Which you Get Information About Hygiene and Toilet?	Baseline	Overall (Direct Districts)	Overall Other Districts
		Endline	Endline
Television	34	12	16
Family members/relatives	17		
Local authority (head of village, RT/RW)		26	23
Government health workers (sanitarians, midwives, cadres, etc.)	24	24	25
Which sources of information you trust/prefer the most than others?			
Television	24	12	16
Family members/relatives	18		
Local authority (head of village, RT/RW)		26	24
Government health workers (sanitarians, midwives, cadres, etc.)	33	26	26

Sanitation Marketing Promotion (SanMark)

The survey results reveal mix pattern across all type of districts for purchasing sanitary materials and supplies. Overall, a significant proportion of respondents cannot purchase sanitary supplies within or nearby their community/village (dusun/desa). For 30-45% respondents, sanitary supplies are accessible at sub-district level. Whereas 28-50% respondents are forced to travel to district level for purchasing sanitary items except direct districts in South Sulawesi. The overall situation requires immediate attention to reduce the travel time and thus saving the associated logistics costs to get sanitary supplies.

Table 3.05.8: Percent Distribution of Respondents Reporting their Knowledge Regarding Place of Availability of Sanitary Materials and Supplies for Constructing Toilet be Purchased by District Type ('Direct' and 'Other') and Province

Place of Availability of Sanitary Materials and Supplies to be Purchased	Direct Districts			Other Districts		
	Province			Province		
	NTT	SS	PP	NTT	SS	PP
				District		
Within or nearby your community/dusun	12	10	6	16	1	0
At village/desa level	12	28	9	25	5	2
At sub-district level	29	48	33	30	44	45
At district level	46	13	48	28	47	50
Don't know	2	1	4	0	2	2
Total	100	100	100	100	100	100

The HHS results reveal significant improvements in awareness level of community members about available options to receive any assistance to build a latrine. The assistance form could be any information or facilitation for availability/receipt of loans/financial support for construction of latrine and/or it could any information/facilitation to access the construction

Materials or other in-kind support etc. The awareness level has increased from 20% (baseline) to 49% in 'direct' districts, approximately two times higher than in 'other' districts (17%). Where it is apparently a significant contribution of programme, however, still almost half of respondents are still unaware of any such useful information. This aspect requires more concentrated efforts on improving the SanMark strategies. The analysis shows, 36% of those who are aware of any form of assistance, have received any assistance. Further analysis points to a very discouraging situation about availability of loans (1-2%) or any financial support comparing to the receipt of some form of in-kind and/or construction materials support. Where the promotion and availability of loans and/or other financial support mechanisms is an important element of SanMark, it is inevitable for equity focused programming.

Table 3.05.9: Percentage Distribution of Households Reporting Level of Awareness About Available Options to Build a Latrine by Baseline, Midline and Endline ('Direct' and 'Other' Districts)

Indicator	Baseline	Midline	Endline	
			Overall (Direct Districts)	Overall Other Districts
* Awareness of any available options to receive any assistance to build a latrine (Have Latrine at Home)	20		49	17
** Recipient of any assistance to help you build a latrine (Respondents Have Latrine at Home)	83		36	26
Awareness of any available options to receive any assistance to build a latrine (Respondents without Latrine at Home)			37	5
* Are you aware of any available options to receive any assistance (loan, financing, gifts/grants, Construction Material/in-kind support etc.) to build a latrine ** Did you receive any assistance (loan, financing, gifts/grants, Construction Material/in kind support etc.) to help you build a latrine				

Table 3.05.10: Percent Distribution of Respondents Reporting the Type of Assistance Received by District Type ('Direct' and 'Other') and Province

Type of assistance received	Direct Districts				Other Districts			
	Province				Province			
	NTT	SS	PP	Total	NTT	SS	PP	Total
					District			
Loan	0	1	5	1	0	0	3	2
Grant/Gift/subsidy	1	4	11	4	60	0	13	17
Construction Material/in-kind support	98	95	80	94	40	71	83	76
Don't know	1	0	4	1	0	29	0	5
Total	100	100	100	100	100	100	100	100

Handwashing with Soap (HWWS)

Pillar 2 of STBM relates to handwashing behaviour. The HHS results indicate reasonable level of respondents practicing handwashing at critical moments. The top three events noted for applying handwashing practice are before and after eating; and after defecation (18%). The weak areas emerged from survey results requiring attention in hygiene messaging are mothers' practices of feeding (4%) and cleaning the child faeces (4%). The results are almost comparable for 'direct' and 'other' districts.

Table 3.05.11: Percent Distribution of Respondents Reporting the Time of Handwashing as Per the Endline by 'Direct' and 'Other' Districts

Indicator	Endline	
When do you usually wash your hands	Overall (Direct Districts)	Overall Other Districts
Before cooking	9	10
Before eating	28	27
After eating	22	21
Before feeding a baby/child	4	4
After cleaning the faeces from a baby/child	4	4
After defecation	18	19
After work/returning home from work	15	16
Others	1	0

Use of soap for handwashing is a critical aspect of hygiene promotion campaigning as advocated by UNICEF. Almost one fourth of the survey respondents are using soap in addition to another 8-9% who are using Powdered or liquid detergent for handwashing purpose. Of those who practice handwashing, 29.4% of respondents reported that they wash their hands with water only, while 27.1% reported using soap and another 8.2% used powdered or liquid detergent. Overall, promotion of handwashing practices requires further improvements.

Table 3.05.12: Percent Distribution of Respondents Reporting the Items Used to Wash their Hands by District Type ('Direct' and 'Other') and Province

Item usually use to wash hands	Direct District				Other Districts			
	Province				Province			
	NTT	SS	PP	Total	NTT	SS	PP	Total
					District			
Water	25	33	27	29	32	31	31	31
Soap	29	27	24	27	21	29	27	26
Powdered or liquid detergent	8	7	15	8	13	2	10	9
Don't know	39	33	34	35	33	39	32	34
Total	100	100	100	100	100	100	100	100

The most commonly reported reason for choosing to wash hands is to be clean (38%), followed by 33% who expressed the view that they wash hands to prevent the spread of diseases – 15% responded that they wash hands to get rid of dirt / smell / sticky things. Together, the results of the KAP relating to HWWS indicate that there is still a real need for handwashing related interventions, both to encourage the use of soap and to ensure that hands are washed at 'critical moments'.

Table 3.05.13: Percent Distribution of Respondents Sharing the Reasons to Wash their Hands by District Type ('Direct' and 'Other') and Province

Reasons to wash hands	Direct District				Other Districts			
	Province				Province			
	NTT	SS	PP	Total	NTT	SS	PP	Total
					District			
To prevent the spread of disease	42	27	36	33	40	32	37	37
To be clean	43	36	36	38	40	41	43	41
To get rid of dirt/smell/sticky things on my hands	11	18	12	15	14	13	7	12
To smell good	2	10	12	8	4	10	11	8
Others	2	10	3	7	2	3	1	2
Total	100	100	100	100	100	100	100	100

3.6 MONITORING AND KNOWLEDGE MANAGEMENT

The evaluation question on monitoring (EQ#3.2) is 'how well did UNICEF monitoring and knowledge management interventions enable the GoI and Communities for programme course correction and advocacy with government?'. The findings herein are structured in two subsections; namely Monitoring System and Knowledge Management, the later drawing extensively from field experiences. The discussion around monitoring system covers UNICEF's contributions in improving the existing monitoring system; the importance of the use of data in planning; evolution of SMS based monitoring system; challenges and improvements to the SMS based monitoring system; trainings on new indicators and improvements of the system introduced by UNICEF's support.

3.6.1 Strengthening of STBM Monitoring

The STBM monitoring system has improved in recent years mainly due to UNICEF's technical assistance. These improvements are visible at the national, provincial and district levels. However, a lot of work needs to be done to strengthen post-ODF monitoring at the community level. Major achievements relate to piloting and implementation of SMS based monitoring and supporting the MoH at the national level in its efforts to improve the monitoring system further, including the STBM website. POKJAs role in the monitoring of STBM implementation at the district level needs more recognition. Simultaneously, the role of the Puskesmas in monitoring the progress of STBM needs to be enhanced through increased earmarked public funding for monitoring.

UNICEF supported MoH by appointing a dedicated KM expert to identify the weaknesses in the existing SMS BMS. Beside this provincial level support, UNICEF supported STBM training on SMS and Web Based Monitoring System at provincial level to train government staff from BAPPEDA, PHO, DHO, district level operators and the sanitarians. The training focused on explaining the modified indicators used in the SMS-based monitoring system. Before SMS based monitoring system, sanitarians were doing manual monitoring and sending the reports to DHO once in every three months to update progress on availability and type of latrines.

Ensuring that monitoring data is used in the planning and implementation of STBM has been a consistent challenge. The fact that the SMS data is sent directly by sanitarians at the Puskesmas to the MoH at the national level is good for ensuring that the data is centralized but it also insulates the district and provincial governments from the data. To address this issue, UNICEF has successfully advocated to the MoH to introduce the provision of feedback to the provincial level based on the monitoring data received.

UNICEF advocated with the national government, MoH at national and provincial level and the district governments to replicate and scale-up the SMS-based monitoring in UNICEF supported provinces under BMG-UNICEF support to STBM. In 2013, NTT was the first province among three provinces (SS, NTT, Papua) that started implementing SMS-based monitoring system. Later, South Sulawesi started using this monitoring system around 2014-2015.

Provincial POKJA do not have any authority to implement any STBM activity but can advocate, guide monitor and coordinate with the concerned district governments for any desired actions (acceleration of STBM). It is thus expected that the provincial POKJA AMPL has maintained data on previously applied indicators, in addition to regularly maintaining data based on current monitoring indicators (as per M&E templates developed for monitoring of the BMGF support in three key area like enabling environment, demand creation and supply facilitation).

Furthermore, the Provincial POKJA is only responsible to standardization of the implementation guidelines, setting standards for the monitoring tools, guidance, advocacy for increased funding and appropriate regulations, coordination among various departments and overall provincial level monitoring of the progress for future planning.

In NTT, Android based Monitoring application was developed and implemented by UNICEF for provincial level monitoring of the STBM programme by the Provincial Pokja. The Pokja can use monitoring information/data to plan, organize and execute its support specific to the needs of each district.

Another important aspect of the STBM monitoring system, highlighted by UNICEF, was the weak or absent feedback system between the STBM secretariat, provinces and districts. Since 2016, UNICEF's technical support to STBM secretariat is focused on improving the feedback system. The work is in-progress and UNICEF has appointed a technical resource person within MoH to support data analysis and data transmission downwards. On completion of the task, a provincial level training workshop is under consideration to disseminate the key challenges and recommendations on improving the data analysis and its usage for planning.

Despite significant improvements on various aspects of the monitoring system at all levels, the current system is still facing some issues about data quality, consolidation and reporting. For example, UNICEF have identified and highlighted that there are a few villages that were triggered and/or have been verified but STBM website data is showing much different numbers on these two indicators. Therefore, the current efforts are also directed to remove such anomalies from the system. In this aspect, UNICEF is working with MoH to introduce the three new indicators to monitor quality of triggering such as success rate, triggering rate and the slippage. (See recommendation #4)

UNICEF's current (2017) efforts to improve the monitoring system includes advocacy to the MoH to introduce three new indicators to better examine the quality of ODF and the actions that need to be taken in response. These are as follows:

- The % of STBM implementation in a district, if this is low, further advocacy to the bupati is necessary to secure increased funding for STBM.
- The % success rate, if this is low then the quality of triggering and follow-up must be improved.
- The verification rate, if this is low and many claimed ODF villages are waiting for the verification process to complete, then steps must be taken to remove the bottlenecks in the verification process.

See Appendix 11 for more details on the evolution of the SMS based monitoring system, its weaknesses, refinement of the indicators; the training of sanitarians on SMS based monitoring system and issues faced to sanitarians in implementing the new indicators and the POKJA's strategy to overcome the challenges faced by the sanitarians regarding the application of the new monitoring system. The Appendix also describes the new android based monitoring system at provincial level introduced in NTT by UNICEF with support from Pokja.

3.6.2 UNICEF Support to Knowledge Management

Under UNICEF-BMGF technical support, the core objective of KM is to contribute to policy influencing, advocacy, better programming and improving the evidence through improved documentation, reporting, review, consolidation of expert viewpoints and monitoring & evaluation. The KM efforts aimed to save efforts of the individual districts from 're-inventing the wheel' when implementing STBM. To achieve these objectives, UNICEF efforts around KM has resulted in varying degree of success for sharing of learning experiences and knowledge management at all levels.

UNICEF's KM efforts were guided from a WASH KM strategy that was prepared by UNICEF in 2014[52]. The strategy outlined the specific activities to be performed at the national level and for each of the three intervention provinces. The KM strategy provided clear guidance on the

[52] United Nations Children's Fund (UNICEF), 2014b. KM Workplan WASH 2014.

type of KM products (quarterly progress reports, human interest stories and other advocacy materials including the multimedia based resources) to be produced, envisioned timeline, and the specific audiences of the various KM products.

The intended audiences of the KM products include the internal audience (UNICEF CO, RO and HQ), donors and STBM partners at the national, province, district and sub-district levels. A positive aspect of the KM strategy was the fact that the collection, analysis and documentation of knowledge was not considered to be the sole responsibility of UNICEF, rather it was conceived as a participatory process involving the government and partners. However, the extent to which KM strategy was applied, varied across districts mainly due to varying existing capacities within various tiers of the government.

A noteworthy achievement of UNICEF support around KM is the wider acceptance and recognition of the need for KM component within government system. Now government officials are upfront in stating that the value of improved KM was never acknowledged before UNICEF's efforts that have resulted in highlighting the value of this component. Most government officials and the local partners as well, met during evaluation admitted that the capacity of the GoI around KM is still too low, despite a reasonable improvement when compared to the government's capacity at onset of UNICEF support to STBM. They appreciated the hand holding done by UNICEF in writing down the minutes of meetings and documentation of the success stories from field by the government itself, as initially the Government was not able to complete these processes independently.

Though, a lot more needs to be done at government level for integrating KM into the Government's systems, UNICEF is successful in sensitizing and enabling the government to understand the crucial role of KM to accelerate and sustain the STBM accomplishments.

In order to strengthen KM system within government system, UNICEF organised a national level KM workshop in 2016. The workshop ended in highlighting some of the critical issues around KM that require prioritization for institutionalization of KM within government system. The three main issues that were highlighted relate to a) sources of knowledge (No data, too much data, lack of consolidated data, retrieval of tacit knowledge), b) weak capacity to process the available knowledge (limited skills to analyse and present knowledge), and C) application of knowledge (either no or limited and ineffective usage) and institutionalization of KM component in government system.

Another aspect of UNICEF's efforts for KM is the real potential of KM products in showcasing the successes and using KM products as an advocacy tool to spread the benefits of UNICEF's support beyond the 'direct' districts. The Evaluators are cognizant of the fact that development of KM products require a reasonable time after onset of the programme. It is noted that the KM component lacked the due attention midway into UNICEF's support because of the introduction of new fund channelling law that has demanded much of UNICEF's time and efforts in the initial years to address the related issues. This component could have been pursued at a faster pace earlier in the Programme. However, the on-going attention that KM gained in last year particularly during the evaluation period, appears sufficient to compensate the time loss. The most difficult task at hand is to enable BAPPEDA and DHO, PHO and other sub-national governments in accomplishing the documentation of the processes implemented during UNICEF support period.

The decentralized context of Indonesia provides both enriching opportunities and challenges for KM products; such as an approach highly successful in one context may prove to be less so in another. The allocation of 10% funds from Dana Desa for sanitation in Luwu Utara district was successfully replicated by UNICEF in the Takalar district with similar results. Village Kaders were successful in supporting sanitarians in the Barru district. However, the same model was not viable for Takalar district where the focus was on strengthening role of

sanitarians through establishment of sanitarian group. The results of both approaches in Takalar and Barru districts proved workable in each context.

In conclusion, where knowledge management did not get the due attention in the early years when the focus was more on Programme implementation, it is firmly on the agenda now. Dedicated, robust efforts are required to compensate for the time lost and to get desired outputs and outcomes. Capacity of creating knowledge management products is noted at the lowest level within the government partners. (See recommendation #5).

3.7 GAPS AND OPPORTUNITIES

This section presents key challenges as highlighted during discussions (all KIIs and FGDs) with the relevant stakeholders.

Role of the Community: Low community turn out in the triggering events has emerged as a limiting factor. The gravity of the problem was the most in Papua, however similar trends were noted in some villages of NTT. At times, only 20-30% of community members may show up in the triggering events. Reportedly, in some instances even the whole community refused to participate in a triggering event. The field teams reflected that effectiveness of triggering directly correlates to level of community participation in triggering events.

Community Expectations: At a few locations the communities expressed desire to have hardware support to construct latrines, and made it conditional to participate in the triggering process. Another aspect is very slow response by the community since the community think that first they must get water supply before they build and use toilets at home. Internal evaluations done by DHO to review the Puskesmas/sanitarians performance vis-à-vis the issues faced during the triggering process indicated that sanitarians and the facilitator could not always provide the wise answers to the community to satisfy/convince them to participate in triggering.

Sanitarian's Capacity: Weak capacity of the sanitarians is another challenge which is referred to by nearly all stakeholders. The key challenge is about their incomplete understanding about the CLTS process and expected outcomes. Generally, for most sanitarians, triggering is all about preparation, planning, executing the triggering and follow-up actions to facilitate the community to build collective commitment to stop OD and start using latrine. The missing link is the ignorance about the need for facilitating community to build collective commitment to stop OD as an established 'norm' and to maintain that norm, community should agree, define and implement agreed sanctions to stop OD. Therefore, the Sanitarians' approach should be such to focus more on developing/building the community collective leadership to introduce the sanctions against people doing ODF.

Partnerships: A challenge cited by the NGO partner of UNICEF is about synchronizing the internal work plan with the government agenda and timeline. The STBM implementation is the prime responsibility of the DHO and therefore head of the Puskesmas. Most activities at community level are planned and executed by the involvement of the Puskesmas and the sanitarian, and thus NGO partners are dependent on government's work plan. When a delay happens due to some reasons on government's part, NGO has to stop and wait Government's approval or availability for any particular activity. This causes an unwanted delay in their agreed timeline with UNICEF and may undermine their performance.

Monitoring: At district and provincial level, cross verification of the STBM monitoring data is a challenge. Sometime data varies between the manual monitoring done by the sub-district level facilitator (only present in Alor) and the data as submitted by the sanitarian through use of SMS-based monitoring system. In such cases, POKJA takes up the issue with the DHO and

DHO should verify the actual data by contacting the respective sanitarians, a time taking process.

Sustainability: Most of the stakeholders highlighted that sustainability of the STBM achievements is the most significant challenge. So far, the government is trying hard to achieve national sanitation of zero % OD by 2019, and putting all its resources to accelerate STBM implementation. However, till now the focus is only on achieving ODF and no clear post-ODF agenda has been worked out yet.

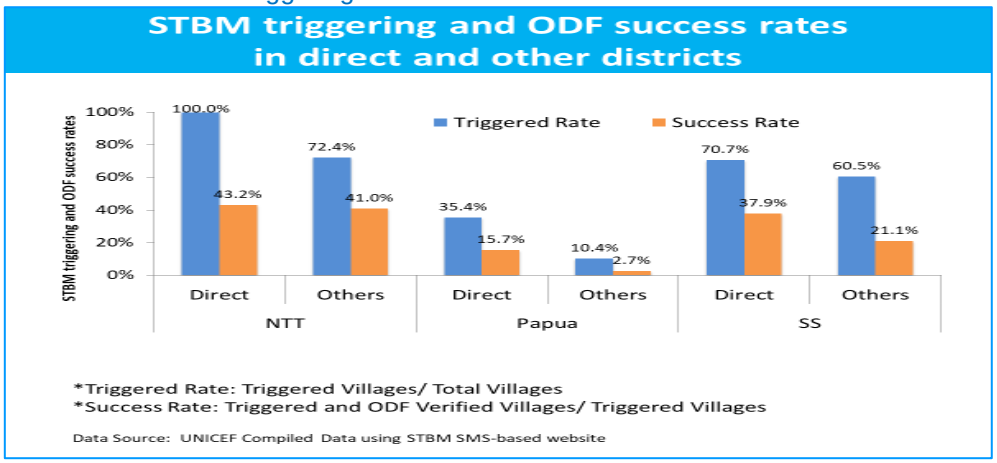
Sanitarian's Workload: A sanitarian cannot visit a village more than 2-5 times in a year. The sanitarians are overburdened. Following are the key contributing factors to increase the workload of the sanitarians; a) large coverage area under the Puskesmas, b) in addition to STBM, sanitarians are also responsible to implement other health promotion related programmes under the Puskesmas, c) are sometime the sanitarians are assigned other administrative/supervisory responsibilities (pharmacy work, driving etc.) outside their official role, d) difficulties in accessing remote villages. An exception is noted in Alor district, the district BAPPEDA has appointed sub-district facilitators to help support sanitarians. Presence of facilitator at sub-district level has proved an effective strategy in reducing the workload of sanitarians, however not replicated by any other district government.

3.8 UNICEF VALUE ADDITIONS

This sub-section presents an overview of the key value additions of UNICEF's support to STBM Programme. For further details on the listed aspects, please refer to Appendix 11.

- STBM Acceleration and Scale-up: The most appreciated value addition of UNICEF's support in 'direct' districts, is demonstrated by an increase in STBM implementation/coverage (high triggering rate) and marginally better success rate for ODF achievements. In UNICEF's 'direct' districts in NTT, the triggering rate is 100% and the success rate is 43%; in contrast, the triggering rate in 'other' districts is 72% and the success rate is 41%. The similarity of the success rates, despite significant differences in triggering rates, can plausibly be linked to UNICEF's contributions to the enabling environment at the provincial level (POKJA AMPL, BAPPEDA, PHO), thereby producing positive impacts on government-led implementation in 'other' districts.

Visual 3.06: STBM Triggering and ODF Success Rates in Direct and Other Districts



- System strengthening approach: UNICEF value additions are evident from improved Government systems for STBM planning and implementation by National STBM Secretariat in the MoH, the POKJA AMPL under BAPPENAS and other Government and sector partners at the national and sub-national levels.

- A shift from output to outcome; UNICEF successfully shifted the focus of the Government from output (latrine construction) to outcome (ODF) by emphasizing the need for high quality triggering - concrete planning or actions for post-ODF agenda, from the Government have not yet materialized however.
- Focus on Behaviour Change Communication; UNICEF efforts to promote long lasting improved WASH behaviours through creation of 'Social Norm' represents a significant value addition to STBM. Presently government acknowledges the value of regular multi-channel communication campaigns as part of post-triggering actions at community level.
- Partnership Dividends; By fostering local partnerships and improved coordination with government, UNICEF has increased the ability of local partners to support government-led implementation of STBM in future.
- KM and Sharing of Lessons Learned; The collection, documentation and sharing of innovations and lessons learned, between provinces and districts (both 'direct' and 'Other') is a commendable contribution of UNICEF. This 'enabled sharing' has empowered government to replicate novel interventions across districts within provinces.

SUSTAINABILITY

This section responds to key evaluation question (EQ#3), *"how application of two different approaches (Joint implementation in 'Direct districts'; and Government –only for 'other districts') affected the implementation, results and sustainability of the achievements?"*

The discussion on sustainability of UNICEF's support revolve around quality of interventions and likelihood of sustainability of the results such as enabling environment (policy, standards, regulation, funds availability, coordination, partnerships), implementation quality, involvement of local networks, upgrading the social norm of latrine use, post-triggering follow-up and focus on post-ODF agenda. The first section offers an overview of the key findings on the listed sustainability aspects, whereas the subsequent section expands on these elements.

Overview: UNICEF efforts, have contributed in embedding the STBM ownership within government system, at least in 'direct' districts, is well-demonstrated. However, post-ODF agenda needs further efforts to sustain the ODF achievements. In this regard continued advocacy efforts are required to enact relevant supporting regulations in ensuring that post-ODF activities are planned, provided funds and emphasized by the government system. Frequent changes of leadership within key departments at provincial and district level negatively impact the sustainability of the achieved results, a factor beyond control of UNICEF. With UNICEF's efforts, coordination forums at provincial and district levels have been revived and capacitated with necessary planning, implementation and other technical skills indicating positive signs for sustainability. With UNICEF support the government has worked with local NGOs. The enhanced capacities of the NGO partners in terms of better understanding of the role of government entities in STBM implementation warrants more likelihood of sustainability. Government needs to further harness the strengths of these NGOs in sustaining the ODF achievements and devising the post-ODF agenda. At community level, sensitized local networks (PKK, volunteers/Kaders etc.) have played a pivotal role in implementing ODF activities, but their role is diffusing with time. Continued active engagement of these local networks needs government support for their potential role in post-ODF monitoring, leading to stabilization of the new social norm. Shared latrine use is common, but in the long term it is not a replacement for having a latrine in each household. Government led STBM implementation needs to help households in moving up the sanitation ladder, not merely focusing on pillar-1 (ODF). The STBM implementation particularly in UNICEF supported 'direct' districts need gradual expansion to include other key pillars of STBM particularly HWWS in priority and then the others as well.

The description below elaborates upon the above overview of sustainability aspects.

The importance of relevant regulations at all levels (Province, district, sub-district and village) is already discussed under evaluation question#1 in 3.1 section and highlighted in the opening section under regulation. Where, an appropriate regulation is required to initiate and implement STBM to achieve ODF, it is also compulsory that a similar regulation is issued to emphasize the post-ODF activities. The issuance of appropriate regulation, circular letter and/or instruction by the bupati for planning, funding and implementing the post-ODF activities will increase the likelihood of maintaining the ODF status by the communities. Likewise, frequent instruction letters from DHO and the head of Puskesmas to all sanitarians for ensuring the monitoring during post-ODF phase, will add to sustainability. UNICEF's advocacy agenda needs to prioritize this aspect.

Frequent changes of leadership within key departments at provincial and district level has significant impact to sustainability. Where the changes are less frequent, likelihood of continuing the existing policies to support STBM is more. This is an aspect which is beyond the control of UNICEF's technical assistance, however, to some extent UNICEF can advocate at appropriate forums to influence the decisions regarding change of key technical persons from key positions.

The quality of coordination and facilitation by the NGOs is also linked with the duration of the partnerships. Notably, the duration of partnerships established during programme period was too short, ranging from for 4-12 months in most cases. Longer partnerships are more suitable to achieve sustainable results/outcome especially when working closely with government to provide technical assistance for capacity development and strengthening the system.

The quality of implementation of interventions for demand creation such as planning and coordination for pre-triggering, triggering and post-triggering, appear weak. Thus far, the emphasis has been on promotion of toilet availability/construction and usage for achieving ODF. The current STBM field implementation planning lacks requisite inputs for norm creation. This may include seeking collective commitments and imposing (drawing agreement) on sanctions for deviant behaviours i.e. open defecation.

In NTT, the PKK has done relatively better (compared to others) in promoting the concepts or ideas of STBM. These forums have been reinforcing the messages and consequently building commitment, by using social events and gathering to re-broadcast STBM concepts. It is noted that leveraging local networks is critical to advancing STBM and achieving accelerated results. The role of such forums amplifies further to monitor compliance and is useful in reinforcing the messages leading to better compliance to new practices e.g. post ODF sustainability.

Achieving ODF and sustaining the ODF status must be promoted as a common agenda / responsibility of all relevant government departments at provincial and district level. The role of POKJA is most critical in this aspect. Inter-sectoral support role of all relevant departments (Education, Public Works etc.) can help the STBM significantly. For example, Infrastructure (Public Works Department – PU) department can allocate funds (DAK Sanitasi, a budget head from National funds) to upgrade the quality of the existing toilets or build communal septic tank in ODF villages. This could also take form of formal reward system for the ODF communities.

The practice of using shared latrines is common amongst those who do not have their own toilets. Usually, people

BOX 3.04: RECOGNITION: NTT

ODF villages were not given any financial reward – only recognition in the form of a certificate / trophy by the bupati during a village event.

In Alor the above practice was expanded by UNICEF to have the bupati sign a ceramic plaque and the villagers placed the same in prominent place in the village. The people believe that there is no need of any financial reward because all villages have enough money and autonomy as well to set their own priorities.

turn to relatives and neighbours to get permission to use their latrines. Although the practice of using shared latrines contributes to reducing the incidence of OD, it does not guarantee the consistent and continued usage of latrines; this is because the possibility of 'denial of permission to access/use toilet' by the latrine owner is always present, for both predictable and unpredictable reasons. Therefore, sustainability of ODF requires that the practice of shared latrine usage needs to be gradually replaced by toilet existence and usage in each household.

Assisting the government in recognizing the importance of post-triggering follow-up activities has been a key focus of UNICEF's efforts. This approach has been successful in increasing the frequency of follow-up activities; UNICEF support has also enhanced the quality of the planning and the capacity of sanitarians in this regard. This is one of the contributing factors to the relatively high success rates in direct districts compared to other districts. By convincing and enabling the government to conduct follow-up activities, UNICEF has helped ensure that this improvement is sustainable in the areas where it has taken hold.

Currently, the UNICEF technical assistance is more focused on Pillar-1 (ODF). Where the Programme is working to ensure the availability of toilet in each household, the importance of maintaining and upgrading the existing toilets needs to be emphasized in parallel to move up to the sanitation ladder. The ODF achievements are more likely to sustain if current scope of implementation is gradually expanded to other pillars especially the pillar-2 (HWWS) and Piller-3 (Safe management of water at household level) on priority and then to other pillars.

Previously, there was reluctance on the part of the government in accepting the reality of slippage, but this has begun to shift through UNICEF's advocacy efforts[53]. *Currently, there are no plans for post-ODF activities and post-ODF monitoring is non-existent*. *However, the increasing willingness of the government to tackle the issue of sustainability is noted*.

One positive development is UNICEF's support for a sustainability check study in Alor, which demonstrates the building national interest in mapping ODF sustainability. *One step planned by BAPPENAS to enhance sustainability is the awarding of rewards to districts / villages who have been re-verified as ODF after two years of certification, another sigh of the increasing awareness of and interest in ODF sustainability*.

3.9 Social Norm Development

The findings in this section respond to the evaluation question "*to what extent did UNICEF's support to STBM enable the government, households and communities in creating and sustaining a social norm of ODF?*" To respond to this question comprehensively, the Evaluators took note of current STBM implementation model and particularly the communication model and interventions (including those for pre-and-post ODF) vis a vis behavioural transformation to the extent of creating/upgrading social norms of latrine use. To complement that, social norms questions were added to the post-KAP/HHS particularly around beliefs, access and practice, normative and empirical expectations, and existence of sanctions, and analysed accordingly to assess existence of norm of exclusive latrine use.

The review of current STBM pre-and-post ODF interventions indicate that the current STBM implementation does not have any specific interventions to create and sustain social norm of exclusive latrine use. The pre-and-post ODF tasks of sanitarians appear to lack any particular focus to create collective commitment (by all members of the community) to sustain the practice of latrine use, once ODF status is awarded. Moreover, no reference was made to the current programming seeking communities impose (agreed) sanctions on those who may not

[53] UNICEF have agreed in discussion with MoH and BAPPENAS to provide support on ODF slippage and sustainability in the 2018 Annual Work Plan, a direct result of this program; as discussed in the evaluation feedback meeting of December 7, 2017.

comply with the agreed behavioural expectations. Informal sanctions exist in the form of public censure, however not in all villages and not formally agreed upon as sanctions for non-compliance. In lieu of the above, it could be argued that the MoH may need to take a considered view of whether it intends to adopt the concept of social norm creation and if it is affirmative, the current programming would require some fine-tuning. This would essentially mean introduction of stronger and consistent BCC interventions, concepts of sanctions (including positive), and interventions around creating triggers and influencers to continue reinforcing the need to stay the course. Moreover, mechanisms to monitor compliance and those found non-conforming to collective behavioural expectations facing sanctions.

There is an all-round acknowledgement that STBM interventions (in 'Direct' districts in particular) have contributed to increasing knowledge (around unhygienic behaviours and consequences) and changing attitudes and practices positively around exclusive latrine use. These assertions corroborate with post-KAP results also. The improved knowledge and awareness has to a degree fostered positive attitudes towards complying with new behavioural beliefs and expectations. Several references were made to the challenges of working with adults (especially older persons) citing difficulties in accepting change. The Post-KAP results including the qualitative interaction suggests that despite being certified ODF communities, a notable proportion is still not absolutely ODF. In several communities, people referred to the practice of open defecation in 'Special Circumstances'. On probing, the Evaluators were told that often these are the farmers, who while working the fields don't take the trouble to come home to use latrine. The relieve themselves in the farms. However, the programme has created this understanding to either dig hole to defecate or cover excreta with sand. This apparently is practised. For most, it was sort of acceptable as they are defecating far away from the village, which minimises the risks.

The numbers for post KAP in terms of personal beliefs, normative and empirical expectations (against the actual prevalence of latrines) and existence of sanctions, all point to 'Unstable Social Norm' of exclusive latrine use.

As highlighted earlier, the commentary did consider the fact that the whole concept of 'Social Norms' creation is relatively new to UNICEF, so is to the government counterparts implementing CLTS/CATS. It would be fair to argue that the whole programming model of how to design and implement interventions to create and sustain new social norms, is still evolving and there is not set formula available for its implementation.

Moreover, Evaluators want to impress that norms creation is a long-term process. The expectations to create/upgrade norms in 2-4 years programming cycle appear unrealistic. For the government counterparts the concept is fairly new, as is for UNICEF. UNICEF needs to work closely with government agencies to unbundle the concept and create set of interventions for social norms creation. It may need to set guidance and standards around criteria and pre-condition in which to communities would be considered having achieved 'Stable Social Norms'. The pre-conditions must set some flexibility for open defecation in so called 'Special Circumstances', as this may continue to happen.

Scalability

BOX 3.05: SCALING UP SANITATION

Excerpts from Scaling Up Sanitation: Evidence from an RCT in Indonesia.

Ensuring sustainability of the project by embedding implementation into district governments was the key element of the scale up strategy...The World Health Organisation, on the basis of evidence gathered over years of experience in scaling up public health interventions, recommends several steps for developing a successful scale up strategy (WHO, 2010). These include identifying, documenting and assessing the nature of the innovation to be scaled up; increasing the capacity of the implementing agency; assessing the broader environment in which the project is to be scaled up; supporting the resource team which will support the scale up; embedding the project within the institutions of the target country; and documenting the scale up strategy.

Ref: Scaling Up Sanitation: Evidence from an RCT in Indonesia: Lisa Cameron; Manisha Shah. January 2017. Support Agencies: Bill and Melinda Gates Foundation and Australian Research Council (ARC Discovery Project DP0987011).

In the decentralized context of the country, it is possible for few districts to be at completely different stages of implementation due to varying capacity of the government at the district and provincial levels. Similarly, the application of the monitoring system varies across districts and provinces. The Government must work dedicatedly to improve its capacity on various areas such as knowledge management, including the extraction and application of best practices and lessons learned; and must work to adopt such practices uniformly for successful scalability. Value additions introduced by UNICEF in 'direct' districts have all potential for replication and scalability, so must be considered by the MoH, BAPPENAS and STBM Secretariat for replication; however, there is need to tailor the best practices (learned from 'direct' districts) to the varying diverse contexts in Indonesia for country-wide adoption. Better rationalized prioritization of those districts where STBM has not been initiated yet or is not progressing well must be considered. The sensitization and experience of the provincial governments obtained through UNICEF support needs to be leveraged by the national entities to scale-up STBM in other areas. (See recommendation #6).

3.10 NON-DAC (OECD) - GENDER, EQUITY AND HUMAN RIGHTS

The commentary in this section is in response to the key evaluation question (EQ#4), *'what approaches, strategies, and interventions are integrated in STBM to enable improved sanitation coverage for poor, minority, men, women, boys, girls, elderly people and person with disabilities?*'.

The assessment of gender, equity, and HRBA aspects of UNICEF's technical assistance is based on both qualitative findings and the household survey results. The analysis is further supported with information extracted from secondary reference material. The section opens with an overview of all the findings on equity, gender and HRBA aspects. The detailed findings have been structured into separate sub-sections on gender and equity. Within gender sub-section, results from HHS are presented to highlight key aspects of equity. The last part discusses the compliance to HRBA considerations.

Overview: Overall, considering that UNICEF's inputs, by design, are limited to technical assistance and support by way of guidance and demonstration, the findings clearly show that the STBM Programme is gender-sensitive; a fact clearly visible at the village and community levels here women and girls are involved in all interventions / actions. However, UNICEF can further influence the government in improving gender norming in the STBM programme. This level of attention can be encouraged by asking for gender-disaggregated data and statistics, and application of monitoring systems, across all types of interventions, particularly for capacity development. UNICEF's intervention in this regard will foster the development of treatment for women and girls that may be different but necessary to ensure equivalency in terms of rights, benefits, obligations and opportunities. At national level, UNICEF advocated

with the relevant ministries to promote the use of Zakat money and appropriate allocations from village funds for rural sanitation/ODF purpose, thereby addressing the sanitation needs of the poor, an important aspect of equity. The selection of deprived regions (provinces and districts) for UNICEF's support reflect equity focus of UNICEF's programming. Despite visible focus on equity, a few aspects of SanMark needs further efforts to comply for equity aspects. By and large, the overall Programme design and implementation of UNICEF's technical assistance corresponds to key aspects of human rights based programming principles. Involvement of relevant government key entities in coordination forums (POKJA) and frequently convened progress review meetings have established some form of accountability within duty bearers. The sensitized communities are now more aware of their water and sanitation rights, however the establishment of a complaint redressal and conflict resolution mechanisms for right-holders remain unaddressed. The commentary below separately elaborates all above highlighted aspects.

Gender Considerations

The commentary looks at the opportunities for women and girls at various stages (design, implementation, communication etc.) of the STBM Programme to assess gender dimensions of the UNICEF's support to STBM. The key aspects discussed includes design and implementation approaches and access to sanitation achievements of the STBM Programme.

At design level, the overall aim of the STBM project, especially for pillar 1 (ODF) and pillar 2 (HWWS) is addressing the gender issue quite well. For example, when households have a latrine at home, then it directly benefits the women and girls more than male family members; women and girls no longer need to go outside for defecation and thus feel safer as a result. Improvements in handwashing practices of women directly affects to their own health and of children. Directly or indirectly, the programme succeeded in promoting the concept of a healthy village and a healthy lifestyle. This was particularly highlighted in South Sulawesi. All these aspects demonstrate, the programme design as a whole is built on gender-sensitive approach.

The programme encourages participation of women and girls in programme activities. At the village level, the STBM team involves women and girls to participate in triggering and post-triggering activities. Village based volunteers were invited to be part of STBM team at village level. During FGDs, the Evaluators noted that village level volunteers, particularly the Posyandu, are mostly women and girls reflecting gender sensitive implementation. Significant involvement of women and girls contributed in greater outreach and penetration for dissemination of STBM messages.

At implementation level: the level of community participation and the diversity of representation of various groups varies from area to area and corresponds to the achievements in STBM so far. There is significant evidence available to indicate reasonable levels of engagement and participation of women and children in Programme activities. For example, most of the sanitarians, the frontline workers for STBM implementation, are female; a very positive fact. Interactions with female sanitarians revealed that they feel honoured for their work, not only by themselves but by the community as well. Female sanitarians report that they feel that this gain in respect is due to their specific role in STBM implementation rather than just their professional role as a sanitarian.

Local women groups namely PKK (women association) were made part of the STBM team at the village level. PKK were provided special training through STBM orientation sessions, on health and hygiene; In Sumba Timur, examples exists where some households constructed toilets due to their active engagement in the discussions by PKK. Overall, the involvement of PKK members has resulted in accelerating the post-triggering actions, thereby contributing to earlier achievement of ODF status.

The other local mechanism promoted by village level STBM teams, is *Gotong Royong* which refers to self-help by the community for those most in need; it involves the use of social capital for helping others in the community. Expanding on, the STBM team promoted a culture to help other community members for construction/upgrade of toilets. The Sustainability study in Alor highlighted that these two mechanisms are key to accelerate ODF and are contributing to sustaining the Post-ODF status of the village.

In Sumba Timur and Alor, a local mechanism was evolved by PKK members named ARISAN to help support the household in meeting their sanitation needs, in particular the construction of toilets. ARISAN is a small group of women in a community who contribute an equal amount to a pool fund on monthly basis; every month a member from the group receives the full collected amount through ballot. The cycle continues for as many months equalling the total number of members in the group.

Discussions with female respondents during FGDs have highlighted some key social issues associated with the Programme implementation and achievements, that affects their role in daily life.

- Overall qualitative findings indicate mixed opinions as were expressed by women and girls about the use of shared latrines, some of the women and girls of the FGDs participants still thought it bad for themselves to go to a neighbour's or a relative's house. However, they were still satisfied about the overall benefit of using latrines, shared or otherwise, as opposed to OD.
- Females, in general, commented that building of a latrine has increased their workload. Their role in maintaining domestic or shared latrines revolved around cleaning, preparation of cleansing materials & water etc. However, the women were divided on their opinions on the increased work. Some reported that they felt positive about their work, considering it a moral duty to support their family members in this way while other were unhappy about such an additional workload but were willing to continue to do it to please their parents.
- The programme has contributed in greater recognition among communities of the need for continued latrine usage. This has resulted in some form of informal positive sanctions. During FGDs and the interview with the head of the village (in 'Tompo' village in the Barru district of South Sulawesi), it was shared that the village head would not sign the letter of recommendation for couples who want to marry, until the couple ensures that a latrine is constructed in the couple's home. A letter to this effect is required to obtain a marriage book from the government. Culturally, such practices can be considered as a trigger to solve sanitation issues in the village. It encourages people to build latrines and to stop OD. However, this was not observed to be the case in other villages visited by the evaluation team.

Despite above highlighted key aspects of gender focus of the Programme, the evaluators note following features of the Programme that needs to be considered by the government and UNICEF.

- Programme documents lack structured database/documentation on the composition of the STBM teams across all three levels (district, sub-district and village). Hence, the Evaluators cannot comment on this aspect.
- Similarly, the Programme did not focus on maintaining detailed nor consolidated information on participants of coordination workshops, training events, exchange field visits, etc. Hence, the Evaluation Team is disabled from providing a gender disaggregated analysis of capacity development initiatives – clearly a missed opportunity. The evaluators consolidated available information on the trainings

conducted; a total of 55 capacity development events were recorded, with a total of 3167 participants across the Programme area.

- Where the availability of an SMS-based monitoring system is a positive development, it does not record any gender-disaggregated information on latrine distribution for households nor for any other pertinent indicator. Also, missing is a tagging of data for women-headed households.

Key Gender Aspects based on HHS Results;

The post-KAP HHS examines knowledge, attitude and practices of households for multiple aspects of access to water and sanitation, communication channels for hygiene promotion, handwashing and elements of social norms. The results of the HHS have been analysed disaggregated by gender particularly for women headed households, education etc.; for the detailed HHS tabulations/results, refer to the tabulations in appendix 14 &15. The description below highlights only selected gender aspects from HHS results.

Of the total HHS respondents 50% were females with 84% of them having completed primary school education (see attached Table 3.10.1). One can clearly see that respondents who had completed primary education (called educated) had a higher percentage (88%) of households with toilets. By and large (98%) all educated female-headed households had toilets within the home.

Table 3.10.1: Percent Distribution of the Level of Education of the Respondent by Gender and Province in Direct Districts

I2. Respondent's Gender	I5. What is the Highest Level of School You Completed	Province Name (based on Direct Districts)			
		NTT	SS	Papua	Total
Male	No formal education	2	1	0	3
	Not completing primary school	7	5	1	13
	Primary	15	17	4	37
	Pre-Secondary	5	13	5	22
	Secondary	3	12	6	21
	Higher	1	2	2	5
	Sub-total	33	50	17	100
Female	No formal education	2	1	0	2
	Not completing primary school	6	6	1	14
	Primary	15	18	3	37
	Pre-Secondary	6	13	5	24
	Secondary	3	9	5	18
	Higher	1	3	1	5
	Sub-total	33	50	16	100
Total	No formal education	2	1	0	3
	Not completing primary school	7	5	1	13
	Primary	15	18	4	37
	Pre-Secondary	5	13	5	23
	Secondary	3	11	6	19
	Higher	1	3	1	5
	Total	33	50	17	100

The HH Survey reveals that 86% of all HHs had a toilet within the home. Across all provinces, in the category of female-headed households, 83% of households had toilets, while 86% of male-headed households had toilets (see Table 3. 10.2). This shows that there is little difference in decision-making for toilet construction between female and male headed households.

Table 3.10.2: Percentage Distribution of the Presence of a Toilet in the Household by Gender and Province in Direct Districts

G7. Household head's gender	S1. Does your house currently have a toilet	Province Name (based on Direct Districts)			
		NTT	SS	Papua	Total
Male	Yes	26	44	16	86
	No	7	6	1	14
	Total	33	50	17	100
Female	Yes	29	42	12	83
	No	6	10	2	17
	Total	35	51	13	100
Total	Yes	27	44	15	86
	No	7	6	1	14
	Total	33	50	17	100

Equity Focus

Equity is assessed by looking through various aspects of UNICEF's support to STBM that has enabled better sanitation access for the women, girls and other socially disadvantaged groups such as poor, older persons and people with disabilities. The key aspects include availability of any financial support for the poor to improve access to sanitation, targeting approach, latrine ownership for the women-headed households, and some aspects of SanMark (availability of loans for sanitation, and latrine designs for people with disabilities and focus on integration of disaster resilient latrine designs) affecting the equity integration.

BOX 3.06: SUCCESS CASE: SOUTH SULAWESI

In Luwu Utara the bupati is a strong supporter of STBM. She has issued instructions to the camat on using Dana Desa funds for STBM interventions, especially in the flood prone areas where the poorest households need to be financially supported to purchase / install toilets / latrines in the household.

By design, CATS implementation discourages the provision of direct subsidies and so the STBM. UNICEF maintained the principles of CATS by not promoting direct subsidies for latrine construction, however equity aspects were addressed by advocating for the utilization of village funds (Dana Desa) for sanitation purpose particularly for helping poor who cannot afford to construct latrine. The Programme focused on implementation of strict criteria for selection of poor. The identification of the poorest households was done during triggering through active involvement of the natural leaders to provide support from Dana Desa. At end, the final decision of using the Dana Desa for the poor rests entirely with the bupati and head of villages, in consensus with the community.

UNICEF assistance to STBM has contributed in increasing the access to sanitation (latrine ownership) in general and particularly for the bottom two quintiles (the 40% poorest). An analysis undertaken by UNICEF internally while consolidating the overall progress during BMGF support period indicated that toilet existence has increased for poorest 40% from 55% ownership to 81% ownership with 94% usage.

Similarly, the use of zakat funds for rural sanitation was advocated by UNICEF at national level. Though currently the proposal is under consideration of the government, it will be a potential source of funding to help ultra-poor for increasing sanitation access. UNICEF also advocated for integration of other government's other programmes that have options to provide financial support for toilet construction for the ultra-poor.

The selection of provinces and districts for UNICEF support indicates the prioritization of equity at the design stage. The selected districts are characterized by low socio-economic indicators and are amongst the most deprived regions in the country. Doing so improves the rate at

which the benefits of ODF can reach deprived parts of the country and enhances the capacity of the Government to deliver services to those who need them the most.

The easy access to sanitary items is an important aspect of equity. The availability of sanitary supplies within communities helps the poor in reducing overall costs for latrine availability. Despite clear intent of UNICEF support to facilitate sanitation supplies, the household survey results present a discouraging situation, where 30%-50% of the respondents in different districts highlighted difficulties (availability of sanitary items at long distance, such as sub-district or district level) to in accessing sanitary supplies (refer to Table 3.05.8 in KAP section).

The Programme lacked a clear focus on promoting the availability of loans and/or any other financial assistance options for general community members; the need for such support mechanisms is not necessarily for the poor, but also for other community members who lack the financial capacity to pay for the costs (purchase of sanitary supplies, construction materials and related items, labour cost) of constructing or upgrading a toilet and allied structures with a single payment. As indicated in the KAP section (Table 3.05.9 & 3.05.10), in direct districts, 51% of respondents were unaware of the existence of any loan facility or financial mechanism.

Availability of latrine designs for persons with disabilities and disaster resilient latrine designs is another equity aspect of rural sanitation. Review of documents and discussions during KIIs and FGDs points to lack of any notable achievements on these equity aspects. Few efforts have been made in Papua to develop latrine designs for the lake-side communities, however limited success is noted so far. Similarly, in South Sulawesi, a successful model has been evolved to establish local entrepreneurs to promote toilet construction using local materials leading to significant reduction in latrine costs. A notable success to help the poor who cannot afford to build commercially available high-cost toilets.

HRBA Considerations

The overall Programme design and implementation of UNICEF's technical assistance corresponds to key aspects of human rights based programming principles. UNICEF's focused approach to developing the capacities of duty-bearers and rights-holders is one supporting argument. Through enhanced capacities at the Government and community levels, the delivery of the basic services, such as water, hygiene and sanitation, ultimately benefits the rights holders on one hand, and improves the service delivery capability of the duty-bearers on the other. Appropriate representation of relevant Government entities in the POKJA and improved coordination establishes an informal mutual accountability mechanism amongst the duty-bearers, the most critical element of HRBA programming. The active role in monitoring played by the POKJA through field visits further strengthens the accountability aspect. The increased level of awareness of the rights-holders of their rights to basic services, such as water, hygiene and sanitation has empowered them to demand those services; this is in-line with HRBA principles. The only limitation related to compliance to HRBA principles is the absence of any formal or informal mechanisms for the rights-holders at community level to raise their voices to the duty bearers, if they encounter some grievance or conflict during programme implementation. For example, there is no evidence available to show focus of the Programme in advocating for the establishment of a complaint redressal and conflict resolution mechanism during community-community and Programme staff-community interactions.

4. CONCLUSION, LESSONS LEARNED, AND RECOMMENDATIONS

4.1 CONCLUSION

This section presents evaluators' judgement of the programme TOC, evaluation hypothesis, and effectiveness and sustainability of UNICEF-BMGF technical assistance to STBM programme.

UNICEF's Technical Assistance to STBM has indeed remained aligned to the ToC pathways and the outcome-level results, namely; the efficient use of resources, increased access to and usage of sanitation facilities, and the creation of social capital; all key ingredients of sustainability and potential scaling up.

Where applied collectively the results are emphatic (e.g. germinated an enabling environment supported by enhanced governance; national, provincial and district levels, creating knowledge-empowered communities that exhibit positive attitude, implementation, and greater ownership and participation) and wherever any aspect of the pathways remained weak, the results too have been affected (e.g. a slowly emerging and unstable new social norm of ODF).

The Evaluators conclude that UNICEF support to STBM has largely been successful in furthering the national ODF momentum, and to increase the coverage and success rate for government implementation. UNICEF has successfully demonstrated the utility of supporting the government led implementation with limited funding, scope and scale, to achieve the wider results. UNICEF support has thus been a cost--efficient model of technical assistance. The success should progress to a scaling up and thereby ensuring a significant contribution towards achieving the national goal for elimination of ODF in Indonesia.

The successful collaborative model demonstrated by UNICEF yielded significant improvements in increasing the impact of sanitation related policies, regulations and the timely availability of funds and advocacy tools. Consequently, the overall implementation capacity of local government has been enhanced in the 'direct districts'. However, a lot more work still needs to be done towards perfecting planning, budgetary analysis, improving the monitoring system (software, hardware, technology integration, use of information), and, in enhancing the government's capacity to vitalise knowledge management and its appropriate utilisation; numerous best practices (e.g. women-led networks, sanitation marketing, communication campaigns), case studies (e.g. local leadership advantages demonstrated by camats), lessons and communication, exhibited through UNICEF supported implementation still needs to be consolidated and disseminated.

The timely engagement of local partners sustains relationships with government officials and bolsters advocacy efforts. Since UNICEF provides only technical assistance and guidance in the 'support' scenario, the involvement of long-term local partners will play a vital role in strengthening implementation efforts.

Through a variety of influencers, such as camat, village head and the local network, aligned to support STBM, the overall burden of delivery is somewhat reduced on already over-worked sanitarians. However, the need to capacitate and train the sanitarians to enhance their triggering skills must not be ruled out. Furthermore, empowering the camat through the creation of formal sanitation forums and committees at the community level will allow regular monitoring, both in the pre-and post ODF phase, a critical element of sustainability. Forums of this kind, with defined inclusion criteria, roles and responsibilities, and activity planning could have bolstered the achievement of sustainable results in the post-ODF phase.

Indonesia's diverse context means that implementation, and wide communications must be tailored to each individual province and district. Engaging religious channels regularly, as this program did selectively where it was feasible considering local context, through trainings and refresher sessions will allow them to play a significant role in socially and religiously reinforcing and following up on implementation aspects.

Overall, the concept of 'Social Norms' in rural sanitation i.e. STBM, is not yet fully integrated into implementation processes. The current programming lacks seeking collective commitment for adoption of 'new norms' within the community. The concept of agreed sanctions is widely practised. There is only limited awareness of 'Social Norms Theory' at all levels. There is need to advocate with government to adopt the 'social norm' concept and integrate it into STBM programming.

The current STBM programming appears to be driven by largely a singular focus on achieving ODF, whereas this has to be balanced with post-ODF sustainability (of behaviours) and progression on sanitation ladder. This realisation has to happen soon to enable programmatic transformation to achieve SDG related goals i.e. safely managed latrines/excreta.

UNICEF's 'Adaptive' approach whereby assistance tailored to varied local context worked effectively. The assistance extended with respect to capacity development, strengthening of monitoring system, and knowledge management remained largely effective. However, there are lessons learnt as to planning and implementing them better.

If UNICEF's model of technical assistance is scaled up across Indonesia, particularly where STBM has yet to establish a strong reference and evidence, Indonesia will eventually accelerate progress towards universal ODF status, and thereby laying the foundation for achieving WASH targets of the SDGs.

4.2 LESSONS LEARNED

This section carries the list of key lessons learnt (including the best practices) around the design and implementation of the programme of such nature, scale and complexity. These have been identified by the key stakeholders themselves, especially where they were asked to reflect on programme strengths and challenges in particular around design, strategies, and implementation. Before documenting them, the Evaluators however cross-checked these ideas and practices with relevant stakeholders, for validation.

The fact that the guidance and practices vary around documenting lessons learnt, the Evaluators did refer to Maurer. R (2012)[54] to frame these lessons learnt. For Maurer, the quality lessons learnt must entail four ingredients or elements i.e. i.e. rationale; pre-conditions; lesson suggestion; and, applicable task. While phrasing the lessons learnt, the Evaluators have made every effort to comply with the Maurer's' standards.

1. **Strong and contextually relevant evidence (message) strengthens Advocacy & Lobbying:** Variable successes with advocacy and lobbying in a highly-decentralised environment e.g. Indonesia, has amplified how critical is the strong and contextually relevant evidence to win over policy makers and key influencers e.g. bupati and others. Teams on the ground admitted that 'stronger the message greater the impact'. For them, had stronger and well-presented evidence were available, they may have had achieved more persuading the local and national public officials to grant approvals and issue regulations. For successful advocacy and lobbying, research and evidence

[54]. Maurer, R. (2012). 'Lessons Learned: Utilizing lessons learned from project evaluations in policy decision making.' *i-eval THINK Piece* (No. 1). Retrieved from: http://www.ilo.org/wcmsp5/groups/public/---ed_mas/---eval/documents/publication/wcms_180328.pdf

creation must be prioritised and adequately resourced to produce quality content to enable the advocates to make a winning case.

2. **Timing is critical for successful advocacy.** The advocacy plans and interventions must be timed and intensified with national and subnational development planning cycles, to leverage these instruments to secure commitments for adequate resources, by integrating advocated agenda into the national and sub-national sectoral/development plans.

3. **'Flexible/Adaptive Models' are best suited to address regional diversities:** Indonesia is rich for its diversity of cultures and regions; hence every region is different and unique. The idea to promote and support the 'Flexible/Adaptive Models' such as for communication, etc. as applied in the 'Direct' districts, have worked well in addressing the contextual diversities in Indonesia. The continuity and scalability of Flexible/Adaptive Models of delivery, is expected to accelerate the successful STBM implementation. However, this may require striking fine balance between standardisation and adaptation to achieve both the uniformity and responsiveness.

4. **BCC must leverage faiths and faith leaders as key influencers:** Indonesia is land of multiple faiths, which influences significantly the lives and choices of followers. Invariably across all 'Direct' districts, the evidences and reflections suggest demonstrated success in involving faiths and faith leaders, as key influencers for BCC. The STBM BCC must effort to leverage belief systems and faith leaders as influencers, for successful and sustainable behavioural change.

5. **Post-triggering BCC campaigning works to reinforce sanitarian messages:** In 'Direct' districts, the post-triggering communication is an evident departure from the past practices. Moreover, the development and application of relevant, interactive and multi-media campaigning worked to reinforce sanitarian message and accelerating successful transition to ODF. The adoption and application of relevant, interactive, and mixed medium commination model with cyclic implementation is likely to further reinforce sanitarians message and strengthen the community's resolve (post-triggering) to construct and use latrine (move away from OD). The STBM programme shall benefit more given its scale-up.

6. **Volunteers and influential local networks are effective means of message dissemination:** Involvement of young volunteers within the community, local networks (particularly the women groups) and other influential people for regular dissemination of key STBM messages is a good strategy to lessen the workload of the overburdened sanitarians.

7. **Timing is critical for success of knowledge management and usability:** despite availability of knowledge management strategy, the limited success with knowledge management highlights the need to time it appropriately to leverage the benefits fully. The KM underpins the relevance and quality of evidence creation, which in turn accelerates and influences the lobbying and advocacy, and consequently the scale-up. Knowledge management (including dissemination as integral to KM) warrants timely planning, adequacy of resources and technical capacities (at all levels), to enable regular reflections, documentation, and dissemination. Interventions such as exposure and exchange visits, newsletters, reflection workshops, could complement KM efforts. Future assistance shall benefit more from KM if there is a concrete KM strategy, rolled out in time, adequate resources are available, and capacities are continuously upgraded to reflection, document and disseminate.

4.3 RECOMMENDATIONS

This section lists strategic and operational recommendations for accelerated STBM implementation with sustainable behavioural change results. Moreover, these recommendations have been framed keeping in view the sanitation related SDG targets.

The recommendations have been drawn by leveraging the field findings, series of consultations (with stakeholders) and finally, evaluators' own understanding and experiences of best sectoral practices. In that sense, these could be argued as a product of 'participatory' work with different layers of stakeholders comprising UNICEF staff, government representatives, and public office holders at district, sub-district and community levels. A validation cum finalisation session or briefing was organised with ERG members towards the end of the assignment and was held on December 7, 2017.

To ease future use of recommendations, each recommendation has been broken into series of practical actions that need to be taken. Moreover, each recommendation carries referrals to filed findings (in the main body of the report e.g. Ref. Text: section# and Page#), and is classified based on priority order i.e. immediate, short-term and Long-term. Furthermore, relevant stakeholder/s are tagged as to assign responsibility for action and follow-up. To the evaluators, this may add value in terms of making recommendations more referenced, direct, and enable decision makers to take more informed actions based on the evaluation. To the evaluators, the added information would enhance the 'usability' of the evaluation.

Table 4.03.1: Recommendations

S #	Recommendations & Actions	Reference to Report Findings	Priority & Responsible Stakeholder/s
1	Improved coordination lies at the core of successful and accelerated implementation of STBM Programme. The successes and achievements vis a vis improved coordination (as evident from UNICEF assistance for revitalising POKJA) shall require: I. Adequate staffing (such as facilitators/coordinators) and financial resources for ownership, logistics management, and documentation; II. Merger or consolidation of POKJA (where 2 or more forums exist) at provincial and/district levels for clarity of functions, accountabilities, and leveraging functional complementarities; III. Encourage and build capacities of POKJA members and support teams for planning, monitoring, research and documentation, and effective advocacy (with bupati and others); IV. Encourage information exchange through documentation, newsletters, and where possible exchange visits.	Section# 3.2.2: Promoting & Strengthening Coordination	Immediate / Short Term National POKJA BAPPENAS/BAPPEDA MoH/ STBM Secretariat & DHO WASH Sector Partners
2	Effective communication underpins success of any behavioural change interventions. The STBM communication model or approach requires a complete overhaul or revamping. The overhaul should entail:	Section#3.4.2: Implementation (Communication Campaigns)	Immediate MoH/STBM Secretariat & DHO

S #	Recommendations & Actions	Reference to Report Findings	Priority & Responsible Stakeholder/s
	I. Introduction of post-triggering communication interventions; II. Leveraging of interactive communication models comprising multiple mediums; III. Involve faiths/faith-based institutions/faith leaders as key influencers; IV. Keep communication 'Adaptive' to adjust messages/mediums to local contexts; V. Prioritise and encourage post-ODF behavioural compliance including guidance on tracking and on progression up sanitation ladders; VI. Invest more on improving communication capacities of Sanitarians and other frontline staff. VII. Leverage the human resources for health promotion/education, particularly those at ground level (in puskesmas and districts) to share the burden of sanitarians. VIII. Leverage technical capacities of Public Information and Communication Dept. (at district level) to tailor the communication strategies, interventions and products to the respond to the local context.	Section#3.3: Capacity Development	BAPPENAS/BAPPEDA Public Information and Communication Dept. WASH Sector Partners
3	Sanitation marketing is integral to diversifying technologies, improving affordability and access, and achieving inclusive access. The STBM needs to lay adequate focus on improving access, affordability, quality, and resilience of sanitation technologies in Indonesia. This may require series of different initiatives such as: I. Comprehensive sanitation marketing assessment for defining scope and scale of interventions and investments; II. Facilitate research and product development to help diversify technologies and make them more affordable; III. Encourage private sector engagement not only to improve access and affordability, but diversifying services such as pit/tank-cleaning and safe excreta management (in situ and offsite); IV. Encourage design diversification for inclusiveness and resilience. Introduce low cost, disability/age specific, and disaster resilient products; V. Encourage/introduce loans and grants (from social protection and Zakat funds) to help extreme poor have access to latrines.	Section#3.4.3: Implementation (Sanitation Marketing)	Short/Medium Term MoH/STBM Secretariat & DHO BAPPENAS/BAPPEDA WASH Sector Partners Private businesses/entrepreneurs

S #	Recommendations & Actions	Reference to Report Findings	Priority & Responsible Stakeholder/s
4	STBM monitoring system has seen improvements, however there are areas that need further work. The monitoring system needs a systematic and gradual upgradation (to align it to SDGs) which may require: I. Systemic assessment to identify and prioritize areas for improvement i.e. software, hardware, indicators, irregularity of the data entry by sanitarians, verification before posting to the STBM website, and others; II. Undertake comprehensive human resource capacity assessment to determine the capacity development needs, develop plan/s and implement at all levels; III. Set mandatory requirements for use of monitoring data for planning, reviews, and resource allocations at all levels; IV. Introduce process and outcome/impact monitoring such e.g. track of slippage tracking and social norms creation into regular monitoring; V. guidelines and of the data management team, reporting standards and integration of available information with the planning cycle).	Section# 3.5: Monitoring	Immediate MoH/STBM Secretariat & DHO BAPPENAS/BAPPEDA WASH Sector Partners
5	Research is integral to knowledge management and evidence creation. The STBM Programme needs a concerted focus on improving research and knowledge management. This may require: I. Clear and well-thought out research and knowledge management strategy and action plan, and adequate resources (human resource, financial including technical assistance from WASH partners); II. Undertake comprehensive capacity assessment, develop plan and implement to build systemic capacities to plan and implement researches and knowledge management interventions; III. Produce and/or support Government on knowledge products and evidences highlight best practices (for replication and scale-up) and cross sectoral linkages of sanitation with health, nutrition, education, gender, livelihoods and others. IV. Promote use of evidence for effective advocacy and seeking support from external stakeholders:	Section# 3.5.2 Knowledge Management	Immediate/Short Term BAPPENAS/BAPPEDA MoH/STBM Secretariat & DHO WASH Sector Partners Universities, research and training entities

S #	Recommendations & Actions	Reference to Report Findings	Priority & Responsible Stakeholder/s
	V. Encourage greater engagement of universities and technical training centres for research, innovation and training.		
6	STBM Secretariat may need to take a considered position on adoption of concept of 'Social Norms Creation' for rural sanitation programme. Given if it decides to embrace concept of 'social norms' it may be required to: I. Take a departure from on individual behavioural change to creating collective behavioural change at community level (as per current triggering approach) but with the 'new social norm' backed by some form of formal agreed sanctions; II. Identify and involve the most influential local networks into STBM implementation in particularly during Post-ODF phase; III. Build capacities of the key implementers such as sanitarians, the heads of Puskesmas and POKJA members, on concepts and practices around social norms creation.	Section: Sustainability (Social norms development)	Short/Medium Term MoH/STBM Secretariat & DHO BAPPENAS/BAPPEDA WASH Sector Partners

Appendix 1: Terms of Reference (ToR)

Note: TORs presented here have been extracted from formal Institutional Contract between UNITEDNATIONSCHILDREN'SFUND (UNICEF) and AAN Associates for the reason of change in scope during Contract Award process. However, for confidentiality purpose, the contractual terms are not reproduced hereunder.

Title Page of the Institutional Contract # 43224628

UNITEDNATIONSCHILDREN'SFUND (UNICEF)
wishes to enter into an institutional contract with
AAN Associates
Apt 112 First Floor Executive Height II F11 Markaz Islamabad, Pakistan
Telephone:512100062
Fax:
for the provision of the following services

WASH STBM Endline Evaluation Survey

as stipulated in the attached document

STATEMENT OF WORK/ToR

1. Title of the assignment
WASH STBM Endline evaluation survey.
This survey is part of the UNICEF support to the Sanitasi Total Berbasis Masyarakat (STBM, or community approaches to total sanitation in English) support to Government of Indonesia, in partnership with UNICEF and the Bill and Melinda Gates Foundation (BMGF); the primary geographic focus of the supported work is in eastern Indonesia.

2. Background and Justification:
In partnership with the Government of Indonesia (GoI), sub-national Governments and the Bill and Melinda Gates Foundation (BMGF), UNICEF initiated a programme in Eastern Indonesia from 2013-2017 in 6 selected districts across 3 provinces in Eastern Indonesia, to further increase Government capacity and to accelerate scaling-up of the National Sanitasi Total Berbasis Masyarakat (STBM) programme across these provinces. UNICEF also has shared learning to National level for replication and acceleration of STBM and will share further on completion of the programme. STBM is a national programme and it has been stated as a high priority for the President of Indonesia and the Ministry of Health to achieve universal access to sanitation by 2019. The programme originally aimed to increase the number of households using latrines and to achieve more than 40% of communities declaring Open Defecation Free (ODF) within the selected districts. Open defecation free status is normally granted by the district after a verification process by the district POKJA AMPL (WASH working group). This process follows the nationally-set ODF criteria by the Ministry of Health, available on the STBM website.

A baseline and Knowledge Attitude and Practice (KAP) household survey was completed in February 2014, aiming for establishing a baseline of sanitation pre-implementation status in the targeted communities. The survey collected data from 1700 households in the districts of Jayapura (Papua), Luwu Utara, Takalar and Barru (South Sulawesi), and Alor and Sumba Timur (NTT) and estimated access to sanitation in each of four sub-districts per district. Interim reports from field offices based on local monitoring by District Health Offices have shown increases in sanitation coverage and the number of ODF communities (for this programme the dusun was normally regarded as community as triggering was done at this level) in focus districts during the course of the programme. Prior to the end of the BMGF programme in

November 2017, an evaluation will be conducted in areas already declared ODF and where field activities have been completed. This evaluation is aiming for evidence-based advocacy for effective programme and scale-up in order to accelerate efforts to achieve universal sanitation access in Indonesia; the national target is to achieve this by 2019.

While key quantitative output indicators, including the number of latrines built in UNICEF-supported districts, percent of triggered communities achieving ODF, percent of households with access to sanitation that belong to the poorest two quintiles, number of programme/non-programme districts with plans and budget for implementing / scaling up STBM, will be evaluated through secondary data (i.e. Indonesian government data such as a national socio-economic survey, ST BM SMS-based routine sanitation monitoring data reported by sanitarians, sub-national government planning documents, etc.), effectiveness and sustainability of the programme, which require more detailed data collection at community, and at household-level, cannot be assessed through secondary data analysis.

Moreover, despite significant efforts to achieve ODF, the extent of and characteristics of sub-optimal household latrine use in ODF communities are poorly understood in Indonesia, resulting in unclear post-ODF programmes. Therefore, an Endline evaluation survey will be conducted with the focus on the effectiveness and sustainability of the joint Government-UNICEF STBM programme.

Using a mixed qualitative and quantitative method, the survey will target UNICEF and Government-intervened ODF communities in order to best capture (1) effectiveness by examining internal (i.e. quality of pre-triggering, triggering, post-triggering, follow-up monitoring and verification processes) and external factors (i.e. technical, financial, institutional, environmental/physical, and social, at the local level) explaining success to achieve ODF, and (2) sustainability by examining presence, extent and patterns of slippage (e. g. proportion of households returning to OD in surveyed ODF verified communities, and its disaggregation by wealth quintile), creation and strength of social norms associated with OD at community (e. g. sanction/ reward mechanisms to prevent OD) and household-level (e. g. belief around unacceptance of OD and a feeling of potential for social sanction within the community if seen defecating in the open), community challenges and measures against slippage, potential factors associated with sub-optimal latrine use (e. g. perceived latrine quality, water access for latrine use and maintenance, and size of households). In an additional secondary analysis, levels of ODF sustainability (i.e. slippage rates) and strength of social norms will be compared between UNICEF and Government-intervened areas and non-UNICEF and Government-only intervened ODF communities in order to examine effectiveness of the additional efforts of UNICEF-Government programmes around ODF verification process and post-ODF monitoring strengthening.

This cross-sectional Endline evaluation survey will also allow us to explore drivers and changes that led to ODF status through comparison between the baseline (pre-intervention) and the Endline (post-intervention) by selecting a subset of surveyed ODF communities from the same sub-district where the baseline survey occurred (if and where possible). Changes may include strength of social norms against OD among households with sanitation access, and KAP (e. g. knowledge on link between OD and diarrhoea, latrine use as a means of preventing child diarrhoea, safe child faeces disposal, handwashing behaviour etc.) However, a comparison analysis that would produce statistically significant indicators of change is not the primary focus of this study given the primary goal is around learning on effectiveness and sustainability and what worked for acceleration and scale-up on STBM in order to use this to push other districts for replication. Undertaking a comparison of intervention and non-intervention villages or ODF/non-ODF villages is not proposed given the envelope of financial resources available. For instance, given the sample size of the baseline (n = 70-80 households per sub-district, four sub-districts per district), more than two times larger household sample size per sub-district (n > 180 households per sub-district) will be required to detect 15%

changes (25% to 10%) in strengthen of social norm (a two-sided test with#= 0. 05 and 80% power). Implication is that the total sample size would increase from the baseline of 1700 to required sample size of at least 4320.

3. Purpose of the assignment:

The primary objectives of the Endline survey in selected UNICEF and Government-intervened ODF communities of Jayapura (Papua), Luwu Utara, Takalar and Barru (South Sulawesi), and Alor and Sumba Timur (NTT) in addition to Government-only intervened ODF communities in other districts of Papua, South Sulawesi and NTT are:

(1) At community level: to understand social norm dynamics in both intervened and non-intervened communities (i.e. the process of creating & sustaining social norms via such parameters as ODF verification processes, intensity of the levels of post-ODF monitoring activities, shared factual beliefs in the community, social norms in these ODF communities, Empirical expectations, Normative expectations, presence of sanctions) via FGDs and key informant interviews and to estimate, via household surveys in selected ODF-verified communities, the slippage rates in these ODF communities. These two approaches will help to better understand the related challenges and community measures in creating and sustaining ODF status.

(2) At household level: to assess key indicators around beliefs and actions (via KAP questions) and social norms as well as the key drivers and barriers to sanitation in ODF communities and its sustainability. Essentially, this will also enable us to examine differences from baseline household survey (in general communities) and Endline household survey (in ODF communities), but actual comparison analysis is not the primary focus of this assignment as per the reasons outlined above. Asset questions will allow a wealth stratification to be undertaken in the analysis to disaggregate by socio-economic status.

(3) Comparison between UNICEF and Government-intervened and Government-only intervened ODF communities: to examine effectiveness of the additional efforts of UNICEF and Government programmes on ODF sustainability, strength of the new social norms and other key indicators around beliefs and actions.

The primary target audience of the evaluation include the UNICEF Country Office (CO), the Government of Indonesia, particularly relevant line ministries Ministry of Health (MoH), BAPPENAS (national planning agency), KEMENDESA and selected provincial and district line agencies, and the Gates Foundation Sanitation programme for outcome reporting. The secondary audience may include other UN agencies and donor agencies working in the area of sanitation, hygiene and health/nutrition in Indonesia, NGOs, mass organisations, Private Sector agencies and development partners, particularly the World Bank. The findings will be presented to the Government. of Indonesia and partners at a special learning session and will be used to push the key recommendations for replication and acceleration of STBM in Indonesia. The results will also be shared by UNICEF at Province level to report on progress and to also discuss on local replication and acceleration of STBM in that area.

4. Scope of Work & Methodologies

4. 1. LOCATIONS

Sampling will be taken place in six districts, namely, Jayapura (Papua), Luwu Utara, Takalar and Barru (South Sulawesi), and Alor and Sumba Timur (NTT) as UNICEF and Government-intervened areas, while 3 other non-UNICEF and Government-only intervened districts in Papua (n = 1), South Sulawesi (n = 1) and NTT (n = 1) will be sampled.

4. 2. SURVEY DESIGN

UNICEF sanitation programme, using the STBM/Community Approaches to Total Sanitation (CATS), aims to eliminate open defecation by closely working with communities to change their beliefs and expectations around sanitation. Furthermore, to achieve longer-term sustainability of sanitation interventions, it is critical to create and sustain new social norms

and expectations in communities around their values and norms dealing with sanitation and community health. However, little is known about development of the social norms through sanitation intervention programmes and its association with sustainability of latrine use behaviour. Moreover, despite substantial efforts to achieve ODF communities, a number of studies in other countries have suggested challenges to sustain ODF status and various slippage patterns have been seen in communities after achieving ODF.

A UNICEF rapid survey conducted in three UNICEF-programme districts (Jayapura, Luwu Utara and Sumba Timur) in August 2016 also reported that 20% of surveyed households, from a combination of both ODF and non-ODF communities, did not show any sign of latrine usage at the time of survey, indicating that it cannot be assumed that access to a latrine guarantees consistent use of the latrine by household members. In some cases, there was a discrepancy between reported use at individual level and observed use at household level. It is, therefore, imperative that latrine use reported, and actual behaviour needs l o be critically evaluated in Indonesia. Baseline (Feb 2014) and the rapid survey (Aug. 2016) questionnaires and results will be made available to help to formulate the Endline design and inform the inception report.

This survey design is cross-sectional using a mixed quantitative and qualitative methods. Total of 36 ODF communities will be sampled in 9 districts (i.e. 6 UNICEF-Government-intervened and 3 Government-only intervened districts). Sampling unit will be a village as ODF verification will be taken place at village-level. However, typical Indonesian villages consist of multiple dusun, and hence a few dusun will be randomly sampled as a representative of an ODF village. Selection criteria of ODF communities will be a community that UNICEF intervened with ODF verification at village-level (i.e. stop open defecation) at least one year ago but not earlier than 3 years ago (i.e. so can be linked to this programme). Additionally, several ODF communities will be sampled in sub-districts where the baseline survey was conducted if and where possible, so that comparison between the baseline and Endline might be made possible depending on the effect size. For Government-only intervened districts, selection criteria of ODF communities will be a community that the ODF status was verified at least one year ago but not earlier than 3 years ago (if ODF verified dates are available). If sufficient number of ODF verified villages doesn't exist in these areas, ODF claimed or certified villages may be considered for sampling. The survey will consist of (1) two FGDs per community, including male and female (2) five key informant interviews per district (Head of village, sanitarians, NGO partners, district health staff, BAPPEDA, etc.), (3) a household survey for all communities with sampling of about 90 households per community, allowing to estimate a 15±5% community-level slippage rate with 95% confidence interval, assuming a community size is 150 households (further adjustment may be needed due to different size of ODF communities selected), and (4) transect walk for all communities to observe presence of human faeces in communities. Due to lack of slippage rate data in our programme districts, 15% slippage rate was chosen based on findings of the rapid survey. Given 20% sub-optimal latrine use in a combination of both ODF and non-ODF communities in Luwu Utara, Sumba Timur and Jayapura, we estimated slightly lower slippage rate (15%) for ODF verified communities. FGDs aim for capturing the processes to achieve ODF and any community measures such as community monitoring, social or financial sanctions, internal pressure mechanisms and toilet maintenance support systems to sustain ODF status at community-level, while a household survey will provide insights around household- and individual respondent-level latrine use behaviour through visual observation of signs of latrine use and self-reporting (frequency of latrine use over time and space). A transect walk will allow to assess if open defecation areas are present as well as to see the general cleanliness of the community.

Baseline and KAP study questionnaire, which UNICEF will provide to a contractor in Bahasa Indonesia, will be used with some modifications, as and where needed, in order to estimate household sanitation access and other key indicators such as social norms and sustainability related issues. UNICEF/UNICEF partners will prepare a list of ODF communities and will

inform the contractor, accordingly. The contractor will randomly choose ODF communities that meet selection criteria. The contractor will inform UNICEF and its partners of their schedule prior to surveys, while UNICEF and partners will be responsible for communication with government officials and other relevant persons.

Type of data and methods proposed for this Endline survey Type of data to be collected and Methodology:

- Level of community compliance with original ODF criteria - ODF check as part of HH survey & transect walk at short notice
- Quality of STBM preparation (before triggering activities - i.e. community meeting, prep for socialization, identifying community leaders, STBM implementation plan - location, timing, platform etc.) - FGDs
- Quality of STBM process (triggering, attendance rates in triggering, development of time-bound community action plan, monitoring, post-triggering/consultation, self-declared (not verified), verification and declaration)-FGDs
- Post-ODF activities (monitoring, re-triggering, activities/support for moving up the sanitation ladder etc.) - FGDs
- Defecation practices in the community (i.e. group of people likely still practicing OD) and beliefs/taboos associated with sub-optimal latrine use esp. via a gender lens - FGDs
- Community-level proxy indicators for measuring community commitment to sustain ODF status (sanctions, internal pressure mechanisms etc.) - FGDs
- Drivers/ barriers for changes to achieve ODF status & social norm dynamics - Key informant interviews
- Potential impact of Tinju Tinja campaign and other communication/ advocacy approaches and tools - Key informant interviews
- Defecation practices in the household (consistent latrine use behaviour at household- and individual-level via observation and self-reporting, child faeces disposal) - Household survey
- Strength of social norms - Household survey
- Potential factors associated with consistent latrine use behaviour (satisfaction with facility, quality of a latrine, access to water etc.) and KAP factors at HH level. - Household survey

Limitations

Number of sampled households per community (dusun) is calculated to estimate community-level slippage rate of 15% with 5% precision and 95% confidence interval, while number of ODF communities to be sampled (n = 36) is calculated based on available budge for the Endline survey. Therefore, slippage rate estimated in this survey will not be district-level representative. This cross-sectional study will be conducted over one month during dry season and will be in line with agreed reporting timeline as well as the need to respect the Ramadhan/ Eid-ul-Fitr period. Hence, potentially important temporal and seasonal variability of slippage patterns will not be captured.

Further methodological guidance including sample size will be discussed and finalized at the inception phase. For Ethics approval, please refer to the documents that can be downloaded, listed below:

- Ethical guidelines for evaluations: http://www.unevaluation.org/document/download/548
- Evaluator's code of conduct: http://www.unicef.org/evaluation/files/Evaluation_Principles_UNEG_Code_of_Conduct.pdf

- Procedure for Ethical Standards: https://www.unicef.sharepoint.com/teams/OoR/SiteAssets/SitePages/Procedures/UNICEF-procedure-on-ethics-in evidence-generation.pdf
- Ethical research involving children: http://www.childethics.com/wp-content/uploads/2013/10/ERIC-compeiunmd-approved-digital-web.pdf STBM: http://stbm-indonesia.org/?page=tentang-stbm&command=stbm&id1=2

Tasks and Deliverable Task

Task	Deliverable
Inception report submission, including implementation plan, objectives, methodology, time frame of the study, detailed sampling frameworks, data collection instruments (EN and Indonesian), application for ethical clearance and tabulation data plans	Inception report finalized after UNICEF inputs incorporated; an important element of this will be a clear methodology and shared understanding and agreement on how the social norms measurement will be undertaken
Local Ethical clearance applied for and granted Deliverable	Ethical clearance shared to UNICEF
Data collection Deliverable	Draft report in English and Bahasa Indonesia containing information and analysis. Power point Presentation to be shared during a meeting with UNICEF in English and Bahasa Indonesia.
Headline results and raw data submission Deliverable	Power point slides summarizing headline results. Cleaned Raw data files (in agreed format)
Final report submission with presentation to national stakeholders and key recommendations highlighted; UNICEF will arrange the venue	Final report in English and final PowerPoint presentation in both English and Bahasa Indonesia: In addition, a separate 4-page summary 'evaluation brief should be provided. The format/ outline of the report will be based on UNICEF's reporting standard with all related data and all tabulations (in agreed format)

5. Reporting Requirements

- Inception report outlining survey methodology and work-plan with milestones
- Draft final report on both quantitative and qualitative aspects with descriptive statistics
- Soft copy of raw data in Bahasa and English in Excel and SPSS format (depending on feasibility after questionnaires have been designed)
- PPT in English and Bahasa Indonesia and final report in English (No hard copies needed)

Appendix 2.1: Endline Evaluation Matrix (EEM)

STBM Endline Evaluation Matrix

Questions	Sub-Questions	Supporting indicators	Method	Tool	Potential information sources
OECD-DAC Evaluation Criteria: Effectiveness					
EQ-1. To what extent has UNICEF been successful in enabling Government of Indonesia (GoI) and sub-national Government(s) to develop and implement the processes for achieving the intended outputs and outcomes of the STBM programme.	1.1 To what extent has UNICEF's assistance contributed to developing/improving rural sanitation related policies, legislation, and availability of public funding (sector's enabling environment)?	▪ Evidence of enabling environment elements such as (approved or draft) sanitation policies, legislation, strategies, standards, and multi-year plans by Government; ▪ Practice of sector reviews and use for rural sanitation planning; ▪ Evidences of sector coordination – forums, plans, meetings, actions – at all levels ▪ Increased public sector allocations for rural sanitation (at least past three years) ▪ Stakeholders views of key UNICEF contributions for improved enabling environment ▪ Evidence from programme documents, and other published research including availability of evidence-based advocacy materials and platforms	QL	KIIs; SSR	Government officials and other relevant stakeholders from BAPPENAS, BAPPEDA, National Ministry of Health; Province Health office; District Health Office; POKJA AMPL; UNICEF; WASH sector experts; governor regulation/instruction on AMPL/STBM; district/bupati regulation, circular letter or instruction; POKJA AMPL report; Village regulation; APBD (District Annual Budget) & Realization
	1.2 How successful has UNICEF been in enhancing the capacities of relevant public agencies and communities to effectively implement CATS/CLTS to achieve ODF?	▪ Evidences of STBM benefitting from standardised training and dissemination materials ▪ Availability of trained and capable human resources for STBM implementation with relevant public agencies at all levels ▪ Organised, sensitized, and trained communities and volunteers implementing ODF/post ODF activities ▪ Stakeholders views on UNICEF contributions for public sector capacity development and effectiveness of approaches and interventions	QL	KIIs; SSR	National Ministry of Health; Province Health office; POKJA AMPL; UNICEF; WASH sector experts; District Health Office (DHO) reports; Training reports; field visits and monitoring reports/data;
EQ-2. KAP & Changing Social Norms: To what degree joint GoI and UNICEF efforts succeeded in improving knowledge and attitudes; and adopting and sustaining critical sanitation behaviour (at community and individual levels) in particular	2.1 To what extent knowledge, attitude and practices at household and community levels have changed due to joint (UNICEF plus Government) and exclusive (Government only) implementation?	▪ Changes in sanitation-related knowledge, attitudes and practices in ODF communities ▪ Changes in availability of functional latrines ▪ Proportion of triggered communities achieving ODF status and in stipulated time ▪ Proportion of communities with organised/ active village forums/volunteers in ODF communities (after one year of ODF certification)	QL; QT	KIIs; FGDs; SSR; HHS	National Ministry of Health; Province Health office; POKJA AMPL; UNICEF; WASH sector experts; community members; Triggering report; STBM website; Village report; Puskesmas report

STBM Endline Evaluation Matrix

Questions	Sub-Questions	Supporting indicators	Method	Tool	Potential information sources
ODF (consistent latrine use by all)?		▪ Proportion of women and other marginalised groups in village forums ▪ Stakeholders views about UNICEF contributions and effectiveness in changing knowledge, attitudes and practices at household and community levels			
	2.2 To what extent did UNICEF's support to STBM enable the government, households and communities in creating and sustaining a social norm of ODF?	▪ Relationship between practice of latrine use, empirical and normative expectations in ODF communities ▪ Evidences of existence of sanctions for practising open defecation ▪ Evidence of community action plan for ODF and post ODF sustainability ▪ Extent of slippage (i.e. sub-optimal use of latrine or reversion to OD) in ODF communities after at least one year of verification ▪ Views of Government officials, implementers and community members on challenges faced to the programme for sustaining the social norm of ODF.	QL; QT	KIIs; FGDs; SSR; HHS	Government officials and other relevant stakeholders; Community members; village leaders; community volunteers; sanitarians/frontline workers, entrepreneurs; masons; SanMark study; APBD (District Annual Budget) & Realization; Training report; Field Monitoring
OECD-DAC Evaluation Criteria: Sustainability **(Intervention logic: Direct implementation (UNICEF or its partners plus Government) and implementation by the Government only without support from UNICEF and other partners (other districts)**					
EQ-3. How application of two different approaches (Joint implementation in 'Direct districts'; and Government – only for 'other districts') affected the implementation, results and sustainability of the achievements?	3.1 What are the key successes, challenges and lessons from the application of the two implementation approaches?	▪ Views of government officials and other relevant stakeholders from the 'direct' and 'other' districts on; a) Most significant challenges, successes and failures in each approach b) UNICEF 'value additions' for direct districts	QL	KIIs; FGDs; SSR	Government officials and other relevant stakeholders from BAPPENAS, BAPPEDA, National Ministry of Health; Province Health office; District Health Office; POKJA AMPL; UNICEF; WASH sector experts; Community members; village leaders; community volunteers; sanitarians/frontline workers, entrepreneurs; masons.
	3.2 How well did UNICEF monitoring and knowledge management interventions enable the GoI and Communities for programme course correction and advocacy with government?	▪ Evidences and views of stakeholders on UNICEF's contributions in strengthening monitoring mechanisms and tools; KM strategy and interventions; and effective application for STBM ▪ Evidences and views of stakeholders on the quality/adequacy and use of information/results through monitoring and other KM products/actions, for advocacy	QL	KIIs; FGDs; SSR	Government officials and other relevant stakeholders from BAPPENAS, BAPPEDA, National Ministry of Health; Province Health office; District Health Office; POKJA AMPL; UNICEF; WASH sector experts;

STBM Endline Evaluation Matrix

Questions	Sub-Questions	Supporting indicators	Method	Tool	Potential information sources
		purpose and enabling (standardisation, systems development) the STBM implementation (CATS/CLTS implementation). ▪ Evidences and views of the stakeholders on communication and dissemination strategy for UNICEF's contributions to STBM ▪ Integration of specific needs of the listed groups in monitoring and reporting tools.			
Non-DAC Evaluation Criteria (Equity, Gender, HRBA)					
EQ-4. What approaches, strategies, and interventions are integrated in STBM to enable improved sanitation coverage for poor, minority, men, women, boys, girls, elderly people and person with disabilities?	4.1 To what extent and how has UNICEF's assistance worked to integrate equity in STBM design, implementation, and results for varied vulnerable groups including e.g. women, girls, the elderly, the disabled, minority groups and the poor.	▪ Views of relevant stakeholders e.g. public officials, communities, and WASH sector partners on UNICEF contributions to STBM processes for equitable results i.e. a) Change in access to sanitation for the vulnerable groups b) Representation and participation of vulnerable groups in activities c) Proportion of village volunteers/natural leaders that are women d) Availability of a financial or social support for poor e) Extent of innovative yet localised solutions for improved access for poor and disadvantaged	QL; QT	KIIs; FGDs; SSR; HHS	Beneficiaries (poor, minority, men, women, boys, girls, elderly people and person with disabilities); village leaders; community volunteers; sanitarians/frontline workers, entrepreneurs; masons.

Legend

EQ = Evaluation Question; FGD = Focus Group Discussion; HHS = Household Survey; HRBA = Human Rights-based Approach
KII = Key Informant Interview; KM = Knowledge Management; OD = Open Defecation; ODF = Open Defecation Free
QL = Qualitative; QT = Quantitative; SSR = Secondary Sources Review

Appendix 2.2: Mapping of Outcome Variables, Plausible Indicators and Programme Targets for Assessment Purpose

The Table App2.1-1 presents an overview of the outcome variables mapped against plausible indicators and targets. This table illustrates the integration of the ToC elements (written in italics after each heading) and the EE framework in the evaluation design.

Table App. 2.1-1: Mapping of outcome variables, plausible indicators and targets

Outcome1: INCREASED SANITATION COVERAGE – *System Strengthening, Political buy-in*	• Support to national policy and planning; • Technical support to government; • Training and capacity building of implementing partners; • Greater availability of sanitation markets; • Communication campaigns and replication in communities as a result of social networking
Outcome2: EQUITY:	• % of the poorest population group served through UNICEF's support to STBM implementation • (Target is 80% of the poorest population groups reached)
OUTCOME3: COMMUNAL OUTCOMES – *Quality of triggering and other processes, ODF verification guidelines*	• % of communities declared ODF six months post-triggering • (Target - 66%[55] of communities will have declared themselves ODF six months post-triggering. It is important to note that this relates to declaration and not the certification and verification process.
OUTCOME4: CONSISTENT USE – *Sustainability, Scale-up and replication*	• % of adults in households who consistently use their latrine 12 months after construction • Slippage rates in terms of consistent latrine use, infrastructure development and replacement, during the programme period and for one year after completion. • (Target: 85% of adults in households in ODF declared communities will consistently use their latrine 12 months after construction)
OUTCOME5: LEARNING – *WASH Advocacy Kit*	• Learning and innovation analysed, recorded and exchanged to assist with capacity development in the sanitation sector. • Development of case studies to distil the lessons learned • Issues to be examined include: ○ Strategic planning ○ Scale and scalability of interventions ○ Capacity needs and capacity building ○ Programme delivery and sequencing ○ Community uptake and market response ○ Slippage rates: Change in social norms; is there slippage/reversal in individual behaviours and what are the causes of this? ○ Policy environments: collection and dissemination of existing policies, strategies and by-laws; develop guides and checklists and make them available to other countries. ○ Monitoring and Evaluation: Monitoring and evaluation mechanisms including protocols for ODF declaration and verification. Consolidation of various monitoring and evaluation tools as a toolkit with relevant protocols for use.

[55] Target taken from the original BMGF Proposal shared with the Evaluators

Appendix 2.3: Assessment Framework for Social Norm, Sustainability and Non-DAC Criteria Elements

FRAMEWORK FOR SOCIAL NORM AND SUSTAINABILITY ASSESSMENT

The following evaluation framework (Table App. 2.2-1 & -2) is aligned with the UNICEF guidance for sustainability assessment and on the approach to integrating of a social norms review into the evaluation[56]. Social norm assessment takes into account the prevalence of OD in communities that have been verified within the target period (i.e. July 2014 – Jun 2016), however at different intervals in the stated period. It may be noted that for this sustainably assessment the evaluation specifically looked at consistent latrine-use behaviour through a quantitative lens as agreed with the UNICEF team. However, through qualitative findings, the MoH criteria for ODF verifications was looked for triangulation purposes.

The analysis considers the time element that ranges from one to three years of OD verification at the time of study. The assessment focused on:

- The level of actual sustainability of past STBM/CLTS interventions (ODF status of intervention communities), and of;
- The presence/absence of key institutional, social, technical, financial and environmental factors known to be supporting the prospect for future sustainability.

Furthermore, the social norm assessment[57] was be enriched by: a) making physical observation as part of the HHS interview, for any signs of latrine use, b) through self-reported frequency of latrine use when at home, and c) self-reported OD practice over the last 7 days by the survey respondent. Specific questions (Table App. 2.2-3) were included in HHS to capture such aspects.

Table App. 2.2-1: UNICEF Social Norm Change Framework

Q#	Key elements	Assessment Parameters
1	Empirical Expectations[58]	What is the prevalence of empirical expectations of latrine use?
2	Normative Expectations[59]	What is the prevalence of normative expectations of latrine use?
3	Existence of Sanctions	What is the prevalence of belief in the existence of sanctions for OD?
4	Consensus and Consistency	Analysis of consistency and consensus between empirical and normative expectations and prevalence of personal normative belief
Note: The other elements of the social norm theory i.e. analysis of the 'conditional preferences' and 'reference network' is excluded from the scope of the evaluation.		

Furthermore, in addition to the likelihood of assessing sustainability of achieved results (outputs and outcomes) the evaluation also explored, to the extent possible, the reasons for actual or likely slippage. Table App. 2.2-2 below summarises the factors to be examined. This also applies of the effectiveness assessment.

Table App. 2.2-2: Framework for Sustainability Evaluation

Dimension	Potential Areas to focus	Data Collection Methods
Institutional	Sanitation policy, regulations and strategy/roadmap; Quality of the processes implemented during pre-triggering and for the ODF verification and declaration.	Review of documents, secondary sources and KIIs.

[56] (a) SUSTAINABILITY CHECKS - guidance to design and implement sustainability monitoring in WASH (13.06.2017) and (b) UNICEF HQ Programme Division/ WASH, New York; UNDP-SIWI Water Governance Facility, Stockholm.

[57] Presentation (14.12.2016): 'How to integrate social norm approach in future, classical UNICEF WASH/CLTS Programme evaluations?' - A tentative model. Jérémie Toubkiss WASH Evaluation Specialist, Evaluation Office, UNICEF NYHQ and Julianna Westerblom, WASH Specialist, UNICEF Chad;

[58] Empirical expectations correspond to community members' beliefs concerning the behaviour of other members in the community;

[59] Normative expectations correspond to the community members' beliefs about what other members of the community think should be done;

Table App. 2.2-2: Framework for Sustainability Evaluation

Dimension	Potential Areas to focus	Data Collection Methods
Social	Other social factors: (1) enabling/disabling factors at household level and at community level affecting the access to improved sanitation; and (2) Knowledge, Attitude and Practices for key aspects of sanitation (latrine availability and consistent use of latrine)	Household Survey, FGDs, KIIs
Supply side	Supply chain issues, availability of sanitary materials at or near village, trained masons, low-cost latrine designs, standards and quality of the available sanitary products.	Review of documents, secondary sources, KIIs, and FGDs
Financial	Availability of public funds at district/sub-district level; Availability of financial assistance for the poor and other microfinance options for the households in general; Availability of rewards and other incentives for the staff and communities involved in implementation Affordability of latrines and other sanitary items for the households; affordability level was assessed based on the perceptions of the survey respondents.	Review of documents, secondary sources, KIIs, and FGDs

Based on the above methodological narrative the evaluation used the following assessment elements. In order to reduce any biases and to improve data collection accuracy, the administration of the questions in the native language were managed through trained and contextually-aware field staff. Tools were pre-tested, giving the evaluators the ability to adjust questions that may lead to a biased response. Furthermore, biases are mitigated from the very start since the questionnaire was administered only after stating assurances of confidentiality and anonymity.

Table App. 2.2-3: Questions Included in Post-KAP HHS (Slippage & Social Norm Assessment)

Q#	Question	Response Options
1	Some people use a latrine and other people do not. How often do members of your household use a latrine? *Note: The overall response to 'options-5' will indicate the slippage rate; 100% result for option-5 will indicate 0% slippage* *Will be used to triangulate / verify responses against question on OD practices by household members in the baseline*	1. Never 2. Rarely 3. Sometimes 4. Often 5. Always
2	Think about the people in your village, such as your family, friends, and neighbours. Out of 10 people in your village, how many do you think said that the members of their household always use a latrine?	Number: _____
3	Do you believe that people in your village should use a latrine? Why do you think people in your village should use a latrine? Think about the people in your village, such as your family, friends, and neighbours. Out of 10 people in your village, how many do you think said that people should use a latrine because it is the right thing to do?	1. Yes 2. No - **SKIP Next** 1. Because it is the right thing to do 2. Other reasons Number: _____
4	If someone in your village was observed defecating in the open, what would happen to her/him. Are people punished for defecating in the open, and if YES, how?	1. Financial penalty 2. Legal penalty 3. Community members scorn / punish 4. Other 5. Nothing happens - **SKIP Next** Specify: _____
Please note that positive reinforcement is tackled in earlier sections of the questionnaire		

Review of the baseline survey tool indicated the absence of any measurement of normative expectations and so as the baseline tool does not mention any specific question to assess the *'normative expectations'*, leaving behind no basis for comparison of Endline with baseline.

ASSESSMENT OF EQUITY, GENDER AND HRBA DIMENSIONS

The assessment of the programme focuses on equity, gender and HRBA, was done through both quantitative and qualitative methods and the review of the programme reports and other documents. For this purpose, specific questions were added in the post-KAP HHS questionnaire and other evaluation tools. The questions were based on the following *selected aspects for Post-KAP HHS*:

- Latrine prevalence in poor HHs; where possible, national level definition of poor was considered. Alternatively, based on the stated average monthly income from/any all sources and asset list during HHS, bottom two quintiles were considered for analysis purpose.
- Any barriers that women face for latrine adoption may be gleaned from female head of households, either as a special tabulation from the HHS or the FGDs.
- Poor people receiving financial support (financing, grants, materials…etc.) for construction of latrine
- Use of handwashing practice by poor – quantitatively reviewed through the HHS and also seen qualitatively in selected 'other districts'
- Community members' perceptions about
    - Most people in this community think it is acceptable for poor HHs to receive any assistance (financing, gifts/grants, materials…etc.) to build a latrine.
    - In this community, OD of poor HHs who cannot afford to build a latrine is acceptable.

Similar aspects were explored through KIIs and FGDs. All data was analysed, disaggregated by income, sex and gender where applicable.

Appendix 3.1: Household Survey Methods and Sampling

Key aspects of the Household Survey (HHS), including the brief on the sampling frame, are described below.

Post-KAP Endline Household Survey

- Quantitative data collection was carried out through a post-KAP HHS by administering face-to-face interviews.
- The baseline/midline KAP questionnaire for the HHS was adapted, to the extent necessary, with a focus on analysing key individual and communal behaviours for the purpose to reflect on changing of social norms.
- In addition to Post-KAP assessment, the HHS additionally focused on:
    - (Referring to the ToR of Endline Survey, the main objective is to capture the effectiveness of BMGF interventions.)
    - The assessment of 'slippage' rate (i.e. the proportion of HHs reverting to OD practice after community has been declared ODF) and;
    - The assessment and analysis of the existence of a new 'social norm' within ODF communities where all HH and all members consistently use latrines.

- The following were key considerations for the development / finalisation of the post-KAP HHS:
    1. The HHS was undertaken for a pre-determined sample of 3,240 HHs from 36 ODF desa (villages) in six *'direct'* and three *'other' districts (see rationale further below)*;
    2. For the selection of the three '*other districts*', at the first stage, a complete listing of other districts was prepared by UNICEF. This list was processed by mapping the presence of any external WASH sector support agency/organisation. In the second stage, all districts that showed presence of any WASH sector partners, including UNICEF, were excluded from the list. Resultantly, the Government-only districts were identified. A second criterion, the presence of at least one ODF-declared village within the target period (i.e. July 2014 – Jun 2016) was ensured. Finally, one district from each province was *randomly* selected as the 'other district' for inclusion in the evaluation scope.
    3. The primary unit for the HHS was a HH;
    4. 360 HHs were interviewed within each district. The pre-determined sample was capable of yielding statistically representative results for the programme targeted communities, with 95% confidence level and ~5% confidence interval or margin of error;
    5. For the selection of desa (villages) within each selected district, a two-step methodology was followed; Initially such desa (villages) that achieved ODF declaration between *01-07-2014* and *30-06-2016* were filtered out; In the next step, preference was given to those desa/villages where the baseline was completed. Cumulatively, out of selected 25 villages, 13 villages were without baseline.
    6. The suggested cut-off date ensured appropriate assessment of sustainability of the newly created norm of 'exclusive latrine use' by all HHs after one-to-three years of achieving ODF status;
    7. Equal number of male and female respondents were targeted as respondents of the evaluation HHS;
    8. For interview, priority for interview was given to the head of the family or the housewife. In the case that either of them were NOT available, other members of the family aged ≥18 were interviewed.
    9. HHS questionnaire included those questions which required 'physical observation' to validate the respondents' responses on latrine availability, latrine conditions, any indication of latrine use. Data collectors (enumerators) took permission from the respondent to record physical observations.

Data Requirements

The distribution of the total allocated sample at dusun (community) level, required dusun (community) level distribution in all desa (village). On receipt of such data, dusun (community) level sampling distribution was determined. *UNICEF enabled the Evaluators with the required data to timely initiate survey planning and undertaking.*

Methodological Limitation

The above-stated methodology inherited a limitation due to the set criteria for exclusion of villages in the survey sampling frame. The exclusive focus on ODF communities on the one hand enabled the Evaluators to look at 'Changing social norms', and, on the other hand, limited the complete assessment of the effectiveness of programme implementation, particularly in areas with triggered-communities that, for any reason, did not achieve ODF Declaration. *To minimize the effect of above stated limitation, the Evaluators included at least 15% of the communities (one community in each district where triggering happened, however ODF declaration status was not achieved) in the sample for qualitative data collection (FGDs, observations etc.).* This enabled the Evaluators to assess the reasons, contributing factors, disablers/de-motivators that hindered communities in achieving ODF status.

Sampling Design

The overall sampling design for this evaluation, as requested by UNICEF, covered *six* 'direct' and *three* 'other' districts. The sample design for this assignment required covering a pre-determined number of HHs (3,240) from 36 ODF desa (villages). The HHs were evenly distributed (360 HHs) among all *nine* districts and 36 desa (villages). Table App. 3.1-1 shows the distribution of desa/villages and HHs by each of the administrative units, while Table App. 3.1-2 outlines the geographic scope of the evaluation

Table App. 3.1-1: Overall Sample Distribution by Districts and Villages

Units	'Direct' districts	'Other' districts	Total
Districts	6	3	9
Desa (villages)	25	11	36
HHs	2,160	1,080	3,240

Table App. 3.1-2: Geographic Scope of the Endline Study

Province	'Direct' Districts	'Other' Districts
Nusa Tenggara Timur	Alor	Manggarai
	Sumba Timur	
Sulawesi Selatan	Barru	Enrekang
	Luwu Utara	
	Takalar	
Papua	Jayapura	Keerom

Sampling of Villages from 'Direct' Districts

Sampling was carried out from data provided by UNICEF Indonesia. This sampling frame consisted of 248 'Direct' villages, of which 109 villages had achieved ODF status within the defined cut-off date.
From these 109, a random sample of 25 villages was drawn within the 6 target districts. Table App. 3.1-3 details the sampling distribution of villages from the 'Direct' districts within each province and corresponding district. *The base filtering criteria resulted in 17 eligible villages, which is less by 7 than the numbers required (24 = 4 per district for six districts). Therefore, seven (07) Triggered (Non-ODF) villages were additionally sampled in order to complete the total number of villages in each district.*

Table App. 3.1-3: Sampling distribution of villages from the 'Direct' districts

Province	Districts	'Direct' Villages		Sampled Villages
		Total	Eligible (as per defined criteria)	ODF Villages
Nusa Tenggara Timur	Alor	110	61	4
Nusa Tenggara Timur	Sumba Timur	32	13	4
Sulawesi Selatan	Barru	8	4	4
Sulawesi Selatan	Luwu Utara	40	4	4
Sulawesi Selatan	Takalar	41	21	4
Papua	Jayapura	17	6	5
Total		248	109	25

Sampling of Villages from 'Other' Districts

Sampling for 'Other' districts (Table App. 3.1-4) was carried out from data provided by UNICEF Indonesia. The sampling frame consisted of 114 villages in the three target provinces. The supplied data did not contain a 'baseline' indicator, therefore the data was only filtered on having ODF Declaration status within the period of study; which resulted in 17 eligible villages. 12 villages were randomly sampled from these 17 eligible villages.

Table App. 3.1-4: Sampling Design for 'Other' Villages by District and Province

Province	District	'Other' Villages		Sampled Villages
		Total	Eligible	ODF Villages
Nusa Tenggara Timur	Manggarai	76	4	4
Sulawesi Selatan	Enrekang	26	10	4
Papua	Keerom	12	3	3
Total		114	17	11

Note: Some of the districts listed in the 'Other' dataset were tagged as such but still listed a partner in the adjacent column. Sampling was carried out by filtering on both columns and ensuring that no partner is listed for any of the 'Other' districts.

Household Selection

The HH payload of each village was evenly distributed among its dusun (community). A random number was drawn between 1 and 10 to be used as 'n' for the interval. The coordinator then picked the first HH from the right facing north, and used the interval for selection of the next closest HH. The process was repeated until the required number of HHs was surveyed. The full list of sampled *villages* from 'Direct' and 'Other' districts is attached as Appendix 3.2.

Response Biases

The evaluation design and data collection methods carefully considered and responded to the possible biases related to sampling and responses to the HHS questions. Some of the key measures incorporated into the design that enabled the measurement process to be bias-free are listed below:

- The sample size was representative for the communities targeted by the Programme at 95% Confidence level with a 5% margin of error;
- The final selection of desa/villages, for each district, after application of necessary inclusion/exclusion criteria, was done by 'random sampling', which reduces the selection bias;
- The sampling distribution covered all six direct districts, and hence ensured optimum coverage to attain representative results for coverage of the Programme supported by UNICEF;
- The formulation of questions for the survey was done in a way to avoid leading questions and to keep the 'socially desirable' responses at a minimum;
- The planned detailed training of the data collectors further ensured minimisation of response bias. The interviews were conducted in an environment facilitating the respondent's comfort. All efforts were invested to ensure that the respondent was not exposed to any situation leading to a state that may have potentially affected his/her response;
- All respondents mostly belonged to a similar demographic and socio-economic profile;
- All respondents were given full assurances and confidence about maintaining confidentiality and anonymity, in order to eliminate the response bias, and;
- Any possible non-response bias was mitigated and managed by interviewing additional households to complete the required number of respondents.

Appendix 3.2: Household Survey Sampling Frame

Sampled Villages for HHS

PROV	DISTRICT	SUB DISTRICT	VILLAGE	HH Survey	FGD
Papua	Jayapura	Depapre	Entiyebo	V	X
Papua	Jayapura	Kemtuk	Nambon	V	V
Papua	Jayapura	Kemtuk Gresi	Bring	V	V
Papua	Jayapura	Nimboran Timur / Namblong	Besum	V	V
Papua	Jayapura	Nimbokrang	Wahab	V	V
Papua	Jayapura	Sentani Timur	Yokiwa	X	V
Papua	Keerom	Arso	Yanamaa / Pir I	V	X
Papua	Keerom	Arso	UPT Pir II / Yamta	X	V
Papua	Keerom	Arso Timur	Upt Pir V / Yamara	V	V
Papua	Keerom	Senggi	Usku	V	V
NTT	Alor	Alor Barat Daya	Wolwal Barat	V	V
NTT	Alor	Alor Timur	Belemana	V	V
NTT	Alor	Pantar	Helandohi	X	X
NTT	Alor	Pantar	Bouweli	V	V
NTT	Alor	Pulau Pura	Pura Utara	V	X
NTT	Alor	Alor Barat Laut	Pulau Buaya	X	V
NTT	Manggarai	Ruteng	Bangka Lao	V	V
NTT	Manggarai	Ruteng	Kakor	V	V
NTT	Manggarai	Ruteng	Pong Lale	V	X
NTT	Manggarai	Wae Rii	Lalong	V	V
NTT	Manggarai	Satar Mese	Pongkor	X	V
NTT	Sumba Timur	Katala Hamu Lingu	Mandahu	V	V
NTT	Sumba Timur	Pahunga Lodu	Pamburu	V	V
NTT	Sumba Timur	Pahunga Lodu	Lambakara	V	X
NTT	Sumba Timur	Tabundung	Tapil	V	V
NTT	Sumba Timur	Pinupahar	Lailunggi	X	V
SS	Luwu Utara	Masamba	Torada	V	V
SS	Luwu Utara	Masamba	Kamiri	V	V
SS	Luwu Utara	Masamba	Baloli	V	V
SS	Luwu Utara	Sukamaju	Banyuwangi	V	V
SS	Enrekang	Baraka	Bone Bone	V	V
SS	Enrekang	Cendana	Pinang	V	V
SS	Enrekang	Cendana	Taulan	V	X
SS	Enrekang	Maiwa	Pasang	V	V
SS	Enrekang	Malua	Kolai	X	V
SS	Barru	Barru	Palakka	V	V
SS	Barru	Barru	Tompo	V	V
SS	Barru	Soppeng Riaja	Paccekke	V	X
SS	Barru	Soppeng Riaja	Kiru-Kiru	V	V
SS	Barru	Pujananting	Gattareng	X	V
SS	Takalar	Galesong Selatan	Bonto Kassi	V	V
SS	Takalar	Galesong Utara	Pakkabba	V	V
SS	Takalar	Pattallassang	Bajeng	V	V
SS	Takalar	Polombangkeng Utara	Lassang	V	V

V	ODF Verified
X	Not ODF Verified

Appendix 3.3: STBM Endline Evaluation Household Survey Questionnaire

The questionnaire for household survey is adapted from the survey tools used for baseline and Endline. In addition to the complete text of the Tool in this section, the evaluators have provided the track-change version of the same tool for convenient trackability purpose. Where required, questions are cross-referenced for support comparative analysis. The final revised HHS questionnaire was translated in BAHASA for undertaking interviews with the survey respondents.

Nama Project *Project Name*	**'Sanitasi Total Berbasis Masyarakat' (STBM)**	**Jenis Kuesioner** *Type of questionnaire*	**STBM Endline Evaluation Post-KAP Survey**
No. Job *Job Number*		**Versi** *Version*	**Revised IR, 24 July, 2017**

aan associates	**AAN Associates Pakistan Address: 108, Executive Heights, F-11/1, Islamabad, Pakistan** www.aanassociates.com		**Nomor Kuesioner** *Questionnaire number*

RESPONDENT DETAIL		
Nama Responden Bpk/Ibu/Sdr. *Name of Respondent (Mr./Mrs/Miss/Ms)*		
Alamat / *Address*		
	Telpon Rumah / *House Phone*	**HP/ *Hand phone***

RECORD OF INTERVIEW														
Nama Pewawancara/ Recruiter *Name of Interviewer/ Recruiter*								**No ID**						
Nama Supervisor *Supervisor name*								**No ID**						
Hari dalam minggu *Day of the Week*	Senin *Mon*	1	Selasa *Tue*	2	Rabu *Wed*	3	Kamis *Thu*	4	Jumat *Fri*	5	Sabtu *Sat*	6	Minggu *Sun*	7
Tanggal Wawancara *Date of Interview*	Tanggal *Date*		Bulan/ *Month*		Tahun/ *Year*		Waktu Mulai */Time Began*		Waktu Selesai/ *Time Ended*		Total Lama Wawancara *Total length of interview*			

PEMBUKAAN *INTRODUCTION*

Selamat _____ nama saya _____ dan saya bekerja untuk UNICEF. Kami mengadakan survei di beberapa rumah tangga dan menanyakan tentang air, sanitasi, kebersihan, dan kondisi kesehatan di rumah tersebut. Rumah Anda telah terpilih menjadi salah satu rumah yang akan diwawancara untuk studi kami.
Hi my name is _____ and I am working with AAN Associates, Pakistan. On behalf of UNICEF, Country Office, Indonesia, We are conducting a survey that asks households about various Water, Sanitation, Hygiene and Health conditions at their home. Your house has been selected to do an interview for our project.

Kami sangat menghargai partisipasi Anda dalam survei ini. Informasi yang Anda berikan akan membantu UNICEF dan Departemen Kesehatan untuk membuat rencana dan kemudian mengevaluasi proyek sanitasi di area ini. Survei ini akan memakan waktu sekitar 45 menit untuk diselesaikan. Informasi yang Anda berikan akan dijaga kerahasiaannya dan tidak akan

dibagikan kepada orang lain selain anggota tim yang bekerja untuk studi ini. Jawaban/ tanggapan yang Anda berikan juga akan dianonimkan dan tidak terikat kembali kepada Anda dengan cara apapun.
We would very much appreciate your participation in this survey. This information was used to help UNICEF and the Ministry of Health plan for and later evaluate the sanitation project in this area. The survey should take about 45 minutes to complete. The information you provide was kept confidential and was not be shared with anyone other than members of our project team. Your responses was also be anonymous and not tied back to you in anyway.

Partisipasi Anda dalam survei ini bersifat sukarela. Jika kami menanyakan sesuatu yang tidak ingin Anda jawab, beritahukan kepada kami dan kami akan menanyakan pertanyaan selanjutnya. Anda juga dapat menghentikan wawancara sewaktu-waktu. Kami berharap Anda dapat berpartisipasi dalam survei ini, karena masukan/ tanggapan Anda sangat penting bagi kami.
Participation in the survey is voluntary. If we ask you any questions you don't want to answer let me know and I was go on to the next question. You can also stop the interview at any time. We hope that you was participate in this survey, as your input is important to us.

Apakah Anda mempunyai pertanyaan tentang survei ini untuk saat ini? *Do you have any questions about the survey at this time?*

Dapatkan kami memulai wawancaranya sekarang? *May I begin the interview now?*

G1. Nama Daerah Khusus/ Provinsi (LINGKARI) SA *Name of Province (CIRCLE) SA*		G2. Nama Kabupaten (LINGKARI) SA *Name of District (CIRCLE) SA*	
Nusa Tenggara Timur (NTT)	1	Alor	1
		Sumba Timur	2
Sulawesi Selatan *South Sulawesi*	2	Luwu Utara	3
		Takalar	4
		Barru	5
Papua	3	Jayapura	6
Nusa Tenggara Timur (NTT)		'Other District' - Manggarai	7
Sulawesi Selatan *South Sulawesi*		'Other District' – Enrekang	8
Papua		'Other District' - Keerom	9

G3	Kecamantan *Subdistrict*	
G4	Desa *Village*	
G5	Dusun / RT/ RW/ Lingkungan	
G6	Nama kepala rumah tangga *Head of Household Name(s)*	
G7	Household head's gender	Male 1 Female 2
G8	Age of a head of household	

KUOTA: 50% Laki-laki *males* and 50% Perempuan *females*

G7. Apa hubungan Anda dengan kepala rumah tangga? SA
What is your relationship to the Head of Household? SA

Saya sendiri adalah Kepala Rumah Tangga *Self - Head of Household*	1	Ayah Mertua *Father-in-law*	9	
Istri/ Ibu *Wife/Mother*	2	Kakek *Grandfather*	10	
Ibu Mertua *Mother-in-law*	3	Anak Laki *Son*	11	
Nenek *Grandmother*	4	Kakak/ Adik Laki *Brother*	12	
Anak Perempuan *Daughter*	5	Keponakan Laki *Nephew*	13	
Kakak/ Adik Perempuan *Sister*	6	Sepupu *Cousin*	14	
Keponakan Perempuan *Niece*	7	Tidak ada hubungan keluarga *Not Related*	15	STOP WAWANCARA DAN UCAPKAN TERIMA KASIH *STOP INTERVIEW AND SAY THANK YOU*
Suami/ Ayah *Husband/Father*	8	Tidak tahu *Unknown*	16	

INSTRUKSI:
- Prioritas untuk diwawancara adalah kepala rumah tangga atau ibu rumah tangga. Jika salah satu dari mereka tidak ada, boleh mewawancara anggota keluarga lain yang berusia ≥18 tahun yang paling mengerti mengenai topik wawancara. *Priority to be interviewed should be given to the head of the family or the housewife. If either of them are*

available, it is allowed to interview other member of the family aged ≥18 years who know about the topic of the interview the most.

G8 Pernyataan kerahasiaan sudah dibacakan kepada saya. Saya telah memahaminya dan saya memberikan persetujuan secara lisan untuk melanjutkan wawancara ini.
The confidentiality statement has been read to me. I understand it and give my verbal permission to proceed with the interview.

Ya *Yes*	1	1.
Tidak *No*	2	STOP WAWANCARA DAN UCAPKAN TERIMA KASIH *STOP INTERVIEW AND SAY THANK YOU*

INFORMASI DEMOGRAFIS *DEMOGRAPHIC INFORMATION*

I1. Dapatkah Anda menyebutkan usia Anda sekarang? SA Usia :_____tahun
May I know your current age?

INTERVIEWER: Yang boleh di wawancara adalah yang berusia ≥18 tahun.
The respondent is eligible for interviewed if his/ her age is ≥18

I2. Jenis Kelamin. SA
Respondent's gender

Pria *Male*	1	Wanita *Female*	2

I3. Ada berapa jumlah orang yang tinggal di rumah pada saat ini? Tidak termasuk tamu atau keluarga yang tinggal/ menginap untuk beberapa hari - *How many people live/or stay in this house today? Not including guest or relatives who stay stay over for few days*
_____ orang

I4. Sekarang saya ingin tahu secara detil usia dan jender dari orang-orang yang tinggal di rumah tangga Anda sekarang ini, tapi tidak termasuk tamu atau keluarga yang tinggal/ menginap untuk beberapa hari. - *Now I'd like to know in detail the age and gender of people live in your household today, but not including guest or relatives who stay over for few days.*

INTERVIEWER:
TANYAKAN UNTUK SETIAP KELOMPOK UMUR DAN JENDER. LALU TULISKAN JAWABAN DAN JUMLAH TOTALNYA DI KOLOM YANG DISEDIAKAN. JUMLAH TOTAL ORANG YANG TINGGAL DI RUMAH HARUS SAMA DENGAN YANG DISEBUT DI I3. *ASK FOR EACH AGE GROUP AND GENDER.THEN WRITE DOWN THE ANSWER AND THE TOTAL IN THE COLUMN GIVEN. THE TOTAL NUMBER OF PEOPLE LIVING IN THE HOUSEHOLD SHOULD BE THE SAME AS THE ONE MENTIONED IN I3.*

USIA *AGE*	**LAKI-LAKI *MALE***	**PEREMPUAN *FEMALE***	**TOTAL**
5 tahun kebawah *5 years and under*			
6 – 15 tahun *years*			
16 – 45 tahun *years*			
46 tahun atau lebih *46 years or above*			
TOTAL			

I5. (BI6) **[JIKA MENJAWAB KODE 2 (TIDAK) PADA I5, MAKA SKIP I6 – LANGSUNG KE I7]**
Apakah pendidikan terakhir yang Anda **tamatkan**? SA
What is the highest level of school you completed? SA

Tidak ada pendidikan formal *No formal education*	1
tidak tamat SD *Not completing primary school*	2
Sekolah Dasar *Primary*	3
Sekolah Menengah Pertama *Pre-Secondary*	4
Sekolah Menegah Atas *Secondary*	5
Perguruan Tinggi *Higher*	5

I6 (BI7.) **[BACAKAN DAN TANYAKAN UNTUK MASING-MASING BARANG. LINGKARI KODE JIKA RESPONDEN MENJAWAB YA]**
Apakah rumah tangga Anda memiliki _____ (SEBUTKAN BARANG SATU PERSATU)? MA
Does your household own the following items? MA

Radio	1	Sepeda *Bicycle*	7
Televisi *Television*	2	Gerobak yang ditarik dengan hewan *Animal drawn cart*	8

HP/ Ponsel/ Telefon genggam *Mobile phone*	3	Mobil/ truk *Car/truck*	9
Telefon rumah *Telephone*	4	Perahu bermesin *Boat with motor*	10
Lemari es/ Kulkas *Refrigerator*	5	Tanah/ lahan pertanian milik sendiri *Own agriculture land*	11
Sepeda motor *Motorcycle/scooter*	6	Peternakan milik sendiri *Own farm animals*	12

I7 What is Average monthly income from all sources, of your households? CHECK TRANSLATION
(Ask for specific answer i.e. not a range of amout)

2. AKSES UNTUK MENDAPATKAN AIR *WATER ACCESS*

BACAKAN: ' Sekarang saya akan bertanya tentang bagaimana Anda mendapatkan air untuk kebutuhan keluarga'.
READ OUT: 'Now I want to ask you about access to water for your families use'.

KARTU BANTU *SHOW CARD*
W1. Pada saat ini, apakah sumber utama Anda untuk mendapatkan air untuk diminum dan memasak? SA
[LINGKARI SATU JAWABAN SAJA UNTUK AKSES YANG PALING UTAMA]
What is your current source of water for drinking and cooking? SA. (CIRCLE ONLY ONE primary source).

1. Sumber yang sudah ada peningkatan *Improved Sources*	
Kran air/ perpipaan sampai ke rumah tangga *Piped into dwelling, plot or yard*	1.1
Keran umum *Public tap/standpipe*	1.2
Air dari sumur bor *Tube well/borehole*	1.3
Sumur dangkal memakai pelindung/ dinding sumur *Protected dug well*	1.4
Mata air dengan bangunan pelindung *Protected Spring*	1.5
Penampungan air hujan *Rainwater collection*	1.6
2. Sumber yang belum ada peningkatan *Unimproved Sources*	
Sumur dangkal tanpa peindung/ tanpa dinding sumur *Unprotected dug well*	2.1
Mata air terbuka/ tanpa bangunan pelindung *Unprotected spring*	2.2
Drum/ tangki kecil berisi air yang ditarik oleh kereta kuda *Cart with small tank/drum*	2.3
Air kemasan *Bottled water*	2.4
Truk / mobil tangki air *Tanker Truck*	2.5
Air permukaan (sungai, bendungan, telaga, empang, danau, kolam, kali, saluran terbuka) *Surface water (river/dam/lake/pond/stream/canal)*	2.6
Lainnya, sebutkan _____*Other (specify)*	X

[**JIKA TERPILIH KODE 2 DI W2 (MENGGUNAKAN SUMBER YANG BERBEDA), TANYAKAN W2-1]**
W2. (BW2-1) Apakah sumber air utama Anda untuk mandi, menyiram toilet, membersihkan rumah, dan lainnya? SA
What is your current main source of water for bathing, toilet flushing, cleaning etc.? SA

1. Sumber yang sudah ada peningkatan *Improved Sources*	
Kran air/ perpipaan sampai ke rumah tangga *Piped into dwelling, plot or yard*	1.1
Keran umum *Public tap/standpipe*	1.2
Air dari sumur bor *Tube well/borehole*	1.3
Sumur dangkal memakai pelindung/ dinding sumur *Protected dug well*	1.4
Mata air dengan bangunan pelindung *Protected Spring*	1.5
Penampungan air hujan *Rainwater collection*	1.6
2. Sumber yang belum ada peningkatan *Unimproved Sources*	
Sumur dangkal tanpa peindung/ tanpa dinding sumur *Unprotected dug well*	2.1
Mata air terbuka/ tanpa bangunan pelindung *Unprotected spring*	2.2
Drum/ tangki kecil berisi air yang ditarik oleh kereta kuda/ sapi/ dll *Cart with small tank/drum*	2.3
Air kemasan *Bottled water*	2.4
Truk / mobil tangki air *Tanker Truck*	2.5

Air permukaan (sungai, bendungan, telaga, empang, danau, kolam, kali, saluran terbuka) *Surface water (river/dam/lake/pond/stream/canal)*	2.6
Lainnya, sebutkan _____*Other (specify)*	X

W3. Apakah Anda bisa mendapatkan air di sumber air tersebut **untuk keperluan rumah tangga** (untuk mandi, menyiram toilet, membersihkan rumah, dan lainnya) selama satu tahun penuh? SA *Do you always have access to this water source for household needs (bathing, toilet flushing, cleaning etc) year round? SA*

Ya *Yes*	1	➔ **KE S1** *TO S1*
Tidak *No*	2	➔ **KE W3A DAN W3B** *TO W3A AND W3B*
Tidak tahu *Don't know*	3	➔ **KE S1** *TO S1*

[JIKA MENJAWAB KODE 2 (TIDAK) PADA W3, MAKA TANYAKAN W3A DAN W3B]

W3A. Kapan/ pada waktu apa Anda TIDAK bisa mendapatkan air dari sumber air tersebut?
If NO, when do you NOT have access to this water source?

Selama musim kemarau *During the dry season*	1
Selama musim hujan *During the rainy season*	2
Tidak tahu *Don't know*	3

W3B. **[GUNAKAN KODE DARI W1 UNTUK MENJAWAB W3B]**
Ketika Anda tidak bisa mendapatkan air dari sumber air tersebut, sumber air utama lain mana yang biasa Anda gunakan? SA *When this source is not available what other main source do you usually use? SA*

1. Sumber yang sudah ada peningkatan *Improved Sources*	
Kran air/ perpipaan sampai ke rumah tangga *Piped into dwelling, plot or yard*	1.1
Keran umum *Public tap/standpipe*	1.2
Air dari sumur bor *Tube well/borehole*	1.3
Sumur dangkal memakai pelindung/ dinding sumur *Protected dug well*	1.4
Mata air dengan bangunan pelindung *Protected Spring*	1.5
Penampungan air hujan *Rainwater collection*	1.6
2. Sumber yang belum ada peningkatan *Unimproved Sources*	
Sumur dangkal tanpa peindung/ tanpa dinding sumur *Unprotected dug well*	2.1
Mata air terbuka/ tanpa bangunan pelindung *Unprotected spring*	2.2
Drum/ tangki kecil berisi air yang ditarik oleh kereta kuda / sapi/ dll *Cart with small tank/drum*	2.3
Air kemasan *Bottled water*	2.4
Truk / mobil tangki air *Tanker Truck*	2.5
Air permukaan (sungai, bendungan, telaga, empang, danau, kolam, kali, saluran terbuka) *Surface water (river/dam/lake/pond/stream/canal)*	2.6
Lainnya, sebutkan _____*Other (specify)*	x

3. SANITASI *SANITATION*

BACAKAN: 'Sekarang saya akan bertanya tentang jamban/ toilet/ wc yang digunakan oleh keluarga anda'
READ OUT: 'Now I want to ask you some questions about the toilet facility your family uses'.

S1. Apakah pada saat ini rumah Anda memiliki jamban/ toilet/ wc/ toilet/ wc? SA
Does your house currently have a toilet? SA

Ya *Yes*	1	➔ **KE S2** *TO S2*
Tidak *No*	2	➔ **LANGSUNG KE S9** *Go TO S9*

INTERVIEWER:

JIKA DI RUMAH TERSEBUT TERDAPATJAMBAN/ TOILET/ WC, TANYAKAN: Bisakah anda menunjukkan kepada saya jamban/ toilet/ wc/ toilet/ wc yang biasa digunakan oleh keluarga anda, nanti setelah interview ini selesai?
DI AKHIR WAWANCARA, LENGKAPI PERTANYAAN OBSERVASI DAN LIHAT JENIS JAMBAN/ TOILET/ WC/ TOILET/ WC YANG DIMILIKI
IF THE HOUSEHOLD HAS A TOILET FACILITY ASK*: Can you show me the toilet facility your family members usually use at the end of our interview? AT THE END COMPLETE OBSERVATION QUESTION AND CAPTURE TYPE OF LATRINE*

S2 – S8 DITANYAKAN JIKA RESPONDEN MEMPUNYAI FASILITAS SANITASI

If Household Has Facility Ask These Questions S2 – S8

S2. Apakah jamban/ toilet/ wc ini juga digunakan oleh keluarga lain, di luar rumah Anda? SA
Do you share this facility with other families outside of your home? SA

Tidak, jamban/ toilet/ wc hanya digunakan oleh keluarga saya *No. Facility only used by my household*	1	➔ **KE S3** *TO S3*
Ya, jamban/ toilet/ wc ini digunakan juga oleh keluarga lain *Yes. Shared*	2	➔ **KE S2A** *TO S2A*

S2A. **[JIKA MENJAWAB KODE 2 (YA) DI S2, MAKA TANYAKAN S2A]**
Jika fasilitas tersebut digunakan juga oleh keluarga lain, berapa jumlah keluarga yang menggunakan fasilitas jamban/ toilet/ wc?
If shared, how many families use this toilet facility?
_____ keluarga

S3. (BS4) **[JANGAN BACAKAN PILIHAN JAWABAN. LINGKARI SEMUA JAWABAN RESPONDEN]**
Mengapa keluarga Anda menggunakan jamban/ toilet/ wc? MA
DO NOT READ. CIRCLE ALL RESPONSES
Why does your family use a toilet facility? MA

Untuk menjaga kesehatan/ mencegah penyakit *For good health/disease prevention*	1
Untuk hidup yang lebih bersih dan sehat di rumah *Cleaner and healthier living in our home*	2
Untuk kenyamanan *Convenience*	3
Untuk menjaga privasi/ keleluasaan ketika menggunakan jamban/ toilet/ wc *To have privacy when use the facilities*	4
Untuk menjadi modern *To be modern*	5
Supaya diterima oleh masyarakat lain (gengsi/ status) *To be accepted well by others (pride/status)*	6
Untuk menghindari penggunaan bersama orang lain *To avoid sharing with others*	7
Supaya tidak menggangu orang lain *To avoid disturbing others*	8
Untuk menghindari rasa malu/ cemooh/ ejekan *To avoid embarrassment/humiliation*	9
Hal tersebut dilakukan oleh semua orang *It's what everybody is doing*	10
Kami diberitahu bahwa itu adalah sesuatu yang benar untuk dilakukan *We were told it was the right thing to have*	11
Tidak tahu *Don't know*	12
Lainnya, sebutkan _____ *Other (specify)*	x

S4. (BS3) **[LINGKARI SEMUA JAWABAN RESPONDEN]**
Siapakah di antara anggota keluarga Anda yang biasanya TIDAK menggunakan jamban/ toilet/ wc? MA
Which members of your immediate family usually DO NOT use this toilet? MA

Saya sendiri *Myself*	1
Suami saya *My husband*	2
Istri saya *My wife*	3
Anak-anak usia 5 tahun dan ke bawah *Children five years and younger*	4
Anak-anak yang berusia lebih dari 5 tahun *Children over age 5*	5
Tidak ada. Semua orang di dalam keluarga menggunakannya *N/A Everyone in the family uses*	6
Tidak tahu *Don't know*	7

S5. (M-S3A) **[LINGKARI SEMUA JAWABAN RESPONDEN]**
Seberapa sering anggota keluarga utama anda menggunakan toilet ini untuk Buang Air Besar di rumah?
How often do members of your immdediate family use this toilet to defecate when at home?

	Tidak Pernah Never/ Rarely	Terkadang Sometimes/	Sering/Biasanya Usually/	Selalu Always	Tidak Tahu	Tidak Aplikabel

		Occationally	Mostly		Don't know	Not applicable
Saya sendiri *Myself*	1	2	3	4	5	6
Suami saya *My husband*	1	2	3	4	5	6
Istri saya *My wife*	1	2	3	4	5	6
Anak-anak usia 5 tahun dan ke bawah *Children five years and younger*	1	2	3	4	5	6
Anak-anak yang berusia lebih dari 5 tahun *Children over age 5*	1	2	3	4	5	6

S6. (M-S3B) **[LINGKARI SEMUA JAWABAN RESPONDEN]**

Saat di rumah, berapa kali dalam 7 hari terkahir anda dan keluarga inti anda buang air besar di tempat terbuka/ BABS (seperti di ladang, semak-semak, pinggir jalan, tepi sungai, pantai, belakang rumah, dsb)

When at home, for how many days during last week (7 days), did you defecate in the open (e.g., field, bush, roadside, side of canal, back of house, etc.)? CHECK TRANSLATION

	Tidak pernah No days	Beberapa hari Some days	Hampir Setiap Hari Most days	Setiap Hari Every day	Tidak Tahu Don't know	Tidak Berlaku Not applicable
Saya sendiri *Myself*	1	2	3	4	5	6
Suami saya *My husband*	1	2	3	4	5	6
Istri saya *My wife*	1	2	3	4	5	6
Elders (> 60 years)	1	2	3	4	5	6

ES1. CHECK TRANSLATION

What type of toilet does your household have?

INTERVIEWER:

CATAT JAWABAN RESPONDEN DI KOTAK INI. SETELAH ITU, BERI KODE YANG SESUAI DI TABEL JAWABAN DI BAWAH. *RECORD RESPONDENTS ANSWER IN THE BELOW BOX AND THEN CIRCLE THE APPROPRIATE CODE IN THE TABLE BELOW.*

1. Jamban/ toilet/ wc yang disiram dengan air *Flush or Pour Flush Toilet*	
Jamban/ toilet/ wc siram dengan system pembuangan lewat pipa *Flushed to piped sewer system*	1.1
Jamban/ toilet/ wc siram, dengan pembuangan ke septitank *Flushed to septic tank*	1.2
Cubluk/Jamban/ toilet/ wc siram Sederhana tanpa tangki *Flushed to pit latrine*	1.3
Jamban/ toilet/ wc siram, tapi tidak tahu kemana pembuangannya *Flush, don't know where*	1.4
2. Jamban/ toilet/ wc sederhana/ cubluk *Pit Latrine*	
Jamban/ toilet/ wc sederhana/cubluk dengan lubang berventilasi *VIP latrine*	2.1
Jamban/ toilet/ wc sederhana/cubluk dengan penutup atas (campuran semen, kayu/bambu) *Pit latrine with slab (concrete, wood/bamboo)*	2.2
Jamban/ toilet/ wc sederhana/cubluk tanpa penutup atas *Pit latrine without slab/open pit*	2.3
Jamban/ toilet/ wc dengan system kompos *Composting toilet*	3
Menolak/ tidak dapat diobservasi *Refused/Not able to observe*	4
Lainnya, sebutkan _____*Other (specify)*	x

ES2. When did your households construct latrine FIRST time? (Record estimated time period in years or months or both) CHECK TRANSLATION

_____ tahun *years* _____ bulan *months*	Tidak tahu *Doesn't know* (99)

ES3. (MS6) Apakah anda pernah memperbaiki/memperbahrui jamban ini sebelumnya? Jika iya, kapan hal tersebut dilakukan?
Have you improved/upgraded this latrine in last THREE years? If yes, when did it happen?

Ya *Yes*	1	_____ tahun *years* _____ bulan *months* Tidak tahu *Don't know when improved* (99)
Tidak *No*	2	-
Tidak tahu *Don't know*	3	-

ES4. (MS7) Apakah anda puas dengan toilet ini sebagai fasilitas anda Buang Air Besar?
Are you satisfied with this toilet facility as a place to defecate?

Sangat Puas Very satisfied	1	Go to Q# ES4
Puas Satisfied	2	Go to Q# ES4
Tidak Puas Dissatisfied	3	
Sangat Tidak Puas Very dissatistied	4	

Jika anda tidak puas, apa alasan anda?
ES4.1. (MS7a) *If you are dissatisfied or very dissatisfied, why is your major resoan? (choose one)*

Konstruksi buruk *Construction is poor*	1
Lokasi toilet tidak nyaman *Toilet location is inconvenient to use*	2
Tidak ada air yang tersedia *Water is not available close to the toilet*	3
Jumlah pengguna toilet terlalu banyak *Too many household members for one toilet (i.e. not available when you try to use it)*	4
Jamban kotor/ bau *Toilet is dirty / dark*	5
Lian-lain, sebutkan ……..	6
Tidak tahu *Don't know*	6

ES4.2. (MS8) Bagaimana kualitas pembuatan jamban ini menurut anda?
What do you think about quality of this latrine construction?

Sangat baik Excellent	1
Baik Good	2
Cukup Fair	3
Buruk Poor	4
Sangat Buruk Very poor	5

ES5. (BS15) Apakah Anda tahu tentang pilihan pembiayaan (pinjaman, arisan, rencana angsuran/ pembayaran) yang tersedia di lingkungan Anda, yang dapat membantu keluarga Anda untuk membangun jamban/ toilet/ wc? Check translation SA
Are you aware of any available options to receive any assistance (loan, financing, gifts/grants, Construction Material/inkind support etc.) to help you build the latrine? SA

Ya *Yes*	1	
Tidak *No*	2	~~KE~~ **S3** *TO S6A*
Tidak tahu *Don't know*	3	

ES6 (BS6/MS9) Apakah Anda menerima bantuan (mis. pinjaman, hadiah / hibah dan lainnya) untuk membantu Anda membangun jamban/ toilet/ wc Anda itu? SA
Did you receive any assistance (loan, financing, gifts/grants, Construction Material/inkind support etc.) to help you build the latrine? SA **IF 'No', Go to ES7**

Ya *Yes*	1	
Tidak *No*	2	➡ **KE S3** *TO S6A*
Tidak tahu *Don't know*	3	

ES6.1. *If yes in Q#ES6, what type of Assiatance you received? MA*

Loan	1	**Please specify the kind/type of** Loan? (for example cash) Specify AMOUNT: _____
Grant/Gift/subsidy	2	**Please specify the kind/type of** Grant/Gift/subsidy? (for example cash, cost-sharing, free labour cost of the mason) Specify: _____
Construction Material/inkind support	3	**Please specify the kind/type of** support? (for example sanitary maerial, free labour cost of the mason) Specify: _____
Tidak tahu *Don't know*	4	

ES7 (BS13) How much did you spend (in total) on constructing your toilet? (ask the total amount spent with subsidies, if any)
Rp._____

ES7.1 Out of this, how much of this was subsidies (in cash or kind)? Rp._____

S7. (BS7/MS11) **[JANGAN BACAKAN PILIHAN JAWABAN. LINGKARI SEMUA JAWABAN RESPONDEN]**
DO NOT READ. CIRCLE ALL RESPONSES
Siapakah di antara anggota keluarga Anda yang dulu memutuskan untuk membangun jamban/ toilet/ wc di rumah tangga Anda? MA
Who in your family made the decision to have a latrine built for your household? MA

Ayah/ Lelaki kepala rumah tangga *Father/Male head of family*	1	
Ibu/ Perempuan kepala rumah tangga *Mother/Female head of family*	2	
Tidak ada. Sudah ada toilet/ kamar kecil/ jamban/ toilet/ wc ketika kami membeli/ menyewa rumah ini *N/A latrine was in the house when we bought/rented it*	3	➔ **LANGSUNG KE S16** *SKIP TO S16*
Lainnya, sebutkan _____*Other (specify)*	x	

S8. (MS12) **[JANGAN BACAKAN PILIHAN JAWABAN. LINGKARI SEMUA JAWABAN RESPONDEN] Check Translation**
Siapakah orang di dalam masyarakat/ komunitas Anda atau apapun, yang memberikan pengaruh terhadap keputusan Anda untuk membangun jamban/ toilet/ wc di rumah tangga Anda? MA
DO NOT READ. CIRCLE ALL RESPONSES
Did anyone in your community/anything have an influence on your deciding to build/construct a latrine for your household? MA

Tokoh/ Pemuka masyarakat *Community leader*	1
Pemuka Agama *Religious leaders*	2
Pejabat daerah setempat terpilih (mis.ketua RT/ RW, Lurah) *Elected official*	3
Pemerintah yang berwenang di Kabupaten atau Kecamatan *District/ subdistrictt government authorities*	4
Tenaga kesehatan masyarakat *Community health worker/sanitarian*	5

Tetangga/ teman *Neighbors/Friends*	6
Tidak satu orang pun *No one specifically*	
Lainnya, sebutkan _____*Other (specify)*	x

S9 – S12 DITANYAKAN JIKA RESPONDEN TIDAK MEMPUNYAI FASILITAS SANITASI

If Household Has No Facility Ask These Questions S9 – S12

JANGAN BACAKAN PILIHAN JAWABAN *DO NOT READ OUT*

S9. Tadi Anda mengatakan bahwa Anda tidak memiliki jamban/ toilet/ wc di rumah Anda. Dimana tempat Anda dan keluarga Anda biasa buang air besar? MA

*You said you had no toilet facility in your house, Where do you and members of your family defecate **most of the time**? MA*

Di semak belukar/ lapangan *Bush/Field*	1
Di kandang babi *Pig Pen*	2
Di kolam ikan *Fish Pond*	3
Di sungai *River*	4
Di pantai *Beach*	5
Di belakang rumah *Behind our house*	6
Jamban Tetangga Neighboorhood toilet	7
Jamban Umum Communal latrine	8
Tidak tahu/ Menolak untuk menjawab *Don't know/Refused*	9
Lainnya, sebutkan _____*Other (specify)*	x

[LINGKARI SEMAQUA JAWABAN RESPONDEN] This is only neighborhood toilet or communal toilet user.

S9a. Anda mengatakan bahwa biasanya menggunakan jamban tetangga dan MCK umum. Seberapa sering anggota keluarga utama anda menggunakan toilet ini untuk Buang Air Besar di rumah pada saat anda di rumah?

You said you usually use neighborhood toilet or communal toilet. How often do members of your immdediate family use neighborhood toilet or communal toilet, to defecate when at home?

	Tidak Pernah Never/ Rarely	Terkadang Sometimes/ Occationally	Sering/Biasanya Usually/ Mostly	Selalu Always	Tidak Tahu Don't know	Tidak Aplikabel Not applicable
Saya sendiri *Myself*	1	2	3	4	5	6
Suami saya *My husband*	1	2	3	4	5	6
Istri saya *My wife*	1	2	3	4	5	6
Elders (> 60 years)	1	2	3	4	5	6
Anak-anak usia 5 tahun dan ke bawah *Children five years and younger*	1	2	3	4	5	6
Anak-anak yang berusia lebih dari 5 tahun *Children over age 5*	1	2	3	4	5	6

JANGAN BACAKAN PILIHAN JAWABAN *DO NOT READ OUT*

S10. Apa yang membuat keluarga Anda tidak mempunyai jamban/ toilet/ wc di rumah Anda? MA.

What keeps your family from having a toilet facility at your home? MA

Tidak ada uang untuk membangun/ membuatnya *No money to construct*	1

Tidak ada material/ peralatan untuk membangun/ membuatnya *No materials to construct*	2
Tidak tersedia air yang cukup *Not enough water available*	3
Tidak tahu bagaimana cara membuatnya *Don't know how to construct*	4
Tidak menyukai toilet/ kamar kecil/ jamban/ toilet/ wc yang pernah saya lihat *Don't like the latrines I've seen constructed*	5
Tidak tertarik/ Lebih memilih untuk untuk melakukan hal yang saat ini sudah dilakukan *Not interested/Prefer to use what we currently do*	6
Tidak ada tanah/ ruang yang cukup/ Tidak dapat membangunnya di tanah kami (karena merupakan tanah sewaan, tanah berbatu / dataran banjir, tanah tidak cukup, dan lainnya) *No land/space available to construct/Unable to construct on our land (renter, rocky soil/flood plain, not enough land, etc.)*	7
Kotorannya dapat digunakan untuk pakan ikan/ hewan lainnya *Waste feeds fish/other animals*	8
Tidak tahu/ Menolak untuk menjawab *Don't know/Refused*	9
Lainnya, sebutkan _____*Other (specify)*	x

S11. Jika Anda akan membangun, jenis jamban/ toilet/ wc seperti apa yang ingin Anda bangun? Bisakah Anda menggambarkannya kepada saya?
If you decide to build a latrine now, what kind of latrine would you build? Can you describe it for me?

INTERVIEWER:
CATAT JAWABAN RESPONDEN DI KOTAK INI. SETELAH ITU, BERI KODE YANG SESUAI DI TABEL JAWABAN DI BAWAH. *RECORD RESPONDENTS ANSWER IN THE BELOW BOX AND THEN CIRCLE THE APPROPRIATE CODE IN THE TABLE BELOW.*

Toilet/ jamban/ toilet/ wc yang terbuat dari keramik / ada klosetnya *Flush or Pour Flush Toilet*	1	
Toilet/ jamban/ toilet/ wc cemplung, tidak terbuat dari keramik, hanya papan *Pit Latrine*	2	
Toilet/ jamban/ toilet/ wc kering yang sekaligus berfungsi untuk mengumpulkan kotoran dan memprosesnya menjadi pupuk/ kompos *Composting toilet*	3	
Tidak tahu *Don't know*	4	
Tidak tertarik untuk membangun toilet/ kamar kecil/ jamban/ toilet/ wc *Not interested in building a latrine*	5	➔ **LANGSUNG KE S13** *SKIP TO S13*
Lainnya, sebutkan _____*Other (specify)*	X	

S12. Menurut pengetahuan Anda, berapa kira-kira biaya yang dibutuhkan untuk membangun jenis jamban/ toilet/ wc seperti itu? **[CATAT HARGA SATU HARGA, BUKAN KISARAN ANTARA DUA HARGA] Check translation.**
If you decide to construct a latrine, Do you know approximately how much it was ***cost you to construct your preffered*** *type of latrine?* ***(ASK FOR BEST GUESS BY GIVING ONE PRICE, NOT A RANGE)***

Amount: _____

KARTU BANTU *SHOW CARD*

S13. (BS18) Saya mempunyai daftar hal-hal yang akan dilakukan orang ketika mereka mempunyai uang lebih. Jika Anda mempunyai uang lebih, apa yang pertama kali ingin Anda lakukan? Apa yang kedua ingin Anda lakukan? Lalu apa yang berikutnya? *I have a list of activities that someone might buy/do whenever they have extra money. Should you have extra money, what would you do first on this list? And what next? Then next?*
[LINGKARI SATU PILIHAN PERTAMA DI KOLOM 'YANG AKAN DILAKUKAN PERTAMA'. SELANJUTNYA TULISKAN PILIHAN DI KOLOM 'YANG AKAN DILAKUKAN KEDUA' DAN 'YANG AKAN DILAKUKAN KETIGA']

	YANG AKAN DILAKUKAN PERTAMA	YANG AKAN DILAKUKAN KEDUA	YANG AKAN DILAKUKAN KETIGA
Membayar pinjaman/ hutang *Pay Debt*	1	1	1
Membeli keperluan anak *Buy the necessity for my children*	2	2	2
Membeli sembako/ makanan/ peralatan rumah tangga untuk keluarga saya *Buy food/ household appliances for my family*	3	3	3
Membeli TV berwarna *Buy a color TV*	4	4	4
Membeli pemutar VCD/ DVD *Buy a VCD/DVD player*	5	5	5
Membeli sepeda motor *Buy a motorcycle*	6	6	6

Membeli sebuah komputer *Buy a computer*	7	7	7
Membeli sebuah telefon genggam/ ponsel/ HP *Buy a Mobile Phone*	8	8	8
Membayar pemasangan telefon rumah *Buy a Fixed-line telephone*	9	9	9
Memperbaiki rumah *Renovate the house*	10	10	10
Membangun/ memperbaiki toilet/ jamban/ toilet/ wc *Build/Renovate the Toilet*	11	11	11
Dimasukkan ke dalam tabungan/ Ditabung *Put into savings account*	12	12	12
Lainnya, sebutkan _____*Other (specify)*	X	X	X

S14. (BS15.) Apakah Anda tahu tentang pilihan pembiayaan (pinjaman, arisan, rencana angsuran/ pembayaran) yang tersedia di lingkungan Anda, yang dapat membantu keluarga Anda untuk membangun jamban/ toilet/ wc? SA *Are you **aware** of any available options to receive any assistance (loan, financing, gifts/grants, Construction Material/inkind support etc.) to help you build the latrine? SA*

Ya *Yes*	1
Tidak *No*	2
Tidak tahu *Don't know*	3

SANITASI *SANITATION*

TANYAKAN KEPADA SEMUA RESPONDEN *ASK OF ALL RESPONDENTS*

JANGAN BACAKAN PILIHAN JAWABAN *DO NOT READ OUT*

S15. (MS20) Apa yang Anda lakukan dengan kotoran bayi dan anak balita (0 – 5 tahun)? MA (Jika di dalam rumah tangga tersebut tidak memiliki bayi/ anak balita, pilih kode 7 dan lanjutkan ke S17)
What do you do with the stools of babies and young children (ages 0-5)? MA (If HH does not have young children cod N/A and Go to S14)

Dibuang di toilet/ jamban/ toilet/ wc *Thrown in toilet facility/latrine*	1
Dibuang ke dalam semak-semak / ladang/ kandang hewan, sungai/ pantai/ saluran/ got *Thrown in the bushes/field/animal pen river/beach/drain*	2
Tidak dibuang/ ditinggalkan di permukaan tanah *Not disposed of/left on the ground*	3
Dikubur di halaman/ ladang *Buried in yard/field*	4
Dibuang di tempat sampah *Thrown in garbage/rubbish bin*	5
Tidak tahu *Don't know*	6
Di dalam rumah tangga ini tidak ada bayi/ anak balita dengan rentang umur tersebut *N/A household does not have young children this age*	7
Lainnya, sebutkan _____*Other (specify)*	x

SALURAN KOMUNIKASI *(Community Participation and) Communication Channels*

CC1. (MS21A) Apakah ada di keluarga Anda yang mengikuti pertemuan untuk membahas tentang sanitasi di lingkungan Anda atau apakah pernah ada petugas sanitasi pemerintah yang mendatangi rumah Anda? SA
Has anyone in your family participated in a meeting about sanitation and or has any government staff (eg sanitarian) visited your home to tallk about building a latrine? SA
IF 'No', Go to Q#CC3

Ya *Yes*	1
Tidak *No*	2
Tidak tahu *Don't know*	3

CC1a. Include translation
Did you receive sufficient information (awarensess messages, supplies, mason etc.) to help constructing a latrine at your home?

Ya *Yes*	1
Tidak *No*	2
What did you miss? Please specify.	3

CC2b. Can you recall THREE key message which you have learned/practice due to your participation in that meeting/activity?

Ya *Yes*	1
Tidak *No*	2
Don't know	3
If 'YES', please specify any Three key messages; (Probe for stop open defecation, Construction/maintenance of latrine, continued use of latrine, any other	

JANGAN BACAKAN PILIHAN JAWABAN *DO NOT READ OUT*

CC3. (BCC1) Apa saja sumber informasi yang membantu Anda untuk mendapatkan informasi tentang kebersihan dan jamban/ toilet/ wc? *What are the sources of information through which you get information about hygiene and toilet?*

LINGKARI KODE UNTUK JAWABAN PERTAMA DI KOLOM PERTAMA, JAWABAN KE KEDUA DI KOLOM KE DUA, DAN JAWABAN KE 3 DI KOLOM KE TIGA. SATU JAWABAN PER KOLOM.

CIRCLE FIRST, SECOND AND THIRD RESPONSES IN EACH COLUMN. ONLY ONE ANSWER PER COLUMN

	JAWABAN PERTAMA The First Answer (SA)	JAWABAN KEDUA Second Answer (SA)	JAWABAN KETIGA Third Answer (SA)
Televisi *Television*	1	1	1
Koran/ tabloid, majalah *Newspaper/Tabloid, Magazine*	2	2	2
Iklan di media cetak (mis. Majalah, tabloid, Koran, dll) *Print Materials*	3	3	3
Tetangga/ teman *Neighbors/Friends*	4	4	4
Dari anak sekolah yang ada dalam keluarga *From School Children in the family*	5	5	5
Anggota keluarga/ saudara *Family members/relatives*	6	6	6
Pemerintah daerah (Kepala Desa, RT/ RW) *Local authority (head of village, RT/RW)*	7	7	7
Pemuka Agama *Religious leaders*	8	8	8
Petugas Kesehatan Pemerintah (sanitarian, bidan, dan lainnya) *Government health workers (sanitarians, midwives, caders, etc.)*	9	9	9
Tidak tahu *Don't know*	10	10	10
Lainnya, sebutkan _____*Other (specify)*	X	X	X

JANGAN BACAKAN PILIHAN JAWABAN *DO NOT READ OUT*

CC4. (BCC2) Sumber informasi manakah yang menurut Anda paling dipercaya orang dalam memberikan informasi tentang kebersihan dan jamban/ toilet/ wc?

Which sources of information you trust/prefer the most than others?

LINGKARI KODE UNTUK JAWABAN PERTAMA DI KOLOM PERTAMA, JAWABAN KE KEDUA DI KOLOM KE DUA, DAN JAWABAN KE 3 DI KOLOM KE TIGA. SATU JAWABAN PER KOLOM.

CIRCLE FIRST, SECOND AND THIRD RESPONSES IN EACH COLUMN. ONLY ONE ANSWER PER COLUMN

	JAWABAN PERTAMA (SA)	JAWABAN KEDUA (SA)	JAWABAN KETIGA (SA)
Televisi *Television*	1	1	1
Koran/ tabloid, majalah *Newspaper/Tabloid, Magazine*	2	2	2
Iklan cetak *Print Materials*	3	3	3
Tetangga/ teman *Neighbors/Friends*	4	4	4
Dari sekolah anak *From School Children in the family*	5	5	5
Anggota keluarga/ saudara *Family members/relatives*	6	6	6
Pemerintah daerah (Kepala Desa, RT/ RW) *Local authority (head of village, RT/RW)*	7	7	7
Pemuka Agama *Religious leaders*	8	8	8
Petugas Kesehatan Pemerintah (sanitarian, bidan, dan lainnya) *Government health workers (sanitarians, midwives, caders, etc.)*	9	9	9

Tidak tahu *Don't know*	10	10	10
Lainnya, sebutkan _____*Other (specify)*	X	X	X

Questions about CATS/CLTS processes - questions from Mike

CP1. Is there any Sanitation committee/association (Forum or group of active volunteers or other organised group of community members) involved in continuous promotion of sanitation[60] (in particular latrine availability and continued use)?
(note on indicator: Participation of a high/low Percentage of community members from all categories including men, women, children, people with disabilities, people from poorest households, people from minority groups, decision makers, opinion leaders, elderly, etc)
IF 'No', Go to Q# CP2.

CP1a. Which of the following group are mostly active or take part in meetings and action planning?

1	**Men**	**2**	**Women**	**3**	**Girls**
4	**Boys**	**5**	**People from Poor households**	**6**	**Elderly people**
7	**Village leader**	**8**	**People with disabilities**	**9**	**People from Minority groups**
10	**Religious people**	**11**	**Professional/Workers (sanitarian, teacher)**	**99**	**Don't Know**

CP2. Do you know, if your/this community has an (sanitation/ODF) action plan to achieve ODF (post-triggering aplanning and actions)? IF 'No', Go to Q#CP3.

Ya *Yes*	1
Tidak *No*	2
Don't know	3

CP2a. Who did develop this community action plan? (Multiple Options)

Community members were involved	1
Government Department (health facility staff etc.) staff	2
UNICEF or its partners staff/team	3
Other NGO/CBO was involved Specify the name	4 Name:
Don't know	

CP3. Have you ever seen any map or sign in your community to stop open defection?

Ya *Yes*	1
Tidak *No*	2
Don't know	3

CP4. Apakah Desa ini sudah diverifikasi sebagai desa ODF? Jika ya, kapan?
Are you aware that Is this community verified as ODF verified? If yes, do you know when? **IF 'No', Go to Q#CP5**

Ya *Yes*	1	_____ tahun *years* _____ bulan *months*
Tidak *No*	2	
Tidak tahu *Don't know*	3	

CP4a. Do you know, HOW this community was verified as 'ODF Community' (what process adopted for ODF verification)?[61]

Participation of a large number of households members in the process	1
A checklist was used for verification with clear verification criteria	2
A large number of households were visited for the verification process	

[60] SUSTAINABILITY CHECKS - guidance to design and implement sustainability monitoring in WASH: UNICEF HQ Programme Division/ WASH, New York; UNDP-SIWI Water Governance Facility, Stockholm.
[61] ibid

A large OD areas around the village were visited for the verification process	3
Involvement of actors other than community members (media, government officials, neighbouring communities etc.) in verification process **SPECIFY THE NAME/S OF THE ACTORS:**	4

CP4b Do you know if your community as a whole did receive any reward or incentive for achieving ODF status? (*Positive reinforcement of rules, instructions, commitments*)

Ya *Yes*	1
Tidak *No*	2
Don't know	3
IF 'YES' Please specify the type of rewrad/incentive awarded to your community?	1. Public recognition 2. Financial rewards 3. In-kind or material support 4. Any other Incentive or reward Specify: _____

CP4c. Do you know, <u>after ODF verification</u>, did anyone come to your household or a community meeting for encouraging you to build/keep using/improve a toilet?

Ya *Yes from a sanitatrian*	1
Yes from a religious leader	2
Yes from a PKK member	3
Yes from a village officer	4
Yes from others Specify_____	5
Tidak *No*	6
Tidak tahu *Don't know*	7

CP4d. Do you know if community members are involved in maintaining/sustaining the ODF status (post-ODF monitoring)?

Ya *Yes*	1
Tidak *No*	2
Don't know	3

CP5. *Where can sanitary materials and supplies for constructing toilet be purchasedt?* **Check translation.**

Within or nearby your community/dusun	1
At village/desa level	2
At sub-district level	3
At district level	4
Tidak tahu *Don't know*	5

CP6. (MS10) Apakah menurut anda rumah tangga misikin di wilayah setempat telah menerima dukungan yang cukup (keuangan, Bantuan dana, Bantuan material.. dsb) dari masyarakat setempat lainnya untuk membangun rumah WC/Jamban?
Do you think poor households in this community have received sufficient support (financing, grants, materials for construction) from the community/ implementing partner (NGO) to build a latrine?

Ya *Yes*	1
Tidak *No*	2
Tidak tahu *Don't know*	3

PENGETAHUAN / PRAKTEK TENTANG DIARE/ KESEHATAN ANAK *Diarrhea Knowledge/Practice/Child Health*

JANGAN BACAKAN PILIHAN JAWABAN *DO NOT READ OUT*

D1. (BD2) Anda mungkin mempunyai/ tidak mempunyai anak-anak berumur 0 – 5 tahun, Anda tetap dapat menjawab pertanyaan ini. Anda mungkin tahu cara-cara yang dapat dilakukan untuk melindungi/ menjaga anak-anak dari penyakit diare/ mencret. Mohon sebutkan semua cara melindung/ menjaga anak dari diare/ mencret yang Anda ketahui. **MA**

You may/maynot have children 0-5, that's fine. But you may know ways to protect young children against diarrhea. Please tell me all of the ways you know to protect young children (age 0-5) against diarrhea in? MA

Memasak air yang akan dikonsumsi *Boil or treat your water*	1
Menggunakan toilet/ jamban/ toilet/ wc/ Membuang kotoran dari anak-anak di toilet/ jamban/ toilet/ wc *Use latrines/dispose feces of children in latrines*	2
Mencuci tangan dengan sabun dan air *Wash hands with soap and water*	3
Memasak makanan sampai benar-benar matang *Cook food well*	4
Menyimpan makanan dengan baik/ menutup makanan (tidak dibiarkan terbuka) *Store food properly/ cover the food*	5
Membeli makanan di tempat yang bersih/ tidak membeli makanan di sembarang tempat *Buy food from a clean place/ not buying food from random place*	6
Mencuci buah dan sayur dengan air yang dapat diminum/ air bersih *Wash fruits and vegetables with potable/safe water*	7
Tidak ada yang bisa Anda lakukan, karena hal tersebut normal untuk terjadi dalam kehidupan *There is nothing you can do, it's a normal part of life*	8
Tidak tahu *Don't know*	9
Lainnya, sebutkan _____*Other (specify)*	X

TANYAKAN D3, HANYA JIKA KELUARGA RESPONDEN MEMILIKI BALITA (0 – 5 TAHUN) – LIHAT I4

ASK ONLY IF HH HAS YOUNG CHILDREN ≤ 5 – SEE I4

D2. (BD3) Dalam dua minggu terakhir ini, apakah anak/ anak-anak Anda yang berusia di bawah 5 tahun mengalami diare (definisi: mengalami 3 kali atau lebih buang air dalam keadaaan mencret dalam waktu 24 jam di hari yang sama atau ada darah di dalam kotoran)?

In the past two weeks has your child/children under the age of five had diarrhea (defined as three or more watery stools in a 24 period/same day or blood in the stool)?

Ya *Yes*	1
Tidak *No*	2
Tidak tahu *Don't know*	3

MENCUCI TANGAN *Hand washing*

BACAKAN: 'Sekarang saya akan bertanya tentang mencuci tangan'

READ OUT: 'Now I want to ask you some questions about hand washing'

JANGAN BACAKAN PILIHAN JAWABAN *DO NOT READ OUT*

HW1. Kapankah biasanya Anda mencuci tangan? MA

When do you usually wash your hands? MA

Sebelum memasak *Before cooking*	1	
Sebelum makan *Before eating*	2	
Setelah makan *After eating*	3	
Sebelum memberi makan/ menyuapi bayi/ anak *Before feeding a baby/child*	4	
Setelah membersihkan kotoran bayi/ anak *After cleaning the feces from a baby/child*	5	
Setelah buang air besar *After defecation*	6	
Setelah pulang bekerja/ Kembali ke rumah setelah bekerja *After work/returning home from work*	7	
Tidak tahu *Don't know*	8	➔ **KE HW4**
Tidak mencuci tangan *Does not wash hands*	9	**4.** *TO HW4*
Lainnya, sebutkan _____*Other (specify)*	x	

JANGAN BACAKAN PILIHAN JAWABAN *DO NOT READ OUT*

HW2. Bisakah Anda katakan, mengapa Anda mencuci tangan Anda/ Apa yang mendorong Anda mencuci tangan? MA

Can you share why you wash your hand (what motivates you to wash your hands)? MA

Untuk mencegah penyebaran penyakit *To prevent the spread of disease*	1
Supaya bersih *To be clean*	2
Supaya harum *To smell good*	3
Untuk menghilangkan kotoran/ bau/ sesuatu yang melekat di tangan saya *To get rid of dirt/smell/sticky things on my hands*	4
Alasan agama/ keyakinan *Religious reasons/beliefs*	5
Saya diajarkan bahwa itu hal yang benar/ baik untuk dilakukan *Was told it was the right thing to do*	6
Karena semua orang melakukan hal tersebut *Because that's what everyone does*	7
Tidak tahu *Don't know*	8
Lainnya, sebutkan _____*Other (specify)*	x

JANGAN BACAKAN PILIHAN JAWABAN *DO NOT READ OUT*

HW3. Apa yang biasa Anda gunakan untuk mencuci tangan? MA
What do you usually use to wash your hands? MA

Air *Water*	1	➔ **KE HW5**
Sabun *Soap*	2	➔ **KE HW3A DAN HW3B** *TO HW3A AND HW3B*
Sabun cuci/ Deterjen bubuk atau cair *Powdered or liquid detergent*	3	
Abu *Ash*	4	➔ **KE HW5**
Kotoran / pasir / lumpur *Dirt/sand/mud*	5	
Lainnya, sebutkan _____*Other (specify)*	x	

[JIKA RESPONDEN TIDAK MENGGUNAKAN SABUN ➔ LANJUTKAN KE HW5] *IF RESPONDENT DOES NOT USE SOAP/POWDERED OR LIQUID DETERGENT ➔ SKIP TO HW5*

HW3A. Tadi Anda mengatakan bahwa Anda menggunakan sabun/ deterjen bubuk atau cair untuk mencuci tangan Anda. Apakah Anda mempunyai sabun/ deterjen bubuk atau cair di rumah pada saat ini ? SA
You said you use soap/powdered or liquid detergent to wash your hands, do you have any in your home today? SA

JIKA RESPONDEN MENJAWAB YA, TANYAKAN 'BISAKAH ANDA TUNJUKKAN KEPADA SAYA?' DAN OBSERVASI *IF YES ASK 'CAN YOU PLEASE SHOW IT TO ME' AND OBSERVE*

JIKA SABUN/DETERJEN BUBUK ATAU CAIR UNTUK MENCUCI TANGAN TERSEDIA PADA SAAT INTERVIEW BERLANGSUNG MAKA LINGKARI KODE 1 (YA) *IF THE SOAP/POWDERED OR LIQUID DETERGENT TO WASH HANDS IS AVAILABLE AT THE TIME OF INTERVIEW THEN CIRCLE CODE 1 (YES)*

NAMUN, JIKA TERNYATA SABUN/DETERJEN BUBUK ATAU CAIR UNTUK MENCUCI TANGAN TIDAK TERSEDIA PADA SAAT INTERVIEW BERLANGSUNG, MAKA LINGKARI KODE 2 (TIDAK TERSEDIA) *BUT THEN, IF THE SOAP/POWDERED OR LIQUID DETERGENT TO WASH HANDS IS NOT AVAILABLE AT THE TIME OF INTERVIEW THEN CIRCLE CODE 2 (NOT AVAILABLE)*

Ya, ada *Yes, available*	1	
Tidak. tidak ada *No, not available*	2	**LANJUTKAN KE HW5**
Tidak dapat melihat/ mengamati *Unable to observe*	3	

JANGAN BACAKAN PILIHAN JAWABAN *DO NOT READ OUT*

HW3B. Apakah ada waktu-waktu tertentu dimana Anda menggunakan sabun lebih banyak/ lebih sering untuk mencuci tangan Anda dibandingkan dengan waktu lainnya? MA
When do you USE SOAP to wash your hands? MA

Ketika tangan saya terlihat kotor *When they are visibly dirty*	1
Ketika tangan saya berbau atau terasa lengket *When they smell or are sticky*	2
Sebelum memasak *Before cooking*	3
Sebelum makan *Before eating*	4
Sebelum memberi makan/ menyuapi bayi/ anak *Before feeding a baby/child*	5
Setelah buang air besar *After defecation*	6

Setelah membersihkan bayi sehabis buang air besar *After cleaning a baby that has defecated*	7
Saya menggunakan sabun setiap cuci tangan *Use every time I wash my hands*	8
Setelah bekerja *After work*	9
Tidak tahu *Don't know*	10
Lainnya, sebutkan _____*Other (specify)*	x

[JIKA RESPONDEN TIDAK MENCUCI TANGAN (KODE 8 / 9 DI HW1), MAKA TANYAKAN HW4]
IF RESPONDENT DOES NOT WASH HANDS (CODE 8 / 9 AT HW 1) ASK

JANGAN BACAKAN PILIHAN JAWABAN *DO NOT READ OUT*
HW4. Tadi Anda mengatakan bahwa Anda tidak mencuci tangan. Dapatkan Anda menyebutkan alasan Anda mengapa Anda tidak mencuci tangan? MA
You said that you do not wash your hands. Can you share the reasons why you don't wash your hands? MA

Tidak ada/ tidak ada cukup air untuk mencuci tangan *No/insufficient water to wash hands*	1
Tidak punya sabun untuk mencuci tangan *No soap available to wash hands*	2
Tidak punya abu untuk mencuci tangan *No ash available to wash hands*	3
Tidak mengerti apa kegunaannya/ tidak penting *Don't understand the purpose/not important*	4
Tidak ada waktu untuk cuci tangan *Don't have time to*	5
Tidak tahu kapan harus mencuci tangan *Don't know when to*	6
Tidak tahu *Don't know*	7
Lainnya, sebutkan _____*Other (specify)*	x

KARTU BANTU *SHOW CARD*
BACAKAN: Tolong perhatikan kartu ini. Ada gambar lima kotak, dimana yang paling kiri adalah 'SANGAT TIDAK SETUJU' kode 1 dan yang paling kanan adalah 'SANGAT SETUJU' kode 5.
TUNJUKKAN KARTU BANTU PERNYATAAN DAN SKALA.
Sekarang saya akan menunjukkan beberapa pertanyaan yang dibuat orang lain mengenai penggunaan jamban/ toilet/ wc dan mencuci tangan. Mohon beritahu seberapa setuju atau tidak setuju Anda terhadap pernyataan tersebut, dengan menggunakan kartu bantu skala ini. Jika Anda setuju dengan pernyataan tersebut, Anda bisa memilih kotak di sebelah kanan (Setuju) atau (Sangat Setuju), sesuai dengan tingkat persetujuan Anda dengan pernyataan tersebut. Jika Anda tidak setuju, Anda bisa memilih kotak di sebelah kiri, (Tidak Setuju) atau (Sangat Tidak Setuju). Jika Anda tidak yakin, Antara setuju dan tidak setuju, Anda dapat memilih kotak yang ditengah, kode 3.

Mari kita mulai dengan pernyataan pertama:
Seberapa jauh Anda setuju atau tidak setuju bahwa …….(BACAKAN PERNYATAAN)

Please take a look at this card. It has 5 boxes on it. The one on the left is Strongly Disagree and the one the right is Strongly Agree. ***SHOW CUE CARDS FOR EACH STATEMENT AND WHAT EACH BOX REPRESENTS FOR THE FIELDS BELOW.*** *I was now ask you some things that people have said about using toilets and washing hands. If you agree with the statement please point to one of the boxes on the right based on your personal level of agreement (Agree or Strongly Agree). If you disagree with the statement please point to one of the boxes on the left based on your personal level of disagreement (Disagree or Strongly Disagree). If you neither agree nor disagree with the statement please point to the box in the middle.*

Let's start from the first statement:
How far do you agree or disagree that ……(READ OUT STATEMENT)

[KARTU BANTU SKALA] *SCALE SHOW CARD*
[LINGKARI SATU JAWABAN SAJA PER PERNYATAAN] *CIRCLE ONLY ONE ANSWER FOR EACH ATTRIBUTE*

ROTASIKAN PERNYATAAN ***ROTATE STATEMENTS***		Sangat tidak Setuju *Strongly Disagree*	Tidak Setuju *Disagree*	Antara Setuju dan Tidak Setuju *Neither Agree nor Disagree*	Setuju *Agree*	Sangat Setuju *Strongly Agree*
R1	Kebanyakan orang di lingkungan ini tidak mempunyai jamban/ toilet/ wc *Most people in this community do not have a toilet*	1	2	3	4	5
R2A (MR2)	Rumah tangga termiskin dari komunitas ini tidak memiliki Jamban/toilet/WC Most poor households in this community do not have a toilet	1	2	3	4	5
R3	Banyak orang berpikir, terlalu mahal untuk mempunyai jamban/ toilet/ wc di rumah mereka *A lot of people think it is too expensive to have a toilet in their house*	1	2	3	4	5
R4	Buang air besar di tempat terbuka dapat diterima oleh masyarakat/ lingkungan di sini *In this community its acceptable to defecate in the open*	1	2	3	4	5
R5	Merupakan hal yang memalukan ketika seseorang dapat melihat orang lain sedang buang air besar di tempat terbuka *It's embarrassing when people can see others defecating in the open*	1	2	3	4	5
R6	Kebanyakan orang merasa malu karena tidak mempunyai jamban/ toilet/ wc di rumah mereka *Most people feel ashamed to not have a toilet in their house*	1	2	3	4	5
R6C (MR9)	Dalam komunitas setempat, Buang air besar dapat diterima saat air tidak tersedia untuk jamban/ toilet/ wc (seperti saat musim kemarau) In this community, open defecation is acceptable when water is not available for a toilet (e.g. dry season).	1	2	3	4	5
R7 (M-NA)	Banyak orang tidak mau membangun jamban/ toilet/ wc di rumah mereka karena bau yang tidak sedap *Many people don't want to build a toilet in their house because it smells*	1	2	3	4	5
R9 (MR11)	Kebanyakan orang di lingkungan ini tidak mempermasalahkan jika anak perempuan mereka menikah dengan seseorang yang tidak mempunyai toilet/ jamban/ toilet/ wc di rumahnya *Most people in this community would not mind if their daughters married a person who did not have a toilet in his house*	1	2	3	4	5
R13 (MR15)	Tidak ada hubungannya antara buang air besar di tempat terbuka dan terkena penyakit diare *There is no relationship between defecating in the open and people having diarrhea*	1	2	3	4	5
R14 (MR16)	Kebanyakan orang berpikir bahwa tidak penting untuk mencuci tangan dengan MENGGUNAKAN SABUN *Most people think it is unnecessary to wash their hands WITH SOAP*	1	2	3	4	5
R16 (MR18)	Cuci tangan hanya diperlukan jika tangan terlihat/ terasa kotor *You only need to wash your hands when they look/feel dirty*	1	2	3	4	5
	Your closest primary school (SD) has adequate enough water, sanitation and handwashing facilities for children.	1	2	3	4	5
	Your closest Pustu has adequate enough water, sanitation and handwashing facilities for patients.	1	2	3	4	5

Social Norm Assessment: Check Translation

Q#	Question	Response Options
SN1	Some people use a latrine and other people do not. How often do ALL members of your household use a latrine? *Note: The overall response to 'options-5' was indicate the slippage rate; 100% result for option-5 was indicate 0% slippage*	1. Never 2. Rarely 3. Sometimes 4. Often 5. Always
SN2	Think about the people in your village, such as your family, friends, and neighbours. Out of 10 people in your village, how many do you think said that the members of their household always use a latrine? (Asssessment of Empirical Expectations)	Number:_____
SN3	Do you believe that people in your village should use a latrine? Why do you think people in your village should use a latrine? Think about the people in your village, such as your family, friends, and neighbours. Out of 10 people in your village, how many do you think said that people should use a latrine because it is the right thing to do? (Asssessment of Normative Expectations)	1. Yes 2. No - **SKIP Next** 1. Because it is the right thing to do 2. Other reasons Number: _____
SN4	If someone in your village was observed defecating in the open, what would happen to her/him? Are people punished punished for defecating in the open, and if YES, how?	1. Financial penalty 2. Legal penalty 3. Community members scorn / punish 4. Other 5. Nothing happens - **SKIP Next** Specify:_____

OBSERVASI MENCUCI TANGAN – *OBSERVATION HAND WASHING*

HANYA UNTUK RESPONDEN YANG MENYATAKAN MEREKA MENCUCI TANGAN DI HW1 9MENJAWAB SELAIN KODE 7 / 8 DI HW1). *ONLY FOR RESPONENTS THAT REPORT TO WASH HANDS IN HW1 (CIRCLED OTHER THAN CODE 7 / 8 IN HW 1)*
JIKA MEREKA MENYATAKAN TIDAK MENCUCI TANGAN DI HW1 (KODE 7/ 8), MAKA LANJUTKAN KE OS1 *IF THEY REPORTED TO NOT WASH HANDS IN Q HW1 9CODE 7/ 8) SKIP TO OS1*

OHW1. Dapatkah Anda menunjukkan kepada saya dimana paling sering biasanya anggota keluarga Anda mencuci tangan? SA
Can you show me where members of your family most often wash their hands? SA

Dalam jarak 10 langkah dari jamban/ toilet/ wc (di dalam atau di luar) *Within 10 paces of the toilet facility (inside or outside)*	1
Dalam jarak 10 langkah dari dapur/ tempat memasak *Within 10 paces of the kitchen/cooking place*	2
Di tempat lain, di rumah atau pekarangan *Elsewhere in home or yard*	3
Di luar pekarangan *Outside of yard*	4
Tidak ada tempat khusus *No specific place*	5
Lainnya, sebutkan _____*Other (specify)*	X
Tidak diperbolehkan untuk melihat *No permission to see*	6

OHW2. **[OBSERVASI]** ***OBSERVE***
Apakah tersedia air di tempat yang disebutkan untuk mencuci tangan? SA
Is water present at the specified place for hand washing? SA

Tidak tersedia air *Water is not available*	1
Tersedia air *Water is available*	2

OHW3. **[OBSERVASI]** ***OBSERVE***
Apakah tersedia sabun/ deterjen di tempat yang disebutkan untuk mencuci tangan? SA
Is soap or detergent present at the specific place for hand washing? SA

Tidak ada satupun yang tersedia *None available*	1
Sabun batangan *Bar soap*	2
Deterjen (bubuk/ cair/ pasta) *Detergent (powder/liquid/paste)*	3
Sabun cair (termasuk sampo) *Liquid soap (including shampoo)*	4
Lainnya, sebutkan _____*Other (specify)*	X

OHW4. **[TANYA DAN OBSERVASI. LINGKARI SEMUA YANG DEMONSTRASIKAN]**
ASK AND OBSERVE. CIRCLE ALL DEMONSTRATED
Bisakah Anda tunjukkan kepada saya bagaimana biasanya Anda mencuci tangan? MA
Can you now show me how you usually wash your hands? MA

Menggunakan air *Water only*	1
Menggunakan sabun dan air *Soap and water*	2
Menggunakan deterjen bubuk atau cair dan air *Powdered or liquid detergent and water*	3
Menggunakan abu *Ash*	4
Menggunakan Kotoran / pasir / lumpur *Dirt/sand/mud*	5
Mengkibas-kibaskan tangan supaya kering *Shook hands to dry*	6
Menggunakan handuk yang terlihat bersih untuk mengeringkan tangan *Used visibly clean cloth to dry*	7
Menggunakan handuk yang terlihat kotor untuk mengeringkan tangan *Used visibly dirty cloth to dry*	8
Tidak dapat mendemostrasikan (keterbatasan perlengkapan untuk mendemonstrasikan) *Cannot demonstrate (lacks resources to demonstrate)*	9
Tidak mau/ menolak untuk mendemostrasikan *Unwilling/Refused to demonstrate*	10
Lainnya, sebutkan _____*Other (specify)*	x

OBSERVASI SANITASI – *OBSERVATION SANITATION*
HANYA UNTUK RESPONDEN YANG MEMPUNYAI TOILET/ KAMAR KECIL/ JAMBAN/ TOILET/ WC DI S1 (KODE 1) *ONLY FOR RESPONDENTS WITH A LATRINE in S1 (CODE 1)*
JIKA RESPONDEN TIDAK MEMPUNYAI TOILET/ KAMAR KECIL/ JAMBAN/ TOILET/ WC MAKA WAWANCARA TELAH SELESAI – UCAPKAN TERIMA KASIH UNTUK WAKTU MEREKA *IF NO LATRINE INTERVIEW IS COMPLETED – THANK THEM FOR THEIR TIME!*

OS1. **[OBSERVASI]** ***OBSERVE***
Dimana jamban/ toilet/ wc yang digunakan oleh keluarga Anda? Dapatkah Anda menunjukkannya kepada saya sekarang? SA
Where is the toilet facility used by members of your family located? Can you show me where it is now? SA

Di dalam rumah milik sendiri/ berada dekat dengan rumah milik sendiri *In own dwelling/attached to own dwelling*	1
Di halaman milik sendiri *In own courtyard*	2
Menolak/ tidak dapat diobservasi *Refused/Not able to observe*	3
Lainnya, sebutkan _____*Other (specify)*	X

OS2. **[OBSERVASI. INTERVIEWER: LIHAT KETERANGAN DI KARTU BANTU]**
[OBSERVATION. REFER TO THE INFORMATION IN THE SHOW CARD]
Jenis jamban/ toilet/ wc seperti apakah yang dimiliki keluarga tersebut?
What kind of toilet facility does the family have?

3. Jamban/ toilet/ wc yang disiram dengan air *Flush or Pour Flush Toilet*		**➔ KE OS2A**
Jamban/ toilet/ wc siram dengan system pembuangan lewat pipa *Flushed to piped sewer system*	1.1	
Jamban/ toilet/ wc siram, dengan pembuangan ke septitank *Flushed to septic tank*	1.2	
Cubluk/Jamban/ toilet/ wc siram Sederhana tanpa tangki *Flushed to pit latrine*	1.3	
Jamban/ toilet/ wc siram, tapi tidak tahu kemana pembuangannya *Flush, don't know where*	1.4	
4. Jamban/ toilet/ wc sederhana/ cubluk *Pit Latrine*		
Jamban/ toilet/ wc sederhana/cubluk dengan lubang berventilasi *VIP latrine*	2.1	
Jamban/ toilet/ wc sederhana/cubluk dengan penutup atas (campuran semen, kayu/bambu) *Pit latrine with slab (concrete, wood/bamboo)*	2.2	
Jamban/ toilet/ wc sederhana/cubluk tanpa penutup atas *Pit latrine without slab/open pit*	2.3	
Jamban/ toilet/ wc dengan system kompos *Composting toilet*	3	
Menolak/ tidak dapat diobservasi *Refused/Not able to observe*	4	
Lainnya, sebutkan _____*Other (specify)*	x	

JIKA TERLINGKAR KODE 1 (TOILET YANG DISIRAM) DI OS2 →TANYAKAN OS2A
IF CIRCLED CODE 1 (FLUSHED TOILET) IN OS2 → ASK OS2A

OS2A. Apakah sumber air yang biasa Anda gunakan dapat memenuhi kebutuhan jamban/ toilet/ wc Anda untuk membilas?
Does the water you have access to adequate to meet your toilet flushing needs?

Ya *Yes*	1
Tidak *No*	2
Tidak tahu *Don't know*	3

OS3. **[OBSERVASI – JIKA SATU ATAU LEBIH DARI TANDA-TANDA DI BAWAH INI TERPILIH, MAKA JAWAB 'YA']**
OBSERVE – IF ONE OR MORE SIGNS BELOW ARE SELECTED, THEN THE ANSWER was 'YES'
- Jalan menuju jamban/ toilet/ wc terlihat seperti habis digunakan *Path to latrine is walked on*
- Terlihat alat pembersih (mis. Sabun, air) yang digunakan untuk membersihkan bagian anal *Visibly used anal cleansing material*
- Tersedia air untuk membilas *If Pour Flush water is available*
- Terlihat kotoran di dalam lubang, dilihat dengan menggunakan senter *Detected feces in pit using flashlight*
- Dudukan jamban/ toilet/ wc terlihat basah *Slab is wet*
- Berbau *Smelly*

Ya *Yes*	1
Tidak *No*	2
Tidak ada toilet/ jamban/ toilet/ wc *N/A No latrine*	3
Menolak/ tidak dapat diobservasi *Refused/Unable to observe*	4

Appendix 4.1: Key Informant Interview – UNICEF and BMGF

KEY INFORMANT INTERVIEW (UNICEF, COUNTRY OFFICE (NATIONAL, REGIONAL/PROVINCIAL, BILL MALINDA GATES FOUNDATION)

Informed Consent

Hi, my name is _____ and I am working with AAN Associates, Pakistan. On behalf of UNICEF, Country Office Indonesia, we are conducting an Evaluation. As part of data collection, we need to ask you various questions on Water, Sanitation, Hygiene and Health situation conditions from you. Taking into account the key role of your office/department/section, we intend to do an interview from you for this evaluation.

We would very much appreciate your uninterrupted availability for this Interview. The information that you will share will be used to synthesize evaluation findings and recommendations. The evaluation findings and recommendations will help GoI, UNICEF and the Ministry of Health to better plan and implement the national sanitation programme. This will also enable UNICEF to revisit your current strategies and future plans to support GoI for strengthening and up-scaling sanitation through CLTS approach. The Interview should take A couple of hours to complete. The information you provide will be kept confidential and will not be shared with anyone other than the evaluation team members. Your responses will also be kept anonymous and not tied back to you in anyway.

Your participation for this interview is voluntary. If we ask you any questions you don't want to answer let me know and I will go on to the next question. You can also stop the interview at any time. We hope that you will allow us to interview you for this evaluation, as your inputs are important to us.

Do you have any questions about the evaluation or the Interview at this time?
May I begin the interview now?

Note: The interviewer to adapt questions based on the role of the specific Office/Section/department in WASH Sector, level of understanding and the participation (in the BMGF Funded UNICEF support to national sanitation Programme (STBM) in Indonesia)) of the Interviewee's position and role.

Date:

Respondent Name (Mr. /Mrs.):

Organisation:

Designation/Position:

Province:

District:

Interviewer Name (Mr. /Mrs.):

Moderator Name:

Note Taker:

Questions for Interview

A. Programme and Sector Context

1. STBM: Please elaborate on the sector context in which the national STBM programme was initiated in Indonesia? Why is UNICEF supporting STBM?
2. Sector Context: Is sanitation a national priority for Indonesia? Please explain. What are the critical sector problems, current status and future directions at national and subnational level especially in relation to decentralization of governance structures?
3. CLTS/CATS: Is CLTS/CATS formally adopted as implementation strategy for rural sanitation in Indonesia? If yes, which (official) guidance documents exist? What was UNICEF's role in adoption of CLTS/CATS as national strategy by GoI?
4. Policy Alignment: (How much) is UNICEFs CLTS/CATS approached fully aligned with other sector partner and GoI adopted implementation strategies? What are the key areas where implementation approach differs (for ODF criteria and subsidies in particular) among sector partner, GoI and of UNICEF?
5. SWAP: Is there a Joint Sector Coordination Mechanism in place? Please explain.
6. UNICEF Project Structure: What is the overall structure /design of UNICEF's support to Government. at all levels? How it is aligned with national priorities? Kindly elaborate separately for:
   a. National level
   b. Provincial level
   c. District/sub-district level
7. UNICEF Modes of Delivery: Please explain, how UNICEF is supporting STBM including its Mode of Delivery. Please explain. [Probe: Financial support to Government (DCT), Capacity Development, PCA to INGO/NGOs]
8. UNICEF Thematic Conversion: Please explain how UNICEF's WASH Section coordinates with other UNICEF Sections.
9. UNICEF Geographic Conversion: Please explain the processes adopted for the selection of province, districts, sub-districts and communities for inclusion into UNICEF direct support to STBM?

B. Equity, Inclusion and Gender Impacts

1. Equity Focus and Inclusion: How did the project ensure that the benefits of the project reached to all segments of the communities taking into account specific needs of the different beneficiary groups, particularly for children, girls, boys, women, elderly and disabled? Who benefitted the most? How and why? Which groups remained inaccessible and why? Was there any vulnerability assessment / Equity Analysis conducted at national level or provincial level before initiating this project?

C. Community level

1. Empowerment of women and children: What role did women and children play in the implementation of the project?
2. Impact on women and children: What was the main impact of the project on women and children? Please explain.
   [Probe for improved physical safety through reduced exposure to physical and sexual violence when openly defecating, and avoiding snakes and other animals]

D. Enabling Environment

1. *CLTS Programmatic Approach: What are the key components of UNICEF's support to Government. for improving the enabling environment in relation to*
   a. Strengthening the implementation of CATS/CLTS
   b. Scale-up of CATS/CLTS in Indonesia?
2. *Re-orientation of local and national policies and strategies; institutional arrangements and partnerships: What are the key achievements so far with regard to any change in sector policy,*

regulations, and any increase in public finances, particularly for targeted provinces and districts? Please share specific examples.

3. *National level Programmatic Capacity Development: What are UNICEF's contributions to enhancing GoI capacity for achieving the stated STBM objectives (Pillar 1 ODF) under UNCEF-BMGF support, at all levels (National, Provincial, district/sub-district)?*
    a. Was any capacity need assessment undertaken at various levels?
    b. What are the key dimensions (e. g. HR, technical, planning, budgeting, monitoring, etc.) of UNICEF supported capacity development initiatives? How did it help the Government in delivering improved sanitation services (Access, Quality of Service)?
4. *Community Involvement/Local Leadership: What are/were the contributions of the community based volunteers, sanitation champions, natural leaders (teachers, health workers, religious leaders etc.) and others in achieving and sustaining the ODF practices?*
5. *Quality assurance: What measures were taken to ensure the quality of the processes implemented? Please elaborate for the following*
    a. Pre-triggering, planning
    b. Triggering (socialization, counselling)
    c. Post-triggering activities (community action plans, monitoring, sanctions, etc.)
6. *Knowledge Management: What key initiatives were undertaken by UNICEF for knowledge management? What are the key achievements in this aspect? How do you see the quality of the knowledge products (success story, case studies, lessons learned events) produced under this project? To what degree these knowledge products are capable of being used as advocacy tools?*
7. *Post ODF Certification Follow Up: Is UNICEF providing sufficient budgets to support post ODF certification activities to create long term sustainability? Which activities are/were supported, if any?* [Probe for ODF celebration events, re-verification, provision of formalized support to natural leaders, continued visits by local governments, marketing and supply of materials]
8. *Private Sector Involvement: To which extend were private sector actors systematically involved in the construction of latrines, including masons, latrine builders and shops selling building materials? What are UNICEF's contributions in enhancing the role of private sector for rural sanitation, particularly in direct districts?* [Probe for manufacturers, distributors, retailers/suppliers]
9. *Sector Regulation and Standardization: To which extend did the project contribute to formally standardize toilet design options and onsite sanitation within the governance structure?* [Probe for availability of officially approved standard design options, existence of regulator incl. approval process]

E. Demand Creation, Sustaining Demand Trough Supply Side Interventions, and Innovation

1. Demand Creation/Changing Social Norms: Which approaches or strategies were implemented for demand creation at household and community level targeting collective behaviour change – social norms?
   [Probe for: i) CATS/CLTS triggering tools to facilitate dialogue and create new beliefs and attitudes towards OD, ii) Collective action planning to achieve collective decision to end OD, iii) Formulation of WASH community groups or inclusion of WASH in existing Community Groups to guide and monitor the process, sanction violators, and ensure coordinated action, iv) Publicly shared pledge made to achieve ODF, v) Signs and maps of households with latrines displayed to reinforce normative expectations with empirical expectations, vi) Verification, certification and rewards given to communities which achieved ODF to help to reinforce normative and empirical expectations]
    - *Are there any cultural, or other taboos affecting the creation of new social norms for continued latrine use by all?*
    - *What factors are limiting the communities (or selected community members) to achieve and sustain ODF status? Kindly share relevant examples? What are the key successes/failures?*
2. Supply Chain Management: What key initiatives were undertaken to strengthen the supply chain of sanitary materials to fulfil the enhanced demand due to demand creation activities?
   [Probe for i) Sanitation Marketing Forum at provincial and district/sub-district levels in the target districts incl. documentation of formation process, ToRs, membership, defined roles and responsibilities among involved stakeholders, Human Centred Design process to develop low cost sanitation products, iii) Possibility to receive Micro Credits, iv) Training of local entrepreneurs, e. g.

masons, v) Cont. availability of low cost material for construction and repair of latrines in line with seasonal income of HH]

3. Integration of CATS and Sanitation Marketing: To which extend was sanitation marketing integrated within CATS to mutually reinforce each other to improve sustainability?
4. CATS Contextualisation: To what extent is the CATS/CLTS model appropriate in Indonesian context which varies widely between regions (geography, ethnicity, religion, etc.)? Does the CATS/CLTS model provide enough flexibility to overcome the variations in local context (e. g. varied degree of decentralization, political ownership and prioritization of sanitation)?
   a. What country specific modifications were introduced to the CATS model?
   b. Does the approved CLTS/STBM approach encourage/discourage the provision of subsidy (in-kind/cash) for poor and other vulnerable groups? What other mechanisms are available to ensure the access of improved sanitation for poor people?
   c. What drivers of change of social norms were established?

   [Probe for Shock, Disgust or Dignity as communities come to understand the faecal-oral route of infection]
5. Access for the Poor: Were Micro - financing options created at scale and supportive to create latrine ownership by the poor? What type of subsidies were provided, if any to support access for the poor?
6. Shared HH Toilets or Public Toilets): What impact have shared toilets/public toilets on sustaining ODF behaviour change?

   [Probe for uncleanliness, attraction to instances for violence, may drive people to continue open defecation practices.]
7. Sanctions: Were there any sanctions formally established against those who continue open defecation? To which extend did they support social acceptability/sustainability of ODF? Please provide examples, if any.

   [Probe for documentation of concept, ToR, type of sanctions applied: e. g. whistle blowing or singing to open defecators, fees, refusing licences for those without toilets, withholding and delaying entitlement payments, etc.).

F. Monitoring

1. Availability of Project Monitoring Mechanism/CATS M&E system: What monitoring mechanisms were established to track, monitor and report on the quality of inputs, processes implemented, progress and the project results at all levels (National, provincial, district/sub-district) and in relation to all partners (Government. - UNICEF, UNICEF-IPs, IPs-Community, UNICEF-Community)?
2. Alignment of CLTS/CATS M&E with governmental monitoring: To which extend is the CATS M&E system aligned with the national/subnational monitoring system and capacities? Please explain.
3. Support to National STBM Database: What are UNICEF's contributions in strengthening the STBM central database, if any? What are the key challenges of the overall monitoring/reporting mechanisms?

   [Probe for strengthening monitoring/reporting system within direct districts, evidences to indicate the use of monitoring reports/internal reviews for course correction]
4. Community Involvement in CLTS/CATS Monitoring: To what extent and how were communities successfully involved in monitoring of inputs and processes implemented (BCC, triggering, post-triggering), progress made, and results achieved at community level?

   [Probe for community level forum, consumer watch groups, documented formation mechanism for community monitoring process, ToR, membership, selection criteria, defined roles and responsibilities]
5. Monitoring of Heath Impacts: Was there any evidence monitored to support a direct impact of ODF on the health of the population?

   [Probe for inclusion of health indicators in CLTS/CATS M&E system]

G. Training, Communication, IEC/BCC

1. Availability of contextualised IEC Material: Did the project develop IEC materials for Behaviour Change Communication in line with cultural habits targeting different groups? What types of materials were developed? What mediums (electronic, print, social media) were used in disseminating the key messages on ODF and other key sanitation aspects?
    a. Was the BCC campaign (IEC materials and mediums used) responsive to the needs of the poor, illiterate, children, girls, women, elderly and disabled in the communities?
    b. How effective were the IEC materials and messages in achieving the desired behavioural changes?

H. Partnerships and Coordination:

1. What kind of partnerships were established for project implementation? To which extend were the partners at various levels responsive in line with agreed commitments and plans for project delivery? Please share examples to elaborate further on success and failure of selected partnerships.
2. POKJA AMPL: Please explain the role of the POKJA AMPL at national, provincial and district/sub-district level? What are the key contributions of POKJA AMPL for project implementation?
   [Probe for the formation process, public recognition/notification status, approved ToRs, membership, defined roles and responsibilities among involved stakeholders]
3. Sector coordination: To which extend did UNICEF contribute to establishing new and strengthening existing coordination mechanisms between project partners (Government, WSP, INGOs, local NGOs and communities) and at all levels (national, provincial, district/sub-district)? What worked and what did not? Please elaborate with examples.

I. Challenges

5. What were the key challenges faced during the project life cycle (planning and initiation phase; implementation; sustainability phase)? What strategies were adopted to overcome these challenges? Kindly elaborate with examples?

	National	Provincial	Community
Policy/regulations			
Finance			
Capacity development			
Coordination/partnership			
Monitoring			
Knowledge management			
Demand creation			
Supply facilitation			

J. Lessons learned

What are the key lessons learned by UNICEF at various levels, with regards to sustainability of the achieved results and scalability?

	National	Provincial	Community
Policy/regulations			
Finance			
Capacity development			
Coordination/partnership			
Monitoring			

Knowledge management
Demand creation
Supply facilitation

K. Key recommendations

Which processes should be modified or strengthened at various levels to scale-up the rural sanitation programme in Indonesia? Kindly elaborate with respect to the following:

	National	Provincial	Community
Policy/regulations			
Finance			
Capacity development			
Coordination/partnership			
Monitoring			
Knowledge management			
Demand creation			
Supply facilitation			

Appendix 4.2: Key Informant Interview – Government Departments

KEY INFORMANT INTERVIEW (GOVERNMENT / STBM SECRETARIAT – PAKOJA AMPL, DISTRICT HEALTH OFFICE AT PROVINCIAL AND DISTRICT/SUB-DISTRICT LEVEL, SANITARIANS)

Informed Consent:

Hi, my name is _____ and I am working with AAN Associates, Pakistan. On behalf of UNICEF, Country Office Indonesia, we are conducting an Evaluation. As part of data collection, we need to ask you various questions on Water, Sanitation, Hygiene and Health situation conditions from you. Taking into account the key role of your office/department/section, we intend to do an interview from you for this evaluation.

We would very much appreciate your uninterrupted availability for this Interview. The information that you will share will be used to synthesize evaluation findings and recommendations. The evaluation findings and recommendations will help GoI, UNICEF and the Ministry of Health to better plan and implement the national sanitation programme. This will also enable UNICEF to revisit your current strategies and future plans to support GoI for strengthening and up-scaling sanitation through CLTS approach. The Interview should take A couple of hours to complete. The information you provide will be kept confidential and will not be shared with anyone other than the evaluation team members. Your responses will also be kept anonymous and not tied back to you in anyway.

Your participation for this interview is voluntary. If we ask you any questions you don't want to answer let me know and I will go on to the next question. You can also stop the interview at any time. We hope that you will allow us to interview you for this evaluation, as your inputs are important to us.

Do you have any questions about the evaluation or the Interview at this time?
May I begin the interview now?

Note: The interviewer to adapt questions based on the specific role of the interviewee, level of understanding and the nature of the involvement in the BMGF Funded UNICEF support to national sanitation Programme (STBM) in Indonesia.

Date:

Respondent Name (Mr. /Mrs.):

Organisation/Department:

Designation/Position:

Province: District:

Village: Dusun/Community:

Interviewer Name (Mr. /Mrs.):

Moderator Name:

Note Taker:

Questions:

STBM Programme and Sector Context

1. What do you think are the main sanitation issues at provincial/district level? Why? Which groups (children, women, elderly, poor and disabled) of population are most at risk and why?
2. Are you aware of the STBM programme? Please elaborate on the broader objectives and strategies of the programme being implemented by GoI. To what degree is the programme contributing to fulfilling the sanitation needs of the communities and how? What are the gaps in addressing the sanitation needs at individual and community level?

Role of the Government Department (DHO, Local government etc.)

1. What is your department's role in STBM implementation at household, community, provincial/district and sub-district levels?
2. What is your (own) role in programme implementation with respect to preparatory phase, pre-triggering, triggering (counselling, simulation, socialization) and post-triggering?

UNICEF's Role and Project Structure

1. Are you aware of UNICEF's role in implementation of STBM programme? What type of collaboration/partnership exist between UNICEF and your department (local health department)? To what extent is the partnership contributing to helping communities achieving ODF status and how? What would happen if UNICEF's support is not there?
    a. Please elaborate the specific activities undertaken by UNICEF for capacity development at individual and departmental level under this partnership?
    b. Did the partnership result in introduction of any new regulation or increased enforcement of the existing regulations related with sanitation?
    c. Are sufficient funds available for STBM implementation? Are you aware of any increase in funds at provincial/district or sub-district level due to UNICEF's efforts?
    d. Please elaborate if you know about fund transfer from UNICEF to Government (direct cash transfer?) and from national budget to your department at provincial and district/sub-district level.
    e. How did UNICEF support help to strengthen the coordination mechanisms at provincial/district and sub-district levels? What is the role of POKJA AMPL? Is there a need to improve its effectiveness? How?

Implementation Strategies

1. What is your opinion regarding the quality/effectiveness of the CLTS/CATS activities (community mobilization, community participation and training, action planning) undertaken in each phase? What worked well and what did not? Please elaborate with examples. What should be done to improve the implementation of these activities?

Programme effectiveness, IEC materials

1. Did the programme develop information, communication, education (IEC) materials to communicate programme messages at individual and community level? What are the key strengths and weaknesses of these materials? Are they available in local language?

Equity, Inclusion and Gender Impacts

1. In your opinion, to what degree are the communities responsive to the activities targeting behavioural change? Which groups (men, women, boys, girls, elderly, disabled, poor rich) are more responsive to the programme messages and activities? Why?

a. Did the programme implement any specific approach or strategy to ensure the involvement and participation of vulnerable groups in particular women, girls, poor, disabled and others? Kindly share groups specific examples.
b. Do you have any specific success story of an individual, community or any situation which highlights the exemplary behavioural change or other significant achievement due to the programme?

2. In your opinion, what are the limiting factors, challenges faced by those groups (children, women, girls, elderly, disabled)) who are not responsive and motivated to; a) build and use latrine for defecation, and b) adopt improved hygiene practices, washing hands etc.
3. What are your recommendations to eliminate these constraining factors for these groups? What challenges/barriers exist that make it difficult for the poor households to construct and use latrine consistently?

Supply Side Interventions/ Sanitation Marketing

1. To what extent did UNICEFs support contribute to an increased access to sanitary materials and availability of the trained masons in the communities?
   a. Did the project introduce any innovative, low-cost latrine designs and other sanitary materials?
   b. Are you aware of any sanitation marketing forum established under this project what is the envisioned purpose and role of this SanMark forum?
   c. What mechanisms were introduced or strengthened to connect the communities with sanitary outlets at village (Desa) sub-district and provincial/district levels?

Monitoring (pre-post ODF, communities' role and capacities) and Sustainability

1. What monitoring mechanisms are set by STBM program to track and report on the progress made at community and household level? How did UNICEF 's efforts contribute to introducing or strengthening existing monitoring and reporting mechanisms? What are the gaps in existing monitoring processes, templates and reporting formats? What do you think to improve the quality of M&E of STBM activities in the village?
   a. To what extent are communities involved in monitoring of pre-post ODF activities? How? Is there a need to improve community's involvement for better monitoring and reporting? How?
   b. Have you ever found any case that the community back to practice OD? If yes, what was the cause? Any idea how to prevent any slippage case in the future?
2. Who is the best key player for those ODF Villages to maintain sustainability?

ODF verification process (quality)

1. Are standard/approved ODF criteria available and uniformly agreed by Government. /STBM and other partners? What is the defined process of ODF verification?
   a. What is the defined role of your department (and yourself) in this verification process?
   b. What are the gaps in certification and declaration process? How can these gaps be rectified? Please explain.

Innovation/low-cost latrine options

1. Do you know if any financial support (loan, grant, cost-sharing, in-kind assistance) is available for the poor households and other vulnerable groups to help them construct latrine? If yes, who is providing this support? What criteria and process is used for identification of poor households?
2. Do you agree that Dana Desa or Village Funds can be allocated for STBM? What would be the practical way of doing so? What do you think about the roles of Village Facilitator of Program Dana Desa in relation to STBM Program?
3. So far, we mostly cover STBM Program in the village. What do you think about urban STBM?

Social Norms (Normative Expectations)

1. What do you think how many (few, many, more, most, all) people in the communities believe that they should use latrine for defecation purpose?
2. What are the reasons (myths/taboos/customs/beliefs) for unhygienic sanitation practices?

Existence of Sanctions

1. Are you aware of any community based sanctions (social & financial) that are in place to stop OD practices at household or community level?
    a. How effective are these sanctions in confining community members from defecating in open? Please give examples to elaborate
    b. Are you aware of any Government regulations requiring people/communities to stop open defecation and start using latrine? If yes, please elaborate.
    (Probe; What type of rule/regulation is? Who, when and by whom it was issued? How effective is its enforcement? Do the communities/households can play any role for its enhanced enforcement?)

Communication Campaign:

1. Are you aware of the 'Tinju Tinja'? If yes, please elaborate what was it about? How effective it was? Who were the target audience? Did it achieve its objectives? Please elaborate with specific examples about its success factors and/or gaps, if any.

Appendix 4.3: Key Informant Interview – Masons / Entrepreneur / Sanitary Mart Owners

KEY INFORMANT INTERVIEW (MASONS / ENTREPRENEUR / SANITARY MART OWNERS)

Informed Consent:
Hi, my name is _____ and I am working with AAN Associates, Pakistan. On behalf of UNICEF, Country Office Indonesia, we are conducting an Evaluation. As part of data collection, we need to ask you various questions on Water, Sanitation, Hygiene and Health situation conditions from you. Taking into account the key role of your office/department/section, we intend to do an interview from you for this evaluation.

We would very much appreciate your uninterrupted availability for this Interview. The information that you will share will be used to synthesize evaluation findings and recommendations. The evaluation findings and recommendations will help GoI, UNICEF and the Ministry of Health to better plan and implement the national sanitation programme. This will also enable UNICEF to revisit your current strategies and future plans to support GoI for strengthening and up-scaling sanitation through CLTS approach. The Interview should take A couple of hours to complete. The information you provide will be kept confidential and will not be shared with anyone other than the evaluation team members. Your responses will also be kept anonymous and not tied back to you in anyway.

Your participation for this interview is voluntary. If we ask you any questions you don't want to answer let me know and I will go on to the next question. You can also stop the interview at any time. We hope that you will allow us to interview you for this evaluation, as your inputs are important to us.

Do you have any questions about the evaluation or the Interview at this time?
May I begin the interview now?

Note: The interviewer to adapt questions based on the specific role of the interviewee, level of understanding and the nature of the involvement in the BMGF Funded UNICEF support to national sanitation Programme (STBM) in Indonesia.

Date:

Respondent Name (Mr. /Mrs.):

Organisation/Department:

Designation/Position:

Province: District:

Village: Dusun/Community:

Interviewer Name (Mr. /Mrs.):

Moderator Name:

Note Taker:

Questions

Programme awareness:

1. Are you aware of STBM programme? Yes/No, if Yes, what do you know about the programme (Probe for broader goal or purpose/objectives etc. and key activities at household and community level)?
2. What do know about UNICEF and Government. 's role and responsibilities in STBM programme (Probe for the role/responsibilities of sanitarians, DHO, local Government. department, camat, village leader or other key actors)?

Perceptions of the programme effectiveness (benefits- outcomes)

3. (If No to the Q-1 skip this question) To what extent has the programme contributed to promoting latrine usage and other hygiene practices at household and within the community?
    a. Did you see any significant increase in the demand for a) construction of new latrines and b) the maintenance and upgrading the existing latrines? Please share specific examples.
    b. What do you think are the five main reasons why people choose to build latrines at home?
    c. What do people perceive as barriers in their access to sanitation facilities?

Equity

1. Are you aware of any supporting mechanisms (in-kind support, grant/subsidy, loan, cost sharing etc.) to help/assist the poor households to build new latrines? Please elaborate with examples.

2. What types of latrine designs are preferred in the community? Are there any differences depending on which group people belong to? (religion, ethnicity, gender, income status, elderly, disabled)?
3. Does people seek your advice about construction of latrine designs? If yes, do they consider your advice? If no, Why not?

Capacity development, quality and effectiveness of training for Masons

1. Did you ever attend any orientation session(s) or training under the STBM programme? if yes, wat was the main focus of the training? How long was this training? Were any IEC materials or other relevant material on latrine designs etc. , shared/used for the training? To what extent are you satisfied with the training content, quality of delivery (skills of the trainer)? Was there any follow up training/exchange of experiences etc. organised after the initial training was conducted?
2. Did the trainings help you to enhance your skills? Please explain.

Programme visibility, involvement mechanism of the Mason

1. How did you get involve with STBM? Were you approached by an INGO, NGO or local Health Office for sanitary work, or did the community hired you to build latrines on their behalf? What was the mechanism to get engaged by the respective community?
2. How did you get paid for your services?

Supply chain/sanitation marketing

1. How has the programme contributed to improving the supply chain of sanitary materials? (Probe for mechanisms established and promoted to connect the mason with the nearby sanitary mart, wholesaler etc.)
    a. Are the sanitary materials easily available within or nearby communities or villages?
    b. To what extent are you satisfied with the quality of the generally preferred sanitary materials used by the common households?

c. What is general perceptions among most community members about the prices of the sanitary materials?

(Record for cheap, very cheap, affordable, costly very costly)

Innovation/low-cost latrine options

1. Are you aware of any innovative latrine designs that the programme has introduced for low-cost latrines (hygienic/semi-hygienic)? If yes, please elaborate.

Social Norm (Normative expectations, sanctions)

1. What do you think, how many (few, many, most, all) people in the community believe that they should build latrines at home?
2. Are you aware of any type of mechanisms/sanctions (financial, social, legal), which prohibit community members to defecate in open?

Sustainability

1. Are you aware of any Govt. regulations requiring people to stop open defecation and using latrines at home? Do you think that the sanitary stuff/latrine/sanitation construction you provided is the best one for sustainability? Is there any weakness? If yes, what is the weakness?
2. What do you think about the continued latrine usage by the community members if there are no sanctions at community level?
3. Have you ever found any case that the community back to practice OD? If yes, what was the cause?

Appendix 4.4: List of People Met During Key Informant Interviews

UNICEF and National Public Stakeholders

Sr#	Name of the respondent	Department Name	Designation
1	Aidan Cronin	Chief of WASH WASH Specialist	UNICEF
2	Mitsunori Odagiri	WASH Specialist	UNICEF
3	Julian Gressando	WASH Specialist	UNICEF
4	Peter Leth	Chief PMER	UNICEF
5	Wildan Setiabudi	Provincial Officer WASH UNICEF	Makassar, South Sulawesi
6	M. Zainal	Provincial Officer WASH UNICEF	Makassar, NTT
7	M. Afrianto Kurniawan	Provincial Officer WASH UNICEF	Jayapura, Papua
8	Wahudin		Bappenas
9	Aldy Mardikanto		Bappenas
10	Kristin Darundiyah		MoH

Provincial Level

Sr#	Name of Province	Name of the respondent	Department Name	Designation
11	NTT	DR. KORNELIUS KODI METE	DINAS KESEHATAN PROPINSI	KEPALA DINAS KESEHATAN PROPINSI
12	NTT	ANNE	BAPPEDA (POKJA AMPL)	KASUBID SUMBER DAYA AIR
13	NTT	ANI LOMI GAH	DINAS PERTAMBANGAN & ENERGI (POKJA AMPL)	KASUBID – BAPPEDA
14	NTT	SHERLY WH	DINAS PERTAMBANGAN & ENERGI (POKJA AMPL)	KASUBID – BAPPEDA
15	NTT	WENY DOPO	BAPPEDA (POKJA AMPL)	KASUBID
16	NTT	SELFI	BAPPEDA (POKJA AMPL)	STAFF BAPPEDA
17	NTT	BUCE GAH	CIS TIMOR (CSO PARTNER)	PROGRAM KOORDINATOR
18	Papua	DR. FENY MAYANA PAISEY, M.SI	DINAS KESEHATAN PROPINSI	KABID KESMAS
19	Papua	AURY	BAPPEDA PROPINSI	KABID SOSIAL BUDAYA
20	Papua	NOKEN HIROSHI	NOKEN HIROSHI	STAFF NGO
21	SS	WILDAN SETIABUDI, B. Eng. MSc.	UNICEF	WASH PROGRAM OFFICER
22	SS	NURTANG GANI	LEMINA	STAFF NGO
23	SS	ARAFAH	BAKTI	STAFF NGO
24	SS	NIRWANA	BAKTI	STAFF NGO
25	SS	KASRI, M. KES	DINAS KESEHATAN PROPINSI	KEPALA BIDANG KESEHATAN LINGKUNGAN
26	SS	IRWAN DERMAYASAMIN IBRAHIM, ST. M.SI	BAPPEDA PROPINSI	KASUBID PENGEMBANGAN WILAYAH

District Level

Sr#	Name of District	Name of the respondent	Department Name	Designation
27	MANGGARAI	MARIA IMA KULATA DELIMA, SSI.	DINAS KESEHATAN	KASIE KESLING KESJAOR DINKES

28	MANGGARAI	PETER RASYID	BAPPEDA	KABID PEMBANGUNAN MANUSIA DAN MASYARAKAT
29	MANGGARAI	GABRIEL GANGGUT	DINAS KESHATAN	KEPALA PUSKESMAS WAEMLENG
30	SUMBA TIMUR	JULIANUS NDJURUMAY, SKM.	DINAS KESEHATAN	KASIE KESLING KESJAOR DINKES
31	SUMBA TIMUR	FRIDA M. YIWA	BAPPEDA	KABID PEMERINTAHAN DAN PEMBANGUNAN MANUSIA
32	SUMBA TIMUR	DOMINIKA MARIA BESSU, AMDKL	DINAS KESEHATAN	SANITARIAN PUSKESMAS KAMBANERO
33	ALOR	DR. CHRISTINE O. MAYA B. LAOEMOERY	DINAS KESEHATAN	KEPALA DINAS KESEHATAN
34	ALOR	MARTEN HITIKANA	BAPPEDA	KEPALA BAPPEDA
35	ALOR	YAMEHA ASAMAU	DINAS KESEHATAN	SANITARIAN PUSKESMAS ALOR
36	ALOR	ANDREAS BLEGUR	BAPPEDA	KABID SOSIAL BUDAYA BAPPEDA/KETUA POKJA AMPL
37	JAYAPURA	WASIK	DINAS KESEHATAN	STAFF KESMAS
38	JAYAPURA	ENRICO STORUS, ST. MT	BAPPEDA	KABID FISIK PRASARANA (FISPRA) BAPPEDA
39	KEEROM	GATOT RUSDIONO, SKM	DINAS KESEHATAN	KABID KESMAS
40	KEEROM	D.E MITTEBOGA	BAPPEDA	KEPALA BAPPEDA
41	KEEROM	YUSNA	DINAS KESEHATAN	STAFF KESMAS
42	LUWU UTARA	INDAH PUTRI	DISTRICT OFFICE	BUPATI LUWU UTARA
43	LUWU UTARA	ANIJAS RUSLI	DINAS KESEHATAN	KEPALA BIDANG KESEHATAN MASYARAKAT
44	LUWU UTARA	ISTIQOMAS	DINAS KESEHATAN	SANITARIAN PUSKESMAS MASAMBA
45	LUWU UTARA	ARMILASARI	DINAS KESEHATAN	SANITARIAN PUSKESMAS MASAMBA
46	LUWU UTARA	IIN FAUSIAH	BAPPEDA	KASIE KESEHATAN LINGKUNGAN KEJAOR
47	TAKALAR	ARIFIN, S.AP., M.AP.	BAPPEDA	KASUBID SOSIAL BUDAYA
48	TAKALAR	HASNIATI, SE	BAPPEDA	KASUBID PEMERINTAHAN
49	TAKALAR	SRI REZEKI, SE., M.AP.	BAPPEDA	FUNGSIONAL PERNCANA PERTAMA
50	TAKALAR	ABD. RIVAL, SKM	DINAS KESEHATAN	SANITARIAN PUSKESMAS
51	TAKALAR	YUSTIANA USMAN, SKM., M. KES	DINAS KESEHATAN	SANITARIAN PUSKESMAS
52	TAKALAR	WAHYUNI	DINAS KESEHATAN	SANITARIAN PUSKESMAS
53	TAKALAR	YULIATI, SKM	DINAS KESEHATAN	SANITARIAN PUSKESMAS
54	TAKALAR	NURBAYA, SKM	DINAS KESEHATAN	SANITARIAN PUSKESMAS
55	TAKALAR	IWAN SETIAWAN, S. SOS., M.SI	DINAS PEMBERDAYAAN MASYARAKAT DESA (DPMD)	STAFF
56	TAKALAR	RAMLI, A.MD	DINAS PEMBERDAYAAN MASYARAKAT DESA (DPMD)	STAFF
57	TAKALAR	NUR AMIN S. PD.M.PD	DINAS PENDIDIKAN	PENAWAS SD
58	ENREKKANG	H.M AMIRUDDIN	DISTRICT OFFICE	WAKIL BUPATI
59	ENREKKANG	MUH. SYARWASI, S.T	BAPPEDA	KABID INFRASTRUKUR DAN PENGEMBANGAN WILAYAH
50	ENREKKANG	MASNA SILAMARANG	BAPPEDA	KASUBID PERUMAHAN, PEMUKIMAN DAN TATA RUANG
61	ENREKKANG	ARSAN	DINAS KESEHATAN	KABID KESEHATAN MASYARAKAT
62	ENREKKANG	HARIADI	DINAS KESEHATAN	SANITARIAN
63	BARRU	'A. IKA SYAMSU ALAM, S. STP, MSI	BAPPEDA	KABID ESDM
64	BARRU	ANDI PANANRANG RASYID	DINAS KESEHATAN	KASIE KESEHATAN LINGUNGAN KESEHATAN KERIJA DAN OLAHRAGA
65	BARRU	ASRIYANTI	DINAS KESEHATAN	SANITARIAN PADONGKOK

Appendix 4.5: Sampling Strategy for the Key Informant Interviews

Key Informant Interviews

A total of *65 KIIs* were conducted at the national level, provincial level, and district/sub-district level. Originally, five KIIs in each of the six districts were planned, however this left a gap of information at provincial and national level. Therefore, the Evaluators recommended undertaking KIIs as per the distribution plan suggested in Table App.4.5-1.

Table App. 4.5-1: KII Distribution

Level	Qty.	Stakeholder / respondents
National	3	UNICEF (Group Interview); Chief of WASH, WASH Specialist, Chief of PME; MoH/STBM Secretariat; BAPPENAS/POKJA AMPL Representative
Provincial	12	STBM Secretariat; POKJA AMPL Representative; Field Office UNICEF at Provincial level; 03 Provincial Health Offices
'Direct' Districts	25	District Health Office (DHO); BAPPEDAS (Planning and Development department at district level); bupati (mayor of a district); camat (head of a sub-district); Puskesmas (local health centre)-Sanitarians (Puskesmas workers); Entrepreneur/Mason
'Other' District	5	DHO; BAPPEDAS (Planning and Development department at district level); bupati (mayor of a district); Puskesmas (local health centre)-Sanitarians (Puskesmas workers);
Total	45	

Table App. 4.5-2 presents an optimised distribution of the KIIs at district level. The optimisation ensured that the Evaluators sufficiently covered the national and provincial stakeholders, while ensuring the best frequency of meetings within each stakeholder group (Table App. 4.5-2).

The KIIs were conducted in five (out of the six) *'direct'* districts of the three provinces, thereby enabling the Evaluators to include one *'other district'*, in consultation with UNICEF.

Table App. 4.5-2: Distribution of KIIs by District, ODF Performance and Type of Stakeholder

Stakeholder	South Sulawesi province		Papua province	Nusa Tenggara Timur (NTT) province		'Other' District (D1)	Total
	Luwu Utara	Takalar or Barru	Jayapura	Alor	Sumba Timur		
	LP	HP	LP	HP	LP		
DHO	1	-	1	1	-	3	6
BAPPEDA	1	-	1	1	-	1	4
POKJA AMPL Representative	-	1	1	-	1	1	4
Bupati (mayor of a district)	1	-	1	1	-	1	4
Camat (head of a sub-district)	-	1	1	-	1		3
Puskesmas (local health centre) – Sanitarians (Puskesmas workers)	1	-	1	1	-	2	5
Entrepreneur / Mason	-	1	1	1	1	-	4
Total	4	3	7	5	3	8	30

Legend: LP = low performing, HP = high performing ODF success rate

Table App. 4.5-3: Distribution of KIIs by Stakeholder at National and Provincial level

Stakeholder	National	Provincial	No. of KII
UNICEF Country Office (Group Interview); Chief of WASH, WASH Specialist, Chief of PME	1	-	1
STBM Secretariat / PHO ii. Ling team	1	6	7
POKJA AMPL Representative / BAPPENAS or BAPPEDA	1	3	4
Field Office UNICEF at Provincial level	-	3	3
Total	3	12	15

Appendix 5.1: Guide for Focus Group Discussion

FOCUSED GROUP DISCUSSION (FGD)
COMMUNITY MEMBERS (MALE / FEMALE)

Separate group discussion to be held with male and female community members.

Informed Consent:
Hi, my name is _____ and I am working with AAN Associates, Pakistan. On behalf of UNICEF, Country Office Indonesia, we are conducting an Endline Evaluation of UNICEF's support to national sanitation programme (STBM) in your community/village. As part of data collection, we need to ask you various questions on Water, Sanitation, Hygiene and Health situation conditions in your community and at household level.

Taking into account the key role of the community members in achieving and sustaining the ODF status of your community, we need to know your opinions. We will ask questions related with the processes adopted for achieving ODF, the challenges faced during all phases, the role of the UNICEF, Government department, and members of the community in achieving and maintaining the ODF status. We also intend to know your reflection on the factors contributed to the success (for ODF declared communities) and failures (for communities failed to achieve ODF status). This would help the evaluators to understand the overall effectiveness of the UNICFE's support to the national sanitation programme (STBM) for improving the implementation in future in your community and other areas.

We would very much appreciate your active participation in the discussion. The information that you will share will be used to synthesize evaluation findings and recommendations. The evaluation findings and recommendations will help GoI, UNICEF and the Ministry of Health to better plan and implement the national sanitation programme in future. This will also enable UNICEF to revisit current strategies and future plans to support GoI for strengthening and up-scaling sanitation through CLTS approach. The information you provide will be kept confidential and will not be shared with anyone other than the evaluation team members. Your responses will also be kept anonymous and not tied back to you in anyway. The group discussion will take 60-90 minutes to complete. Your cooperation would be highly appreciated.

Your participation for this group discussion is voluntary. If we ask you any questions you don't want to answer let me know and I will go on to the next question. You can also stop the discussion at any time. We hope that you will allow us to interview you for this evaluation, as your inputs are important to us.

Do you have any questions about the evaluation or the group discussion at this time?
May we begin the group discussion now?

Note/Instructions: *The Moderator to adapt questions based on the types of the participants, total number of participants and anticipated level of understanding about the Programme or the topic under discussion. The Moderator will ensure;*

- Equal opportunity is given to each participant for sharing his/her opinion.
- Views of each participant are listened and given due respect while maintaining the dignity for each member participating in the discussion regardless of the difference of opinion.
- Group discussion is held in secure and safe place in a pleasant/comfortable environment.

Date:
Province:

District:

Village;
Dusun/
Community
ODF Status?

ODF Declaration Date
Estimated time period
(Moth / Year)

Declared; Yes/ No
Verified: Yes/No

FGD Moderator Name:
FGD Facilitator Name:
Note Taker:
Other Detail:

Possible Types of FGD Participants:

Kepala Desa (Community head)
Religious leader
Puskesmas representative (local health unit/cluster of Community)
Health workers/Sanitarians
Community mobilizer/teacher/champions of sanitation
Male heads of households
Female heads of households/mothers of young kids
Female community worker
Disabled, community members with special needs
Members of households with and without latrines (at least 2 members from each group)

Group Type: Male / Female

Actual Participants

S#	Name	Age (Years)	Profession	Role in the Community / Programme
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				

Questions

[Ask always all questions in each FGD session.]

WASH Problems, Reasons, Consequences

[Let the respondents spell out their own thoughts, ask follow-up questions in order to make sure that all three topics are covered]

1. What are the main 5 water, sanitation and hygiene related PROBLEMS in your Community?

2. What do you think are the REASONS for these water, sanitation and hygiene related issues at your Community?
3. What are the CONSEQUENCES of the problems mentioned for you, your family and your community?

Awareness and Governmental Support

1. Are you aware of any INGO, NGO, or Government programme that is supporting your Community to solve these issues? [Yes/No].
    a. If Yes, share the name of the organisation or Government. department, or the Programme name; [if respondents are not aware of STBM, probe separately for STBM]. Do you think that the support offered by [said]programme/department is appropriate to address the water, sanitation and hygiene issues of your community specially in relation to the needs of children, girls, boys, women, elderly and disabled people?
2. Did any representative of the Government/INGO/NGO partner visit your Community to arrange sessions/meetings with you to explain the objective of the National Sanitation Programme STBM?
3. Did any representative of the Government/INGO/NGO conducted Health and Hygiene training/awareness sessions to explain the importance of sanitation and respective consequences of poor/unimproved sanitation practices)? [Yes/No].
    a. [If Yes], how frequently did/do they visit your Community? (weekly, monthly, every 3 months, every 6 months, once a year)? How many of you ever attended such a session?
    a. [If No], why did you not attend the sessions?
4. Do you think that the sanitarians/local health workers, have been able to fulfil their proposed/expected roles/duties of helping you in improving your knowledge on health and sanitation issues and for adoption of improved sanitation practices? [Yes/No]. *[Ask separately from each respondent/ role of the sanitarians]*
    a. If Yes, please explain
    b. If No, what needs to be done differently
5. What is the most important learning you remember from these trainings/awareness sessions? *[Let selected respondents spell out their own thoughts]*

Community Involvement and Participation/Local Leadership

1. Have you formed a specific Community Group especially dealing with water/sanitation/hygiene issues? [Yes/No].
2. Have you selected a leader from your Community to communicate your concerns to the sanitarians? Does the leader also attend the session/meetings with the sanitarians and take the initiative of raising problems being faced by the Communities in constructing latrines? [Yes/No].
3. Do the Sanitarians/Community Health Workers listen to and follow the inputs or suggestions from your Community leader/Community Group representative for future planning of the programme? [Yes/No].
4. Which of your water, sanitation or hygiene problems were addressed already, if any? *[Ask selected participants separately to get at least 2-3 reasons from each respondent]*

Availability and Affordability of Materials

1. Did you have all material needed for constructing your latrine available within your Community or nearby within reach? [Yes/No]
    a. If No, what did you do?
2. Do you think the material needed to construct a latrine was expensive? [Yes/No]
3. Did you receive any financial support (in cash or kind) to construct your latrine? [Yes/No]
    a. If Yes, was the support given to you sufficient to construct the latrine you wanted?

Reaching ODF, post ODF Triggering and Monitoring, Verification, Certification

1. Did your Community achieve ODF status? [Yes/No].
    a. If No, what do you think are the main 5 reasons for not achieving ODF status?
    b. If Yes, are there any post triggering sessions and periodic monitoring visits takes place for sustaining the ODF status of your Community?
    c. If Yes, what were the procedures followed for the verification of ODF status and official declaration?
    d. For some reason, have you ever practiced OD recently? Why?
    e. Do you know, or have you ever heard that your neighbour is practicing back to OD? If yes, do you know why?

2. In your opinion, how many families in your Community SHARE latrines? What do you think are the reasons for people using shared latrines in your Community? *[Ask selected participants separately to get at least 2-3 reasons from each respondent]*

Monitoring and Sustainability

1. Do you have any idea how is Government monitoring the community in relation to STBM activities?
2. And also how monitoring ODF village for its sustainability?

Changing Social Norms: ODF, Continuity of use

1. Are you aware of people in your Community who still defecate in the open? What do you think are the reasons/beliefs/taboos that steer people in your Community to practice open defecation?
2. How many families in your Community ALWAYS use latrines for defecation? *[few, many, almost all, everyone]*
3. What do you think, how many people in your community believe that everyone SHOULD use latrine for defecation? *[few, many, almost all, everyone]*
4. What are the main 3 consequences of not having a latrine at home? *[Ask from every respondent to share their views, probe for the health consequences)*

In your opinion, what are the reasons that families in your Community do not have a latrine at home? *[Ask selected participants separately to get answers e. g. affordability, accessibility, maintenance, personal beliefs, taboos etc.]*

5. How do people relief themselves when they are working outside the house, in the field, at the market etc.? *[Let the respondents spell out their own thoughts]*

Sanctions

6. Are you aware of any type of social, financial or legal sanctions that exist, if someone from your Community is caught defecating in open? [Yes/No]
    a. If Yes, what type of sanctions exists? *[probe… e.g. people throw stones, say bad names]*
    b. If Yes, are these existing sanctions/mechanisms helpful to sustain/regain the ODF status of your Community?

Equity

7. In your opinion, who in your Community has benefitted most from the STBM programme? Have the needs of the children, girls, boys, women, elderly and disabled people been emphasized properly? [Yes/No]
    a. If Not, please explain?

8. Do you think it is very important that girls and women should have access to latrines? [Yes/No]
    a. If No, please explain.

Disposal of Baby Faeces

9. How do people in your Community dispose-off faeces from young babies? How do they clean up after baby has defecated?

Water borne Diseases

10. Do you know any diseases that can affect children due to unsafe sanitation practices? [Probe for Diarrhoea]

Social Norms: Washing Hands

11. Do you think it is important to wash hands especially after defecating? [Yes/No]
12. Are you aware of any health-related consequences that effect you if you don't wash hands after defecating or before cooking and eating food? [Yes/No]
13. Are you aware of people in your Community who don't wash their hands with soap after using the toilet? What do you think are the reasons/beliefs/taboos that steer people in your Community to not wash their hands with soap after using the toilet? *[Probe for availability of water, soap]*
14. How many families in your Community ALWAYS wash their hands after using the latrine for defecation? *[few, many, almost all, everyone]*
15. What do you think, how many people in your community believe that everyone SHOULD wash their hands with soap after using the latrine for defecation? *[few, many, almost all, everyone]*
16. What are the main 3 consequences of not washing hands*? [Ask from every respondent to share their views, probe for the health consequences)*

Appendix 5.2: List of Participants of the FGDs

FGD#	Participant S.#	District	Desa/Dusun	NAME	Gender/Sex	AGE
1	1	JAYAPURA	Nambon	FERDINAN	Male	32
1	2	JAYAPURA	Nambon	YAKONES DWAA	Male	39
1	3	JAYAPURA	Nambon	HANS SAMON	Male	43
1	4	JAYAPURA	Nambon	ONESIMUS DWAA	Male	59
1	5	JAYAPURA	Nambon	YOHAN OYOMSARU	Male	62
1	6	JAYAPURA	Nambon	ISAY YARU	Male	52
1	7	JAYAPURA	Nambon	YUNUS DWAA	Male	59
1	8	JAYAPURA	Nambon	FREDRIK SAMON	Male	41
2	9	JAYAPURA	Bring	AMOS	Male	65
2	10	JAYAPURA	Bring	SALMAN	Male	35
2	11	JAYAPURA	Bring	PILIPUS	Male	26
2	12	JAYAPURA	Bring	FRANS	Male	60
2	13	JAYAPURA	Bring	ADALOF	Male	60
2	14	JAYAPURA	Bring	YOWAF	Male	73
2	15	JAYAPURA	Bring	ROBERT	Male	43
2	16	JAYAPURA	Bring	AYUB	Male	27
3	17	JAYAPURA	Besum	ALBERT	Male	29
3	18	JAYAPURA	Besum	ISAK	Male	19
3	19	JAYAPURA	Besum	SAMUEL	Male	19
3	20	JAYAPURA	Besum	DANIEL	Male	18
3	21	JAYAPURA	Besum	BARNABAS	Male	25
3	22	JAYAPURA	Besum	ALEX	Male	32
3	23	JAYAPURA	Besum	LEWI	Male	28
3	24	JAYAPURA	Besum	WELLEM	Male	35
4	25	JAYAPURA	Wahab	AZER	Male	35
4	26	JAYAPURA	Wahab	ANGEL	Male	37
4	27	JAYAPURA	Wahab	MATIUS	Male	35
4	28	JAYAPURA	Wahab	SEM	Male	54
4	29	JAYAPURA	Wahab	TOMAS	Male	34
4	30	JAYAPURA	Wahab	STEVANUS	Male	57
4	31	JAYAPURA	Wahab	GERI	Male	29
4	32	JAYAPURA	Wahab	TOMAS NAPO	Male	64
5	33	JAYAPURA	Yokiwa	YULIAHUS AWOITOUW	Male	40
5	34	JAYAPURA	Yokiwa	FRENGKI MIMITAUW	Male	41
5	35	JAYAPURA	Yokiwa	RAYMUNDUS BEREK	Male	42
5	36	JAYAPURA	Yokiwa	SOLEMAN AWOITAU	Male	69
5	37	JAYAPURA	Yokiwa	PAULUS DOYAPO	Male	42
5	38	JAYAPURA	Yokiwa	YONATHAN DOYAPO	Male	64
5	39	JAYAPURA	Yokiwa	ARNOLD AWOITAUW	Male	60
5	40	JAYAPURA	Yokiwa	YOSEPH AWOITAUW	Male	37
6	41	KEEROM	UPT Pir II / Yamta	AGUS	Male	57
6	42	KEEROM	UPT Pir II / Yamta	SUTRISNO	Male	43
6	43	KEEROM	UPT Pir II / Yamta	SIHONO	Male	62
6	44	KEEROM	UPT Pir II / Yamta	MARIO	Male	33
6	45	KEEROM	UPT Pir II / Yamta	RIBEN	Male	29
6	46	KEEROM	UPT Pir II / Yamta	TERINUS	Male	42
6	47	KEEROM	UPT Pir II / Yamta	PONIRAN	Male	63
6	48	KEEROM	UPT Pir II / Yamta	RUTHIN	Male	44
7	49	KEEROM	Upt Pir V / Yamara	ANDREAS	Male	54
7	50	KEEROM	Upt Pir V / Yamara	NIMROT SEN	Male	45
7	51	KEEROM	Upt Pir V / Yamara	ANDRIAN BATE	Male	45
7	52	KEEROM	Upt Pir V / Yamara	MARTEN WENDA	Male	46
7	53	KEEROM	Upt Pir V / Yamara	IWAN TABUNI	Male	20

7	54	KEEROM	Upt Pir V / Yamara	ALBERT HIKREYHIRIOR	Male	47
7	55	KEEROM	Upt Pir V / Yamara	DENIS	Male	33
7	56	KEEROM	Upt Pir V / Yamara	YOSEP KAMBU	Male	22
8	57	KEEROM	Usku / Warlef	VICTOR	Male	29
8	58	KEEROM	Usku / Warlef	FRANS	Male	63
8	59	KEEROM	Usku / Warlef	SAMUEL	Male	27
8	60	KEEROM	Usku / Warlef	YANCE.J.WAMBALIAW	Male	36
8	61	KEEROM	Usku / Warlef	DENIS	Male	28
8	62	KEEROM	Usku / Warlef	AMOS	Male	63
8	63	KEEROM	Usku / Warlef	NEHEMIA WAMBALIAW	Male	36
8	64	KEEROM	Usku / Warlef	OSCAR	Male	24
9	65	ALOR	Wolwal Barat	YAKOBUS MALAIMOI	Male	25
9	66	ALOR	Wolwal Barat	ISAK ATAKARI	Male	43
9	67	ALOR	Wolwal Barat	ABADITUS	Male	42
9	68	ALOR	Wolwal Barat	WAHID	Male	32
9	69	ALOR	Wolwal Barat	TAJUDIN	Male	26
9	70	ALOR	Wolwal Barat	MAHMUD	Male	44
9	71	ALOR	Wolwal Barat	NURDIN	Male	48
9	72	ALOR	Wolwal Barat	RAHMIN	Male	39
10	73	ALOR	Belemana	DARMAN L	Male	26
10	74	ALOR	Belemana	SEPRIANSYAH	Male	40
10	75	ALOR	Belemana	DAUD YUKO	Male	42
10	76	ALOR	Belemana	OLFIANUS	Male	38
10	77	ALOR	Belemana	MENAHEN M	Male	38
10	78	ALOR	Belemana	PAULUS	Male	40
10	79	ALOR	Belemana	EDISON	Male	48
10	80	ALOR	Belemana	IMANUEL	Male	22
11	81	ALOR	Bouweli	JOHANIS DANG	Male	65
11	82	ALOR	Bouweli	SAMUEL MAU	Male	45
11	83	ALOR	Bouweli	MELKISEDEK DANG	Male	40
11	84	ALOR	Bouweli	JERMIAS WAANG	Male	35
11	85	ALOR	Bouweli	ISKANDAR ILLU	Male	33
11	86	ALOR	Bouweli	GERRY ROBINSON	Male	22
11	87	ALOR	Bouweli	JEFRY WAANG	Male	21
11	88	ALOR	Bouweli	MAXION UMA	Male	25
12	89	ALOR	Pulau Buaya	HAMDAN KAPITANG	Male	30
12	90	ALOR	Pulau Buaya	HAMDI ZAINUN	Male	29
12	91	ALOR	Pulau Buaya	HASYIM	Male	32
12	92	ALOR	Pulau Buaya	JAFAR SUNARI	Male	43
12	93	ALOR	Pulau Buaya	SAHLAN H.SONTO	Male	32
12	94	ALOR	Pulau Buaya	TRISNO H. DAHLAN	Male	25
12	95	ALOR	Pulau Buaya	RIZAL ABIDIN	Male	31
12	96	ALOR	Pulau Buaya	ABDUL SYUKUR	Male	24
13	97	MANGGARAI	Bangka Lao	YUSTINUS HASAN	Male	33
13	98	MANGGARAI	Bangka Lao	GERADUS NAPUT	Male	43
13	99	MANGGARAI	Bangka Lao	ROBERTUS NDAGU	Male	41
13	100	MANGGARAI	Bangka Lao	DIONISIUS MBEMBOS	Male	43
13	101	MANGGARAI	Bangka Lao	FANSY SYUKUR	Male	44
13	102	MANGGARAI	Bangka Lao	DION TATA	Male	26
13	103	MANGGARAI	Bangka Lao	YANTO	Male	35
13	104	MANGGARAI	Bangka Lao	YOHANES PAPU	Male	45
14	105	MANGGARAI	Kakor	VINSENSIUS MOT	Male	45
14	106	MANGGARAI	Kakor	TOBIAS JEHURU	Male	36
14	107	MANGGARAI	Kakor	BONEFASIUS TANGGUNG	Male	35
14	108	MANGGARAI	Kakor	LEDRARDUS ABUR	Male	42
14	109	MANGGARAI	Kakor	PHILLIPUS JEMPARUT	Male	29
14	110	MANGGARAI	Kakor	MAKSIMUS PEGAU	Male	34
14	111	MANGGARAI	Kakor	AGUSTINUS AMPUR	Male	37
14	112	MANGGARAI	Kakor	FELIKSIANUS MEGO	Male	45
15	113	MANGGARAI	Pongkor	PRISKUS F RAMBANG	Male	23
15	114	MANGGARAI	Pongkor	VICTOR MUNDUT	Male	43
15	115	MANGGARAI	Pongkor	GASPUR MAJAN	Male	41
15	116	MANGGARAI	Pongkor	DEDIMUS UGUL	Male	31
15	117	MANGGARAI	Pongkor	PAULUS HADIBRATA	Male	42
15	118	MANGGARAI	Pongkor	YOHANES JOHAN	Male	26
15	119	MANGGARAI	Pongkor	BENEDICTUS N	Male	40

15	120	MANGGARAI	Pongkor	ROMANUS NORMAN	Male	40
16	121	MANGGARAI	Lalong	RAIMUNDUS BATA	Male	35
16	122	MANGGARAI	Lalong	PETRUS HAMIN	Male	30
16	123	MANGGARAI	Lalong	NATISAS MASUR	Male	41
16	124	MANGGARAI	Lalong	HENDRIKUS KAUT	Male	42
16	125	MANGGARAI	Lalong	ADRIANUS YONO	Male	28
16	126	MANGGARAI	Lalong	RAFAEL JEHADU	Male	43
16	127	MANGGARAI	Lalong	YUVENTUS ANDI	Male	31
16	128	MANGGARAI	Lalong	DOMINIKUS BEN	Male	32
17	129	SUMBA TIMUR	Mandahu	PETRUS META YUSA	Male	60
17	130	SUMBA TIMUR	Mandahu	SOLEMAN H MBERA	Male	26
17	131	SUMBA TIMUR	Mandahu	STEFANUS K LELU	Male	45
17	132	SUMBA TIMUR	Mandahu	META YWA	Male	45
17	133	SUMBA TIMUR	Mandahu	HINA NJUKA AMAH	Male	50
17	134	SUMBA TIMUR	Mandahu	GERSON G LELI	Male	27
17	135	SUMBA TIMUR	Mandahu	MARINUS Y KERING	Male	31
17	136	SUMBA TIMUR	Mandahu	YOU NDAPA	Male	23
18	137	SUMBA TIMUR	Pamburu	YERMIAS LURANJAWALI	Male	31
18	138	SUMBA TIMUR	Pamburu	DANIEL H RANJA	Male	30
18	139	SUMBA TIMUR	Pamburu	MARKUS K DORAT	Male	32
18	140	SUMBA TIMUR	Pamburu	KARAMBI M	Male	32
18	141	SUMBA TIMUR	Pamburu	NGALLA H NDIMA	Male	39
18	142	SUMBA TIMUR	Pamburu	YUDA L L KATI	Male	20
18	143	SUMBA TIMUR	Pamburu	YUNUS PURUNAMA	Male	37
18	144	SUMBA TIMUR	Pamburu	RUBEN NG H WALI	Male	20
19	145	SUMBA TIMUR	Tapil	SAMUEL HINGGI RANJA	Male	39
19	146	SUMBA TIMUR	Tapil	LU HADA MBIWA	Male	32
19	147	SUMBA TIMUR	Tapil	M.YIWARIMBANG	Male	45
19	148	SUMBA TIMUR	Tapil	P.NDAMANGANNGA	Male	70
19	149	SUMBA TIMUR	Tapil	MELKIANUS U TANGA	Male	45
19	150	SUMBA TIMUR	Tapil	BERNABAS ND	Male	35
19	151	SUMBA TIMUR	Tapil	K.NGGIKU	Male	69
19	152	SUMBA TIMUR	Tapil	CORNELIS	Male	41
20	153	SUMBA TIMUR	Lailunggi	FERDI U TAMU	Male	32
20	154	SUMBA TIMUR	Lailunggi	AGUS KILIMADA	Male	50
20	155	SUMBA TIMUR	Lailunggi	ADI RENGGI	Male	39
20	156	SUMBA TIMUR	Lailunggi	SIMON B JANGAR	Male	30
20	157	SUMBA TIMUR	Lailunggi	MATIAS H	Male	28
20	158	SUMBA TIMUR	Lailunggi	DOMINGGUS	Male	43
20	159	SUMBA TIMUR	Lailunggi	TINUS PURA	Male	40
20	160	SUMBA TIMUR	Lailunggi	DAJARU N RIMBANG	Male	40

21	161	ENREKKANG	Bone Bone	HAMDAN	Male	38
21	162	ENREKKANG	Bone Bone	MURLIN	Male	42
21	163	ENREKKANG	Bone Bone	SUKMAN	Male	40
21	164	ENREKKANG	Bone Bone	RAHMAT	Male	42
21	165	ENREKKANG	Bone Bone	MARWAN	Male	25
21	166	ENREKKANG	Bone Bone	MUH. FAHRI	Male	28
21	167	ENREKKANG	Bone Bone	BASRI	Male	42
21	168	ENREKKANG	Bone Bone	YUSUF	Male	40
22	169	ENREKKANG	Pinang	MUH SYUKUR	Male	54
22	170	ENREKKANG	Pinang	MUNAWIR	Male	33
22	171	ENREKKANG	Pinang	JAILANI	Male	43
22	172	ENREKKANG	Pinang	JAMALUDDIN	Male	55
22	173	ENREKKANG	Pinang	SYAHRUL	Male	46
22	174	ENREKKANG	Pinang	ASMAN	Male	53
22	175	ENREKKANG	Pinang	DARWAN	Male	29
22	176	ENREKKANG	Pinang	AL MUTADIR	Male	27
23	177	ENREKKANG	Pasang	ANWAR	Male	51
23	178	ENREKKANG	Pasang	AMRAN	Male	44
23	179	ENREKKANG	Pasang	SURIYAWAN	Male	48
23	180	ENREKKANG	Pasang	TONI	Male	42
23	181	ENREKKANG	Pasang	MUNSIR SABARA	Male	53
23	182	ENREKKANG	Pasang	SULTANI	Male	49
23	183	ENREKKANG	Pasang	RAHMAT ALAMSYAH	Male	32
23	184	ENREKKANG	Pasang	SHARIF	Male	29
24	185	ENREKKANG	Kolai	YANAR LAITA	Male	47
24	186	ENREKKANG	Kolai	SUHARDI	Male	53
24	187	ENREKKANG	Kolai	TAKHRIM	Male	35
24	188	ENREKKANG	Kolai	ABDUL MUKMIN	Male	30
24	189	ENREKKANG	Kolai	MULIADI	Male	47
24	190	ENREKKANG	Kolai	SOFYAN	Male	39
24	191	ENREKKANG	Kolai	HERMAN	Male	40
24	192	ENREKKANG	Kolai	AMRAN	Male	34
25	193	BARRU	Palakka	BABATEPU	Male	40
25	194	BARRU	Palakka	ARNISAL	Male	27
25	195	BARRU	Palakka	MUH YUSUF	Male	29
25	196	BARRU	Palakka	SAHAR	Male	41
25	197	BARRU	Palakka	FAHRISAL	Male	25
25	198	BARRU	Palakka	HAMZAH	Male	31
25	199	BARRU	Palakka	MUH. SUBUR	Male	27
25	200	BARRU	Palakka	SAFARUDDIN	Male	42
26	201	BARRU	Tompo	SYAHARUDDIN	Male	32
26	202	BARRU	Tompo	SYAMSUDDIN	Male	38
26	203	BARRU	Tompo	AGUS	Male	26
26	204	BARRU	Tompo	SUPRIAD	Male	25
26	205	BARRU	Tompo	ALIYAS	Male	31
26	206	BARRU	Tompo	MULIADI	Male	30
26	207	BARRU	Tompo	R. FANDI	Male	29
26	208	BARRU	Tompo	IRVAN	Male	37
27	209	BARRU	Paccekke	BAKRI	Male	36
27	210	BARRU	Paccekke	JUFRI	Male	38
27	211	BARRU	Paccekke	TAMARUDDIN	Male	24
27	212	BARRU	Paccekke	FINTA	Male	40
27	213	BARRU	Paccekke	MANSUR	Male	41
27	214	BARRU	Paccekke	RISWAN	Male	38
27	215	BARRU	Paccekke	ASRI	Male	28
27	216	BARRU	Paccekke	SULAIMAN	Male	44
28	217	BARRU	Kiru-kiru	A. MULIADI	Male	40
28	218	BARRU	Kiru-kiru	AMAL	Male	38
28	219	BARRU	Kiru-kiru	AWAL	Male	37
28	220	BARRU	Kiru-kiru	AHMAD	Male	30
28	221	BARRU	Kiru-kiru	IBRAHIM	Male	32
28	222	BARRU	Kiru-kiru	JUSMAN	Male	34
28	223	BARRU	Kiru-kiru	RUSDI	Male	40
28	224	BARRU	Kiru-kiru	RAHMAD	Male	42
29	225	LUWU UTARA	Torada	CENNING	Male	36
29	226	LUWU UTARA	Torada	NADI	Male	34
29	227	LUWU UTARA	Torada	HARBI	Male	37
29	228	LUWU UTARA	Torada	BAHRIADI	Male	35

29	229	LUWU UTARA	Torada	SUDIRMAN	Male	40
29	230	LUWU UTARA	Torada	BAYU	Male	44
29	231	LUWU UTARA	Torada	H. BADU	Male	43
29	232	LUWU UTARA	Torada	RUSMANSYAH	Male	45
30	233	LUWU UTARA	Kamiri	SUGIARTO	Male	35
30	234	LUWU UTARA	Kamiri	EDY SUAIB	Male	29
30	235	LUWU UTARA	Kamiri	KASWAN	Male	33
30	236	LUWU UTARA	Kamiri	YASRUDDIN	Male	40
30	237	LUWU UTARA	Kamiri	TALING	Male	45
30	238	LUWU UTARA	Kamiri	HAMZAH	Male	34
30	239	LUWU UTARA	Kamiri	WAHLIL	Male	40
30	240	LUWU UTARA	Kamiri	MUH. RASALI	Male	35
31	241	LUWU UTARA	Baloli	MUKMIN	Male	45
31	242	LUWU UTARA	Baloli	SAHRING	Male	39
31	243	LUWU UTARA	Baloli	PUDDING	Male	35
31	244	LUWU UTARA	Baloli	PALMETTE	Male	42
31	245	LUWU UTARA	Baloli	ALAM	Male	32
31	246	LUWU UTARA	Baloli	SURAHMAN	Male	30
31	247	LUWU UTARA	Baloli	WARDING	Male	29
31	248	LUWU UTARA	Baloli	PAK ALI	Male	30
32	249	LUWU UTARA	Banyuwangi	SOHAN	Male	29
32	250	LUWU UTARA	Banyuwangi	JAENO	Male	35
32	251	LUWU UTARA	Banyuwangi	RIBUT	Male	33
32	252	LUWU UTARA	Banyuwangi	HUSNI	Male	42
32	253	LUWU UTARA	Banyuwangi	ISRODI	Male	40
32	254	LUWU UTARA	Banyuwangi	PURWANTO	Male	36
32	255	LUWU UTARA	Banyuwangi	ISROI	Male	44
32	256	LUWU UTARA	Banyuwangi	SAHRI	Male	30
33	257	TAKALAR	Bonto Kassi	NASIR	Male	30
33	258	TAKALAR	Bonto Kassi	RAJAMUDDIN	Male	44
33	259	TAKALAR	Bonto Kassi	AWALUDDIN	Male	31
33	260	TAKALAR	Bonto Kassi	GINANDAR	Male	25
33	261	TAKALAR	Bonto Kassi	ASRUL	Male	35
33	262	TAKALAR	Bonto Kassi	ASDULLAH	Male	33
33	263	TAKALAR	Bonto Kassi	ISHAK	Male	32
33	264	TAKALAR	Bonto Kassi	SYAMSUDDIN	Male	45
34	265	TAKALAR	Pakkabba	SYAMSUL RIJAL	Male	37
34	266	TAKALAR	Pakkabba	SAHIR	Male	20
34	267	TAKALAR	Pakkabba	H DAHLAN	Male	45
34	268	TAKALAR	Pakkabba	RAMLI	Male	27
34	269	TAKALAR	Pakkabba	AGUS	Male	39
34	270	TAKALAR	Pakkabba	MAKMUR	Male	35
34	271	TAKALAR	Pakkabba	SUDIRMAN	Male	40
34	272	TAKALAR	Pakkabba	RIJAL	Male	25
35	273	TAKALAR	Bajeng	DG RAMANG	Male	43

35	274	TAKALAR	Bajeng	SAHARUDDIN	Male	32
35	275	TAKALAR	Bajeng	ALWI	Male	45
35	276	TAKALAR	Bajeng	ASRULLAH	Male	27
35	277	TAKALAR	Bajeng	FAHMI	Male	22
35	278	TAKALAR	Bajeng	ASMAN	Male	26
35	279	TAKALAR	Bajeng	RUSMAN	Male	29
35	280	TAKALAR	Bajeng	SUARDI	Male	24
36	281	TAKALAR	Lassang	ASRI	Male	40
36	282	TAKALAR	Lassang	SAHARUDDIN	Male	44
36	283	TAKALAR	Lassang	MUSTARI	Male	27
36	284	TAKALAR	Lassang	GAFUR	Male	45
36	285	TAKALAR	Lassang	DG NANRING	Male	45
36	286	TAKALAR	Lassang	K DG NGAGO	Male	44
36	287	TAKALAR	Lassang	RAPI	Male	45
36	288	TAKALAR	Lassang	IRFAN	Male	32
37	289	**JAYAPURA**	**Nambon**	ROSALINA DWAA	Female	47
37	290	**JAYAPURA**	**Nambon**	LINCE DWAA	Female	45
37	291	**JAYAPURA**	**Nambon**	JENNY. S. DWAA	Female	24
37	292	**JAYAPURA**	**Nambon**	MARTINA WAISIMA	Female	48
37	293	**JAYAPURA**	**Nambon**	YONICE SAMONSABRA	Female	37
37	294	**JAYAPURA**	**Nambon**	SARCE DEMETOUW	Female	33
37	295	**JAYAPURA**	**Nambon**	YOAN MANURI	Female	42
37	296	**JAYAPURA**	**Nambon**	HERLINA. S. BENEY	Female	39
38	297	**JAYAPURA**	**Bring**	HELENA	Female	52
38	298	**JAYAPURA**	**Bring**	ELSIH	Female	50
38	299	**JAYAPURA**	**Bring**	DEBBIE	Female	43
38	300	**JAYAPURA**	**Bring**	MARTHA	Female	47
38	301	**JAYAPURA**	**Bring**	ANITA	Female	23
38	302	**JAYAPURA**	**Bring**	MINCE	Female	53
38	303	**JAYAPURA**	**Bring**	LEFINA	Female	43
38	304	**JAYAPURA**	**Bring**	SARA	Female	39
38	305	**JAYAPURA**	**Besum**	YULIANA SANGRANGBANO	Female	52
39	306	**JAYAPURA**	**Besum**	SUSANA WAO	Female	38
39	307	**JAYAPURA**	**Besum**	ESTER SANGRANGBANO	Female	39
39	308	**JAYAPURA**	**Besum**	YULIANA SEM	Female	46
39	309	**JAYAPURA**	**Besum**	AGUSTINA BALLY	Female	54
39	310	**JAYAPURA**	**Besum**	DINA KASIMAT	Female	42
39	311	**JAYAPURA**	**Besum**	EMILDA SEM	Female	19
39	312	**JAYAPURA**	**Besum**	NAOMI KASIMAN	Female	28
40	313	**JAYAPURA**	**Wahab**	LINDA	Female	20
40	314	**JAYAPURA**	**Wahab**	EMPI	Female	34
40	315	**JAYAPURA**	**Wahab**	MERRY	Female	35
40	316	**JAYAPURA**	**Wahab**	LOIS	Female	33
40	317	**JAYAPURA**	**Wahab**	MIKKE	Female	41
40	318	**JAYAPURA**	**Wahab**	HELENA	Female	54
40	319	**JAYAPURA**	**Wahab**	MERLIN	Female	26
40	320	**JAYAPURA**	**Wahab**	TASYA	Female	32
41	321	**JAYAPURA**	**Yokiwa**	ANANCE MANUPAPAMI	Female	31
41	322	**JAYAPURA**	**Yokiwa**	MERIANA UDUAS	Female	36
41	323	**JAYAPURA**	**Yokiwa**	DORINA MIMITAWO	Female	35
41	324	**JAYAPURA**	**Yokiwa**	MERRY PUHILI	Female	35
41	325	**JAYAPURA**	**Yokiwa**	ADRIANA TOKORO	Female	49
41	326	**JAYAPURA**	**Yokiwa**	YOKBET IBO	Female	65
41	327	**JAYAPURA**	**Yokiwa**	ZEBERINA EHAH	Female	49
41	328	**JAYAPURA**	**Yokiwa**		Female	
42	329	**KEEROM**	**UPT Pir II / Yamta**	HANOFIA	Female	54
42	330	**KEEROM**	**UPT Pir II / Yamta**	FREDERIKA KENSIMAY	Female	48
42	331	**KEEROM**	**UPT Pir II / Yamta**	WAHYU	Female	39
42	332	**KEEROM**	**UPT Pir II / Yamta**	SRI	Female	54
42	333	**KEEROM**	**UPT Pir II / Yamta**	NUR	Female	39
42	334	**KEEROM**	**UPT Pir II / Yamta**	ATA	Female	24

42	335	**KEEROM**	**UPT Pir II / Yamta**	KATARINA	Female	62
42	336	**KEEROM**	**UPT Pir II / Yamta**	META	Female	31
42	337	**KEEROM**	**Upt Pir V / Yamara**	RIANA	Female	25
42	338	**KEEROM**	**Upt Pir V / Yamara**	PURNAMI	Female	38
42	339	**KEEROM**	**Upt Pir V / Yamara**	MONLI	Female	23
42	340	**KEEROM**	**Upt Pir V / Yamara**	ARI	Female	30
42	341	**KEEROM**	**Upt Pir V / Yamara**	SANTI	Female	30
42	342	**KEEROM**	**Upt Pir V / Yamara**	SUSANA	Female	54
42	343	**KEEROM**	**Upt Pir V / Yamara**	DORLINCE	Female	27
42	344	**KEEROM**	**Upt Pir V / Yamara**	JENI	Female	32
43	345	**KEEROM**	**Usku / Warlef**	MARTHA	Female	23
43	346	**KEEROM**	**Usku / Warlef**	ALEDA	Female	37
43	347	**KEEROM**	**Usku / Warlef**	ERNI	Female	20
43	348	**KEEROM**	**Usku / Warlef**	PATRICIA	Female	38
43	349	**KEEROM**	**Usku / Warlef**	VERA	Female	32
43	350	**KEEROM**	**Usku / Warlef**	ROSMINA	Female	49
43	351	**KEEROM**	**Usku / Warlef**	SUSANA	Female	40
43	352	**KEEROM**	**Usku / Warlef**	YULIANA	Female	47
44	353	ENREKKANG	Bone Bone	DAWIRA	Female	36
44	354	ENREKKANG	Bone Bone	MUANNAS	Female	37
44	355	ENREKKANG	Bone Bone	JUARSE	Female	61
44	356	ENREKKANG	Bone Bone	NADRA	Female	27
44	357	ENREKKANG	Bone Bone	ASLIA	Female	47
44	358	ENREKKANG	Bone Bone	HISMA	Female	26
44	359	ENREKKANG	Bone Bone	LISDA	Female	37
44	360	ENREKKANG	Bone Bone	ULFA	Female	22
45	361	ENREKKANG	Pinang	NURHIDAYANTI	Female	26
45	362	ENREKKANG	Pinang	NURHAYATI	Female	32
45	363	ENREKKANG	Pinang	DARMAWATI	Female	28
45	364	ENREKKANG	Pinang	RADIA	Female	52
45	365	ENREKKANG	Pinang	RASMI	Female	50
45	366	ENREKKANG	Pinang	HASRIANI	Female	22
45	367	ENREKKANG	Pinang	NASMA	Female	37
45	368	ENREKKANG	Pinang	NURHAYANI	Female	47
46	369	ENREKKANG	Pasang	SURIANI	Female	47
46	370	ENREKKANG	Pasang	NURSIA	Female	37
46	371	ENREKKANG	Pasang	SITI AMINAH	Female	31
46	372	ENREKKANG	Pasang	JUMRIAH	Female	48
46	373	ENREKKANG	Pasang	JASMIATI	Female	43
46	374	ENREKKANG	Pasang	ROSDIANA	Female	42
46	375	ENREKKANG	Pasang	MASNAWATI	Female	46
46	376	ENREKKANG	Pasang	RAHMATIA	Female	41
47	377	ENREKKANG	Kolai	MUSLIMAH	Female	27
47	378	ENREKKANG	Kolai	SIANA	Female	39
47	379	ENREKKANG	Kolai	SAPIRA RAIS	Female	36
47	380	ENREKKANG	Kolai	ISMA DENIARI	Female	30
47	381	ENREKKANG	Kolai	JAYANTI EKAWATI	Female	32
47	382	ENREKKANG	Kolai	NUSATI	Female	44
47	383	ENREKKANG	Kolai	DARMI	Female	49
47	384	ENREKKANG	Kolai	HAJIRA	Female	35
48	385	BARRU	Palakka	RIKA	Female	23
48	386	BARRU	Palakka	ROSDIANA	Female	26
48	387	BARRU	Palakka	HARDIANTI	Female	31
48	388	BARRU	Palakka	KARTINI	Female	25
48	389	BARRU	Palakka	SUKARIA	Female	30
48	390	BARRU	Palakka	SUWARNI	Female	24
48	391	BARRU	Palakka	SORIANI	Female	28
48	392	BARRU	Palakka	SUSIANTI	Female	27
49	393	BARRU	Tompo	HJ. DARMA	Female	30
49	394	BARRU	Tompo	RAHMAWATI	Female	28
49	395	BARRU	Tompo	NURAENI	Female	24
49	396	BARRU	Tompo	SUKMAWATI	Female	25

49	397	BARRU	Tompo	HADRIANI	Female	25
49	398	BARRU	Tompo	A. HASNA	Female	40
49	399	BARRU	Tompo	HASMA	Female	35
49	400	BARRU	Tompo	JUMRIANI	Female	28
50	401	BARRU	Paccekke	RESKI	Female	27
50	402	BARRU	Paccekke	ASRIANI	Female	25
50	403	BARRU	Paccekke	YANA	Female	30
50	404	BARRU	Paccekke	BAWASIAH	Female	34
50	405	BARRU	Paccekke	SIDA	Female	30
50	406	BARRU	Paccekke	SUNUSI	Female	37
50	407	BARRU	Paccekke	WIDYA	Female	26
50	408	BARRU	Paccekke	HASRA	Female	27
51	409	BARRU	Kiru-kiru	NOVALIANA	Female	28
51	410	BARRU	Kiru-kiru	SUDARMIN	Female	30
51	411	BARRU	Kiru-kiru	JUSMIATI	Female	40
51	412	BARRU	Kiru-kiru	BUAEDA	Female	34
51	413	BARRU	Kiru-kiru	HASNI	Female	27
51	414	BARRU	Kiru-kiru	ASRIDA	Female	30
51	415	BARRU	Kiru-kiru	NILAWATI	Female	29
51	416	BARRU	Kiru-kiru	SURIANA	Female	31
52	417	LUWU UTARA	Torada	AGUSTINA	Female	35
52	418	LUWU UTARA	Torada	MARIANA	Female	29
52	419	LUWU UTARA	Torada	ROSNAWATI	Female	30
52	420	LUWU UTARA	Torada	SUHARTATI	Female	44
52	421	LUWU UTARA	Torada	FATMA	Female	39
52	422	LUWU UTARA	Torada	HJ. TAMASE	Female	45
52	423	LUWU UTARA	Torada	NOVI	Female	29
52	424	LUWU UTARA	Torada	ST. RABIAH	Female	35
53	425	LUWU UTARA	Kamiri	NASMI	Female	34
53	426	LUWU UTARA	Kamiri	SARNA	Female	30
53	427	LUWU UTARA	Kamiri	JASMA	Female	35
53	428	LUWU UTARA	Kamiri	NURHAYATI	Female	40
53	429	LUWU UTARA	Kamiri	KABURIA	Female	39
53	430	LUWU UTARA	Kamiri	MALLA	Female	29
53	431	LUWU UTARA	Kamiri	SURIANI	Female	30
53	432	LUWU UTARA	Kamiri	NASRA	Female	33
54	433	LUWU UTARA	Baloli	HADAWIAH	Female	30
54	434	LUWU UTARA	Baloli	ST. SULFIAH S	Female	35
54	435	LUWU UTARA	Baloli	RASIDAH	Female	29
54	436	LUWU UTARA	Baloli	HUSNAENI	Female	40
54	437	LUWU UTARA	Baloli	JASNA	Female	43
54	438	LUWU UTARA	Baloli	HASNITA	Female	35
54	439	LUWU UTARA	Baloli	SUJUDIAH	Female	45
54	440	LUWU UTARA	Baloli	JAMILAH	Female	30
55	441	LUWU UTARA	Banyuwangi	MURSINEM	Female	44
55	442	LUWU UTARA	Banyuwangi	KRISTIANI	Female	29

55	443	LUWU UTARA	Banyuwangi	LASMIATI	Female	43
55	444	LUWU UTARA	Banyuwangi	ENDRILESTARI	Female	27
55	445	LUWU UTARA	Banyuwangi	SRIYATI	Female	29
55	446	LUWU UTARA	Banyuwangi	SUMARTI	Female	33
55	447	LUWU UTARA	Banyuwangi	MISTI	Female	40
55	448	LUWU UTARA	Banyuwangi	LATIFAH	Female	32
56	449	TAKALAR	Bonto Kassi	JUMRIANI	Female	28
56	450	TAKALAR	Bonto Kassi	ST WAHIDAH	Female	34
56	451	TAKALAR	Bonto Kassi	ST AISYAH	Female	20
56	452	TAKALAR	Bonto Kassi	ST MARYAM	Female	45
56	453	TAKALAR	Bonto Kassi	NURHAYATI	Female	38
56	454	TAKALAR	Bonto Kassi	KAMISA	Female	37
56	455	TAKALAR	Bonto Kassi	FITRIANI	Female	22
56	456	TAKALAR	Bonto Kassi	RAHMAWATI	Female	45
57	457	TAKALAR	Pakkabba	HASNIA	Female	40
57	458	TAKALAR	Pakkabba	RIKA	Female	22
57	459	TAKALAR	Pakkabba	SYAMSIAH	Female	40
57	460	TAKALAR	Pakkabba	SURIANI	Female	40
57	461	TAKALAR	Pakkabba	SYAMSIAH	Female	39
57	462	TAKALAR	Pakkabba	HASNIAH	Female	39
57	463	TAKALAR	Pakkabba	SYAHRIANJ	Female	36
57	464	TAKALAR	Pakkabba	ROSTINA	Female	40
58	465	TAKALAR	Bajeng	SALMA	Female	42
58	466	TAKALAR	Bajeng	JUMRIANA	Female	37
58	467	TAKALAR	Bajeng	SURIANI	Female	38
58	468	TAKALAR	Bajeng	NURHAYATI	Female	41
58	469	TAKALAR	Bajeng	DG SO'NA	Female	40
58	470	TAKALAR	Bajeng	SYAMSIAH	Female	40
58	471	TAKALAR	Bajeng	RADIATI	Female	45
58	472	TAKALAR	Bajeng	SRI RATIH	Female	27
59	473	TAKALAR	Lassang	KASMAWATI	Female	20
59	474	TAKALAR	Lassang	RATNA	Female	45
59	475	TAKALAR	Lassang	SALAWATI	Female	32
59	476	TAKALAR	Lassang	MARDIANA	Female	35
59	477	TAKALAR	Lassang	NURHAYATI	Female	22
59	478	TAKALAR	Lassang	JUNAEDA	Female	35
59	479	TAKALAR	Lassang	ROSNAWATI	Female	41
59	480	TAKALAR	Lassang	BASMAWATI	Female	44
60	481	MANGGARAI	Bangka Lao	DARIA IDA	Female	23
60	482	MANGGARAI	Bangka Lao	MARGARETA JULIA	Female	21
60	483	MANGGARAI	Bangka Lao	YOSEFINA ANUT	Female	22
60	484	MANGGARAI	Bangka Lao	MONIKA BIBA	Female	42
60	485	MANGGARAI	Bangka Lao	SOFIA INDAH	Female	34
60	486	MANGGARAI	Bangka Lao	SOFIA ALUT	Female	42
60	487	MANGGARAI	Bangka Lao	MARIA DANUL	Female	41
60	488	MANGGARAI	Bangka Lao	FRANSISKA WIS	Female	41
61	489	MANGGARAI	Kakor	MARIA GORETI JAUNG	Female	44
61	490	MANGGARAI	Kakor	YOHANA DALUS	Female	45
61	491	MANGGARAI	Kakor	MARIA GORETI TRINCE	Female	39
61	492	MANGGARAI	Kakor	EDELTRUDIS BURGA	Female	29
61	493	MANGGARAI	Kakor	ROFINA SELIMAN	Female	34
61	494	MANGGARAI	Kakor	SUSANA SRIYENI	Female	36
61	495	MANGGARAI	Kakor	FELIANA ROSTIN	Female	34
61	496	MANGGARAI	Kakor	NATALIA DEWI	Female	42
62	497	MANGGARAI	Pongkor	ELVIRA SURTIN	Female	30
62	498	MANGGARAI	Pongkor	KOSMELIA JEMAMU	Female	35
62	499	MANGGARAI	Pongkor	VICTORIA JURIA	Female	40
62	500	MANGGARAI	Pongkor	HIPOLITA NOVITA	Female	31
62	501	MANGGARAI	Pongkor	FRANSISCA IDA	Female	24
62	502	MANGGARAI	Pongkor	FELISITAS GASA	Female	27
62	503	MANGGARAI	Pongkor	MARIN M	Female	42
62	504	MANGGARAI	Pongkor	PRAKSEDIS	Female	43
63	505	MANGGARAI	Lalong	LIDIA BUHUNG	Female	27
63	506	MANGGARAI	Lalong	AGNES SETIA	Female	44

63	507	MANGGARAI	Lalong	MARIA FATIMA	Female	37
63	508	MANGGARAI	Lalong	BERGITA JELIMAN	Female	33
63	509	MANGGARAI	Lalong	ELISABET PITA	Female	40
63	510	MANGGARAI	Lalong	RENSIANA IDA	Female	38
63	511	MANGGARAI	Lalong	BIBIANA IMBUNG	Female	32
63	512	MANGGARAI	Lalong	TOLIANA JELAMUT	Female	30
64	513	SUMBA TIMUR	Mandahu	NISANTIAWAN L EWUT	Female	18
64	514	SUMBA TIMUR	Mandahu	KATRINA K NGGUNA	Female	39
64	515	SUMBA TIMUR	Mandahu	YOHANA D WOTUNG	Female	40
64	516	SUMBA TIMUR	Mandahu	PINCE B KARUKU	Female	23
64	517	SUMBA TIMUR	Mandahu	ARDIANA K NARA	Female	18
64	518	SUMBA TIMUR	Mandahu	NDANGA PAI	Female	54
64	519	SUMBA TIMUR	Mandahu	FREDERIKA B NALLA	Female	22
64	520	SUMBA TIMUR	Mandahu	YUNITA P KUALAK	Female	23
65	521	SUMBA TIMUR	Pamburu	ESTER N.KAHI	Female	36
65	522	SUMBA TIMUR	Pamburu	YUNITA H LADA	Female	31
65	523	SUMBA TIMUR	Pamburu	MARTA M	Female	60
65	524	SUMBA TIMUR	Pamburu	NDABU NINDI	Female	60
65	525	SUMBA TIMUR	Pamburu	KUKU YOWO	Female	65
65	526	SUMBA TIMUR	Pamburu	MINA IPO HOY	Female	30
65	527	SUMBA TIMUR	Pamburu	APRIANA W H	Female	41
65	528	SUMBA TIMUR	Pamburu	LUNGA LANGGA NAU	Female	56
66	529	SUMBA TIMUR	Tapil	PUTRI MBANGI	Female	25
66	530	SUMBA TIMUR	Tapil	DESI NDANGA	Female	34
66	531	SUMBA TIMUR	Tapil	NDAWI NGGANA	Female	42
66	532	SUMBA TIMUR	Tapil	NAWAR K ATTA	Female	29
66	533	SUMBA TIMUR	Tapil	YUSTINA P LEMBA	Female	19
66	534	SUMBA TIMUR	Tapil	MAY TOLANG	Female	65
66	535	SUMBA TIMUR	Tapil	ADRIANA ULLU LENDI	Female	37
66	536	SUMBA TIMUR	Tapil	HALA H BAANAI	Female	48
67	537	SUMBA TIMUR	Lailunggi	DAMARIS	Female	45
67	538	SUMBA TIMUR	Lailunggi	MILKA NDABU	Female	33
67	539	SUMBA TIMUR	Lailunggi	MEGAWARNI K NGGAJI	Female	22
67	540	SUMBA TIMUR	Lailunggi	ASTRINCE MAU	Female	29
67	541	SUMBA TIMUR	Lailunggi	ANTONETA DJ BUNGA	Female	40
67	542	SUMBA TIMUR	Lailunggi	MARLAN T PANGAMBANG	Female	40
67	543	SUMBA TIMUR	Lailunggi	DEVANTARI N LAPIR	Female	24
67	544	SUMBA TIMUR	Lailunggi	ATALIA JERA	Female	29
68	545	ALOR	Wolwal Barat	EKA SANTI	Female	30
68	546	ALOR	Wolwal Barat	AMINAH	Female	37
68	547	ALOR	Wolwal Barat	SELFINA P	Female	44

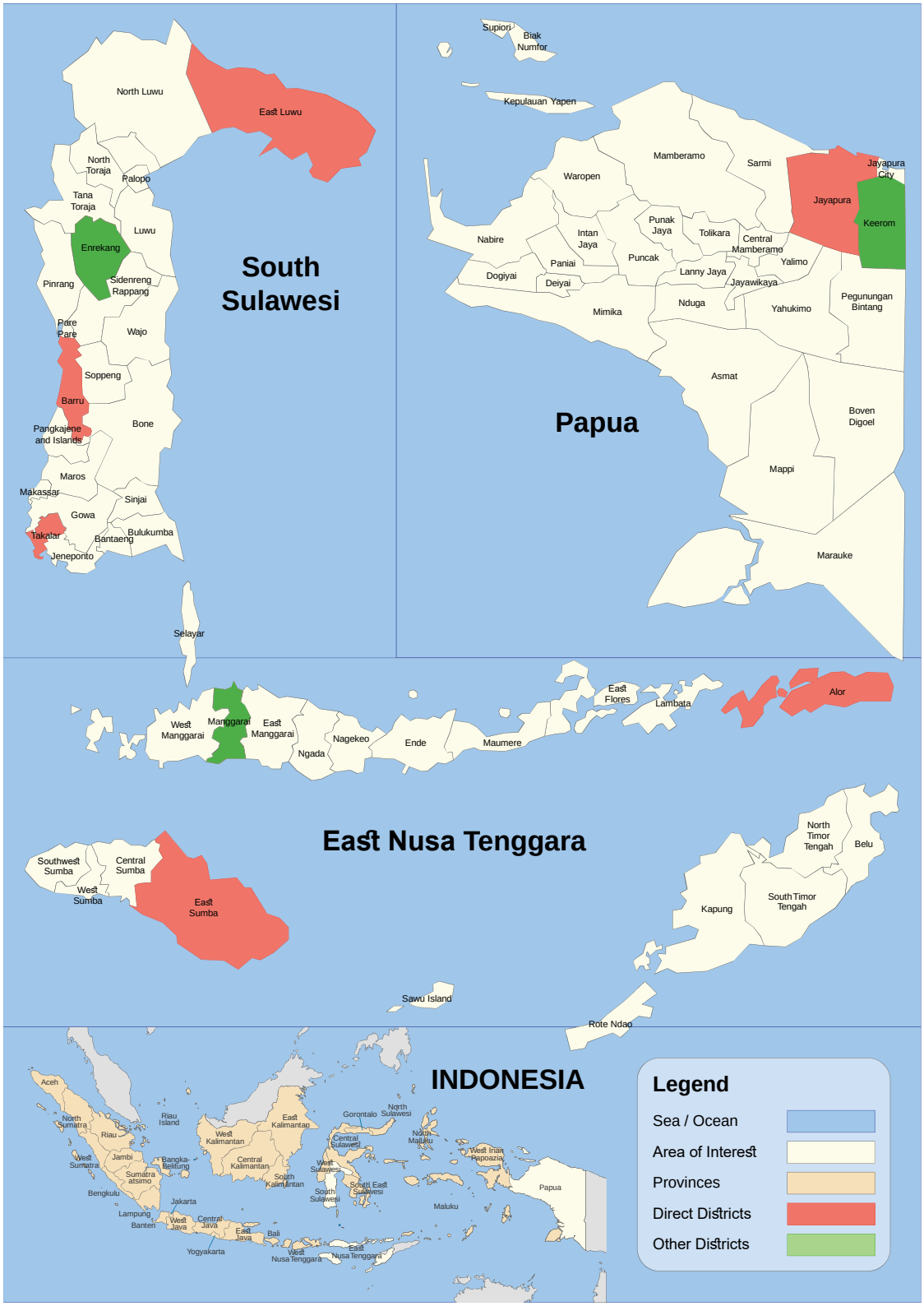
68	548	ALOR	Wolwal Barat	NASRA K	Female	35
68	549	ALOR	Wolwal Barat	KARTINI S	Female	45
68	550	ALOR	Wolwal Barat	SANARIA M	Female	37
68	551	ALOR	Wolwal Barat	WAISA M	Female	34
68	552	ALOR	Wolwal Barat	SALEHA	Female	41
69	553	ALOR	Belemana	YUNITA M	Female	23
69	554	ALOR	Belemana	MERRY M	Female	43
69	555	ALOR	Belemana	MASALINA	Female	44
69	556	ALOR	Belemana	MARSELINDA	Female	47
69	557	ALOR	Belemana	CHATERINA	Female	21
69	558	ALOR	Belemana	YULINDA	Female	39
69	559	ALOR	Belemana	YUIANA	Female	28
69	560	ALOR	Belemana	KOBA	Female	33
70	561	ALOR	Bouweli	NELCI PULING	Female	30
70	562	ALOR	Bouweli	RUMI ERLIANA	Female	29
70	563	ALOR	Bouweli	SUSIANTI	Female	36
70	564	ALOR	Bouweli	KATERINA KLAPIN	Female	45
70	565	ALOR	Bouweli	THERESIANA W	Female	28
70	566	ALOR	Bouweli	NOVILALANG	Female	26
70	567	ALOR	Bouweli	ORIYANTI	Female	28
70	568	ALOR	Bouweli	NELLA	Female	20
71	569	ALOR	Pulau Buaya	MUTIARA A SOKAN	Female	34
71	570	ALOR	Pulau Buaya	HAJAR LAAN	Female	28
71	571	ALOR	Pulau Buaya	IRMA ANAS	Female	22
71	572	ALOR	Pulau Buaya	RUCMINA SULAEMAN	Female	31
71	573	ALOR	Pulau Buaya	FITRA AN AHMAD	Female	24
71	574	ALOR	Pulau Buaya	ISNAENI	Female	22
71	575	ALOR	Pulau Buaya	SUMIYATI TULANG	Female	30
71	576	ALOR	Pulau Buaya	RUHAYAT ARBAT	Female	47

Appendix 5.3: Sampling Strategy for the FGDs

Two FGDs were conducted in each of the four selected communities of the nine selected districts, thereby equalling 72 FGDs.

PROV	DISTRICT	SUB DISTRICT	VILLAGE
Papua	Jayapura	Depapre	Entiyebo
Papua	Jayapura	Kemtuk	Nambon
Papua	Jayapura	Kemtuk Gresi	Bring
Papua	Jayapura	Nimboran Timur / Namblong	Besum
Papua	Jayapura	Nimbokrang	Wahab
Papua	Jayapura	Sentani Timur	Yokiwa
Papua	Keerom	Arso	Yanamaa / Pir I
Papua	Keerom	Arso	UPT Pir II / Yamta
Papua	Keerom	Arso Timur	Upt Pir V / Yamara
Papua	Keerom	Senggi	Usku
NTT	Alor	Alor Barat Daya	Wolwal Barat
NTT	Alor	Alor Timur	Belemana
NTT	Alor	Pantar	Bouweli
NTT	Alor	Pulau Pura	Pura Utara
NTT	Alor	Alor Barat Laut	Pulau Buaya
NTT	Manggarai	Ruteng	Bangka Lao
NTT	Manggarai	Ruteng	Kakor
NTT	Manggarai	Ruteng	Pong Lale
NTT	Manggarai	Satar Mese	Pongkor
NTT	Manggarai	Wae Rii	Lalong
NTT	Sumba Timur	Katala Hamu Lingu	Mandahu
NTT	Sumba Timur	Pahunga Lodu	Pamburu
NTT	Sumba Timur	Pahunga Lodu	Lambakara
NTT	Sumba Timur	Tabundung	Tapil
NTT	Sumba Timur	Pinupahar	Lailunggi
SS	Luwu Utara	Masamba	Torada
SS	Luwu Utara	Masamba	Kamiri
SS	Luwu Utara	Masamba	Baloli
SS	Luwu Utara	Sukamaju	Banyuwangi
SS	Enrekang	Baraka	Bone Bone
SS	Enrekang	Cendana	Pinang
SS	Enrekang	Cendana	Taulan
SS	Enrekang	Maiwa	Pasang
SS	Enrekang	Malua	Kolai
SS	Barru	Barru	Palakka
SS	Barru	Barru	Tompo
SS	Barru	Soppeng Riaja	Paccekke
SS	Barru	Soppeng Riaja	Kiru-Kiru
SS	Barru	Pujananting	Gattareng
SS	Takalar	Galesong Selatan	Bonto Kassi
SS	Takalar	Galesong Utara	Pakkabba
SS	Takalar	Pattallassang	Bajeng
SS	Takalar	Polombangkeng Utara	Lassang

Appendix 6: Map for Geographic Coverage of the Evaluation



Appendix 7: Ethical Clearance Approval Letter

UNIVERSITAS KATOLIK INDONESIA
ATMA JAYA

Nomor : 904 /III/LPPM-PM.10.05/07/2017

24 Juli 2017

Kepada Yth.
Nadeem Haider
AAN Associates, 108, Executive Heights, F-11/1, Islamabad 44000
E-mail : nadeem.haider@aanassociates.com

Hal. : Persetujuan *Ethical Clearance*

Dengan hormat,

Setelah melakukan *peer review* terhadap proposal penelitian berjudul:

"Sanitasi Total Berbasis Masyarakat (STBM) - Endline Survey""

dengan ini kami sampaikan bahwa Komisi Etika Penelitian Universitas Katolik Indonesia Atma Jaya menyatakan bahwa proposal laik etik untuk dilaksanakan, sesuai masukan dari Tim Komisi Etika Penelitian terlampir.

Diharapkan setelah pelaksanaan, Saudara dapat memberikan laporan beserta uraian pelaksanaan penjaminan aspek etika penelitian tersebut.

Demikian kami sampaikan, atas perhatian dan kerjasamanya kami ucapkan terima kasih.

Hormat kami,

Dr. Alexander Seran, MA
Ketua Komisi Etika Penelitian Unika Atma Jaya

Appendix 8: Five Pillars of the STBM Programme

The Five Pillars of the STBM Programme

Pillar 1: Stop Open Defecation
The first pillar worked on a behaviour change strategy to end OD in Indonesia. This behaviour change was followed by the promotion of healthy sanitary latrines that meet the health standards and requirements of improved sanitation.

Pillar 2: Hand Washing with Soap and running water
Pillar 2 was concerned with the promotion of HWWS behaviour. HWWS aimed to promote handwashing behaviour at the right time (after defecation, before eating etc.) and using the correct technique.

Pillar 3: Drinking Water and Food Management
Drinking Water Management and HH Food Management promotes safe methods of storing and utilizing drinking water and food in the HH.

Pillar 4: Domestic Solid Waste Management
The purpose of HH Waste Security was to avoid garbage storage inside the HH through the promotion of the immediate disposal of garbage. This involved the collection, transportation, processing and recycling/disposal of waste material in ways that avoid harming public health and the environment.

Pillar 5: Domestic Liquid Waste Water Management.
This pillar covered HH practices related to the safe handling and disposal of liquid waste. Wastewater refers to used water that has the potential to cause diseases. The aspects covered under this pillar were:

- Safe methods of handling liquid waste in the house to avoid puddles.
- HH liquid waste in the form of faeces and urine channelled into septic tanks equipped with wells.
- HH wastewater in the form of waste water resulting from kitchen, bathroom, and kitchen waste.
- Means of HW channelled to the drain waste.

Appendix 9: CATS and CLTS

The Community-Led Total Sanitation (CLTS) approach was evolved between 2000-2003 primarily by the pioneering work of Kamal Kar in Bangladesh and later by Robert Chambers from 2003-2008. It comprises of a set of nine well-defined principles to mobilize communities for complete eradication of open defecation. Later, in 2008, with the adoption of new global WASH strategy for 2006-2015, UNICEF came up with an umbrella approach of the Community Approaches to Total Sanitation (CATS) concept, which is an umbrella term used by UNICEF sanitation practitioners to encompass a wide range of community-based sanitation programming. The description below encompasses the key differences[62] between CLTS, as a separate approach, and CATS, as a set of approaches (including CLTS):

- CATS empowers communities through active involvement and stewardship by the government whereas under CLTS, the communities are largely responsible for driving the change.
- CATS covers multiple approaches such as 'School led total sanitation (SLTS), hygiene education, behaviour change communication, sanitation marketing, total sanitation campaign, healthy villages, and other approaches as appropriate based on community analysis and solutions to Eliminate OD, move up the sanitation ladder, sustain and scale-up the change, whereas CLTS is a singular approach to eliminate OD;
- CATS offers more flexibility to allow for innovation and customization to local conditions whereas CLTS is somewhat inflexible.
- The key motivators for CATS are 'Respect, dignity and pride' compared to 'Shame, shock and disgust'.
- CLTS emphasize to provide any subsidies though rewards for achieving ODF can be argued as some form of subsidies. in contrary, CATS allow to offer some form of financial support under certain conditions.

Box 3.07: CLTS

CLTS can be defined as 'An innovative methodology for mobilizing communities to completely eliminate open defecation (OD). Communities are facilitated to conduct their own appraisal and analysis of OD and take their own action to become ODF (open defecation free). At the heart of CLTS lies the recognition that merely providing toilets does not guarantee their use, nor result in improved sanitation and hygiene. [...] CLTS focuses on the behavioural change needed to ensure real and sustainable improvements – investing in community mobilization instead of hardware, and shifting the focus from toilet construction for individual households to the creation of open defecation-free villages. By raising awareness that as long as even a minority continues to defecate in the open everyone is at risk of disease, CLTS triggers the community's desire for collective change.'

Source: Evaluation of the WASH Sector Strategy 'Community Approaches to Total Sanitation' (CATS); Final Evaluation Report, March 2014. United Nations Children's Fund, New York, 2014

<u>The CLTS Process</u>

CLTS aims to provide awareness among the community members that OD is a problem with health and environment-related consequences, and it can be eliminated by behaviour change. The process of CLTS has suggested a sequence of steps that need to be followed; these steps act like a tool to trigger communities especially in rural areas. Steps to follow in achieving ODF through triggering are;

1. Introduction and rapport building
2. Participatory analysis
3. Ignition moment
4. Action planning by community
5. Follow up

[62] CATS vs. CLTS – Draft Summary: Based on Discussions on the CATS CoP; Dec. 9 – 14, 2015. Extracted from the document shared by Jeremie Toubkiss; Evaluation Advisor, UNICEF HQ.

The process for ODF achievement (verification/declaration) comprises of three phases, namely a) Pre-triggering, b) Triggering and c) Post-triggering.

Pre-triggering (Step 1)

Pre-triggering is the process by which communities are assessed to be suitable for CLTS intervention. It involves rapport-building with the facilitators, which involves several visits of the identified communities with respect to different criteria. This process is used to identify communities that are expected to respond well to triggering. This phase covers step 1 i.e. introduction and rapport-building.

Triggering (Step 2-4)

Triggering usually takes place at the dusun (community) level by the sanitarians from the Puskesmas (local health centre) or front-line workers. The process can be modified according to the perceptions, norms and myths of the residents of that area. The dusun (community) is a smaller administrative unit of a village. The ODF declaration (certification) is done at the desa (village) level which is usually comprises of multiple dusun (communities).

The triggering process involves the 'ignition phase', which brings the community people together on similar thinking grounds, enabling them to see OD as a real problem. The process of triggering in CLTS is to create a sense of disgust in the community by physical demonstration of sanitation problems. Leaders that are selected to work towards bringing the change are selected from the community. They can be anyone that can influence the behaviour of their people. They are known as the Natural Leaders or Champions of sanitation.
,

Post-triggering (Step 5)

Intensive post-triggering visits by sanitarians was a salient feature of the UNICEF's support to STBM. While the government an STBM monitoring system in place, which was also used by UNICEF, the system was not detailed enough to capture all the required information. Therefore, an additional programme monitoring tool was developed and implemented by UNICEF.

After a successful ignition phase, the post-triggering phase informs the communities of proper sanitation services and guides them through it, in order to enable them to gain access to improved latrines and water sources. This was supported by the facilitators, placed at the community levels by NGOs, who provided the communities with relevant guidance according to their local situations.

Appendix 10: STBM Programme Overview Additional Information

ODF Declaration and Verification

STBM verification is conducted to measure behaviour change in the community. ODF status is normally granted through a verification process by the district POKJA AMPL (WASH working group). This process followed the nationally-set ODF criteria by the MoH.

The verification process is initiated by a request from the village to the district government and Puskesmas (local health centre). Verification may also be conducted as part of a regular monitoring regimen to determine whether ODF status should be granted. The verification team was required to survey 100% of the houses in the community; the team used a combination of interviews and observations to ascertain compliance with the relevant criteria. Once this process was complete, the verification team had to report the criteria of the assessment, the result achieved and the planned next steps to the village. The next steps depended on the outcome of the verification, which may have been 1) to postpone the declaration, 2) to continue the declaration, 3) to maintain ODF status or 4) to revoke ODF status[63].

The STBM Verification process used the STBM Verification Guidelines issued by Indonesia's MoH. Table 1.03.1 outlines the criteria used to determine whether a community can be declared ODF[64].

Table App. 10: ODF Declaration Guidelines/Criteria

#	Criteria	Answer	Note
1	The toilet has a cover to prevent insects from touching the faeces/ excrement	Yes	Clear. If it is goose neck (i.e. water seal), then cover is no longer required
2	Distance of disposal pit into wells/shallow wells >10 m	Yes	Clear. If it is <10 m, then
3	Faeces from babies and elder people (if any) are disposed to the toilet	Yes	Biofill, etc.
4	Everyone in the house uses the latrine	Yes	Clear. If it is <10 m, then
5	Access to anal cleansing is available	Yes	Storage stool must be waterproof. For example: concrete septic tank,
6	No faeces seen in the houses, garden, river		Biofill, etc.

Baseline and Midline Surveys

The baseline Household Survey (HHS) was conducted in February 2014 in 1700 Households (HHs) from all six intervention districts to assess the Knowledge, Attitude and Practices (KAP) before Programme implementation. Focus Group Discussions (FGDs), In-Depth Interviews (IDIs) and observations were used to assess pre-KAP situation. The objectives of this survey were to establish a baseline of the pre-implementation status in targeted communities and to inform UNICEF-BMGF programme design and support to government on accelerating STBM[65].

In 2016, a rapid midline household survey was carried out in three of the six intervention districts (Sumba Timur, Luwu Utara and Jayapura) to assess the progress at midpoint of UNICEF's technical assistance. The sample was 100 HHs per district, adding up to a total of 300 HHs. The HH survey was complemented by FGDs, interviews and observations to assess

63 Ministry of Health of the Republic of Indonesia (MoH), 2013a. Guidance Book on Verification of Community Based Total Sanitation. [.pdf, online] Available at: http://www.communityledtotalsanitation.org/sites/communityledtotalsanitation.org/files/STBM_Verification_Guideline.pdf [Accessed: 6 June 2017].

64 ibid

65 Sanitation and Hand Washing Baseline and Knowledge, Attitudes and Practices (KAP) Study in Support of the Strengthening Community Approaches to Total Sanitation (STBM) Project in Six Districts of Eastern Indonesia. Nov 2014.

KAP. The objective of the midline survey was to assess the progress made in relation to key indicators and to explore issues with ODF status sustainability[66].

SMS Based Monnitoring System

SMS data was generated at the sub-district level where sanitarians provided monthly SMS inputs and reports on ODF declaration events. This data was then sent directly to a database at the national level in the MoH. The process followed a specific format so that the data could be compiled automatically in the system. The format included information to identify the sender (mobile number, name, village name and sub-district name). In areas without reliable access to the internet or to electricity, monitoring templates are filled manually and consolidated at the district level.

Development of the Monitoring Templates/Frameworks

UNICEF's support to STBM aimed to strengthen the field monitoring of the STBM Programme. For this purpose, UNICEF supported the local governments in developing the monitoring templates[67] to gather detailed information at the district level in both 'direct' and 'indirect' districts. These templates have been revised and updated thrice, in October 2015, May 2016 and April 2017. The 'determinants and indicators' are divided into many categories: enabling environment, demand creation, supply and Monitoring and Evaluation (M&E). Space is also provided for the facilitator to note down comments at the province level, the district level and any other comments.

The source of each response is also recorded, and the month/year in which the data was collected if available. A variety of sources is possible, ranging from planning/design documents, communications to/from government officials, records and so on.

Knowledge Management

UNICEF-BMGF assistance prioritised supporting and strengthening the knowledge management. This included assistance around improving and facilitating the reflections, documentation, wider dissemination (for information and possible replication) of learning. The key activities included collection and dissemination of data; data analysis for knowledge creation; documentation; dissemination (at all levels); and adoption and replication of knowledge produced. The focus was to not only disseminate locally but across the region to inform the WASH interventions and investments in other countries.[68] Knowledge management activities involve:

1. The collection and sharing of data.
2. The analysis of data/information to generate knowledge.
3. The documentation of knowledge.
4. The dissemination of knowledge.
5. The adoption and application of knowledge.

Knowledge management also facilitates cross-learning across different programmes, improved coordination between the different levels of government, the capacity building of human resources, and planning. Details on the activities listed above were part of the evaluation.

The lessons extracted by the knowledge management activities of UNICEF support to STBM are collected in review documents published by the East Asia and the Pacific Regional Office

[66] WASH Rapid Midline Survey as Part of STBM Support from the BMGF Supported Work in Eastern Indonesia 2016.

[67] While the Government has a STBM monitoring system which is used by UNICEF to assess progress, it is not detailed enough to capture all the information required by UNICEF, and hence the monitoring template referred to here is the UNICEF developed one.

[68] Programme Document: Proposal for UNICEF support to STBM; U.S. Fund for UNICEF (USF)

(EAPRO) in 2013 and another in 2015. These 'remote reviews' were developed by review teams in each country in the region, including UNICEF country offices (which produced country status updates), Plan International, WaterAid and the WSP. Interviews with key national and regional informants and case studies also contributed relevant information. Topics covered included various aspects of CATS implementation, such as urban CLTS, sanitation marketing, ODF verification techniques etc. Once prepared, these reviews were discussed with regional review partners in various events and conferences.

Analysis of the ToC

Find below evaluators' a short appraisal of the UNICEF-BMGF Assistance for STBM Programme.

- In terms of composition, the ToC comprises five outcomes, ten strategies, and a series of intermediate outcomes and outputs. The strategies are further separated into four categories namely *a) enabling environment, b) supply chain, c) demand creation, and d) quality of the ODF verification process;*
- The ToC identifies results at several levels i.e. intermediate outputs, outputs, intermediate outcomes, outcomes and impact. It lists bottlenecks and consolidates risks and assumptions. The consolidation of risks and assumptions appears to be inconsistent with UNICEF ToC guidelines[69], that suggest listing risks and assumptions separately and distinguishing them across varied levels of results;
- The impact indicator is clear and relates to relevant SDGs, whereas outcome and interim outcome indicators appear less explicit and inconsistent with standard criteria of SMART indicators i.e. specific, measurable, achievable, realistic, and time-bound;
- The listing of bottlenecks is useful, however their placement at the bottom has diluted their utility. The ToC could prove more useful if bottlenecks could be placed across different levels of result areas.
- The availability of the ToC and that too while programme was in implementation is indeed encouraging and useful for evaluation. The causal linkages or pathways of change, are clear and in that way enabled an objective assessment of logic of the planned interventions vis-a-vis the envisioned results, achievements and UNICEF's added value. The evaluation is focused more on the outcome level results.

[69] Revised Supplementary Programme Note on the ToC for the UNICEF Strategic Plan 2014-2017

Appendix 11: Additional Information – Chapter 3 – Evaluation Findings

11.1 UNICEF Value Additions

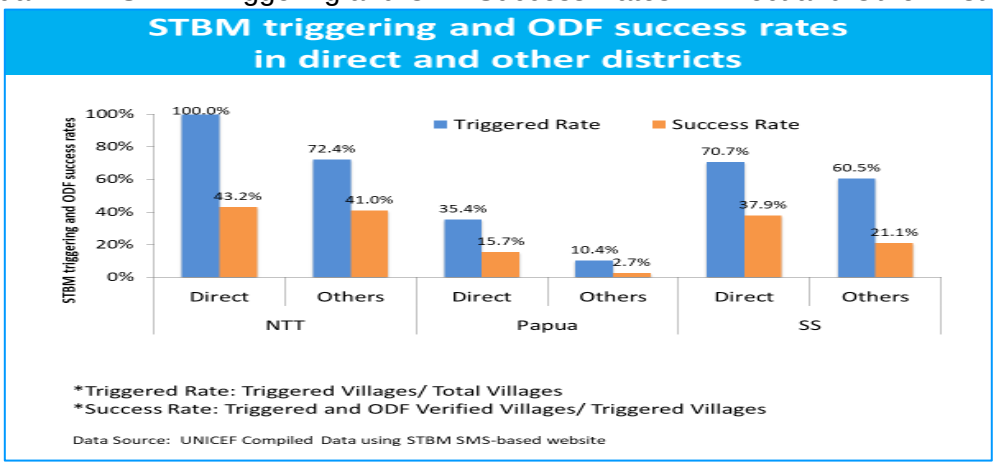
STBM Acceleration and Scale-up

In two 'direct' districts of NTT province, all villages were triggered (100%) whereas the triggering rate is about 72% for 'Other' districts, indicating a significant difference in STBM coverage due to presence of UNICEF in 'direct' districts compared to districts where government is implementing STBM without UNICEF support. However, a marginal difference is noted in success rate (43% to 41%) of both categories of districts in NTT. The plausible explanations are the better backstopping and strong push factor to the districts governments (All bupati) and the DHOs by the more proactive provincial POKJA AMPL, the active role of the BAPPEDA and the high level of commitment and motivation by the PHO due to UNICEF advocacy and technical support at provincial level. All technical support and advocacy efforts of the UNICEF has resulted in an improved enabling environment at provincial level that has helped all the districts to improve the quality of implementation leading to a comparable success rate. The other contributing factor is the presence of a reasonable number of local partners (small NGOs) that are supporting the government in STBM implementation.

The data from 'direct' districts of two other provinces also clearly reflects that UNICEF technical assistance has contributed significantly in expanding the STBM coverage (triggering rate, (TR) and improving the success rate (SR) in 'direct' districts, comparing to situation in 'other' districts.

1. For Papua, TR is at 35% for 'direct' districts compared to 10% in 'Other' districts. Similarly, the SR is around 16% in 'direct' district compared to nearly 3% for 'other' districts.
2. For SS, TR is at almost 71% for 'direct' districts compared to approximately 61% in 'Other' districts. Similarly, the SR is around 38% in 'direct' district compared to 21% for 'other' districts.

Visual 11.1: STBM Triggering and ODF Success Rates in Direct and Other Districts



System strengthening approach

UNICEF has contributed in enhancing the overall capacity of the National STBM Secretariat under the MoH that coordinates with BAPPENAS, the Working Group for Drinking Water and Environmental Sanitation (POKJA AMPL), other relevant government departments and WASH sector partners to improve the planning and implementation of STBM at the national and sub-national levels. UNICEF has been able to revive mostly dormant POKJAs in a number of districts, through its advocacy.

A shift from output to outcome

Low quality of triggering (very low attendance of the community members, poor level of participation that is associated with reward/incentive expectations, and weak capacity of the sanitarians) was cited as one of the most cited challenge to STBM scale-up. Prior to UNICEF support to STBM, quality of triggering was not noted as a barrier to STBM scale-up, however, with UNICEF technical support, government is now convinced on the need of high quality triggering. Though any concrete planning or actions are still waited from government, to increase the number of sanitarians (insufficient number of sanitarians is a contributing factor to low quality of the triggering).

A high-quality triggering in the first instance, results in a faster and smoother process towards ODF status. High quality triggering also ensures that the community takes the lead in eliminating OD and develops solutions to its own problems. On the other hand, weak triggering, always requires extensive follow-up activities and post-triggering monitoring. In current circumstances, a sanitarian is responsible to cover approximately 30,000 people (estimated population in the catchment area of a Puskesmas, each Puskesmas generally has only one sanitarian); *it is difficult for the current number of sanitarians to execute post-triggering monitoring and other follow-up activities*. Although, Posyandu-based health workers and other community based Kaders are present to support sanitarians, they however, are not accountable for ODF related achievements and failures. *Therefore, specific target setting for the sanitarians and linking these to accountability is required in the long run to ensure sustainable results.*

Focus on Behaviour Change Communication

Prior to UNICEF support, the government did not focus on behaviour change communication as a tool to support STBM due to focus on 'increase in number of latrines' partly due to the view that triggering alone was sufficient to achieve ODF. As such, *UNICEF efforts to promote long lasting improved WASH behaviours through creation of 'Social Norm' represents a significant value addition to STBM*. Presently government acknowledges the value of regular multi-channel communication campaigns as part of post-triggering actions at community level.

Partnership Dividends

By establishing partnerships and building the capacity of partners, UNICEF has increased the ability of its partners to support the current programme, and, has also enhanced the sustainability of STBM in general. The connections formed between the partners and the government during coordination, the experience gained by the partners and the training received will enable these organisations to continue to support STBM in the future, with or without UNICEF. The government will have access to better implementing partners, as well as experienced individuals to use in future training.

KM and Sharing of Lessons Learned

The collection, documentation and sharing of innovations and lessons learned, between provinces and districts of all categories is a commendable contribution of UNICEF. This *'enabled sharing'* has empowered government to replicate novel interventions from one district to all others regardless of economic status of the recipient district.

11.2 UNICEF Contribution to Strengthening of STBM Monitoring

In continuation of the key findings on the monitoring system presented in section 3.5.1 of the main report, this appendix elaborates upon the following:

- The evolution of the SMS based monitoring system, its weaknesses, refinement of the indicators
- The training of sanitarians on SMS based monitoring system and issues faced to sanitarians in implementing the new indicators and the POKJA's strategy to overcome the challenges faced by the sanitarians regarding the application of the new monitoring system.
- The new Android based monitoring system at provincial level introduced in NTT by UNICEF with support from POKJA AMPL.

SMS based Monitoring System (SMS BMS)

WSP supported the pilot implementation of SMS BMS in five provinces including the NTT province. The development and application of SMS-based STBM monitoring system was considered a feasible solution to address the current challenges and future needs of the STBM Programme. By 2014, SMS based monitoring system was being implemented in six provinces. At start of UNICEF support to STBM in 2013, due to lack of sufficient funds for M&E, MoH asked for UNICEF assistance. UNICEF undertaken a SWOT type assessment for the monitoring at provincial level to strategize its inputs. UNICEF supported MoH by appointing a dedicated KM expert to look into the significant challenges of the existing SMS BMS. At that time, the system encountered the challenges listed below related to both software and hardware:

1. No baseline was conducted or available, or not necessarily a single baseline done. All ovinces and districts have had different data except six provinces (5 WSP and NTT) where system was piloted, had collected baseline data and monitoring was done to collect progress updates.
2. Progress Reporting to MoH was done manually
3. Progress was tracked at Dusun (sub-village) level, where triggering was done
4. Village level ODF progress was not tracked and reported until 2014. UNICEF convinced MoH to change the monitoring system to collect ODF progress data at village level.

It is worth mentioning that before introduction of SMS-based monitoring, no data was collected on OD, which remained a major gap in tracking and consolidation of the data on ODF progress at all levels. Previously, use of pit latrine was equated to OD for reporting purpose.

Before SMS based monitoring system, sanitarians were doing manual monitoring and sending the reports to DHO once in every three months to update progress on availability and type of latrines. The manual monitoring was covering the following three types of latrines following the MoH definitions;

1. Pit latrine (Camplung) – pit covered with slab made up of any local material, wood cement etc., faeces directly go into a big hole usually sufficient for 8-12 months or even more to get it filled depending upon the usage and load. A Pit latrine can still be categorized as a 'healthy' latrine, if it meets the MoH minimum requirement about a healthy latrine.
2. Pour Flush latrine (Plengsengan) but not connected with septic tank.
3. Flush Latrine with water (Leher Angsa / goose neck latrine) – Considered as Improved

The training focused on explaining the indicators used in the SMS-based monitoring system. The new system is built to capture the following four indicators;

1. Permanent latrine (JSP) - Healthy & Improved – meet healthy latrine requirements with permanent structure/superstructure)
2. Semi-permanent latrine (JSSP) - Healthy & Unimproved) - meet healthy latrine requirements with semi-permanent structure/superstructure – usually made up of local materials such as bamboo etc.
3. Sharing latrine - can be improved or unimproved – latrine use by more than one household; STBM recognizes it as basic access
4. Open Defecation (OD) – a) defecating in open b) or using unhealthy latrine

New indicators: In 2015, MoH realized the need of consolidated and standardized data and wanted a shift of monitoring focus from progress updates to standardized reporting on ODF. In 2015, UNICEF highlighted the unreliability of ODF verification data due to various gaps in verification process and related to inconsistencies of indicators and definitional issues. For example, even till 2015, there were some districts that were reporting ODF at sub-village level rather at village level as prescribed by MoH. UNICEF took the lead in organising a national level meeting to initiate sector wide consultations for developing the standard ODF verification guidelines. UNICEF hired a national consultant and guidelines were revised and were piloted in East Java and NTT. In early 2016, the revised ODF verification guideline were adopted and published by MoH and STBM secretariat for implementation across country.

The term 'Improved' sanitation is a JMP (Joint Monitoring Programme) standard, and is not exactly translated in the same way by MoH. Furthermore, JMP categories the 'Sharing Latrine' as 'Unimproved' (in SDGs, termed as 'Limited' access) because of sustainability issue of the sharing toilets. For instance, it is not necessary that a toilet owner always allows the use of his/her toilet by others. Therefore, JMP categorization has less emphasis on the condition and structure of the toilet in case of shared latrine. Whereas, according to MoH Criteria, a Pit latrine can also be categorized as 'healthy/hygienic' if it meets MoH requirements of a hygienic latrine.

According to the new SMS-based monitoring system, two conditions are necessary to meet for categorizing a latrine into 'improved sanitation' category, a latrine should be; a) hygienic/healthy – must have underground hole); and 2) it should be permanent – this means it must have a proper superstructure.

Training of Sanitarians on Data Collection

As a priority, UNICEF convinced MoH on the need for establishing a baseline for the provinces and districts that were implementing the system. Districts were encouraged to start implementing regular monitoring. For that purpose, it became necessary to build capacities of the provincial and district governments. Therefore, in 2014, UNICEF supported a national training on SMS BMS that was attended by provincial staff from all 34 provinces across the country. It was now the provincial government's responsibility to train its district staff. UNICEF has further supported the MoH by appointing a dedicated resource person to assist the STBM secretariat in strengthening the monitoring system, thereby increasing the usability of the monitoring data for planning and decision-making.

Post training, all sanitarians were asked to collect data as per new indicators and categorization to prepare a baseline for the SMS-based monitoring system. The exercise resulted in a significantly different picture of the overall sanitation situation. (for example, in Alor, the data was quite different than the actual situation). When investigated thoroughly by the DHO and POKJA, it was realized that there is a lack of understanding on the new indicators at sanitarians' end while recording their observations. All sanitarians could not understand the difference between the indicator definitions and how to categorize a latrine. *It is important to mention here that quality of the training was not the issue since pre-post assessment did not yielded such reflections, however it was more about the confusion on indicators between the*

old and new format of the SMS based monitoring system. With support from POKJA and district governments, UNICEF advocated for more focus on providing guidance and counselling to sanitarians through monthly progress review and coordination meetings. *It has taken nearly six months for sanitarians to understand well and implement properly the new indicators in the SMS based monitoring system.*

New Android-based Data Collection

In NTT – Android Based – Originally Android based Monitoring application was developed by OCHA for monitoring its interventions in emergency context. It is an open source application. UNICEF created a monitoring format using this application based on the BMGF program M&E template. So far it is only being implemented in NTT province for provincial level monitoring of the STBM programme by the Provincial POKJA. For this training, the first main training event on the use of this application was convened in September 2016 and it is expected that by the end of next year, all districts will be able to use this application to report on STBM progress to Provincial POKJA. Each district can update the website using this application as and when accomplished, the POKJA members at provincial level can use this information for analysis of the needs of each district to plan and provide need specific support from POKJA. For example, if a district is still lacking in introducing the required regulations or availability of funds or weak coordination or another. The POKJA can use this information/data to plan, organise and execute its support specific to the needs of each district. If a district is lacking funds, the POKJA can advocate with local government for increased funding etc. All six districts in NTT (direct and indirect) have been provided training on the use of android based monitoring application.

An internal evaluation of the BMGF at provincial level was conducted in NTT in July 2017, where all six districts were invited. During this reflective evaluation process, the introduction and use of this application was acknowledged as a ‘good practice’ and it was recommended to prepare proper documentation of the process and achievements about the application to show case others as best practice. POKJA will do this in future using its own resources and with technical guidance from UNICEF.

It is important to mention that this Android based monitoring application covers many new indicators to make it comprehensive to cover all programmatic aspects of the STBM programme, i.e. reflective of the Enabling Environment approach taken. A detailed review of this application clearly indicate that it is built on a style/scope as was used in new UNICEF’s Global Online Bottleneck Analysis Tool adopted in 2015-16. The application is very handy, and one can easily access/review the latest status of any indicator of the STBM related progress.

Appendix 12: Team Roles

Table App. 12: Team Roles

Position	Name	Role Description
Team Lead / Evaluation and Social Norm Expert	Nadeem Haider	To manage the evaluation, with key tasks including literature review, design of evaluation methodology, inception report writing, data collection, data analysis (particularly relating to social norms), reporting, quality assurance, and external communication.
Deputy Team Lead / Social Norm Expert	Asmat Ali Gill	To lead in development of the evaluation framework, design, methodology (in particular social norm/sustainability assessment), tools development, undertaking selected KIIs/FGDs, data consolidation, analysis, and report writing. Additionally, responsible to coordinate with the Client, international team members, national Evaluators and local partners to ensure smooth execution of all processes.
Principal Consultant	Hussain Tawawalla	To support the Team Lead in evaluation design, literature review, report writing, data analysis, management and any other delegated responsibilities. To contribute expertise in conducting evaluations.
International WASH Expert	Simone Klawitter	To contribute to evaluation design and literature review. To contribute expertise in WASH and in conducting evaluations.
Statistical Analyst (Social Norm Expert)	Zia ul Islam and Aemal Khan	To support the team lead in the design and planning of data collection activities, to organise and process data and to analyse collected data.
Research Officer	Saad Ibrahim Rasheed	To support the evaluation by carrying out literature review, report writing, communication, data collection/processing/analysis, fieldwork and any other delegated tasks.
Research Associate	Sadia Ausim	To support the evaluation by carrying out literature review, report writing, communication, data collection/processing/analysis, fieldwork and any other delegated tasks.
National Evaluation / WASH Expert		To participate in literature review, report writing, tool development and data collection (KIIs).
National Evaluation Coordinator		To facilitate the team in preparing for and conducting fieldwork by providing assistance with logistics, translations, interpretation, coordination with stakeholders, follow-up, monitoring and training (of master trainers for field staff training).

Appendix 13: List of Documents Reviewed

1. Exploring Determinants of Handwashing with Soap in Indonesia: A Quantitative Analysis; Environmental Research and Public Health (2016)
2. Cameron; Shah.L; Scaling Up Sanitation: Evidence from an RCT in Indonesia; Monash University; University of California, Los Angeles and NBER (2017)
3. Rosenboom.J; Sanitation for all: Scaling up is hard to do; www.devex.com (2016)
4. Direktur Kesehatan dan Gizi Masyarakat, Bappenas; BAKTIHUSADA (2016)
5. Strengthening and Scaling up Community Approaches to Total Sanitation in Indonesia; Bill and Melinda Gates foundation (2016)
6. UNICEF WASH Project; Bill and Melinda Gates foundation (2012)
7. UNICEF WASH Project; Bill and Melinda Gates foundation (2012)
8. Scaling-up and Strengthening Community Approaches to Total Sanitation in Indonesia 1st progress report; Bill and Melinda Gates foundation (2013)
9. Scaling-up and Strengthening Community Approaches to Total Sanitation in Indonesia 2nd progress report; Bill and Melinda Gates foundation (2014)
10. Scaling-up and Strengthening Community Approaches to Total Sanitation in Indonesia 3rd progress report; Bill and Melinda Gates foundation (2015)
11. Scaling-up and Strengthening Community Approaches to Total Sanitation in Indonesia 4th progress report; Bill and Melinda Gates foundation (2016)
12. Overview of the UNICEF Indonesia plan to capture progress and key programme output indicators and their Means of Verification as part of the BMGF partnership for advancing STBM; Bill and Melinda Gates foundation (2017)
13. STBM indicators
14. M; STBM M&E Indicators Report; Papua Office
15. STBM M&E Indicators Report; South Sulawesi Field Office
16. STBM M&E Indicators for NTT Template; (2015)
17. STBM Determinants and indicators Template; (2015)
18. STBM Determinants and indicators Template; (2015)
19. STBM Determinants and indicators Template; (2015)
20. BMGF targetprogress; (2016)
21. Papua Indicators revised; (2016)
22. SS Indicators; (2016)
23. STBM M&E Indicators for Papua; (2017)
24. STBM M&E Indicators for SouthSulavesi; (2017)
25. AAN/AAG Presentation Field Trips; (2016)
26. AAN/AAG Presentation Field Trips; (2016)
27. Presentation Field Trips BMGF; (2016)
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Appendix 14: HHS Tabulations (Direct Districts)

HHS Results/Tabulation for 'Direct' Districts
(HHS Results/Tabulation for 'Other' Districts are presented in Appendix 15)

Distribution of **Respondents** by District type, sex and province

Province	Direct			Others		
	Male	Female	Total	Male	Female	Total
Nusa Tenggara Timur (NTT)	359	362	721	165	195	360
South Sulawesi	536	544	1080	184	178	362
Papua	183	177	360	177	183	360
Total	1078	1083	2161	526	556	1082

Percent distribution of **Respondents** by sex and province

Province	Direct			Others		
	Male	Female	Total	Male	Female	Total
Nusa Tenggara Timur (NTT)	49.8	50.2	100.0	45.8	54.2	100.0
South Sulawesi	49.6	50.4	100.0	50.8	49.2	100.0
Papua	50.8	49.2	100.0	49.2	50.8	100.0
Total	49.9	50.1	100.0	48.6	51.4	100.0

Distribution of **Head of households** by District type, sex and province

Province	Direct			Others		
	Male	Female	Total	Male	Female	Total
Nusa Tenggara Timur (NTT)	631	90	721	331	29	360
South Sulawesi	949	131	1080	306	56	362
Papua	326	34	360	326	34	360
Total	1906	255	2161	963	119	1082

Demographics

Table 1: Distribution of households by province, Sex of respondents and head of households

Sex		Direct				Other			
		Province			Total	Province			Total
		Nusa Tenggara Timur (NTT)	South Sulawesi	Papua		Nusa Tenggara Timur (NTT)	South Sulawesi	Papua	
Respondents	Male	359	536	183	1078	165	184	177	526
	Female	362	544	177	1083	195	178	183	556
	Total	721	1080	360	2161	360	362	360	1082
Head of Households	Male	631	949	326	1906	331	306	326	963
	Female	90	131	34	255	29	56	34	119
	Total	721	1080	360	2161	360	362	360	1082

Table 2: Distribution of respondents by province and Sex

Age of respondent	Direct											
	G1. Name of Province											
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua			Total		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
< 20 years	3	7	10	19	11	30	8	5	13	30	23	53
20 years <30 years	41	70	111	89	115	204	33	29	62	163	214	377
30 years < 40 years	93	118	211	142	159	301	47	49	96	282	326	608
40 years < 50 years	87	85	172	157	142	299	31	46	77	275	273	548
50 years < 60 years	74	51	125	79	80	159	35	29	64	188	160	348
60 years < 70 years	45	19	64	31	25	56	19	16	35	95	60	155
70 years < 80 years	14	10	24	17	11	28	10	2	12	41	23	64
80 years < 90 years	2	2	4	1	1	2	0	0	0	3	3	6
90 years & above	0	0	0	1	0	1	0	1	1	1	1	2
Total	359	362	721	536	544	1080	183	177	360	1078	1083	2161

** Age of respondents in question I1 has been recoded into groups and given the name as I1_A.*

Table 3: Distribution of head of households by province and Sex

Age of head of household	Direct											
	G1. Name of Province											
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua			Total		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
< 20 years	0	0	0	1	0	1	0	0	0	1	0	1
20 years <30 years	58	6	64	83	2	85	30	1	31	171	9	180
30 years < 40 years	172	18	190	220	13	233	77	3	80	469	34	503
40 years < 50 years	172	19	191	302	28	330	83	5	88	557	52	609
50 years < 60 years	132	20	152	196	50	246	81	9	90	409	79	488
60 years < 70 years	62	16	78	101	26	127	40	15	55	203	57	260
70 years < 80 years	28	10	38	41	10	51	14	1	15	83	21	104
80 years < 90 years	6	1	7	2	0	2	1	0	1	9	1	10
90 years & above	0	0	0	3	2	5	0	0	0	3	2	5
Total	630	90	720	949	131	1080	326	34	360	1905	255	2160

** Age of respondents in question G8 has been recoded into groups and given the variable name as G8_A.*

Table 4: Distribution of respondents reporting their relationship to the head of household by province, district and Sex

Sex	Relationship to the head of household	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Self - Head of Household	337	442	153	932	183	154	142	165	135	153
	Wife/Mother	3	1	5	9	0	3	1	0	0	5
	Mother-in-law	0	0	0	0	0	0	0	0	0	0
	Grandmother	0	1	0	1	0	0	1	0	0	0
	Daughter	0	1	1	2	0	0	0	0	1	1
	Sister	1	1	0	2	1	0	1	0	0	0
	Niece	1	1	0	2	0	1	1	0	0	0
	Husband/Father	1	4	0	5	1	0	2	1	1	0
	Father-in-law	1	4	1	6	0	1	2	1	1	1

Table 4: Distribution of respondents reporting their relationship to the head of household by province, district and Sex

Sex	Relationship to the head of household	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
	Grandfather	0	2	0	2	0	0	0	1	1	0
	Son	15	77	22	114	7	8	29	5	43	22
	Brother	0	2	1	3	0	0	2	0	0	1
	Nephew	0	0	0	0	0	0	0	0	0	0
	Cousin	0	0	0	0	0	0	0	0	0	0
	Not Related	0	0	0	0	0	0	0	0	0	0
	Unknown	0	0	0	0	0	0	0	0	0	0
	Total	359	536	183	1078	192	167	181	173	182	183
	Self - Head of Household	73	85	25	183	34	39	22	31	32	25
	Wife/Mother	250	348	134	732	107	143	113	123	112	134
	Mother-in-law	1	4	2	7	0	1	2	2	0	2
	Grandmother	1	2	0	3	1	0	0	0	2	0
	Daughter	18	61	15	94	9	9	23	9	29	15
	Sister	1	3	0	4	0	1	1	1	1	0
	Niece	1	0	1	2	1	0	0	0	0	1
	Husband/Father	17	31	0	48	17	0	15	16	0	0
Female	Father-in-law	0	7	0	7	0	0	2	4	1	0
	Grandfather	0	0	0	0	0	0	0	0	0	0
	Son	0	1	0	1	0	0	0	0	1	0
	Brother	0	1	0	1	0	0	0	1	0	0
	Nephew	0	0	0	0	0	0	0	0	0	0
	Cousin	0	1	0	1	0	0	1	0	0	0
	Not Related	0	0	0	0	0	0	0	0	0	0
	Unknown	0	0	0	0	0	0	0	0	0	0
	Total	362	544	177	1083	169	193	179	187	178	177
	Self - Head of Household	410	527	178	1115	217	193	164	196	167	178
	Wife/Mother	253	349	139	741	107	146	114	123	112	139
	Mother-in-law	1	4	2	7	0	1	2	2	0	2
	Grandmother	1	3	0	4	1	0	1	0	2	0
	Daughter	18	62	16	96	9	9	23	9	30	16
	Sister	2	4	0	6	1	1	2	1	1	0
	Niece	2	1	1	4	1	1	1	0	0	1
	Husband/Father	18	35	0	53	18	0	17	17	1	0
Total	Father-in-law	1	11	1	13	0	1	4	5	2	1
	Grandfather	0	2	0	2	0	0	0	1	1	0
	Son	15	78	22	115	7	8	29	5	44	22
	Brother	0	3	1	4	0	0	2	1	0	1
	Nephew	0	0	0	0	0	0	0	0	0	0
	Cousin	0	1	0	1	0	0	1	0	0	0
	Not Related	0	0	0	0	0	0	0	0	0	0
	Unknown	0	0	0	0	0	0	0	0	0	0
	Total	721	1080	360	2161	361	360	360	360	360	360

Table 5: Distribution of respondents reporting their highest level of school completed by province, district and Sex

Sex	Highest level of education	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	No formal education	20	12	2	34	7	13	0	11	1	2
	Not completing primary school	80	49	6	135	34	46	13	25	11	6
	Primary	167	187	41	395	96	71	62	57	68	41
	Pre-Secondary	51	140	51	242	32	19	51	54	35	51
	Secondary	31	126	66	223	16	15	46	26	54	66
	Higher	10	22	17	49	7	3	9	0	13	17
	Total	359	536	183	1078	192	167	181	173	182	183
Female	No formal education	20	7	0	27	8	12	2	2	3	0
	Not completing primary school	70	63	16	149	19	51	20	29	14	16
	Primary	167	200	37	404	81	86	70	62	68	37
	Pre-Secondary	62	140	55	257	36	26	43	58	39	55
	Secondary	31	101	59	191	17	14	36	34	31	59
	Higher	12	33	10	55	8	4	8	2	23	10
	Total	362	544	177	1083	169	193	179	187	178	177
Total	No formal education	40	19	2	61	15	25	2	13	4	2
	Not completing primary school	150	112	22	284	53	97	33	54	25	22
	Primary	334	387	78	799	177	157	132	119	136	78
	Pre-Secondary	113	280	106	499	68	45	94	112	74	106
	Secondary	62	227	125	414	33	29	82	60	85	125
	Higher	22	55	27	104	15	7	17	2	36	27
	Total	721	1080	360	2161	361	360	360	360	360	360

Table 6: Distribution of respondents by province, Sex, income quintiles and level of education

Income Quantiles	Level of education	Direct								
		Province								
		Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
		Male	Female	Total	Male	Female	Total	Male	Female	Total
Highest quintile	No formal education	0	0	0	6	2	8	0	0	0
	Not completing primary school	0	2	2	19	21	40	1	1	2
	Primary	3	6	9	42	38	80	8	4	12
	Pre-Secondary	3	6	9	54	38	92	12	12	24
	Secondary	10	2	12	50	41	91	13	13	26
	Higher	4	1	5	11	23	34	9	5	14
	Total	20	17	37	182	163	345	43	35	78
2nd highest quintile	No formal education	1	1	2	4	0	4	1	0	1
	Not completing primary school	7	3	10	9	9	18	0	2	2
	Primary	10	16	26	42	59	101	6	8	14
	Pre-Secondary	6	11	17	38	49	87	13	15	28
	Secondary	3	4	7	31	34	65	18	17	35
	Higher	2	2	4	4	7	11	3	0	3
	Total	29	37	66	128	158	286	41	42	83
Medium quintile	No formal education	0	0	0	2	2	4	0	0	0
	Not completing primary school	4	5	9	9	11	20	1	6	7
	Primary	13	21	34	54	44	98	5	7	12
	Pre-Secondary	3	4	7	17	32	49	7	7	14
	Secondary	4	3	7	25	14	39	12	6	18
	Higher	0	6	6	3	2	5	3	2	5
	Total	24	39	63	110	105	215	28	28	56

Table 6: Distribution of respondents by province, Sex, income quintiles and level of education

Income Quantiles	Level of education	Direct								
		Province								
		Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
		Male	Female	Total	Male	Female	Total	Male	Female	Total
2nd lowest quintile	No formal education	7	9	16	0	2	2	1	0	1
	Not completing primary school	33	31	64	8	17	25	3	3	6
	Primary	64	63	127	17	34	51	13	7	20
	Pre-Secondary	17	17	34	13	7	20	14	10	24
	Secondary	8	14	22	8	6	14	11	13	24
	Higher	1	2	3	1	1	2	1	0	1
	Total	130	136	266	47	67	114	43	33	76
Lowest quintile	No formal education	11	9	20	0	1	1	0	0	0
	Not completing primary school	33	29	62	3	4	7	1	1	2
	Primary	76	61	137	23	19	42	7	10	17
	Pre-Secondary	22	23	45	14	11	25	4	10	14
	Secondary	6	7	13	10	3	13	6	10	16
	Higher	3	1	4	2	0	2	0	2	2
	Total	151	130	281	52	38	90	18	33	51
Total	No formal education	19	19	38	12	7	19	2	0	2
	Not completing primary school	77	70	147	48	62	110	6	13	19
	Primary	166	167	333	178	194	372	39	36	75
	Pre-Secondary	51	61	112	136	137	273	50	54	104
	Secondary	31	30	61	124	98	222	60	59	119
	Higher	10	12	22	21	33	54	16	9	25
	Total	354	359	713	519	531	1050	173	171	344

** I7_1 has been created using I7 for Income quintiles.*

Table 7: Distribution of respondents reporting items owned by province and Sex

Items owned by household	Direct								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Radio	14	9	23	46	28	74	49	39	88
Television	73	77	150	479	504	983	146	143	289
Mobile phone	164	167	331	402	425	827	133	110	243
Telephone	1	0	1	5	3	8	0	1	1
Refrigerator	10	8	18	308	322	630	61	73	134
Motorcycle/scooter	103	112	215	462	419	881	118	108	226
Bicycle	7	8	15	61	52	113	32	33	65
Animal drawn cart	0	1	1	12	9	21	4	3	7
Car/truck	0	1	1	10	16	26	7	6	13
Boat with motor	6	6	12	2	1	3	3	6	9
Own agriculture land	333	335	668	349	337	686	133	141	274
Own farm animals	331	310	641	262	251	513	104	103	207
Total	1042	1034	2076	2398	2367	4765	790	766	1556

** $i6_A is created from multiple opinions questions from i6_1 to i6_9.*

Table 8: Distribution of households showing average monthly income by province and Sex

Monthly Average Income	Direct											
	Province									Total		
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua					
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
< 1,000	41	13	54	63	9	72	19	4	23	123	26	149
1,000 < 5,000	0	0	0	12	0	12	10	1	11	22	1	23
5,000 < 100,000	44	9	53	0	0	0	4	0	4	48	9	57
100,000 < 300,000	161	23	184	9	2	11	10	3	13	180	28	208
300,000 < 500,000	99	11	110	20	13	33	20	7	27	139	31	170
500,000 < 600,000	149	19	168	62	28	90	50	6	56	261	53	314
600,000 < 800,000	30	6	36	80	8	88	24	2	26	134	16	150
800,000 < 1,000,000	9	1	10	55	9	64	20	1	21	84	11	95
1,000,000 < 2,000,000	65	4	69	320	36	356	82	6	88	467	46	513
2,000,000 < 4,000,000	26	4	30	258	23	281	63	3	66	347	30	377
4,000,000 < 6,000,000	3	0	3	40	1	41	6	0	6	49	1	50
6,000,000 & above	2	0	2	2	0	2	3	0	3	7	0	7
Total	629	90	719	921	129	1050	311	33	344	1861	252	2113

* I7A has been created from I7 by converting income into groups.

Table 9: Distribution of households showing average monthly income by province, district and Sex

Sex	Monthly Average Income	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	< 1,000	32	41	9	82	32	0	41	0	0	9
	1,000 < 5,000	0	8	0	8	0	0	5	3	0	0
	5,000 < 100,000	22	0	2	24	22	0	0	0	0	2
	100,000 < 300,000	103	6	7	116	71	32	0	1	5	7
	300,000 < 500,000	47	14	12	73	19	28	1	0	13	12
	500,000 < 600,000	85	36	35	156	23	62	9	1	26	35
	600,000 < 800,000	16	50	10	76	8	8	19	1	30	10
	800,000 < 1,000,000	4	32	13	49	1	3	11	1	20	13
	1,000,000 < 2,000,000	30	162	43	235	11	19	46	55	61	43
	2,000,000 < 4,000,000	15	146	35	196	4	11	29	91	26	35
	4,000,000 < 6,000,000	3	23	4	30	1	2	3	19	1	4
	6,000,000 & above	1	1	3	5	0	1	0	1	0	3
	Total	358	519	173	1050	192	166	164	173	182	173
Female	< 1,000	22	31	14	67	22	0	27	1	3	14
	1,000 < 5,000	0	4	11	15	0	0	1	3	0	11
	5,000 < 100,000	31	0	2	33	29	2	0	0	0	2
	100,000 < 300,000	81	5	6	92	48	33	3	1	1	6
	300,000 < 500,000	63	19	15	97	21	42	1	4	14	15
	500,000 < 600,000	83	54	21	158	22	61	8	4	42	21
	600,000 < 800,000	20	38	16	74	6	14	13	6	19	16
	800,000 < 1,000,000	6	32	8	46	2	4	15	5	12	8
	1,000,000 < 2,000,000	39	194	45	278	13	26	59	73	62	45
	2,000,000 < 4,000,000	15	135	31	181	4	11	36	79	20	31
	4,000,000 < 6,000,000	0	18	2	20	0	0	3	11	4	2
	6,000,000 & above	1	1	0	2	1	0	0	0	1	0
	Total	361	531	171	1063	168	193	166	187	178	171
Total	< 1,000	54	72	23	149	54	0	68	1	3	23
	1,000 < 5,000	0	12	11	23	0	0	6	6	0	11
	5,000 < 100,000	53	0	4	57	51	2	0	0	0	4

Table 9: Distribution of households showing average monthly income by province, district and Sex

Sex	Monthly Average Income	Direct									
		Province			Total	Province					
		NTT	SS	PP		NTT		SS			PP
						District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
	100,000 < 300,000	184	11	13	208	119	65	3	2	6	13
	300,000 < 500,000	110	33	27	170	40	70	2	4	27	27
	500,000 < 600,000	168	90	56	314	45	123	17	5	68	56
	600,000 < 800,000	36	88	26	150	14	22	32	7	49	26
	800,000 < 1,000,000	10	64	21	95	3	7	26	6	32	21
	1,000,000 < 2,000,000	69	356	88	513	24	45	105	128	123	88
	2,000,000 < 4,000,000	30	281	66	377	8	22	65	170	46	66
	4,000,000 < 6,000,000	3	41	6	50	1	2	6	30	5	6
	6,000,000 & above	2	2	3	7	1	1	0	1	1	3
	Total	719	1050	344	2113	360	359	330	360	360	344

Table 10: Distribution of respondents by province, Sex and income quintiles

Income Quantiles	Direct								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Highest quintile	20	17	37	182	163	345	43	35	78
2nd highest quintile	29	37	66	128	158	286	41	42	83
Medium quintile	24	39	63	110	105	215	28	28	56
2nd lowest quintile	130	136	266	47	67	114	43	33	76
Lowest quintile	151	130	281	52	38	90	18	33	51
Total	354	359	713	519	531	1050	173	171	344

Table 11: Distribution of head of households by province, Sex and income quintiles

Income Quantiles	Direct								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Highest quintile	33	4	37	318	27	345	75	3	78
2nd highest quintile	62	4	66	261	25	286	77	6	83
Medium quintile	54	9	63	185	30	215	52	4	56
2nd lowest quintile	238	28	266	77	37	114	64	12	76
Lowest quintile	238	43	281	80	10	90	43	8	51
Total	625	88	713	921	129	1050	311	33	344

Water Sources

Table 1: Distribution of respondents reporting available water sources for drinking and cooking by province, district and Sex

Sex	Drinking water sources	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Piped into dwelling, plot or yard	86	232	12	330	64	22	74	23	135	12
	Public tap/standpipe	43	9	2	54	41	2	6	2	1	2
	Tube well/borehole	1	171	17	189	0	1	36	121	14	17
	Protected dug well	116	104	12	232	32	84	63	17	24	12
	Protected Spring	20	1	10	31	2	18	0	1	0	10
	Rainwater collection	10	0	27	37	9	1	0	0	0	27
	Unprotected dug well	18	5	22	45	16	2	0	5	0	22
	Unprotected spring	17	0	18	35	4	13	0	0	0	18
	Bottled water	0	1	51	52	0	0	1	0	0	51
	Tanker Truck	0	0	2	2	0	0	0	0	0	2
	Surface water (river/dam/lake/pond/stream/canal)	48	0	10	58	24	24	0	0	0	10
	Water gallon	0	10	0	10	0	0	1	4	5	0
	Total	359	533	183	1075	192	167	181	173	179	183
Female	Piped into dwelling, plot or yard	85	228	13	326	62	23	73	22	133	13
	Public tap/standpipe	38	5	2	45	37	1	5	0	0	2
	Tube well/borehole	5	169	19	193	0	5	42	116	11	19
	Protected dug well	121	108	17	246	18	103	54	32	22	17
	Protected Spring	21	7	6	34	3	18	0	6	1	6
	Rainwater collection	10	0	31	41	10	0	0	0	0	31
	Unprotected dug well	15	6	11	32	12	3	1	5	0	11
	Unprotected spring	22	0	13	35	7	15	0	0	0	13
	Bottled water	0	6	55	61	0	0	2	2	2	55
	Tanker Truck	0	1	2	3	0	0	0	0	1	2
	Surface water (river/dam/lake/pond/stream/canal)	45	0	8	53	20	25	0	0	0	8
	Water gallon	0	13	0	13	0	0	2	3	8	0
	Total	362	543	177	1082	169	193	179	186	178	177
Total	Piped into dwelling, plot or yard	171	460	25	656	126	45	147	45	268	25
	Public tap/standpipe	81	14	4	99	78	3	11	2	1	4
	Tube well/borehole	6	340	36	382	0	6	78	237	25	36

Table 1: Distribution of respondents reporting available water sources for drinking and cooking by province, district and Sex

Sex	Drinking water sources	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
	Protected dug well	237	212	29	478	50	187	117	49	46	29
	Protected Spring	41	8	16	65	5	36	0	7	1	16
	Rainwater collection	20	0	58	78	19	1	0	0	0	58
	Unprotected dug well	33	11	33	77	28	5	1	10	0	33
	Unprotected spring	39	0	31	70	11	28	0	0	0	31
	Bottled water	0	7	106	113	0	0	3	2	2	106
	Tanker Truck	0	1	4	5	0	0	0	0	1	4
	Surface water (river/dam/lake/pond/stream/canal)	93	0	18	111	44	49	0	0	0	18
	Water gallon	0	23	0	23	0	0	3	7	13	0
	Total	721	1076	360	2157	361	360	360	359	357	360

Table 2: Distribution of respondents reporting improved sources of water for drinking and cooking by province, Sex and nature of water sources

Nature of water sources	Sources of water for drinking and cooking	Direct								
		Province								
		Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
		M	F	Total	M	F	Total	M	F	Total
Improved	Piped into dwelling, plot or yard	86	85	171	232	228	460	12	13	25
	Public tap/standpipe	43	38	81	9	5	14	2	2	4
	Tube well/borehole	1	5	6	171	169	340	17	19	36
	Protected dug well	116	121	237	104	108	212	12	17	29
	Protected Spring	20	21	41	1	7	8	10	6	16
	Rainwater collection	10	10	20	0	0	0	27	31	58
	Total	276	280	556	517	517	1034	80	88	168
Unimproved	Unprotected dug well	18	15	33	5	6	11	22	11	33
	Unprotected spring	17	22	39	0	0	0	18	13	31
	Bottled water	0	0	0	1	6	7	51	55	106
	Tanker Truck	0	0	0	0	1	1	2	2	4
	Surface water (river/dam/lake/pond/stream/canal)	48	45	93	0	0	0	10	8	18
	Water gallon	0	0	0	10	13	23	0	0	0
	Total	83	82	165	16	26	42	103	89	192
All		359	362	721	533	543	1076	183	177	360

Table 3: Distribution of respondents reporting available water sources for toilet and other uses by province, district and Sex

S	Water source for toilet	Direct									
		Province			Total	Province					
						NTT		SS			PP
						District					
		NTT	SS	PP		Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
M	Piped into dwelling, plot or yard	86	235	12	333	64	22	74	26	135	12
	Public tap/standpipe	42	8	2	52	40	2	6	0	2	2
	Tube well/borehole	1	173	19	193	0	1	37	120	16	19
	Protected dug well	115	112	33	260	33	82	64	20	28	33
	Protected Spring	21	1	12	34	1	20	0	1	0	12
	Rainwater collection	11	0	32	43	10	1	0	0	0	32
	Unprotected dug well	17	6	42	65	15	2	0	6	0	42
	Unprotected spring	17	0	18	35	4	13	0	0	0	18
	Cart with small tank/drum	0	0	0	0	0	0	0	0	0	0
	Bottled water	0	0	1	1	0	0	0	0	0	1
	Surface water (river/dam/lake/pond/stream/canal)	49	0	11	60	25	24	0	0	0	11
	Total	359	535	182	1076	192	167	181	173	181	182
F	Piped into dwelling, plot or yard	85	232	11	328	62	23	73	24	135	11
	Public tap/standpipe	34	6	2	42	34	0	6	0	0	2
	Tube well/borehole	4	171	32	207	0	4	42	115	14	32
	Protected dug well	109	121	35	265	15	94	57	35	29	35
	Protected Spring	24	7	9	40	3	21	0	7	0	9
	Rainwater collection	10	0	31	41	10	0	0	0	0	31
	Unprotected dug well	15	6	33	54	12	3	1	5	0	33
	Unprotected spring	22	0	16	38	7	15	0	0	0	16
	Cart with small tank/drum	0	0	0	0	0	0	0	0	0	0
	Bottled water	0	0	0	0	0	0	0	0	0	0
	Surface water (river/dam/lake/pond/stream/canal)	59	0	8	67	26	33	0	0	0	8
	Total	362	543	177	1082	169	193	179	186	178	177
Total	Piped into dwelling, plot or yard	171	467	23	661	126	45	147	50	270	23
	Public tap/standpipe	76	14	4	94	74	2	12	0	2	4

Table 3: Distribution of respondents reporting available water sources for toilet and other uses by province, district and Sex

S	Water source for toilet	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
	Tube well/borehole	5	344	51	400	0	5	79	235	30	51
	Protected dug well	224	233	68	525	48	176	121	55	57	68
	Protected Spring	45	8	21	74	4	41	0	8	0	21
	Rainwater collection	21	0	63	84	20	1	0	0	0	63
	Unprotected dug well	32	12	75	119	27	5	1	11	0	75
	Unprotected spring	39	0	34	73	11	28	0	0	0	34
	Cart with small tank/drum	0	0	0	0	0	0	0	0	0	0
	Bottled water	0	0	1	1	0	0	0	0	0	1
	Surface water (river/dam/lake/pond/stream/canal)	108	0	19	127	51	57	0	0	0	19
	Total	721	1078	359	2158	361	360	360	359	359	359

Table 4: Distribution of respondents reporting sources of water for toilet and other uses by province, Sex and nature of water sources

Nature of water sources	Sources of water for toilet and other uses	Direct								
		Province								
		Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
		M	F	Total	M	F	Total	M	F	Total
Improved	Piped into dwelling, plot or yard	86	85	171	235	232	467	12	11	23
	Public tap/standpipe	42	34	76	8	6	14	2	2	4
	Tube well/borehole	1	4	5	173	171	344	19	32	51
	Protected dug well	115	109	224	112	121	233	33	35	68
	Protected Spring	21	24	45	1	7	8	12	9	21
	Rainwater collection	11	10	21	0	0	0	32	31	63
	Total	276	266	542	529	537	1066	110	120	230
Unimproved	Unprotected dug well	17	15	32	6	6	12	42	33	75
	Unprotected spring	17	22	39	0	0	0	18	16	34
	Cart with small tank/drum	0	0	0	0	0	0	0	0	0
	Bottled water	0	0	0	0	0	0	1	0	1
	Surface water (river/dam/lake/pond/stream/canal)	49	59	108	0	0	0	11	8	19
	Total	83	96	179	6	6	12	72	57	129
All		359	362	721	535	543	1078	182	177	359

Toilets

Table 1: Distribution of households having toilets by province, district and Sex

Sex	Have toilet	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Yes	288	465	168	921	160	128	170	127	168	168
	No	71	71	15	157	32	39	11	46	14	15
	Total	359	536	183	1078	192	167	181	173	182	183
Female	Yes	290	476	164	930	154	136	166	152	158	164
	No	72	68	13	153	15	57	13	35	20	13
	Total	362	544	177	1083	169	193	179	187	178	177
Total	Yes	578	941	332	1851	314	264	336	279	326	332
	No	143	139	28	310	47	96	24	81	34	28
	Total	721	1080	360	2161	361	360	360	360	360	360

Table 2: Distribution of households Share toilet facility with others by province, district and Sex

Sex	Share toilet facility with others	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	No. Facility only used by my household	251	449	157	857	140	111	167	117	165	157
	Yes. Shared	37	16	11	64	20	17	3	10	3	11
	Total	288	465	168	921	160	128	170	127	168	168
Female	No. Facility only used by my household	255	452	152	859	142	113	161	143	148	152
	Yes. Shared	35	24	12	71	12	23	5	9	10	12
	Total	290	476	164	930	154	136	166	152	158	164
Total	No. Facility only used by my household	506	901	309	1716	282	224	328	260	313	309
	Yes. Shared	72	40	23	135	32	40	8	19	13	23
	Total	578	941	332	1851	314	264	336	279	326	332

Table 3: Distribution of households reporting reasons for using the toiler facility by province and Sex

Reasons for using toilet facility	Direct								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	M	F	Total	M	F	Total	M	F	Total
For good health and cleaning	279	281	560	395	405	800	152	145	297
Convenience	140	129	269	388	400	788	128	130	258
To be proud/showy	6	0	6	54	42	96	15	12	27
As routine	6	2	8	71	76	147	18	13	31
Don't know	3	3	6	0	0	0	0	1	1
Total	434	415	849	908	923	1831	313	301	614

Table 4: Distribution of households reporting members of immediate family usually do not use the toilet by province and Sex

Members of family usually don't use the toilet	Direct								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	M	F	Total	M	F	Total	M	F	Total
Myself	5	6	11	16	11	27	4	10	14
My husband	0	7	7	0	7	7	0	9	9
My wife	4	0	4	8	0	8	1	0	1
Children five years and younger	45	39	84	24	28	52	6	9	15
Children over age 5	15	7	22	10	9	19	3	2	5
N/A Everyone in the family uses	226	238	464	408	419	827	157	144	301
Don't know	2	0	2	18	15	33	4	6	10
Total	297	297	594	484	489	973	175	180	355

Table 5: Distribution of households reporting frequency of defecation by immediate family members when at home by province and Sex

Frequency of defecation immediate family members	Direct								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	M	F	Total	M	F	Total	M	F	Total
Never/rarely	38	33	71	14	15	29	1	1	2
Sometimes / occasionally	17	24	41	10	16	26	6	16	22
Usually / mostly	30	27	57	36	39	75	9	7	16
Always	264	273	537	454	461	915	159	149	308
Not applicable	288	290	578	465	476	941	168	164	332
Don't know	8	5	13	7	15	22	0	1	1
Total	645	652	1297	986	1022	2008	343	338	681

Table 6: Distribution of the respondents reporting frequency of defecation in open (7 days) when at home by province and Sex

Frequency of defecation by the respondent in open	Direct								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	M	F	Total	M	F	Total	M	F	Total
No days	261	262	523	385	389	774	162	141	303
Some days	18	26	44	22	22	44	3	11	14
Most days	16	11	27	5	10	15	1	4	5
Every day	21	13	34	73	73	146	4	12	16
Not applicable	288	290	578	465	476	941	168	164	332
Don't know	1	2	3	2	8	10	5	5	10
Total	605	604	1209	952	978	1930	343	337	680

Table 7: Distribution of respondents reporting the type of toilets in their households by province and Sex

Type of toilet	Direct											
	Province											
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua			Total		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Flushed to piped sewer system	67	49	116	248	234	482	88	95	183	403	378	781
Flushed to septic tank	145	172	317	264	278	542	127	119	246	536	569	1105
Flushed to pit latrine	34	25	59	5	7	12	0	1	1	39	33	72
Flush, don't know where	0	1	1	0	0	0	0	0	0	0	1	1
VIP latrine	1	2	3	4	2	6	2	2	4	7	6	13
Pit latrine with slab (concrete, wood/bamboo)	8	8	16	2	0	2	8	7	15	18	15	33
Pit latrine without slab/open pit	36	34	70	1	9	10	0	0	0	37	43	80
Composting toilet	0	1	1	0	0	0	0	1	1	0	2	2
Others	0	1	1	0	0	0	0	0	0	0	1	1
Refused/Not able to observe	0	0	0	0	1	1	0	0	0	0	1	1
Total	291	293	584	524	531	1055	225	225	450	1040	1049	2089

Table 8: Average period of time when first time latrine was constructed by province, district, period and Sex

Period	Sex	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Months	M	74	93	80	81	87	56	87	64	151	80
	F	74	98	79	82	88	57	96	60	156	79
	Total	74	95	80	82	87	56	91	62	153	80
Year	M	6.2	7.7	6.7	6.8	7.2	4.7	7.2	5.3	12.6	6.7
	F	6.2	8.1	6.6	6.8	7.4	4.7	8.0	5.0	13.0	6.6
	Total	6.2	7.9	6.6	6.8	7.3	4.7	7.6	5.1	12.8	6.6

Table 9: Distribution of respondents reporting that they have improved/upgraded latrine in their households during last three years by province, district and Sex

Sex	improved/upgraded this latrine in last THREE years	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
M	Yes	49	42	15	106	15	34	7	8	27	15
	No	237	418	152	807	144	93	159	118	141	152
	Don't know	2	5	1	8	1	1	4	1	0	1
	Total	288	465	168	921	160	128	170	127	168	168
F	Yes	40	32	16	88	15	25	9	7	16	16
	No	243	434	145	822	138	105	150	142	142	145
	Don't know	7	10	3	20	1	6	7	3	0	3
	Total	290	476	164	930	154	136	166	152	158	164
Total	Yes	89	74	31	194	30	59	16	15	43	31
	No	480	852	297	1629	282	198	309	260	283	297
	Don't know	9	15	4	28	2	7	11	4	0	4
	Total	578	941	332	1851	314	264	336	279	326	332

Table 10: Distribution of respondents reporting their satisfaction with the toilet facility as a place to defecate by province, district and Sex

Sex	Degree of satisfaction	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
M	Very satisfied	23	10	19	52	17	6	5	4	1	19
	Satisfied	191	355	126	672	130	61	137	88	130	126
	Dissatisfied	73	94	22	189	13	60	26	33	35	22
	Very dissatisfied	1	6	1	8	0	1	2	2	2	1
	Total	288	465	168	921	160	128	170	127	168	168
F	Very satisfied	27	7	14	48	15	12	4	1	2	14
	Satisfied	182	364	136	682	124	58	134	107	123	136
	Dissatisfied	78	99	14	191	14	64	26	41	32	14
	Very dissatisfied	3	6	0	9	1	2	2	3	1	0
	Total	290	476	164	930	154	136	166	152	158	164
Total	Very satisfied	50	17	33	100	32	18	9	5	3	33
	Satisfied	373	719	262	1354	254	119	271	195	253	262
	Dissatisfied	151	193	36	380	27	124	52	74	67	36
	Very dissatisfied	4	12	1	17	1	3	4	5	3	1
	Total	578	941	332	1851	314	264	336	279	326	332

Table 11: Distribution of respondents reporting their awareness of any available options to receive any assistance (loan, financing, gifts/grants, Construction Material/in-kind support etc.) to help you build the latrine by province, district and Sex

Sex	Awareness of available options to receive assistance	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
M	Yes	163	247	58	468	135	28	64	66	117	58
	No	114	199	106	419	22	92	97	61	41	106
	Don't know	11	19	4	34	3	8	9	0	10	4
	Total	288	465	168	921	160	128	170	127	168	168
F	Yes	164	235	41	440	132	32	62	67	106	41
	No	110	204	117	431	19	91	94	81	29	117
	Don't know	16	37	6	59	3	13	10	4	23	6
	Total	290	476	164	930	154	136	166	152	158	164
Total	Yes	327	482	99	908	267	60	126	133	223	99
	No	224	403	223	850	41	183	191	142	70	223
	Don't know	27	56	10	93	6	21	19	4	33	10
	Total	578	941	332	1851	314	264	336	279	326	332

Participation

Table 1: Distribution of households reporting participation in meeting about sanitation and visit of government official regarding construction of a latrine by province, district and Sex

Sex	Participation in meeting and visit of government official	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Yes	234	76	58	368	145	89	20	11	45	58
	No	116	402	102	620	43	73	139	140	123	102
	Don't know	9	58	23	90	4	5	22	22	14	23
	Total	359	536	183	1078	192	167	181	173	182	183
Female	Yes	211	81	45	337	114	97	17	21	43	45
	No	139	421	107	667	50	89	147	151	123	107
	Don't know	12	42	25	79	5	7	15	15	12	25
	Total	362	544	177	1083	169	193	179	187	178	177
Total	Yes	445	157	103	705	259	186	37	32	88	103
	No	255	823	209	1287	93	162	286	291	246	209
	Don't know	21	100	48	169	9	12	37	37	26	48
	Total	721	1080	360	2161	361	360	360	360	360	360

Table 2. Distribution of households received sufficient information helpful to construct a latrin by province, district and Sex

Sex	Received sufficient information	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Yes	201	57	40	298	138	63	13	4	40	40
	No	33	19	18	70	7	26	7	7	5	18
	What did you miss? Please specify.	0	0	0	0	0	0	0	0	0	0
	Total	234	76	58	368	145	89	20	11	45	58
Female	Yes	167	67	23	257	103	64	11	20	36	23
	No	44	14	21	79	11	33	6	1	7	21
	What did you miss? Please specify.	0	0	1	1	0	0	0	0	0	1
	Total	211	81	45	337	114	97	17	21	43	45
Total	Yes	368	124	63	555	241	127	24	24	76	63
	No	77	33	39	149	18	59	13	8	12	39
	What did you miss? Please specify.	0	0	1	1	0	0	0	0	0	1
	Total	445	157	103	705	259	186	37	32	88	103

Table 3: Distribution of households able to recall three key messages learned/practice in the participated meeting by province, district, and Sex

Sex	Recall three key messages learned in the meeting	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Yes	165	33	23	221	123	42	6	1	26	23
	No	54	28	22	104	13	41	4	8	16	22
	Don't know	15	15	13	43	9	6	10	2	3	13
	Total	234	76	58	368	145	89	20	11	45	58
Female	Yes	124	41	13	178	92	32	3	9	29	13
	No	62	23	20	105	9	53	4	7	12	20
	Don't know	25	17	12	54	13	12	10	5	2	12
	Total	211	81	45	337	114	97	17	21	43	45
Total	Yes	289	74	36	399	215	74	9	10	55	36
	No	116	51	42	209	22	94	8	15	28	42
	Don't know	40	32	25	97	22	18	20	7	5	25
	Total	445	157	103	705	259	186	37	32	88	103

Table 4: Distribution of households reporting the sources of information to get information about hygiene and toilet by province and Sex

Sources of information to get information	Direct								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Television	29	14	43	193	180	373	107	126	233
Newspaper/Tabloid, Magazine	13	8	21	12	9	21	9	6	15
Print Materials	6	9	15	9	15	24	10	12	22
Neighbours/Friends	48	48	96	189	226	415	44	55	99
From School Children in the family	28	27	55	71	61	132	25	18	43
Family members/relatives	47	71	118	263	257	520	36	47	83
Local authority (head of village, RT/RW)	310	313	623	433	434	867	107	101	208
Religious leaders	57	47	104	88	53	141	22	19	41
Government health workers (sanitarians, midwives, cadres, etc.)	320	323	643	260	283	543	131	123	254
Others	7	10	17	18	14	32	0	0	0
Don't know	164	171	335	42	63	105	26	10	36
Total	1029	1041	2070	1578	1595	3173	517	517	1034

Table 5: Distribution of households reporting trusted/preferable source of information by province and Sex

Sources of information	Direct								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Television	25	11	36	168	154	322	113	126	239
Internet	1	0	1	0	0	0	0	0	0
Newspaper/Tabloid, Magazine	1	5	6	7	2	9	7	8	15
Neighbours/Friends	36	39	75	150	180	330	34	43	77
From School Children in the family	17	21	38	34	34	68	18	16	34
Family members/relatives/self	60	75	135	284	285	569	45	52	97
Local authority (head of village, RT/RW)	313	306	619	431	430	861	105	108	213
Religious leaders/organisations	62	51	113	149	124	273	19	17	36
Government & other health workers and other organisations	315	321	636	296	320	616	143	137	280
Posyandu	0	5	5	0	0	0	0	0	0
Others	9	4	13	18	17	35	4	2	6
Don't know	165	172	337	42	56	98	29	9	38
Total	1004	1010	2014	1579	1602	3181	517	518	1035

Sanitation

Table 1: Distribution of respondents reporting existence of any sanitation association (forum, active volunteers, or other organised group) involved in promoting sustainable sanitation by province, district and Sex

Sex	Existence of sanitation association	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Yes	130	69	42	241	83	47	17	13	39	42
	No	165	251	82	498	74	91	86	130	35	82
	Don't know	64	216	59	339	35	29	78	30	108	59
	Total	359	536	183	1078	192	167	181	173	182	183
Female	Yes	119	75	38	232	66	53	16	16	43	38
	No	167	260	92	519	69	98	86	129	45	92
	Don't know	76	209	47	332	34	42	77	42	90	47
	Total	362	544	177	1083	169	193	179	187	178	177
Total	Yes	249	144	80	473	149	100	33	29	82	80
	No	332	511	174	1017	143	189	172	259	80	174
	Don't know	140	425	106	671	69	71	155	72	198	106
	Total	721	1080	360	2161	361	360	360	360	360	360

Table 2: Distribution of respondents reporting most active groups taking part in meetings and action planning by province and Sex

Mostly Active Groups	Direct								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Men	81	64	145	41	35	76	35	30	65
Women	68	66	134	45	47	92	29	28	57
Girls	17	11	28	1	1	2	4	10	14
Boys	17	8	25	1	0	1	9	13	22
People from Poor households	25	20	45	6	2	8	0	6	6
Elderly people	0	2	2	1	2	3	4	5	9
Village leader	48	39	87	37	28	65	19	24	43
People with disabilities	0	0	0	1	0	1	0	0	0
People from Minority groups	1	0	1	0	0	0	1	1	2
Religious people	4	6	10	2	6	8	7	3	10
Professional/Workers (sanitarian, teacher)	26	40	66	12	21	33	3	2	5
Don't know	1	1	2	1	0	1	1	1	2
Total	288	257	545	148	142	290	112	123	235

Table 3: Distribution of respondents reporting action plan to achieve ODF (post-triggering planning and actions) in the community by province, district and Sex

Sex	Action Plan to achieve ODF	Direct									
		Province			Total	Province					
						NTT		SS		PP	
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Yes	224	118	63	405	120	104	19	57	42	63
	No	72	251	77	400	34	38	100	88	63	77
	Don't know	63	167	43	273	38	25	62	28	77	43
	Total	359	536	183	1078	192	167	181	173	182	183
Female	Yes	200	107	64	371	85	115	13	54	40	64
	No	69	256	83	408	35	34	110	94	52	83
	Don't know	93	181	30	304	49	44	56	39	86	30
	Total	362	544	177	1083	169	193	179	187	178	177
Total	Yes	424	225	127	776	205	219	32	111	82	127
	No	141	507	160	808	69	72	210	182	115	160
	Don't know	156	348	73	577	87	69	118	67	163	73
	Total	721	1080	360	2161	361	360	360	360	360	360

Table 4: Distribution of respondent reporting the result in case of someone found defecating in the open by province and Sex

Result, if someone found defecating in the open	Direct								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Financial penalty	1	2	3	3	3	6	8	7	15
Legal penalty	13	15	28	0	2	2	1	3	4
Community members scorn / punish	16	21	37	51	47	98	8	17	25
Nothing happens	266	248	514	471	487	958	155	123	278
Others	65	80	145	11	5	16	12	27	39
None	1	4	5	0	0	0	2	13	15
Total	362	370	732	536	544	1080	186	190	376

Table 5: Distribution of respondents ever seen any map or sign in the community to stop open defecation

Sex	Ever seen any map or sign in the community to stop open defecation	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Yes	254	61	21	336	144	110	32	5	24	21
	No	85	399	126	610	32	53	122	145	132	126
	Don't know	20	76	36	132	16	4	27	23	26	36
	Total	359	536	183	1078	192	167	181	173	182	183
Female	Yes	266	54	28	348	132	134	23	11	20	28
	No	77	395	136	608	28	49	122	149	124	136
	Don't know	19	95	13	127	9	10	34	27	34	13
	Total	362	544	177	1083	169	193	179	187	178	177
Total	Yes	520	115	49	684	276	244	55	16	44	49
	No	162	794	262	1218	60	102	244	294	256	262
	Don't know	39	171	49	259	25	14	61	50	60	49
	Total	2163	3240	1080	6483	1083	1080	1080	1080	1080	1080

Table 6: Distribution of respondents reporting that community verified as ODF verified or not by province, district and Sex

Sex	Community verified as ODF verified	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Yes	241	29	48	318	136	105	3	8	18	48
	No	33	165	57	255	18	15	64	74	27	57
	Don't know	85	342	78	505	38	47	114	91	137	78
	Total	359	536	183	1078	192	167	181	173	182	183
Female	Yes	233	32	44	309	112	121	4	11	17	44
	No	31	179	52	262	15	16	85	61	33	52
	Don't know	98	333	81	512	42	56	90	115	128	81
	Total	362	544	177	1083	169	193	179	187	178	177
Total	Yes	474	61	92	627	248	226	7	19	35	92
	No	64	344	109	517	33	31	149	135	60	109
	Don't know	183	675	159	1017	80	103	204	206	265	159
	Total	721	1080	360	2161	361	360	360	360	360	360

Table 8: Distribution of respondents reporting way of getting ODF verification by province and Sex

How the community was got ODF verification	Direct								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Participation of a large number of households members in the process	117	100	217	23	21	44	41	35	76
A checklist was used for verification with clear verification criteria	78	88	166	8	9	17	18	11	29
A large OD areas around the village were visited for the verification process	74	67	141	7	8	15	10	13	23
Involvement of actors other than community members (media, government officials, neighbouring communities etc.) in verify	28	20	48	0	1	1	0	0	0
The participation of other parties besides the community (media, government agencies, local communities)	131	120	251	6	9	15	17	9	26
Total	428	395	823	44	48	92	86	68	154

Table 9: Distribution of respondents having knowledge that community received any reward/incentive for achieving the ODF status by Province, district and Sex

Sex	Have knowledge that community achieved any reward/incentive in respect of ODF status	Direct									
		Province			Total	Province					
						NTT	SS				PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Yes	158	13	17	188	94	64	1	6	6	17
	No	45	5	16	66	22	23	0	0	5	16
	Don't know	38	11	15	64	20	18	2	2	7	15
	Total	241	29	48	318	136	105	3	8	18	48
Female	Yes	146	11	15	172	59	87	1	5	5	15
	No	43	13	16	72	33	10	2	4	7	16
	Don't know	44	8	13	65	20	24	1	2	5	13
	Total	233	32	44	309	112	121	4	11	17	44
Total	Yes	304	24	32	360	153	151	2	11	11	32
	No	88	18	32	138	55	33	2	4	12	32
	Don't know	82	19	28	129	40	42	3	4	12	28
	Total	474	61	92	627	248	226	7	19	35	92

Table 10: Distribution of respondents reporting the type of reward/incentive awarded to the communities by province and Sex

Type of reward/incentive awarded to community	Direct								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Public recognition	25	19	44	7	6	13	13	7	20
Financial rewards	4	0	4	3	3	6	0	3	3
In-kind or material support	7	9	16	1	2	3	8	7	15
Other incentives or rewards	131	123	254	5	5	10	3	2	5
Clothes	0	0	0	0	0	0	0	0	0
Total	167	151	318	16	16	32	24	19	43

Table 11: Distribution of respondents reporting anyone came to them for encouraging to build/keep using/improve the toilet after ODF verification by province and Sex

Did anyone came to encourage to build/keep using/improve the toilet?	Direct								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Yes from a sanitarian	94	96	190	3	2	5	6	4	10
Yes from a PKK member	6	9	15	2	4	6	2	2	4
Yes from a village officer	109	113	222	10	11	21	13	9	22
Midwife	2	3	5	1	0	1	1	0	1
Total	211	221	432	16	17	33	22	15	37

Table 12: Distribution of respondents reporting their involvement in maintaining/sustaining the ODF status

Sex	Weather the community members involved in maintaining sustaining the ODF status	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Yes	119	8	13	140	86	33	0	5	3	13
	No	27	3	1	31	4	23	1	0	2	1
	Don't know	12	2	3	17	4	8	0	1	1	3
	Total	158	13	17	188	94	64	1	6	6	17
Female	Yes	101	9	12	122	56	45	1	5	3	12
	No	20	2	3	25	3	17	0	0	2	3
	Don't know	25	0	0	25	0	25	0	0	0	0
	Total	146	11	15	172	59	87	1	5	5	15
Total	Yes	220	17	25	262	142	78	1	10	6	25
	No	47	5	4	56	7	40	1	0	4	4
	Don't know	37	2	3	42	4	33	0	1	1	3
	Total	304	24	32	360	153	151	2	11	11	32

Table 13: Distribution of respondents reporting their knowledge regarding place of availability of sanitary materials and supplies for constructing toilet be purchased by province and Sex

Place of availability of sanitary materials and supplies to be purchased	Direct								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Within or nearby your community/dusun	58	47	105	75	63	138	13	19	32
At village/desa level	51	58	109	199	203	402	21	29	50
At sub-district level	120	148	268	347	335	682	93	87	180
At district level	219	196	415	83	95	178	130	131	261
Don't know	5	9	14	7	13	20	14	8	22
Total	453	458	911	711	709	1420	271	274	545

Table 14: Distribution of respondents reporting the sufficient report to poor households by province, district and Sex

Sex	Sufficient support to poor households	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Yes	144	21	19	184	115	29	3	3	15	19
	No	79	5	16	100	20	59	0	5	0	16
	Don't know	136	510	148	794	57	79	178	165	167	148
	Total	359	536	183	1078	192	167	181	173	182	183
Female	Yes	115	20	14	149	92	23	3	4	13	14
	No	89	9	23	121	18	71	0	7	2	23
	Don't know	158	515	140	813	59	99	176	176	163	140
	Total	362	544	177	1083	169	193	179	187	178	177
Total	Yes	259	41	33	333	207	52	6	7	28	33
	No	168	14	39	221	38	130	0	12	2	39
	Don't know	294	1025	288	1607	116	178	354	341	330	288
	Total	721	1080	360	2161	361	360	360	360	360	360

Sanitation and illness

Table 1: Distribution of respondents reporting the ways to protect their children against diarrhoea by province and Sex

Ways adopted to protect young children	Direct											
	Province											
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua			Total		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Boil or treat your water	250	245	495	445	438	883	130	132	262	825	815	1640
Use latrines/dispose faeces of children in latrines	180	177	357	256	234	490	83	71	154	519	482	1001
Wash hands with soap and water	228	247	475	294	299	593	107	106	213	629	652	1281
Cook food well	82	100	182	207	196	403	68	91	159	357	387	744
Store food properly/ cover the food	31	39	70	173	171	344	26	32	58	230	242	472
Buy food from a clean place/ not buying food from random place	13	17	30	134	131	265	15	23	38	162	171	333
Wash fruits and vegetables with potable/safe water	51	69	120	151	143	294	15	24	39	217	236	453
There is nothing you can do, it's a normal part of life	1	7	8	5	7	12	1	0	1	7	14	21
Adopt hygienic style	19	29	48	4	6	10	1	0	1	24	35	59
Wash hands after defecation	0	0	0	0	0	0	0	0	0	0	0	0
Use clean water	1	0	1	0	0	0	0	0	0	1	0	1
Provide medicine	1	0	1	0	0	0	0	0	0	1	0	1
Others	22	34	56	4	11	15	2	3	5	28	48	76
Do not know	38	26	64	7	9	16	11	7	18	56	42	98
Total	917	990	1907	1680	1645	3325	459	489	948	3056	3124	6180

Table 2: Distribution of respondents reporting that their children under age of five victimised of diarrhoea (3 or more watery stools within 24 hours or same day) by province district and Sex

Sex	Children under age 5 had diarrhoea	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Yes	18	10	1	29	9	9	6	2	2	1
	No	132	147	81	360	77	55	54	45	48	81
	Don't know	1	2	2	5	0	1	0	2	0	2
	Total	151	159	84	394	86	65	60	49	50	84
Female	Yes	15	23	5	43	7	8	4	13	6	5
	No	146	138	62	346	70	76	43	48	47	62
	Don't know	0	4	3	7	0	0	0	2	2	3
	Total	161	165	70	396	77	84	47	63	55	70
Total	Yes	33	33	6	72	16	17	10	15	8	6
	No	278	285	143	706	147	131	97	93	95	143
	Don't know	1	6	5	12	0	1	0	4	2	5
	Total	312	324	154	790	163	149	107	112	105	154

Table 3: Distribution of respondents reporting that their children under age of five victimised of diarrhoea (3 or more watery stools within 24 hours or same day) by province district and income quintiles

Income Quintiles	Children under age 5 had diarrhoea	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Highest quintile	Yes	0	15	0	15	0	0	2	12	1	0
	No	14	108	37	159	5	9	24	69	15	37
	Don't know	0	5	0	5	0	0	0	4	1	0
	Total	14	128	37	179	5	9	26	85	17	37
2nd highest quintile	Yes	3	12	3	18	1	2	3	3	6	3
	No	29	67	35	131	10	19	25	18	24	35
	Don't know	0	1	3	4	0	0	0	0	1	3
	Total	32	80	41	153	11	21	28	21	31	41
Medium quintile	Yes	2	3	0	5	1	1	2	0	1	0
	No	31	49	22	102	15	16	18	3	28	22
	Don't know	0	0	0	0	0	0	0	0	0	0
	Total	33	52	22	107	16	17	20	3	29	22
2nd lowest quintile	Yes	13	0	2	15	4	9	0	0	0	2
	No	112	30	27	169	37	75	4	0	26	27
	Don't know	1	0	0	1	0	1	0	0	0	0
	Total	126	30	29	185	41	85	4	0	26	29
Lowest quintile	Yes	14	1	1	16	9	5	1	0	0	1
	No	89	24	14	127	77	12	19	3	2	14
	Don't know	0	0	2	2	0	0	0	0	0	2
	Total	103	25	17	145	86	17	20	3	2	17
Total	Yes	32	31	6	69	15	17	8	15	8	6
	No	275	278	135	688	144	131	90	93	95	135
	Don't know	1	6	5	12	0	1	0	4	2	5
	Total	308	315	146	769	159	149	98	112	105	146

Handwashing

Table 1: Distribution of respondents reporting the time of hands washing by province and Sex

Usually wash hands	Direct											
	Province											
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua			Total		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Before cooking	69	114	183	71	192	263	63	105	168	203	411	614
Before eating	325	335	660	518	534	1052	161	165	326	1004	1034	2038
Before eating	168	194	362	495	490	985	131	133	264	794	817	1611
Before feeding a baby/child	32	53	85	63	89	152	18	28	46	113	170	283
After cleaning the faeces from a baby/child	30	47	77	79	102	181	6	13	19	115	162	277
After defecation	221	226	447	313	363	676	86	98	184	620	687	1307
After work/returning home from work	195	186	381	298	222	520	88	65	153	581	473	1054
Others	5	4	9	19	8	27	0	1	1	24	13	37
Don't know	0	0	0	0	0	0	0	0	0	0	0	0
Do not wash hands	2	5	7	0	0	0	0	0	0	2	5	7

Table 1: Distribution of respondents reporting the time of hands washing by province and Sex

Usually wash hands	Direct											
	Province											
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua			Total		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Total	1047	1164	2211	1856	2000	3856	553	608	1161	3456	3772	7228

Table 2: Distribution of respondents sharing the reasons to wash their hands (motivates to wash hands) by province and Sex

Reasons to wash hands	Direct											
	Province											
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua			Total		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
To prevent the spread of disease	315	323	638	363	406	769	153	154	307	831	883	1714
To be clean	328	331	659	516	515	1031	154	154	308	998	1000	1998
To smell good	17	19	36	136	137	273	49	56	105	202	212	414
To get rid of dirt/smell/sticky things on my hands	95	72	167	258	259	517	47	56	103	400	387	787
Religious reasons/beliefs	1	0	1	55	38	93	5	3	8	61	41	102
Was told it was the right thing to do	9	8	17	83	68	151	3	9	12	95	85	180
Because that's what everyone does	4	3	7	18	24	42	2	3	5	24	30	54
Others	1	4	5	2	0	2	0	0	0	3	4	7
Don't know	3	0	3	0	0	0	0	0	0	3	0	3
Total	773	760	1533	1431	1447	2878	413	435	848	2617	2642	5259

Table 3: Distribution of respondents reporting the items to be used to wash their hands by province and Sex

Item usually use to wash hands	Direct											
	Province											
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua			Total		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Water	230	229	459	532	536	1068	144	142	286	906	907	1813
Soap	276	275	551	427	433	860	123	137	260	826	845	1671
Powdered or liquid detergent	56	85	141	80	129	209	73	85	158	209	299	508
Ash	0	0	0	0	0	0	0	0	0	0	0	0
Dirt/sand/mud	0	0	0	1	0	1	0	0	0	1	0	1
Others	0	0	0	4	4	8	0	0	0	4	4	8
Don’t know	359	362	721	536	542	1078	183	177	360	1078	1081	2159
Total	921	951	1872	1580	1644	3224	523	541	1064	3024	3136	6160

Table 4: Distribution of respondents reporting use of soap to wash their hands by province and Sex

Reasons to wash hands with soap	Direct											
	Province											
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua			Total		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
When they are visibly dirty	182	204	386	401	425	826	137	144	281	720	773	1493
When they smell or are sticky	97	100	197	357	365	722	48	59	107	502	524	1026
Before cooking	44	99	143	58	126	184	46	65	111	148	290	438
Before eating	234	229	463	173	245	418	88	94	182	495	568	1063
Before feeding a baby/child	25	38	63	45	64	109	12	11	23	82	113	195
After defecation	125	143	268	221	263	484	33	54	87	379	460	839
After cleaning a baby that has defecated	23	29	52	51	84	135	4	13	17	78	126	204
Use every time I wash my hands	29	55	84	41	55	96	8	17	25	78	127	205
After work	111	105	216	164	129	293	21	27	48	296	261	557
Others	6	7	13	4	1	5	0	1	1	10	9	19
None	0	0	0	0	0	0	0	0	0	0	0	0
Total	876	1009	1885	1515	1757	3272	397	485	882	2788	3251	6039

Opinions on location, cost, absence of toilets

Table 1: Distribution of respondents giving their opinion that most people in this community do not have a toilet in their house by province, district and respondent's Sex

Sex	Opinion that most of the people do not have a toilet	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Strongly Disagree	104	106	26	236	75	29	46	1	59	26
	Disagree	197	260	128	585	104	93	118	43	99	128
	Neither Agree nor Disagree	17	92	11	120	3	14	14	63	15	11
	Agree	36	55	18	109	10	26	3	44	8	18
	Strongly Agree	5	23	0	28	0	5	0	22	1	0
	Total	359	536	183	1078	192	167	181	173	182	183
Female	Strongly Disagree	111	91	24	226	67	44	46	5	40	24
	Disagree	184	297	124	605	90	94	123	60	114	124
	Neither Agree nor Disagree	33	88	15	136	4	29	7	64	17	15
	Agree	34	49	14	97	8	26	3	39	7	14
	Strongly Agree	0	19	0	19	0	0	0	19	0	0
	Total	362	544	177	1083	169	193	179	187	178	177
Total	Strongly Disagree	215	197	50	462	142	73	92	6	99	50
	Disagree	381	557	252	1190	194	187	241	103	213	252
	Neither Agree nor Disagree	50	180	26	256	7	43	21	127	32	26
	Agree	70	104	32	206	18	52	6	83	15	32
	Strongly Agree	5	42	0	47	0	5	0	41	1	0
	Total	721	1080	360	2161	361	360	360	360	360	360

Table 2: Distribution of respondents giving their opinion that most poor households in this community do not have a toilet in their house by province, district and respondent's Sex

Sex	Opinion that most of poor households do not have a toilet	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Strongly Disagree	101	30	20	151	74	27	17	1	12	20
	Disagree	165	242	117	524	92	73	110	34	98	117
	Neither Agree nor Disagree	54	137	20	211	10	44	43	54	40	20
	Agree	38	112	25	175	16	22	11	71	30	25
	Strongly Agree	1	15	1	17	0	1	0	13	2	1
	Total	359	536	183	1078	192	167	181	173	182	183
Female	Strongly Disagree	92	22	12	126	56	36	14	2	6	12
	Disagree	178	261	121	560	97	81	122	38	101	121
	Neither Agree nor Disagree	51	136	20	207	6	45	35	61	40	20
	Agree	41	114	24	179	10	31	8	78	28	24
	Strongly Agree	0	11	0	11	0	0	0	8	3	0
	Total	362	544	177	1083	169	193	179	187	178	177
Total	Strongly Disagree	193	52	32	277	130	63	31	3	18	32
	Disagree	343	503	238	1084	189	154	232	72	199	238
	Neither Agree nor Disagree	105	273	40	418	16	89	78	115	80	40
	Agree	79	226	49	354	26	53	19	149	58	49
	Strongly Agree	1	26	1	28	0	1	0	21	5	1
	Total	721	1080	360	2161	361	360	360	360	360	360

Table 3: Distribution of respondents giving their opinion that a lot of people think that it is to expensive to have a toilet in their house by province, district and respondent's Sex

Sex	A lot of people think that it is too expensive to have toilet in their house	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Strongly Disagree	42	38	20	100	33	9	32	1	5	20
	Disagree	163	190	115	468	108	55	70	29	91	115
	Neither Agree nor Disagree	43	133	21	197	3	40	48	54	31	21
	Agree	88	151	27	266	46	42	31	79	41	27
	Strongly Agree	23	24	0	47	2	21	0	10	14	0
	Total	359	536	183	1078	192	167	181	173	182	183
Female	Strongly Disagree	36	27	17	80	24	12	19	2	6	17
	Disagree	155	187	114	456	91	64	81	34	72	114
	Neither Agree nor Disagree	65	159	27	251	9	56	59	64	36	27
	Agree	92	147	18	257	44	48	19	72	56	18
	Strongly Agree	14	24	1	39	1	13	1	15	8	1
	Total	362	544	177	1083	169	193	179	187	178	177
Total	Strongly Disagree	78	65	37	180	57	21	51	3	11	37
	Disagree	318	377	229	924	199	119	151	63	163	229
	Neither Agree nor Disagree	108	292	48	448	12	96	107	118	67	48
	Agree	180	298	45	523	90	90	50	151	97	45
	Strongly Agree	37	48	1	86	3	34	1	25	22	1
	Total	721	1080	360	2161	361	360	360	360	360	360

Table 4: Distribution of respondents giving their opinion that in the community it is acceptable to defecate in the open by province, district and respondent's Sex

Sex	In the community its acceptable to defecate in the open	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Strongly Disagree	98	111	33	242	61	37	59	10	42	33
	Disagree	213	249	115	577	125	88	107	50	92	115
	Neither Agree nor Disagree	26	85	21	132	2	24	13	42	30	21
	Agree	18	87	14	119	4	14	2	67	18	14
	Strongly Agree	4	4	0	8	0	4	0	4	0	0
	Total	359	536	183	1078	192	167	181	173	182	183
Female	Strongly Disagree	101	95	19	215	60	41	44	20	31	19
	Disagree	218	275	109	602	106	112	114	59	102	109
	Neither Agree nor Disagree	26	98	36	160	1	25	16	53	29	36
	Agree	16	67	13	96	2	14	4	49	14	13
	Strongly Agree	1	9	0	10	0	1	1	6	2	0
	Total	362	544	177	1083	169	193	179	187	178	177
Total	Strongly Disagree	199	206	52	457	121	78	103	30	73	52
	Disagree	431	524	224	1179	231	200	221	109	194	224
	Neither Agree nor Disagree	52	183	57	292	3	49	29	95	59	57
	Agree	34	154	27	215	6	28	6	116	32	27
	Strongly Agree	5	13	0	18	0	5	1	10	2	0
	Total	721	1080	360	2161	361	360	360	360	360	360

Table 5: Distribution of respondents giving their opinion that It's embarrassing when people can see others defecating in the open by province, district and respondent's Sex

Sex	It's embarrassing when people can see others defecating in the open	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Strongly Disagree	16	18	16	50	3	13	8	1	9	16
	Disagree	30	34	72	136	22	8	6	12	16	72
	Neither Agree nor Disagree	5	101	19	125	0	5	15	70	16	19
	Agree	234	296	70	600	137	97	100	72	124	70
	Strongly Agree	74	87	6	167	30	44	52	18	17	6
	Total	359	536	183	1078	192	167	181	173	182	183
Female	Strongly Disagree	9	8	14	31	4	5	0	2	6	14
	Disagree	35	29	77	141	23	12	5	8	16	77
	Neither Agree nor Disagree	9	92	20	121	1	8	22	62	8	20
	Agree	209	311	61	581	107	102	97	88	126	61
	Strongly Agree	100	104	5	209	34	66	55	27	22	5
	Total	362	544	177	1083	169	193	179	187	178	177
Total	Strongly Disagree	25	26	30	81	7	18	8	3	15	30
	Disagree	65	63	149	277	45	20	11	20	32	149
	Neither Agree nor Disagree	14	193	39	246	1	13	37	132	24	39
	Agree	443	607	131	1181	244	199	197	160	250	131
	Strongly Agree	174	191	11	376	64	110	107	45	39	11
	Total	721	1080	360	2161	361	360	360	360	360	360

Table 6: Distribution of respondents giving their opinion that most people feel ashamed to not have a toilet in their house by province, district and respondent's Sex

Sex	Most people feel ashamed to not have a toilet in their house	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Strongly Disagree	15	1	12	28	4	11	0	1	0	12
	Disagree	22	65	83	170	10	12	14	19	32	83
	Neither Agree nor Disagree	21	159	22	202	0	21	77	57	25	22
	Agree	225	279	59	563	146	79	81	81	117	59
	Strongly Agree	76	32	7	115	32	44	9	15	8	7
	Total	359	536	183	1078	192	167	181	173	182	183
Female	Strongly Disagree	8	3	15	26	4	4	0	0	3	15
	Disagree	20	58	69	147	13	7	11	21	26	69
	Neither Agree nor Disagree	23	155	25	203	1	22	76	53	26	25
	Agree	227	296	64	587	130	97	80	102	114	64
	Strongly Agree	84	32	4	120	21	63	12	11	9	4
	Total	362	544	177	1083	169	193	179	187	178	177
Total	Strongly Disagree	23	4	27	54	8	15	0	1	3	27
	Disagree	42	123	152	317	23	19	25	40	58	152
	Neither Agree nor Disagree	44	314	47	405	1	43	153	110	51	47
	Agree	452	575	123	1150	276	176	161	183	231	123
	Strongly Agree	160	64	11	235	53	107	21	26	17	11
	Total	721	1080	360	2161	361	360	360	360	360	360

Table 7: Distribution of respondents giving their opinion that in the community Open defecation is acceptable when water is not available for toilet by province, district and respondent's Sex

Sex	Open defecation is acceptable when water is not available	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Strongly Disagree	32	38	18	88	7	25	17	0	21	18
	Disagree	202	228	106	536	116	86	95	48	85	106
	Neither Agree nor Disagree	43	180	27	250	9	34	61	69	50	27
	Agree	69	78	32	179	54	15	7	45	26	32
	Strongly Agree	13	12	0	25	6	7	1	11	0	0
	Total	359	536	183	1078	192	167	181	173	182	183
Female	Strongly Disagree	37	31	16	84	9	28	19	0	12	16
	Disagree	207	239	115	561	108	99	93	60	86	115
	Neither Agree nor Disagree	50	196	24	270	10	40	62	81	53	24
	Agree	56	73	22	151	35	21	5	41	27	22
	Strongly Agree	12	5	0	17	7	5	0	5	0	0
	Total	362	544	177	1083	169	193	179	187	178	177
Total	Strongly Disagree	69	69	34	172	16	53	36	0	33	34
	Disagree	409	467	221	1097	224	185	188	108	171	221
	Neither Agree nor Disagree	93	376	51	520	19	74	123	150	103	51
	Agree	125	151	54	330	89	36	12	86	53	54
	Strongly Agree	25	17	0	42	13	12	1	16	0	0
	Total	721	1080	360	2161	361	360	360	360	360	360

Handwashing; opinions and practices

Table 1: Distribution of respondents reporting place of washing hands by the family members by province, district and Sex

Sex	Place of washing hands by family members	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Within 10 paces of the toilet facility (inside or outside)	87	111	67	265	67	20	41	22	48	67
	Within 10 paces of the kitchen/cooking place	120	275	66	461	61	59	138	36	101	66
	Elsewhere in home or yard	41	34	34	109	9	32	2	5	27	34
	Outside of yard	5	4	8	17	1	4	0	1	3	8
	No specific place	35	110	6	151	2	33	0	109	1	6
	Not allowed to observe	8	2	0	10	0	8	0	0	2	0
	None	63	0	2	65	52	11	0	0	0	2
	Total	359	536	183	1078	192	167	181	173	182	183
Female	Within 10 paces of the toilet facility (inside or outside)	94	101	54	249	67	27	41	13	47	54
	Within 10 paces of the kitchen/cooking place	112	286	62	460	50	62	134	36	116	62
	Elsewhere in home or yard	42	17	41	100	6	36	2	4	11	41
	Outside of yard	2	2	10	14	0	2	2	0	0	10
	No specific place	38	133	7	178	3	35	0	133	0	7
	Not allowed to observe	11	3	0	14	0	11	0	1	2	0
	None	63	2	3	68	43	20	0	0	2	3
	Total	362	544	177	1083	169	193	179	187	178	177
Total	Within 10 paces of the toilet facility (inside or outside)	181	212	121	514	134	47	82	35	95	121
	Within 10 paces of the kitchen/cooking place	232	561	128	921	111	121	272	72	217	128
	Elsewhere in home or yard	83	51	75	209	15	68	4	9	38	75
	Outside of yard	7	6	18	31	1	6	2	1	3	18
	No specific place	73	243	13	329	5	68	0	242	1	13
	Not allowed to observe	19	5	0	24	0	19	0	1	4	0
	None	126	2	5	133	95	31	0	0	2	5
	Total	721	1080	360	2161	361	360	360	360	360	360

Table 2: Distribution of respondents reporting the availability of water at the place of washing hands by province, district and Sex

Sex	Availability of water at the place for washing hands	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Water is not available	30	18	29	77	9	21	0	12	6	29
	Water is available	329	518	154	1001	183	146	181	161	176	154
	Total	359	536	183	1078	192	167	181	173	182	183
Female	Water is not available	29	21	24	74	7	22	0	16	5	24
	Water is available	333	523	153	1009	162	171	179	171	173	153
	Total	362	544	177	1083	169	193	179	187	178	177
Total	Water is not available	59	39	53	151	16	43	0	28	11	53
	Water is available	662	1041	307	2010	345	317	360	332	349	307
	Total	721	1080	360	2161	361	360	360	360	360	360

Table 3: Distribution of respondents reporting the presence of soap or detergent at the place of washing hands by province, district and gender

Gender	Presence of soap or detergent at the place of washing hands	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Water only	38	68	26	132	10	28	2	56	10	26
	Soap and water	144	314	97	555	110	34	117	109	88	97
	Powdered or liquid detergent and water	172	141	53	366	68	104	62	5	74	53
	Ash	1	8	7	16	1	0	0	0	8	7
	None	4	5	0	9	3	1	0	3	2	0
	Total	359	536	183	1078	192	167	181	173	182	183
Female	Water only	34	48	13	95	4	30	0	46	2	13
	Soap and water	147	304	107	558	104	43	111	121	72	107
	Powdered or liquid detergent and water	173	172	46	391	56	117	67	17	88	46
	Ash	7	16	11	34	5	2	1	2	13	11
	None	1	4	0	5	0	1	0	1	3	0
	Total	362	544	177	1083	169	193	179	187	178	177
Total	Water only	72	116	39	227	14	58	2	102	12	39
	Soap and water	291	618	204	1113	214	77	228	230	160	204
	Powdered or liquid detergent and water	345	313	99	757	124	221	129	22	162	99
	Ash	8	24	18	50	6	2	1	2	21	18
	None	5	9	0	14	3	2	0	4	5	0
	Total	721	1080	360	2161	361	360	360	360	360	360

Table 4: Distribution of respondents reporting usual way of washing hands by province and gender

Usual way of washing hands	Direct											
	Province											
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua			Total		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
Water only	122	139	261	314	298	612	122	125	247	558	562	1120
Soap and water	273	278	551	423	434	857	156	160	316	852	872	1724
Powdered or liquid detergent and water	41	56	97	49	72	121	58	71	129	148	199	347
Ash	0	1	1	1	0	1	3	3	6	4	4	8
Dirt/sand/mud	0	0	0	2	0	2	1	1	2	3	1	4
Shook hands to dry	103	113	216	13	11	24	1	1	2	117	125	242
Used visibly clean cloth to dry	45	48	93	20	29	49	2	0	2	67	77	144
Used visibly dirty cloth to dry	7	6	13	7	8	15	0	0	0	14	14	28
Cannot demonstrate (lacks resources to demonstrate)	1	0	1	1	0	1	2	0	2	4	0	4
Unwilling/Refused to demonstrate	25	20	45	10	6	16	1	0	1	36	26	62
Total	617	661	1278	840	858	1698	346	361	707	1803	1880	3683

Sanctions

Table 1: Distribution of households reporting the frequency of using toilet by household members by province, district and gender

Gender	Frequency of using toilet	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Never	2	8	1	11	0	2	1	6	1	1
	Rarely	4	8	8	20	0	4	0	8	0	8
	Sometimes	23	14	2	39	4	19	1	8	5	2
	Often	83	87	31	201	37	46	11	58	18	31
	Always	247	419	141	807	151	96	168	93	158	141
	Total	359	536	183	1078	192	167	181	173	182	183
Female	Never	11	5	2	18	0	11	1	3	1	2
	Rarely	9	6	14	29	1	8	1	3	2	14
	Sometimes	14	7	3	24	1	13	1	5	1	3
	Often	67	86	30	183	33	34	9	52	25	30
	Always	261	440	128	829	134	127	167	124	149	128
	Total	362	544	177	1083	169	193	179	187	178	177
Total	Never	13	13	3	29	0	13	2	9	2	3
	Rarely	13	14	22	49	1	12	1	11	2	22
	Sometimes	37	21	5	63	5	32	2	13	6	5
	Often	150	173	61	384	70	80	20	110	43	61
	Always	508	859	269	1636	285	223	335	217	307	269
	Total	721	1080	360	2161	361	360	360	360	360	360

Table 2: Distribution of households reporting out of 10 households, how many members per households are using toilet by province, district and gender

Gender	Household members using toilet out of 10 households	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Nobody uses toilet in household	0	0	1	1	0	0	0	0	0	1
	Only one household	1	0	2	3	1	0	0	0	0	2
	Two households	2	0	5	7	0	2	0	0	0	5
	Three households	1	2	17	20	0	1	1	1	0	17
	Four households	4	1	11	16	1	3	0	0	1	11
	Five households	23	7	16	46	8	15	0	7	0	16
	Six households	14	20	12	46	5	9	0	18	2	12
	Seven households	36	37	14	87	3	33	1	30	6	14
	Eight households	57	76	42	175	8	49	6	46	24	42
	Nine households	40	99	25	164	11	29	5	40	54	25
	Ten households	181	294	38	513	155	26	168	31	95	38
	Total	359	536	183	1078	192	167	181	173	182	183
Female	Nobody uses toilet in household	0	0	4	4	0	0	0	0	0	4
	Only one household	0	1	4	5	0	0	0	1	0	4
	Two households	0	0	15	15	0	0	0	0	0	15
	Three households	1	0	11	12	0	1	0	0	0	11
	Four households	4	1	7	12	1	3	0	1	0	7
	Five households	31	14	7	52	4	27	0	14	0	7
	Six households	8	16	12	36	5	3	0	15	1	12
	Seven households	53	37	17	107	6	47	1	31	5	17

Table 2: Distribution of households reporting out of 10 households, how many members per households are using toilet by province, district and gender

Gender	Household members using toilet out of 10 households	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
	Eight households	52	78	34	164	7	45	1	44	33	34
	Nine households	42	98	21	161	9	33	7	45	46	21
	Ten households	171	299	45	515	137	34	170	36	93	45
	Total	362	544	177	1083	169	193	179	187	178	177
	Nobody uses toilet in household	0	0	5	5	0	0	0	0	0	5
	Only one household	1	1	6	8	1	0	0	1	0	6
	Two households	2	0	20	22	0	2	0	0	0	20
	Three households	2	2	28	32	0	2	1	1	0	28
	Four households	8	2	18	28	2	6	0	1	1	18
Total	Five households	54	21	23	98	12	42	0	21	0	23
	Six households	22	36	24	82	10	12	0	33	3	24
	Seven households	89	74	31	194	9	80	2	61	11	31
	Eight households	109	154	76	339	15	94	7	90	57	76
	Nine households	82	197	46	325	20	62	12	85	100	46
	Ten households	352	593	83	1028	292	60	338	67	188	83
	Total	721	1080	360	2161	361	360	360	360	360	360

Normative

Table 3: Distribution of respondents reporting they believe that the people in the village should use a latrine by province, district and gender

Gender	Belief of the respondent to use the toilet by people	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Yes	359	536	183	1078	192	167	181	173	182	183
	No	0	0	0	0	0	0	0	0	0	0
	Total	359	536	183	1078	192	167	181	173	182	183
Female	Yes	360	544	177	1081	169	191	179	187	178	177
	No	2	0	0	2	0	2	0	0	0	0
	Total	362	544	177	1083	169	193	179	187	178	177
Total	Yes	719	1080	360	2159	361	358	360	360	360	360
	No	2	0	0	2	0	2	0	0	0	0
	Total	721	1080	360	2161	361	360	360	360	360	360

Table 4: Distribution of respondents reporting that they believe that the people in village should use a latrine by province, and gender

Reasons that people should use a latrine	Direct								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Because it is the right thing to do	254	255	509	441	460	901	166	150	316
Health Environment related reason	163	170	333	116	109	225	11	21	32
Personal Preference	21	27	48	45	42	87	5	5	10
External pressure	1	2	3	0	1	1	0	0	0
Others	179	188	367	158	150	308	17	28	45
None	1	0	1	1	0	1	1	2	3
Total	619	642	1261	761	762	1523	200	206	406

Vignette question - normative expectations

Table 5: Distribution of respondents reporting that he/she thinks that how many out of 10 people should use a latrine because it is the right thing to do by province, district and gender

Gender	People out of 10 should use a latrine	Direct									
		Province			Total	Province					
						NTT		SS		PP	
						District					
		NTT	SS	PP		Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Nobody uses toilet	0	0	1	1	0	0	0	0	0	1
	Only one person	7	1	1	9	7	0	1	0	0	1
	Two persons	4	0	14	18	2	2	0	0	0	14
	Three persons	1	1	8	10	0	1	0	0	1	8
	Four persons	5	1	14	20	1	4	0	0	1	14
	Five persons	28	3	17	48	7	21	0	1	2	17
	Six persons	13	5	15	33	5	8	0	2	3	15
	Seven persons	49	31	24	104	3	46	0	24	7	24
	Eight persons	45	61	31	137	7	38	6	28	27	31
	Nine persons	35	90	24	149	3	32	5	32	53	24
	Ten persons	172	343	34	549	157	15	169	86	88	34
	Total	359	536	183	1078	192	167	181	173	182	183
Female	Nobody uses toilet	2	0	3	5	0	2	0	0	0	3
	Only one person	3	1	5	9	3	0	0	1	0	5
	Two persons	2	0	19	21	2	0	0	0	0	19
	Three persons	0	0	9	9	0	0	0	0	0	9
	Four persons	8	0	11	19	2	6	0	0	0	11
	Five persons	33	3	19	55	4	29	0	1	2	19
	Six persons	10	6	11	27	4	6	0	3	3	11
	Seven persons	61	34	17	112	6	55	0	25	9	17
	Eight persons	52	50	24	126	4	48	3	18	29	24
	Nine persons	28	72	25	125	5	23	7	26	39	25
	Ten persons	163	378	34	575	139	24	169	113	96	34
	Total	362	544	177	1083	169	193	179	187	178	177
Total	Nobody uses toilet	2	0	4	6	0	2	0	0	0	4
	Only one person	10	2	6	18	10	0	1	1	0	6
	Two persons	6	0	33	39	4	2	0	0	0	33
	Three persons	1	1	17	19	0	1	0	0	1	17
	Four persons	13	1	25	39	3	10	0	0	1	25
	Five persons	61	6	36	103	11	50	0	2	4	36

Table 5: Distribution of respondents reporting that he/she thinks that how many out of 10 people should use a latrine because it is the right thing to do by province, district and gender

Gender	People out of 10 should use a latrine	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
	Six persons	23	11	26	60	9	14	0	5	6	26
	Seven persons	110	65	41	216	9	101	0	49	16	41
	Eight persons	97	111	55	263	11	86	9	46	56	55
	Nine persons	63	162	49	274	8	55	12	58	92	49
	Ten persons	335	721	68	1124	296	39	338	199	184	68
	Total	721	1080	360	2161	361	360	360	360	360	360

Existence of sanctions

Table 6: Distribution of respondents reporting the result of defecation in open, if happened by province and gender

Result of defecation in open	Direct								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Financial penalty	1	2	3	3	3	6	8	7	15
Legal penalty	13	15	28	0	2	2	1	3	4
Community members scorn / punish	16	21	37	51	47	98	8	17	25
Nothing happens	266	248	514	471	487	958	155	123	278
Others	65	80	145	11	5	16	12	27	39
None	1	4	5	0	0	0	2	13	15
Total	362	370	732	536	544	1080	186	190	376

Table 7: Distribution of households reporting the frequency of using toilet by household members by province, district and village

Village	Frequency of using toilet	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Wolwal Barat	Never	0	0	0	0	0	0	0	0	0	0
	Rarely	1	0	0	1	1	0	0	0	0	0
	Sometimes	5	0	0	5	5	0	0	0	0	0
	Often	15	0	0	15	15	0	0	0	0	0
	Always	69	0	0	69	69	0	0	0	0	0
	Total	90	0	0	90	90	0	0	0	0	0
Belemana	Never	0	0	0	0	0	0	0	0	0	0
	Rarely	0	0	0	0	0	0	0	0	0	0
	Sometimes	0	0	0	0	0	0	0	0	0	0
	Often	18	0	0	18	18	0	0	0	0	0
	Always	73	0	0	73	73	0	0	0	0	0
	Total	91	0	0	91	91	0	0	0	0	0
Bouweli	Never	0	0	0	0	0	0	0	0	0	0
	Rarely	0	0	0	0	0	0	0	0	0	0
	Sometimes	0	0	0	0	0	0	0	0	0	0

Table 7: Distribution of households reporting the frequency of using toilet by household members by province, district and village

Village	Frequency of using toilet	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
	Often	17	0	0	17	17	0	0	0	0	0
	Always	73	0	0	73	73	0	0	0	0	0
	Total	90	0	0	90	90	0	0	0	0	0
Pura Utara	Never	0	0	0	0	0	0	0	0	0	0
	Rarely	0	0	0	0	0	0	0	0	0	0
	Sometimes	0	0	0	0	0	0	0	0	0	0
	Often	20	0	0	20	20	0	0	0	0	0
	Always	70	0	0	70	70	0	0	0	0	0
	Total	90	0	0	90	90	0	0	0	0	0
Bangka Lao	Never	0	0	0	0	0	0	0	0	0	0
	Rarely	0	0	0	0	0	0	0	0	0	0
	Sometimes	0	0	0	0	0	0	0	0	0	0
	Often	0	0	0	0	0	0	0	0	0	0
	Always	0	0	0	0	0	0	0	0	0	0
	Total	0	0	0	0	0	0	0	0	0	0
Kakor	Never	0	0	0	0	0	0	0	0	0	0
	Rarely	0	0	0	0	0	0	0	0	0	0
	Sometimes	0	0	0	0	0	0	0	0	0	0
	Often	0	0	0	0	0	0	0	0	0	0
	Always	0	0	0	0	0	0	0	0	0	0
	Total	0	0	0	0	0	0	0	0	0	0
Pong Lale	Never	0	0	0	0	0	0	0	0	0	0
	Rarely	0	0	0	0	0	0	0	0	0	0
	Sometimes	0	0	0	0	0	0	0	0	0	0
	Often	0	0	0	0	0	0	0	0	0	0
	Always	0	0	0	0	0	0	0	0	0	0
	Total	0	0	0	0	0	0	0	0	0	0
Lalong	Never	0	0	0	0	0	0	0	0	0	0
	Rarely	0	0	0	0	0	0	0	0	0	0
	Sometimes	0	0	0	0	0	0	0	0	0	0
	Often	0	0	0	0	0	0	0	0	0	0
	Always	0	0	0	0	0	0	0	0	0	0
	Total	0	0	0	0	0	0	0	0	0	0
Mandahu	Never	1	0	0	1	0	1	0	0	0	0
	Rarely	3	0	0	3	0	3	0	0	0	0
	Sometimes	5	0	0	5	0	5	0	0	0	0
	Often	33	0	0	33	0	33	0	0	0	0
	Always	48	0	0	48	0	48	0	0	0	0
	Total	90	0	0	90	0	90	0	0	0	0
Pamburu	Never	5	0	0	5	0	5	0	0	0	0
	Rarely	6	0	0	6	0	6	0	0	0	0
	Sometimes	18	0	0	18	0	18	0	0	0	0
	Often	10	0	0	10	0	10	0	0	0	0
	Always	51	0	0	51	0	51	0	0	0	0
	Total	90	0	0	90	0	90	0	0	0	0
Lambakara	Never	4	0	0	4	0	4	0	0	0	0
	Rarely	3	0	0	3	0	3	0	0	0	0
	Sometimes	3	0	0	3	0	3	0	0	0	0
	Often	19	0	0	19	0	19	0	0	0	0
	Always	61	0	0	61	0	61	0	0	0	0
	Total	90	0	0	90	0	90	0	0	0	0

Table 7: Distribution of households reporting the frequency of using toilet by household members by province, district and village

Village	Frequency of using toilet	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Tapil	Never	3	0	0	3	0	3	0	0	0	0
	Rarely	0	0	0	0	0	0	0	0	0	0
	Sometimes	6	0	0	6	0	6	0	0	0	0
	Often	18	0	0	18	0	18	0	0	0	0
	Always	63	0	0	63	0	63	0	0	0	0
	Total	90	0	0	90	0	90	0	0	0	0
Torada	Never	0	1	0	1	0	0	1	0	0	0
	Rarely	0	1	0	1	0	0	1	0	0	0
	Sometimes	0	0	0	0	0	0	0	0	0	0
	Often	0	4	0	4	0	0	4	0	0	0
	Always	0	84	0	84	0	0	84	0	0	0
	Total	0	90	0	90	0	0	90	0	0	0
Kamiri	Never	0	1	0	1	0	0	1	0	0	0
	Rarely	0	0	0	0	0	0	0	0	0	0
	Sometimes	0	0	0	0	0	0	0	0	0	0
	Often	0	0	0	0	0	0	0	0	0	0
	Always	0	89	0	89	0	0	89	0	0	0
	Total	0	90	0	90	0	0	90	0	0	0
Baloli	Never	0	0	0	0	0	0	0	0	0	0
	Rarely	0	0	0	0	0	0	0	0	0	0
	Sometimes	0	0	0	0	0	0	0	0	0	0
	Often	0	6	0	6	0	0	6	0	0	0
	Always	0	84	0	84	0	0	84	0	0	0
	Total	0	90	0	90	0	0	90	0	0	0
Banyuwangi	Never	0	0	0	0	0	0	0	0	0	0
	Rarely	0	0	0	0	0	0	0	0	0	0
	Sometimes	0	2	0	2	0	0	2	0	0	0
	Often	0	10	0	10	0	0	10	0	0	0
	Always	0	78	0	78	0	0	78	0	0	0
	Total	0	90	0	90	0	0	90	0	0	0
Bone Bone	Total	0	0	0	0	0	0	0	0	0	0
	Rarely	0	0	0	0	0	0	0	0	0	0
	Sometimes	0	0	0	0	0	0	0	0	0	0
	Often	0	0	0	0	0	0	0	0	0	0
	Always	0	0	0	0	0	0	0	0	0	0
	Total	0	0	0	0	0	0	0	0	0	0
Pinang	Never	0	0	0	0	0	0	0	0	0	0
	Rarely	0	0	0	0	0	0	0	0	0	0
	Sometimes	0	0	0	0	0	0	0	0	0	0
	Often	0	0	0	0	0	0	0	0	0	0
	Always	0	0	0	0	0	0	0	0	0	0
	Total	0	0	0	0	0	0	0	0	0	0
Pasang	Never	0	0	0	0	0	0	0	0	0	0
	Rarely	0	0	0	0	0	0	0	0	0	0
	Sometimes	0	0	0	0	0	0	0	0	0	0
	Often	0	0	0	0	0	0	0	0	0	0
	Always	0	0	0	0	0	0	0	0	0	0
	Total	0	0	0	0	0	0	0	0	0	0
Kolai	Never	0	0	0	0	0	0	0	0	0	0
	Rarely	0	0	0	0	0	0	0	0	0	0
	Sometimes	0	0	0	0	0	0	0	0	0	0

Table 7: Distribution of households reporting the frequency of using toilet by household members by province, district and village

Village	Frequency of using toilet	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
	Often	0	0	0	0	0	0	0	0	0	0
	Always	0	0	0	0	0	0	0	0	0	0
	Total	0	0	0	0	0	0	0	0	0	0
Palakka	Never	0	1	0	1	0	0	0	0	1	0
	Rarely	0	0	0	0	0	0	0	0	0	0
	Sometimes	0	0	0	0	0	0	0	0	0	0
	Often	0	8	0	8	0	0	0	0	8	0
	Always	0	81	0	81	0	0	0	0	81	0
	Total	0	90	0	90	0	0	0	0	90	0
Tompo	Never	0	0	0	0	0	0	0	0	0	0
	Rarely	0	1	0	1	0	0	0	0	1	0
	Sometimes	0	1	0	1	0	0	0	0	1	0
	Often	0	5	0	5	0	0	0	0	5	0
	Always	0	83	0	83	0	0	0	0	83	0
	Total	0	90	0	90	0	0	0	0	90	0
Paccekke	Never	0	0	0	0	0	0	0	0	0	0
	Rarely	0	1	0	1	0	0	0	0	1	0
	Sometimes	0	5	0	5	0	0	0	0	5	0
	Often	0	18	0	18	0	0	0	0	18	0
	Always	0	66	0	66	0	0	0	0	66	0
	Total	0	90	0	90	0	0	0	0	90	0
Kiru-Kiru	Never	0	1	0	1	0	0	0	0	1	0
	Rarely	0	0	0	0	0	0	0	0	0	0
	Sometimes	0	0	0	0	0	0	0	0	0	0
	Often	0	12	0	12	0	0	0	0	12	0
	Always	0	77	0	77	0	0	0	0	77	0
	Total	0	90	0	90	0	0	0	0	90	0
Bonto Kassi	Never	0	4	0	4	0	0	0	4	0	0
	Rarely	0	8	0	8	0	0	0	8	0	0
	Sometimes	0	4	0	4	0	0	0	4	0	0
	Often	0	36	0	36	0	0	0	36	0	0
	Always	0	38	0	38	0	0	0	38	0	0
	Total	0	90	0	90	0	0	0	90	0	0
Pakkabba	Never	0	0	0	0	0	0	0	0	0	0
	Rarely	0	0	0	0	0	0	0	0	0	0
	Sometimes	0	1	0	1	0	0	0	1	0	0
	Often	0	18	0	18	0	0	0	18	0	0
	Always	0	71	0	71	0	0	0	71	0	0
	Total	0	90	0	90	0	0	0	90	0	0
Bajeng	Never	0	3	0	3	0	0	0	3	0	0
	Rarely	0	2	0	2	0	0	0	2	0	0
	Sometimes	0	5	0	5	0	0	0	5	0	0
	Often	0	33	0	33	0	0	0	33	0	0
	Always	0	47	0	47	0	0	0	47	0	0
	Total	0	90	0	90	0	0	0	90	0	0
Lassang	Never	0	2	0	2	0	0	0	2	0	0
	Rarely	0	1	0	1	0	0	0	1	0	0
	Sometimes	0	3	0	3	0	0	0	3	0	0
	Often	0	23	0	23	0	0	0	23	0	0
	Always	0	61	0	61	0	0	0	61	0	0
	Total	0	90	0	90	0	0	0	90	0	0

Table 7: Distribution of households reporting the frequency of using toilet by household members by province, district and village

Village	Frequency of using toilet	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Entiyebo / Tablanusu	Never	0	0	0	0	0	0	0	0	0	0
	Rarely	0	0	7	7	0	0	0	0	0	7
	Sometimes	0	0	3	3	0	0	0	0	0	3
	Often	0	0	12	12	0	0	0	0	0	12
	Always	0	0	29	29	0	0	0	0	0	29
	Total	0	0	51	51	0	0	0	0	0	51
Nambon	Never	0	0	0	0	0	0	0	0	0	0
	Rarely	0	0	1	1	0	0	0	0	0	1
	Sometimes	0	0	1	1	0	0	0	0	0	1
	Often	0	0	9	9	0	0	0	0	0	9
	Always	0	0	25	25	0	0	0	0	0	25
	Total	0	0	36	36	0	0	0	0	0	36
Bring	Never	0	0	3	3	0	0	0	0	0	3
	Rarely	0	0	7	7	0	0	0	0	0	7
	Sometimes	0	0	0	0	0	0	0	0	0	0
	Often	0	0	11	11	0	0	0	0	0	11
	Always	0	0	20	20	0	0	0	0	0	20
	Total	0	0	41	41	0	0	0	0	0	41
Besum	Never	0	0	0	0	0	0	0	0	0	0
	Rarely	0	0	2	2	0	0	0	0	0	2
	Sometimes	0	0	0	0	0	0	0	0	0	0
	Often	0	0	2	2	0	0	0	0	0	2
	Always	0	0	51	51	0	0	0	0	0	51
	Total	0	0	55	55	0	0	0	0	0	55
Wahab / Warombaim	Never	0	0	0	0	0	0	0	0	0	0
	Rarely	0	0	3	3	0	0	0	0	0	3
	Sometimes	0	0	0	0	0	0	0	0	0	0
	Often	0	0	6	6	0	0	0	0	0	6
	Always	0	0	19	19	0	0	0	0	0	19
	Total	0	0	28	28	0	0	0	0	0	28
Yanamaa / Pir I	Never	0	0	0	0	0	0	0	0	0	0
	Rarely	0	0	0	0	0	0	0	0	0	0
	Sometimes	0	0	0	0	0	0	0	0	0	0
	Often	0	0	0	0	0	0	0	0	0	0
	Always	0	0	0	0	0	0	0	0	0	0
	Total	0	0	0	0	0	0	0	0	0	0
UPT Pir II / Yamta	Never	0	0	0	0	0	0	0	0	0	0
	Rarely	0	0	0	0	0	0	0	0	0	0
	Sometimes	0	0	0	0	0	0	0	0	0	0
	Often	0	0	0	0	0	0	0	0	0	0
	Always	0	0	0	0	0	0	0	0	0	0
	Total	0	0	0	0	0	0	0	0	0	0
Upt Pir V / Yamara	Never	0	0	0	0	0	0	0	0	0	0
	Rarely	0	0	0	0	0	0	0	0	0	0
	Sometimes	0	0	0	0	0	0	0	0	0	0
	Often	0	0	0	0	0	0	0	0	0	0
	Always	0	0	0	0	0	0	0	0	0	0
	Total	0	0	0	0	0	0	0	0	0	0
Usku / Warlef	Never	0	0	0	0	0	0	0	0	0	0
	Rarely	0	0	0	0	0	0	0	0	0	0
	Sometimes	0	0	0	0	0	0	0	0	0	0

Table 7: Distribution of households reporting the frequency of using toilet by household members by province, district and village

Village	Frequency of using toilet	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
	Often	0	0	0	0	0	0	0	0	0	0
	Always	0	0	0	0	0	0	0	0	0	0
	Total	0	0	0	0	0	0	0	0	0	0
Karya bumi	Never	0	0	0	0	0	0	0	0	0	0
	Rarely	0	0	2	2	0	0	0	0	0	2
	Sometimes	0	0	1	1	0	0	0	0	0	1
	Often	0	0	21	21	0	0	0	0	0	21
	Always	0	0	125	125	0	0	0	0	0	125
	Total	0	0	149	149	0	0	0	0	0	149
Total	Never	13	13	3	29	0	13	2	9	2	3
	Rarely	13	14	22	49	1	12	1	11	2	22
	Sometimes	37	21	5	63	5	32	2	13	6	5
	Often	150	173	61	384	70	80	20	110	43	61
	Always	508	859	269	1636	285	223	335	217	307	269
	Total	721	1080	360	2161	361	360	360	360	360	360

Use of cleansing material

Table 1: Distribution of respondents reporting the location of toilet facility being used by family members by province, district and gender

Gender	Location of toilet facility	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	In own dwelling/attached to own dwelling	138	271	101	510	90	48	146	90	35	101
	In own courtyard	145	191	67	403	69	76	24	36	131	67
	Someone else's yard	0	0	0	0	0	0	0	0	0	0
	Other people's farm	0	0	0	0	0	0	0	0	0	0
	Outside the yard a bit away from home	0	0	0	0	0	0	0	0	0	0
	Refused/Not able to observe	76	74	15	165	33	43	11	47	16	15
	Total	359	536	183	1078	192	167	181	173	182	183
Female	In own dwelling/attached to own dwelling	130	297	112	539	78	52	147	104	46	112
	In own courtyard	148	170	51	369	75	73	19	41	110	51
	Someone else's yard	0	0	0	0	0	0	0	0	0	0
	Other people's farm	0	0	0	0	0	0	0	0	0	0
	Outside the yard a bit away from home	0	0	0	0	0	0	0	0	0	0
	Refused/Not able to observe	84	77	14	175	16	68	13	42	22	14
	Total	362	544	177	1083	169	193	179	187	178	177
Total	In own dwelling/attached to own dwelling	268	568	213	1049	168	100	293	194	81	213
	In own courtyard	293	361	118	772	144	149	43	77	241	118
	Someone else's yard	0	0	0	0	0	0	0	0	0	0
	Other people's farm	0	0	0	0	0	0	0	0	0	0
	Outside the yard a bit away from home	0	0	0	0	0	0	0	0	0	0
	Refused/Not able to observe	160	151	29	340	49	111	24	89	38	29
	Total	721	1080	360	2161	361	360	360	360	360	360

Table 2: Distribution of respondents reporting the kind of toilet being used by their families by province and gender

Kind of toilet	Direct											
	Province											
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua			Total		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Flushed to piped sewer system	58	43	101	261	239	500	95	105	200	414	387	801
Flushed to septic tank	148	180	328	247	267	514	128	120	248	523	567	1090
Flushed to pit latrine	35	26	61	6	5	11	1	1	2	42	32	74
Flush, don't know where	0	0	0	0	0	0	0	0	0	0	0	0
VIP latrine	2	1	3	4	1	5	1	2	3	7	4	11
Pit latrine with slab (concrete, wood/bamboo)	8	6	14	0	0	0	2	6	8	10	12	22
Pit latrine without slab/open pit	37	32	69	4	7	11	0	0	0	41	39	80
Composting toilet	0	0	0	0	0	0	0	0	0	0	0	0
Toilet using bamboo	0	0	0	0	0	0	0	0	0	0	0	0
Refused/Not able to observe	359	362	721	535	544	1079	183	177	360	1077	1083	2160
Total	647	650	1297	1057	1063	2120	410	411	821	2114	2124	4238

Table 3: Distribution of respondents reporting the access to adequate water to meet the needs of flushing in toilet by province, district and gender

Gender	Access to water to meet the needs of slushing in the toilet	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Yes	233	450	138	821	152	81	166	118	166	138
	No	7	6	28	41	3	4	2	3	1	28
	Don't know	0	1	1	2	0	0	1	0	0	1
	Total	240	457	167	864	155	85	169	121	167	167
Female	Yes	245	452	129	826	150	95	164	133	155	129
	No	4	11	30	45	2	2	2	7	2	30
	Don't know	0	1	2	3	0	0	0	1	0	2
	Total	249	464	161	874	152	97	166	141	157	161
Total	Yes	478	902	267	1647	302	176	330	251	321	267
	No	11	17	58	86	5	6	4	10	3	58
	Don't know	0	2	3	5	0	0	1	1	0	3
	Total	489	921	328	1738	307	182	335	262	324	328

Table 4: Distribution of respondents reporting that the path to latrine is walked on by province, district and gender

Gender	Path to latrine is walked on	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Yes	271	401	128	800	158	113	135	110	156	128
	No	17	64	40	121	2	15	35	17	12	40
	Total	288	465	168	921	160	128	170	127	168	168
Female	Yes	273	396	127	796	151	122	131	123	142	127
	No	17	80	37	134	3	14	35	29	16	37
	Total	290	476	164	930	154	136	166	152	158	164
Total	Yes	544	797	255	1596	309	235	266	233	298	255
	No	34	144	77	255	5	29	70	46	28	77
	Total	578	941	332	1851	314	264	336	279	326	332

Table 5: Distribution of respondents reporting visibly used anal cleansing material by province, district and gender

Gender	Visibly used anal cleansing material	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Yes	188	420	105	713	136	52	162	104	154	105
	No	100	45	63	208	24	76	8	23	14	63
	Total	288	465	168	921	160	128	170	127	168	168
Female	Yes	197	403	113	713	133	64	158	101	144	113
	No	93	73	51	217	21	72	8	51	14	51
	Total	290	476	164	930	154	136	166	152	158	164
Total	Yes	385	823	218	1426	269	116	320	205	298	218
	No	193	118	114	425	45	148	16	74	28	114
	Total	578	941	332	1851	314	264	336	279	326	332

Table 6: Distribution of respondents reporting their observation regarding the availability of water for pour flush by province, district and gender

Gender	Availability of water for pour flush	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Yes	240	441	120	801	152	88	165	115	161	120
	No	48	24	48	120	8	40	5	12	7	48
	Total	288	465	168	921	160	128	170	127	168	168
Female	Yes	247	430	121	798	148	99	155	128	147	121
	No	43	46	43	132	6	37	11	24	11	43
	Total	290	476	164	930	154	136	166	152	158	164
Total	Yes	487	871	241	1599	300	187	320	243	308	241
	No	91	70	91	252	14	77	16	36	18	91
	Total	578	941	332	1851	314	264	336	279	326	332

Table 7: Distribution of respondents reporting their observation regarding detection of faeces in the pit using flashlight by province, district and gender

Gender	Detected faeces in pit using flashlight	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Yes	106	149	54	309	24	82	14	48	87	54
	No	182	316	114	612	136	46	156	79	81	114
	Total	288	465	168	921	160	128	170	127	168	168
Female	Yes	102	132	46	280	27	75	14	42	76	46
	No	188	344	118	650	127	61	152	110	82	118
	Total	290	476	164	930	154	136	166	152	158	164
Total	Yes	208	281	100	589	51	157	28	90	163	100
	No	370	660	232	1262	263	107	308	189	163	232
	Total	578	941	332	1851	314	264	336	279	326	332

Table 8: Distribution of respondents reporting their observation that the slab is wet by province, district and gender

Gender	Slab is wet	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Yes	162	276	94	532	78	84	93	74	109	94
	No	126	189	74	389	82	44	77	53	59	74
	Total	288	465	168	921	160	128	170	127	168	168
Female	Yes	179	274	88	541	79	100	82	101	91	88
	No	111	202	76	389	75	36	84	51	67	76
	Total	290	476	164	930	154	136	166	152	158	164
Total	Yes	341	550	182	1073	157	184	175	175	200	182
	No	237	391	150	778	157	80	161	104	126	150
	Total	578	941	332	1851	314	264	336	279	326	332

Table 9: Distribution of respondents reporting their observation regarding the smell by province, district and gender

Gender	Smelly	Direct									
		Province			Total	Province					
						NTT		SS			PP
		NTT	SS	PP		District					
						Alor	Sumba Timur	Luwu Utara	Takalar	Barru	Jayapura
Male	Yes	115	58	56	229	13	102	8	28	22	56
	No	173	407	112	692	147	26	162	99	146	112
	Total	288	465	168	921	160	128	170	127	168	168
Female	Yes	135	59	42	236	26	109	9	34	16	42
	No	155	417	122	694	128	27	157	118	142	122
	Total	290	476	164	930	154	136	166	152	158	164
Total	Yes	250	117	98	465	39	211	17	62	38	98
	No	328	824	234	1386	275	53	319	217	288	234
	Total	578	941	332	1851	314	264	336	279	326	332

Table 10: Distribution of respondents reporting their observations regarding the toilet by province and gender

Observations	Direct											
	Province											
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua			Total		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Path to latrine is walked on	271	273	544	401	396	797	128	127	255	800	796	1596
Visibly used anal cleansing material	188	197	385	420	403	823	105	113	218	713	713	1426
If Pour Flush water is available	240	247	487	441	430	871	120	121	241	801	798	1599
Detected faeces in pit using flashlight	106	102	208	149	132	281	54	46	100	309	280	589
Slab is wet	162	179	341	276	274	550	94	88	182	532	541	1073
Smelly	115	135	250	58	59	117	56	42	98	229	236	465
Total	1082	1133	2215	1745	1694	3439	557	537	1094	3384	3364	6748

Appendix 15: HHS Tabulations (Other Districts)

HHS Results

Distribution of **Respondents** by gender and province

Province	Direct			Others		
	M	F	Total	M	F	Total
Nusa Tenggara Timur (NTT)	359	362	721	165	195	360
South Sulawesi	536	544	1080	184	178	362
Papua	183	177	360	177	183	360
Total	1078	1083	2161	526	556	1082

Percent distribution of **Respondents** within province by gender

Province	Direct			Others		
	M	F	Total	M	F	Total
Nusa Tenggara Timur (NTT)	49.8	50.2	100.0	45.8	54.2	100.0
South Sulawesi	49.6	50.4	100.0	50.8	49.2	100.0
Papua	50.8	49.2	100.0	49.2	50.8	100.0
Total	49.9	50.1	100.0	48.6	51.4	100.0

Distribution of **Head of households** by gender and province

Province	Direct			Others		
	M	F	Total	M	F	Total
Nusa Tenggara Timur (NTT)	631	90	721	331	29	360
South Sulawesi	949	131	1080	306	56	362
Papua	326	34	360	326	34	360
Total	1906	255	2161	963	119	1082

Percent distribution of **Head of households** within province by gender

Province	Direct			Others		
	M	F	Total	M	F	Total
Nusa Tenggara Timur (NTT)	87.5	12.5	100.0	91.9	8.1	100.0
South Sulawesi	87.9	12.1	100.0	84.5	15.5	100.0
Papua	90.6	9.4	100.0	90.6	9.4	100.0
Total	88.2	11.8	100.0	89.0	11.0	100.0

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Table 1: Distribution of households by province, Sex of respondents and head of households

Sex		Other			
		Province			Total
		Nusa Tenggara Timur (NTT)	South Sulawesi	Papua	
Respondents	M	165	184	177	526
	F	195	178	183	556
	Total	360	362	360	1,082
Head of Households	M	331	306	326	963
	F	29	56	34	119
	Total	360	362	360	1,082

Table 2: Distribution of respondnets by province and Sex

Age of respondent	Other											
	G1. Name of Province											
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua			Total		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
< 20 years	0	1	1	3	2	5	9	8	17	12	11	23
20 years <30 years	21	44	65	17	16	33	39	38	77	77	98	175
30 years < 40 years	34	60	94	48	45	93	38	47	85	120	152	272
40 years < 50 years	44	47	91	71	61	132	39	45	84	154	153	307
50 years < 60 years	33	28	61	26	33	59	28	29	57	87	90	177
60 years < 70 years	20	11	31	17	16	33	19	12	31	56	39	95
70 years < 80 years	13	3	16	2	4	6	2	3	5	17	10	27
80 years < 90 years	0	1	1	0	1	1	3	1	4	3	3	6
90 years & above	0	0	0	0	0	0	0	0	0	0	0	0
Total	165	195	360	184	178	362	177	183	360	526	556	1082

Table 3: Distribution of head of households by province and Sex

Age of head of household	Other											
	G1. Name of Province											
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua			Total		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
< 20 years	0	0	0	2	0	2	0	0	0	2	0	2
20 years <30 years	28	0	28	16	4	20	24	3	27	68	7	75
30 years < 40 years	91	5	96	79	2	81	82	1	83	252	8	260
40 years < 50 years	99	5	104	116	20	136	92	16	108	307	41	348
50 years < 60 years	63	8	71	54	12	66	72	4	76	189	24	213
60 years < 70 years	33	9	42	31	13	44	41	8	49	105	30	135
70 years < 80 years	16	1	17	6	4	10	7	2	9	29	7	36
80 years < 90 years	1	1	2	1	1	2	7	0	7	9	2	11
90 years & above	0	0	0	0	0	0	0	0	0	0	0	0
Total	331	29	360	305	56	361	325	34	359	961	119	1,080

Table 4: Distribution of respondnets reporting their relatioship to the head of household by province, district and Sex

Sex	Relatioship to the head of household	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M,garai	E.kang	Keerom	
M	Self - Head of Household	150	175	139	464
	Wife/Mother	2	0	3	5
	Mother-in-law	0	0	0	0
	Grandmother	0	0	0	0
	Daughter	0	0	0	0
	Sister	0	0	0	0
	Niece	0	0	0	0

	Husband/Father	1	2	0	3
	Father-in-law	0	1	0	1
	Grandfather	0	0	0	0
	Son	10	4	31	45
	Brother	2	1	1	4
	Nephew	0	1	2	3
	Cousin	0	0	1	1
	Not Related	0	0	0	0
	Unknown	0	0	0	0
	Total	165	184	177	526
F	Self - Head of Household	25	50	23	98
	Wife/Mother	161	89	142	392
	Mother-in-law	0	0	0	0
	Grandmother	1	0	0	1
	Daughter	4	1	16	21
	Sister	1	2	0	3
	Niece	0	0	1	1
	Husband/Father	0	32	0	32
	Father-in-law	3	1	0	4
	Grandfather	0	1	0	1
	Son	0	2	1	3
	Brother	0	0	0	0
	Nephew	0	0	0	0
	Cousin	0	0	0	0
	Not Related	0	0	0	0
	Unknown	0	0	0	0
	Total	195	178	183	556
Total	Self - Head of Household	175	225	162	562
	Wife/Mother	163	89	145	397
	Mother-in-law	0	0	0	0
	Grandmother	1	0	0	1
	Daughter	4	1	16	21
	Sister	1	2	0	3
	Niece	0	0	1	1
	Husband/Father	1	34	0	35
	Father-in-law	3	2	0	5
	Grandfather	0	1	0	1
	Son	10	6	32	48
	Brother	2	1	1	4
	Nephew	0	1	2	3
	Cousin	0	0	1	1
	Not Related	0	0	0	0
	Unknown	0	0	0	0
	Total	360	362	360	1082

Table 5: Distribution of respondents reporting their highest level of school completed by province, district and Sex

Sex	Highest level of education	Others			
		Province			Total
		NTT	SS	PP	
		District			
		Manggarai	Enrekang	Keerom	
M	No formal education	7	0	5	12
	Not completing primary school	49	3	15	67
	Primary	75	27	42	144

	Pre-Secondary	18	56	38	112
	Secondary	14	98	67	179
	Higher	2	0	10	12
	Total	165	184	177	526
F	No formal education	15	1	3	19
	Not completing primary school	31	3	12	46
	Primary	100	45	66	211
	Pre-Secondary	23	55	36	114
	Secondary	19	66	50	135
	Higher	7	8	16	31
	Total	195	178	183	556
Total	No formal education	22	1	8	31
	Not completing primary school	80	6	27	113
	Primary	175	72	108	355
	Pre-Secondary	41	111	74	226
	Secondary	33	164	117	314
	Higher	9	8	26	43
	Total	360	362	360	1082

able 6: Distribution of respondents by province, Sex, income quintiles and level of education

Income Quantiles	Level of education	Other								
		Province								
		Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
		M	F	Total	M	F	Total	M	F	Total
Highest quintile	No formal education	0	0	0	0	0	0	0	1	1
	Not completing primary school	1	1	2	2	1	3	0	1	1
	Primary	1	6	7	2	5	7	3	8	11
	Pre-Secondary	0	1	1	9	14	23	7	9	16
	Secondary	1	0	1	29	23	52	16	10	26
	Higher	1	3	4	0	7	7	4	4	8
	Total	4	11	15	42	50	92	30	33	63
2nd highest quintile	No formal education	1	1	2	0	0	0	1	0	1
	Not completing primary school	4	3	7	0	0	0	1	2	3
	Primary	8	3	11	8	12	20	7	7	14
	Pre-Secondary	5	3	8	26	17	43	5	5	10
	Secondary	1	3	4	36	17	53	5	8	13
	Higher	1	2	3	0	1	1	0	1	1
	Total	20	15	35	70	47	117	19	23	42
Medium quintile	No formal education	3	6	9	0	0	0	0	0	0
	Not completing primary school	24	14	38	0	1	1	3	0	3
	Primary	37	53	90	8	19	27	5	11	16
	Pre-Secondary	9	10	19	17	19	36	1	3	4
	Secondary	7	7	14	22	20	42	2	2	4
	Higher	0	2	2	0	0	0	0	1	1
	Total	80	92	172	47	59	106	11	17	28
2nd lowest quintile	No formal education	2	7	9	0	0	0	0	0	0
	Not completing primary school	18	13	31	1	1	2	1	1	2
	Primary	26	35	61	5	5	10	3	7	10
	Pre-Secondary	4	9	13	2	1	3	1	4	5
	Secondary	5	8	13	0	0	0	2	1	3
	Higher	0	0	0	0	0	0	0	1	1
	Total	55	72	127	8	7	15	7	14	21
	No formal education	1	1	2	0	1	1	4	2	6

Lowest quintile	Not completing primary school	2	0	2	0	0	0	10	7	17
	Primary	3	3	6	3	2	5	22	30	52
	Pre-Secondary	0	0	0	0	4	4	20	14	34
	Secondary	0	1	1	8	4	12	32	24	56
	Higher	0	0	0	0	0	0	4	6	10
	Total	6	5	11	11	11	22	92	83	175
Total	No formal education	7	15	22	0	1	1	5	3	8
	Not completing primary school	49	31	80	3	3	6	15	11	26
	Primary	75	100	175	26	43	69	40	63	103
	Pre-Secondary	18	23	41	54	55	109	34	35	69
	Secondary	14	19	33	95	64	159	57	45	102
	Higher	2	7	9	0	8	8	8	13	21
	Total	165	195	360	178	174	352	159	170	329

able 7: Distribution of respondents reporting items owned by province and Sex

Items owned by household	Other								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	M	F	Total	M	F	Total	M	F	Total
Radio	7	5	12	21	13	34	31	30	61
Television	59	67	126	179	176	355	140	164	304
Mobile phone	96	113	209	84	82	166	133	135	268
Telephone	1	1	2	1	1	2	0	3	3
Refrigerator	1	1	2	64	72	136	70	103	173
Motorcycle/scooter	28	43	71	134	113	247	133	146	279
Bicycle	2	1	3	0	0	0	18	34	52
Animal drawn cart	0	1	1	0	0	0	2	1	3
Car/truck	0	0	0	0	1	1	10	14	24
Boat with motor	0	0	0	1	0	1	1	2	3
Own agriculture land	155	181	336	116	131	247	126	132	258
Own farm animals	76	94	170	61	63	124	102	108	210
Total	425	507	932	661	652	1313	766	872	1638

Table 8: Distribution of households showing average monthly income by province and Sex

Monthly Average Income	Other											
	Province									Total		
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua					
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
< 1,000	1	0	1	14	2	16	62	8	70	77	10	87
1,000 < 5,000	0	0	0	1	2	3	94	7	101	95	9	104
5,000 < 100,000	1	0	1	0	0	0	0	0	0	1	0	1
100,000 < 300,000	7	2	9	2	1	3	4	0	4	13	3	16
300,000 < 500,000	18	3	21	0	0	0	2	0	2	20	3	23
500,000 < 600,000	97	9	106	12	4	16	15	4	19	124	17	141
600,000 < 800,000	84	9	93	10	2	12	9	0	9	103	11	114
800,000 < 1,000,000	38	0	38	18	6	24	4	0	4	60	6	66
1,000,000 < 2,000,000	73	3	76	168	25	193	49	10	59	290	38	328
2,000,000 < 4,000,000	7	3	10	73	11	84	48	3	51	128	17	145

4,000,000 < 6,000,000	3	0	3	1	0	1	6	0	6	10	0	10
6,000,000 & above	2	0	2	0	0	0	4	0	4	6	0	6
Total	331	29	360	299	53	352	297	32	329	927	114	1041

Table 9: Distribution of households showing average monthly income by province, district and Sex

Sex	Monthly Average Income	Others			Total
		Province			
		NTT	SS	PP	
		District			
		M.garai	E.kang	Keerom	
M	< 1,000	1	10	39	50
	1,000 < 5,000	0	0	49	49
	5,000 < 100,000	1	0	0	1
	100,000 < 300,000	4	1	4	9
	300,000 < 500,000	10	0	1	11
	500,000 < 600,000	45	9	6	60
	600,000 < 800,000	44	6	4	54
	800,000 < 1,000,000	18	10	2	30
	1,000,000 < 2,000,000	38	106	24	168
	2,000,000 < 4,000,000	3	36	24	63
	4,000,000 < 6,000,000	1	0	3	4
	6,000,000 & above	0	0	3	3
	Total	165	178	159	502
F	< 1,000	0	6	31	37
	1,000 < 5,000	0	3	52	55
	5,000 < 100,000	0	0	0	0
	100,000 < 300,000	5	2	0	7
	300,000 < 500,000	11	0	1	12
	500,000 < 600,000	61	7	13	81
	600,000 < 800,000	49	6	5	60
	800,000 < 1,000,000	20	14	2	36
	1,000,000 < 2,000,000	38	87	35	160
	2,000,000 < 4,000,000	7	48	27	82
	4,000,000 < 6,000,000	2	1	3	6
	6,000,000 & above	2	0	1	3
	Total	195	174	170	539
Total	< 1,000	1	16	70	87
	1,000 < 5,000	0	3	101	104
	5,000 < 100,000	1	0	0	1
	100,000 < 300,000	9	3	4	16
	300,000 < 500,000	21	0	2	23

	500,000 < 600,000	106	16	19	141
	600,000 < 800,000	93	12	9	114
	800,000 < 1,000,000	38	24	4	66
	1,000,000 < 2,000,000	76	193	59	328
	2,000,000 < 4,000,000	10	84	51	145
	4,000,000 < 6,000,000	3	1	6	10
	6,000,000 & above	2	0	4	6
	Total	360	352	329	1041

ble 10: Distribution of respondents by province, Sex and income quintiles

Income Quantiles	Other								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	M	F	Total	M	F	Total	M	F	Total
Highest quintile	4	11	15	42	50	92	30	33	63
2nd highest quintile	20	15	35	70	47	117	19	23	42
Medium quintile	80	92	172	47	59	106	11	17	28
2nd lowest quintile	55	72	127	8	7	15	7	14	21
Lowest quintile	6	5	11	11	11	22	92	83	175
Total	165	195	360	178	174	352	159	170	329

Table 11: Distribution of head of households by province, Sex and income quintiles

Income Quantiles	Other								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	M	F	Total	M	F	Total	M	F	Total
Highest quintile	12	3	15	81	11	92	59	4	63
2nd highest quintile	33	2	35	98	19	117	35	7	42
Medium quintile	162	10	172	92	14	106	26	2	28
2nd lowest quintile	115	12	127	11	4	15	17	4	21
Lowest quintile	9	2	11	17	5	22	160	15	175
Total	331	29	360	299	53	352	297	32	329

Water Sources

Table 1: Distribution of respondents reporting available water sources for drinking and cooking by province, district and gender

Sex	Drinking water sources	Others			Total
		Province			
		NTT	SS	PP	
		District			
		M.Garai	Enrekang	Keerom	
M	Piped into dwelling, plot or yard	19	77	0	96
	Public tap/standpipe	67	12	0	79
	Tube well/borehole	7	2	1	10

	Protected dug well	0	6	1	7
	Protected Spring	28	17	0	45
	Rainwater collection	0	0	134	134
	Unprotected dug well	0	0	1	1
	Unprotected spring	34	33	2	69
	Bottled water	0	0	30	30
	Tanker Truck	0	0	2	2
	Surface water (river / dam / lake / pond / stream / canal)	10	37	5	52
	Water gallon	0	0	1	1
	Total	165	184	177	526
F	Piped into dwelling, plot or yard	27	83	0	110
	Public tap/standpipe	79	13	0	92
	Tube well/borehole	7	2	5	14
	Protected dug well	1	7	0	8
	Protected Spring	35	25	2	62
	Rainwater collection	0	0	127	127
	Unprotected dug well	0	0	2	2
	Unprotected spring	39	18	1	58
	Bottled water	0	0	42	42
	Tanker Truck	0	1	3	4
	Surface water (river / dam / lake / pond / stream / canal)	7	29	1	37
	Water gallon	0	0	0	0
	Total	195	178	183	556
Total	Piped into dwelling, plot or yard	46	160	0	206
	Public tap/standpipe	146	25	0	171
	Tube well/borehole	14	4	6	24
	Protected dug well	1	13	1	15
	Protected Spring	63	42	2	107
	Rainwater collection	0	0	261	261
	Unprotected dug well	0	0	3	3
	Unprotected spring	73	51	3	127
	Bottled water	0	0	72	72
	Tanker Truck	0	1	5	6
	Surface water (river / dam / lake / pond / stream / canal)	17	66	6	89
	Water gallon	0	0	1	1
	Total	360	362	360	1082

Table 2: Distribution of respondents reporting improved sources of water for drinking and cooking by province, gender and nature of water sources

Nature of water sources	Sources of water for drinking and cooking	Other								
		Province								
		Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
		M	F	Total	M	F	Total	M	F	Total
Improved	Piped into dwelling, plot or yard	19	27	46	77	83	160	0	0	0
	Public tap / standpipe	67	79	146	12	13	25	0	0	0
	Tube well / borehole	7	7	14	2	2	4	1	5	6
	Protected dug well	0	1	1	6	7	13	1	0	1
	Protected Spring	28	35	63	17	25	42	0	2	2
	Rainwater collection	0	0	0	0	0	0	134	127	261
	Total	121	149	270	114	130	244	136	134	270
Unimproved	Unprotected dug well	0	0	0	0	0	0	1	2	3
	Unprotected spring	34	39	73	33	18	51	2	1	3
	Bottled water	0	0	0	0	0	0	30	42	72
	Tanker Truck	0	0	0	0	1	1	2	3	5

	Surface water (river / dam / lake / pond / stream / canal)	10	7	17	37	29	66	5	1	6
	Water gallon	0	0	0	0	0	0	1	0	1
	Total	44	46	90	70	48	118	41	49	90
All		165	195	360	184	178	362	177	183	360

Table 3: Distribution of respondents reporting avaiable water sources for toilet and other uses by province, district and gender

Sex	Water source for toilet	Others			Total
		Province			
		NTT	SS	PP	
		District			
		M.Garai	Enrekang	Keerom	
M	Piped into dwelling, plot or yard	18	74	1	93
	Public tap / standpipe	63	4	0	67
	Tube well / borehole	7	2	7	16
	Protected dug well	0	10	19	29
	Protected Spring	20	5	0	25
	Rainwater collection	0	0	41	41
	Unprotected dug well	0	0	101	101
	Unprotected spring	25	35	1	61
	Cart with small tank / drum	0	15	0	15
	Bottled water	0	1	0	1
	Surface water (river / dam / lake / pond / stream / canal)	32	38	7	77
	Total	165	184	177	526
F	Piped into dwelling, plot or yard	26	79	1	106
	Public tap / standpipe	69	3	0	72
	Tube well / borehole	9	2	8	19
	Protected dug well	1	6	22	29
	Protected Spring	32	4	3	39
	Rainwater collection	0	0	31	31
	Unprotected dug well	0	0	112	112
	Unprotected spring	39	20	1	60
	Cart with small tank / drum	0	30	0	30
	Bottled water	0	1	0	1
	Surface water (river / dam / lake / pond / stream / canal)	19	33	5	57
	Total	195	178	183	556
Total	Piped into dwelling, plot or yard	44	153	2	199
	Public tap / standpipe	132	7	0	139
	Tube well / borehole	16	4	15	35
	Protected dug well	1	16	41	58
	Protected Spring	52	9	3	64
	Rainwater collection	0	0	72	72
	Unprotected dug well	0	0	213	213
	Unprotected spring	64	55	2	121
	Cart with small tank / drum	0	45	0	45
	Bottled water	0	2	0	2
	Surface water (river / dam / lake / pond / stream / canal)	51	71	12	134
	Total	360	362	360	1082

Table 4: Distribution of respondents reporting sources of water for toilet and other uses by province, gender and nature of water sources

	Sources of water for toilet and other uses	Other
		Province

Nature of water sources		Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
		M	F	Total	M	F	Total	M	F	Total
Improved	Piped into dwelling, plot or yard	18	26	44	74	79	153	1	1	2
	Public tap / standpipe	63	69	132	4	3	7	0	0	0
	Tube well / borehole	7	9	16	2	2	4	7	8	15
	Protected dug well	0	1	1	10	6	16	19	22	41
	Protected Spring	20	32	52	5	4	9	0	3	3
	Rainwater collection	0	0	0	0	0	0	41	31	72
	Total	108	137	245	95	94	189	68	65	133
Unimproved	Unprotected dug well	0	0	0	0	0	0	101	112	213
	Unprotected spring	25	39	64	35	20	55	1	1	2
	Cart with small tank / drum	0	0	0	15	30	45	0	0	0
	Bottled water	0	0	0	1	1	2	0	0	0
	Surface water (river / dam / lake / pond / stream / canal)	32	19	51	38	33	71	7	5	12
	Total	57	58	115	89	84	173	109	118	227
All		165	195	360	184	178	362	177	183	360

Table 5: Distribution of respondents reporting access to water source for household needs (bathing, toilet flushing, cleaning etc.) year round by province and gender

Nature of water sources	Income Quantiles	Other								
		Province								
		Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
		M	F	Total	M	F	Total	M	F	Total
Improved	Highest	4	11	15	23	35	58	23	24	47
	2nd highest	14	12	26	45	35	80	11	17	28
	Medium	53	62	115	34	46	80	9	13	22
	2nd lowest	44	60	104	6	7	13	6	9	15
	Lowest	6	4	10	1	4	5	72	59	131
	Total	121	149	270	109	127	236	121	122	243
Unimproved	Highest	0	0	0	19	15	34	7	9	16
	2nd highest	6	3	9	25	12	37	8	6	14
	Medium	27	30	57	13	13	26	2	4	6
	2nd lowest	11	12	23	2	0	2	1	5	6
	Lowest	0	1	1	10	7	17	20	24	44
	Total	44	46	90	69	47	116	38	48	86
Total	Highest	4	11	15	42	50	92	30	33	63
	2nd highest	20	15	35	70	47	117	19	23	42
	Medium	80	92	172	47	59	106	11	17	28
	2nd lowest	55	72	127	8	7	15	7	14	21
	Lowest	6	5	11	11	11	22	92	83	175
	Total	165	195	360	178	174	352	159	170	329

Table 6: Distribution of respondents reporting nature of water sources for toilet and other uses by province, gender, nature of water sources and income quintiles

Nature of water sources	Income Quantiles	Other								
		Province								
		Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
		M	F	Total	M	F	Total	M	F	Total
Improved	Highest	3	10	13	15	17	32	9	10	19
	2nd highest	12	12	24	34	23	57	9	7	16
	Medium	48	58	106	34	44	78	3	7	10
	2nd lowest	40	55	95	6	6	12	3	6	9
	Lowest	5	2	7	1	1	2	36	32	68
	Total	108	137	245	90	91	181	60	62	122
Unimproved	Highest	1	1	2	27	33	60	21	23	44
	2nd highest	8	3	11	36	24	60	10	16	26
	Medium	32	34	66	13	15	28	8	10	18
	2nd lowest	15	17	32	2	1	3	4	8	12
	Lowest	1	3	4	10	10	20	56	51	107
	Total	57	58	115	88	83	171	99	108	207
Total	Highest	4	11	15	42	50	92	30	33	63
	2nd highest	20	15	35	70	47	117	19	23	42
	Medium	80	92	172	47	59	106	11	17	28
	2nd lowest	55	72	127	8	7	15	7	14	21
	Lowest	6	5	11	11	11	22	92	83	175
	Total	165	195	360	178	174	352	159	170	329

Table 7: Distribution of respondents showing the comparison of nature of water sources for drinking/cooking and toilet/other uses by province, gender and income quintiles.

Nature of water sources	Income Quantiles	Other					
		For drinking water			For toilet and other uses		
		M	F	Total	M	F	Total
Improved	Highest	50	70	120	27	37	64
	2nd highest	70	64	134	55	42	97
	Medium	96	121	217	85	109	194
	2nd lowest	56	76	132	49	67	116
	Lowest	79	67	146	42	35	77
	Total	351	398	749	258	290	548
Unimproved	Highest	26	24	50	49	57	106
	2nd highest	39	21	60	54	43	97
	Medium	42	47	89	53	59	112
	2nd lowest	14	17	31	21	26	47
	Lowest	30	32	62	67	64	131
	Total	151	141	292	244	249	493
Total	Highest	76	94	170	76	94	170
	2nd highest	109	85	194	109	85	194
	Medium	138	168	306	138	168	306
	2nd lowest	70	93	163	70	93	163
	Lowest	109	99	208	109	99	208
	Total	502	539	1041	502	539	1041

Table 8: Distribution of respondents reporting access to water for household needs (bathing, toilet flushing, cleaning etc.) year around by province, district and gender

Sex	Access to water	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M.Garai	Enrekang	Keerom	
M	Yes	128	180	125	433
	No	37	4	50	91
	Don't know	0	0	2	2
	Total	165	184	177	526
F	Yes	148	177	144	469
	No	47	1	39	87
	Don't know	0	0	0	0
	Total	195	178	183	556
Total	Yes	276	357	269	902
	No	84	5	89	178
	Don't know	0	0	2	2
	Total	360	362	360	1082

Table 9: Distribution of respondents reporting access to water source for household needs (bathing, toilet flushing, cleaning etc.) year round by province, gender and income quintiles

Access to water	Income Quantiles	Other								
		Province								
		Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
		M	F	Total	M	F	Total	M	F	Total
Yes	Highest	2	7	9	42	50	92	22	22	44
	2nd highest	16	12	28	69	47	116	11	18	29
	Medium	60	69	129	47	59	106	7	14	21
	2nd lowest	46	58	104	8	7	15	4	13	17
	Lowest	4	2	6	9	11	20	68	65	133
	Total	128	148	276	175	174	349	112	132	244
No	Highest	2	4	6	0	0	0	8	11	19
	2nd highest	4	3	7	1	0	1	8	5	13
	Medium	20	23	43	0	0	0	4	3	7
	2nd lowest	9	14	23	0	0	0	3	1	4
	Lowest	2	3	5	2	0	2	22	18	40
	Total	37	47	84	3	0	3	45	38	83
Don't know	Highest	0	0	0	0	0	0	0	0	0
	2nd highest	0	0	0	0	0	0	0	0	0
	Medium	0	0	0	0	0	0	0	0	0
	2nd lowest	0	0	0	0	0	0	0	0	0
	Lowest	0	0	0	0	0	0	2	0	2
	Total	0	0	0	0	0	0	2	0	2
Total	Highest	4	11	15	42	50	92	30	33	63
	2nd highest	20	15	35	70	47	117	19	23	42
	Medium	80	92	172	47	59	106	11	17	28
	2nd lowest	55	72	127	8	7	15	7	14	21

	Lowest	6	5	11	11	11	22	92	83	175
	Total	165	195	360	178	174	352	159	170	329

Table 10: Distribution of respondents reporting the period when they do not have access to water source by province, district and gender

Sex	Time of non-access to water	Others			Total
		Province			
		NTT	SS	PP	
		District			
		M.Garai	Enrekang	Keerom	
M	During the dry season	37	0	50	87
	During the rainy season	0	3	0	3
	Don't know	0	1	0	1
	Total	37	4	50	91
F	During the dry season	46	0	39	85
	During the rainy season	1	1	0	2
	Don't know	0	0	0	0
	Total	47	1	39	87
Total	During the dry season	83	0	89	172
	During the rainy season	1	4	0	5
	Don't know	0	1	0	1
	Total	84	5	89	178

Table 11: Distribution of respondents reporting the main source they usually when current source of water is not available by province and gender

Steps taken in case of non-access to water source	Other								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	M	F	Total	M	F	Total	M	F	Total
Piped into dwelling, plot or yard	0	1	1	1	0	1	0	0	0
Public tap / standpipe	0	0	0	0	0	0	0	0	0
Tube well / borehole	0	0	0	0	0	0	2	0	2
Protected dug well	0	0	0	0	0	0	3	2	5
Protected Spring	6	11	17	0	0	0	0	0	0
Rainwater collection	0	0	0	0	0	0	0	2	2
Unprotected dug well	0	0	0	0	0	0	8	8	16
Unprotected spring	14	15	29	0	0	0	2	0	2
Cart with small tank / drum	0	0	0	1	0	1	1	0	1
Bottled water	0	0	0	0	0	0	9	13	22
Tanker Truck	1	0	1	0	0	0	4	1	5
Surface water (river / dam / lake / pond / stream / canal)	16	20	36	0	0	0	17	13	30
Water gallon	0	0	0	2	1	3	0	0	0
Well (not specified protected or unprotected)	0	0	0	0	0	0	1	0	1
Water faucet in neighbouring hamlet	0	0	0	0	0	0	0	0	0
Re-digging	0	0	0	0	0	0	2	0	2
Water springs (not specified protected or unprotected)	0	0	0	0	0	0	1	0	1
Wait until there is water	0	0	0	0	0	0	0	0	0
Total	37	47	84	4	1	5	50	39	89

End line Sanitation

Table 1: Distribution of households having toilets by province, district and gender

Sex	Have toilet	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M.Garai	Enrekang	Keerom	
M	Yes	122	170	161	453
	No	43	14	16	73
	Total	165	184	177	526
F	Yes	134	162	166	462
	No	61	16	17	94
	Total	195	178	183	556
Total	Yes	256	332	327	915
	No	104	30	33	167
	Total	360	362	360	1082

Table 2: Distribution of households Share toilet facility with others by province, district and gender

Sex	Share toilet facility with others	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M.Garai	E.kang	Keerom	
M	No. Facility only used by my household	89	168	158	415
	Yes. Shared	33	2	3	38
	Total	122	170	161	453
F	No. Facility only used by my household	104	157	163	424
	Yes. Shared	30	5	3	38
	Total	134	162	166	462
Total	No. Facility only used by my household	193	325	321	839
	Yes. Shared	63	7	6	76
	Total	256	332	327	915

Table 3: Distribution of households reporting reasons for using the toiler facility by province and gender

Reasons for using toilet facility	Other								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	M	F	Total	M	F	Total	M	F	Total
For good health and cleaning	122	133	255	162	149	311	141	145	286
Convenience	96	106	202	95	81	176	108	118	226
To be proud/showy	1	1	2	7	10	17	13	8	21
As routine	4	8	12	4	3	7	9	9	18
Don't know	0	0	0	0	0	0	0	2	2
Total	223	248	471	268	243	511	271	282	553

Table 4: Distribution of households reporting members of immediate family usually do not use the toilet by province and gender

Members of family usually don't use the toilet	Other								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	M	F	Total	M	F	Total	M	F	Total
Myself	0	0	0	17	1	18	3	3	6
My husband	0	0	0	0	1	1	0	2	2
My wife	0	0	0	7	0	7	1	0	1
Children five years and younger	3	9	12	2	2	4	3	3	6
Children over age 5	1	1	2	2	0	2	0	0	0
N/A Everyone in the family uses	117	124	241	151	156	307	156	159	315
Don't know	1	0	1	0	2	2	0	1	1
Total	122	134	256	179	162	341	163	168	331

Table 5: Distribution of households reporting frequency of defecation by immediate family members when at home by province and gender

Frequency of defecation immediate family members	Other								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	M	F	Total	M	F	Total	M	F	Total
Never/rarely	2	3	5	2	6	8	5	6	11
Sometimes / occasionally	8	11	19	1	1	2	10	6	16
Usually / mostly	6	11	17	12	14	26	3	2	5
Always	120	133	253	161	155	316	148	157	305
Not applicable	122	134	256	170	162	332	161	166	327
Don't know	5	2	7	36	25	61	1	1	2
Total	263	294	557	382	363	745	328	338	666

Table 6: Distribution of the respondents reporting frequency of defecation in open (7 days) when at home by province and gender

Frequency of defecation by the respondent in open	Other								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	M	F	Total	M	F	Total	M	F	Total
No days	119	132	251	66	65	131	159	166	325
Some days	14	17	31	2	1	3	1	2	3
Most days	3	5	8	14	18	32	1	2	3
Every day	5	5	10	97	93	190	3	4	7
Not applicable	122	134	256	170	162	332	161	166	327
Don't know	6	6	12	35	21	56	0	0	0
Total	269	299	568	384	360	744	325	340	665

Table 7: Distribution of respondents reporting the type of toilets in their households by province and gender

Type of toilet	Other											
	Province											
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua			Total		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total

Flushed to piped sewer system	68	67	135	68	55	123	67	81	148	203	203	406
Flushed to septic tank	24	18	42	84	72	156	84	85	169	192	175	367
Flushed to pit latrine	13	17	30	20	36	56	39	28	67	72	81	153
Flush, don't know where	1	0	1	1	0	1	0	0	0	2	0	2
VIP latrine	2	1	3	0	0	0	1	2	3	3	3	6
Pit latrine with slab (concrete, wood/bamboo)	18	25	43	0	0	0	14	22	36	32	47	79
Pit latrine without slab/open pit	18	27	45	0	0	0	15	18	33	33	45	78
Composting toilet	13	16	29	0	0	0	0	0	0	13	16	29
Others	3	0	3	0	0	0	0	0	0	3	0	3
Refused/Not able to observe	0	0	0	0	0	0	0	0	0	0	0	0
Total	160	171	331	173	163	336	220	236	456	553	570	1123

Table 8: Average period of time when first time latrine was constructed by province, district, period and gender

Period	Sex	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M.Garai	E.kang	Keerom	
Months	M	55	85	70	75
	F	59	77	71	72
	Total	57	81	70	73
Year	M	4.6	7.1	5.8	6.2
	F	5.0	6.4	5.9	6.0
	Total	4.8	6.8	5.9	6.1

able 9: Distribution of respondents reporting that they have improved/upgraded latrine in their households during last three years by province, district and gender

Sex	improved/upgraded this latrine in last THREE years	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M.Garai	E.kang	Keerom	
M	Yes	17	11	18	46
	No	105	159	136	400
	Don't know	0	0	7	7
	Total	122	170	161	453
F	Yes	26	4	12	42
	No	108	158	149	415
	Don't know	0	0	5	5
	Total	134	162	166	462
Total	Yes	43	15	30	88
	No	213	317	285	815
	Don't know	0	0	12	12
	Total	256	332	327	915

Table 10: Distribution of respondents reporting their satisfaction with the toilet facility as a place to defecate by province, district and gender

Sex	Degree of satisfaction	Others			
		Province			Total
		NTT	SS	PP	
		District			

		M.Garai	E.kang	Keerom	
M	Very satisfied	1	5	14	20
	Satisfied	52	164	85	301
	Dissatisfied	58	1	54	113
	Very dissatisfied	11	0	8	19
	Total	122	170	161	453
F	Very satisfied	3	2	9	14
	Satisfied	56	153	108	317
	Dissatisfied	64	7	42	113
	Very dissatisfied	11	0	7	18
	Total	134	162	166	462
Total	Very satisfied	4	7	23	34
	Satisfied	108	317	193	618
	Dissatisfied	122	8	96	226
	Very dissatisfied	22	0	15	37
	Total	256	332	327	915

ble 11: Distribution of respondents reporting their awareness of any available options to receive any assistance (loan, financing, gifts/grants, Construction Material/in-kind support etc.) to help you build the latrine by province, district and gender

Sex	Awareness of available options to receive assistance	Others			Total
		Province			
		NTT	SS	PP	
		District			
		M.Garai	E.kang	Keerom	
M	Yes	14	45	32	91
	No	80	103	124	307
	Don't know	28	22	5	55
	Total	122	170	161	453
F	Yes	8	34	19	61
	No	104	102	144	350
	Don't know	22	26	3	51
	Total	134	162	166	462
Total	Yes	22	79	51	152
	No	184	205	268	657
	Don't know	50	48	8	106
	Total	256	332	327	915

Table 12: Distribution of respondents reporting that they heavy received or not any assistance (loan, financing, gifts/grants, Construction Material/in-kind support etc.) to help you build the latrine by province, district and gender

Sex	Received any assistance	Others			Total
		Province			
		NTT	SS	PP	
		District			
		M.Garai	E.kang	Keerom	
M	Yes	4	6	18	28
	No	10	37	14	61
	Don't know	0	2	0	2
	Total	14	45	32	91

F	Yes	0	1	11	12
	No	8	31	8	47
	Don't know	0	2	0	2
	Total	8	34	19	61
Total	Yes	4	7	29	40
	No	18	68	22	108
	Don't know	0	4	0	4
	Total	22	79	51	152

Table 13: Distribution of respondents reporting the type of assistance received by province and gender

Type of assistance received	Other											
	Province											
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua			Total		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Loan	0	0	0	0	0	0	0	1	1	0	1	1
Grant/Gift/subsidy	3	0	3	0	0	0	3	1	4	6	1	7
Construction Material/in-kind support	2	0	2	5	0	5	16	9	25	23	9	32
Don't know	0	0	0	1	1	2	0	0	0	1	1	2
Total	5	0	5	6	1	7	19	11	30	30	12	42

Table 14: Distribution of respondents reporting that they have received any grant/gift/subsidy to construct latrine by province and gender

Grant/Gift/subsidy	Other											
	Province											
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua			Total		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Latrine	0	0	0	0	0	0	0	0	0	0	0	0
Cement	0	0	0	0	0	0	0	0	0	0	0	0
Zinc	0	0	0	0	0	0	0	0	0	0	0	0
Nail	0	0	0	0	0	0	0	0	0	0	0	0
Free cost of work	1	0	1	0	0	0	0	0	0	1	0	1
Free material	0	0	0	0	0	0	1	1	2	1	1	2
Cash	2	0	2	0	0	0	2	0	2	4	0	4
Others	0	0	0	0	0	0	0	0	0	0	0	0
Total	3	0	3	0	0	0	3	1	4	6	1	7

Table 15: Distribution of respondnets reporting that they have received construction Material/inkind support to construct latrine by province and gender

Construction Material/inkind support	Other											
	Province											
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua			Total		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Latrine	1	0	1	3	0	3	3	1	4	7	1	8
Cement	2	0	2	5	0	5	10	2	12	17	2	19
Zinc	2	0	2	1	0	1	12	2	14	15	2	17
Nail	1	0	1	0	0	0	3	0	3	4	0	4
Steel bar	1	0	1	0	0	0	0	0	0	1	0	1
Bricks	0	0	0	0	0	0	1	0	1	1	0	1
Paralon / pipes	1	0	1	1	0	1	3	1	4	5	1	6
Wood	2	0	2	0	0	0	6	1	7	8	1	9
Cash	0	0	0	0	0	0	3	3	6	3	3	6
Others	1	0	1	1	0	1	11	4	15	13	4	17
Total	11	0	11	11	0	11	52	14	66	74	14	88

Table 16: Average total cost spend on construction per toilet and average amount of subsidies included in this total cost by province. district and gender

Total cost and amount of subsidies received	Sex	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M.Garai	Enrekang	Keerom	
Average total cost spend on construction per toilet	M	0	2,081,250	0	2,081,250
	F	0	1,666,667	0	1,666,667
	Total	0	1,903,571	0	1,903,571
average amount of subsidies included in total cost	M	0	312,500	0	312,500
	F	0	595,833	0	595,833
	Total	0	433,929	0	433,929

Table 17: Distribution of households reporting decision made by family mmber to built the latrine by province and gender

Decisive member of the family to built the latrine	Other								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	M	F	Total	M	F	Total	M	F	Total
Father/Male head of family	113	121	234	164	143	307	155	154	309
Mother/Female head of family	52	74	126	13	30	43	61	88	149
N/A latrine was in the house when we bought/rented it	0	1	1	4	2	6	0	2	2
Others	4	7	11	1	1	2	4	1	5
Family	1	5	6	0	1	1	2	0	2
Myself	2	0	2	0	0	0	0	0	0
Government/village officials	0	0	0	0	0	0	2	1	3
Total	172	208	380	182	177	359	224	246	470

Table 18: Distribution of respondents reporting the person/authorities influencing in the decision to build/construct latrine by province, district and gender

Sex	Influencing persons on decision	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M.Garai	E.kang	Keerom	
M	Community leader	4	32	36	72
	Religious leaders	0	25	9	34
	Elected official	28	110	40	178
	Distric/ subdistrictt government authorities	7	28	20	55
	Community health worker/sanitarian	34	64	35	133
	Neighbors/Friends	21	12	5	38
	Myself	0	0	0	0
	Family	0	0	2	2
	Others	2	0	4	6
	Don't know	0	0	0	0
	None	65	38	96	199
	Total	122	170	161	453
F	Community leader	5	29	30	64
	Religious leaders	0	26	10	36
	Elected official	36	106	36	178
	Distric/ subdistrictt government authorities	4	17	19	40
	Community health worker/sanitarian	45	59	34	138

	Neighbors/Friends	14	17	6	37
	Myself	0	0	0	0
	Family	0	0	7	7
	Others	6	0	7	13
	Don't know	0	0	0	0
	None	71	40	103	214
	Total	134	162	166	462
Total	Community leader	9	61	66	136
	Religious leaders	0	51	19	70
	Elected official	64	216	76	356
	Distric/ subdistrictt government authorities	11	45	39	95
	Community health worker/sanitarian	79	123	69	271
	Neighbors/Friends	35	29	11	75
	Myself	0	0	0	0
	Family	0	0	9	9
	Others	8	0	11	19
	Don't know	0	0	0	0
	None	136	78	199	413
	Total	256	332	327	915

Table 19: Distribution of respondnets reporting place of defecation in case no toilet at home by province, district and gender

Sex	Place of defecation in case of no toilet at home	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M.Garai	E.kang	Keerom	
M	Bush/Field	12	0	2	14
	River	3	4	1	8
	Behind our house	1	0	13	14
	Neighbourhood toilet	32	10	2	44
	Communal latrine	6	0	0	6
	Others	0	0	4	4
	Do not know / Refuse to answer	0	0	0	0
	Total	43	14	16	73
F	Bush/Field	11	0	0	11
	River	3	1	1	5
	Behind our house	3	0	7	10
	Neighbourhood toilet	53	14	4	71
	Communal latrine	8	0	2	10
	Others	0	0	5	5
	Do not know / Refuse to answer	0	0	0	0
	Total	61	15	17	93
Total	Bush/Field	23	0	2	25
	River	6	5	2	13
	Behind our house	4	0	20	24
	Neighbourhood toilet	85	24	6	115
	Communal latrine	14	0	2	16
	Others	0	0	9	9
	Do not know / Refuse to answer	0	0	0	0
	Total	104	29	33	166

Table 20: Distribution of respondents reporting reasons for not having a toilet at home by province, district and gender

Sex	Reasons for not having a toilet at home	Others			
		Province			Total
		NTT	SS	PP	
		District			

		M.Garai	E.kang	Keerom	
M	No money to construct	41	14	15	70
	No materials to construct	40	7	3	50
	Not enough water available	6	0	1	7
	Don't know how to construct	1	1	0	2
	No land/space available to construct/Unable to construct on our land	4	0	2	6
	Damaged by natural disaster	0	0	0	0
	New house just built, New family/household, Just moved to new house	1	0	3	4
	Others	2	0	3	5
	Total	43	14	16	73
F	No money to construct	57	15	16	88
	No materials to construct	49	8	4	61
	Not enough water available	15	1	0	16
	Don't know how to construct	0	0	1	1
	No land/space available to construct/Unable to construct on our land	6	0	0	6
	Damaged by natural disaster	1	0	1	2
	New house just built, New family/household, Just moved to new house	2	0	0	2
	Others	4	0	1	5
	Total	61	16	17	94
Total	No money to construct	98	29	31	158
	No materials to construct	89	15	7	111
	Not enough water available	21	1	1	23
	Don't know how to construct	1	1	1	3
	No land/space available to construct/Unable to construct on our land	10	0	2	12
	Damaged by natural disaster	1	0	1	2
	New house just built, New family/household, Just moved to new house	3	0	3	6
	Others	6	0	4	10
	Total	104	30	33	167

Table 21: Distribution of respondents reporting their decision to built a latrine and its type by province, gender by choice level

Choice	Decision to build a latrine by its type	Other								
		Province								
		Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
		M	F	Total	M	F	Total	M	F	Total
First	Flush or Pour Flush Toilet	22	37	59	11	12	23	6	9	15
	Pit Latrine	0	0	0	0	0	0	0	0	0
	Composting toilet	0	0	0	0	0	0	0	0	0

	Not interested in building toilets / latrines / WC/No funds	0	0	0	3	0	3	0	0	0
	WC ever built by the government	2	0	2	0	0	0	0	0	0
	Permanent latrine and has a closet	15	19	34	0	2	2	1	2	3
	Toilets, septitank, pipes, tiles water tub	0	0	0	0	1	1	2	2	4
	Ordinary toilets without ceramics oe simple with zinc roof	4	5	9	0	1	1	4	3	7
	Others	0	0	0	0	0	0	2	1	3
	None	0	0	0	0	0	0	1	0	1
	Total	43	61	104	14	16	30	16	17	33
Other	Flush or Pour Flush Toilet	42	59	101	11	15	26	12	15	27
	Pit Latrine	1	2	3	0	0	0	0	2	2
	Composting toilet	0	0	0	0	0	0	2	0	2
	Not interested in building toilets / latrines / WC/No funds	0	0	0	0	0	0	0	0	0
	WC ever built by the government	0	0	0	0	0	0	0	0	0
	Permanent latrine and has a closet	0	0	0	0	0	0	0	0	0
	Toilets, septitank, pipes, tiles water tub	0	0	0	0	0	0	0	0	0
	Ordinary toilets without ceramics oe simple with zinc roof	0	0	0	0	0	0	0	0	0
	Others	0	0	0	0	0	0	0	0	0
	None	0	0	0	3	1	4	2	0	2
	Total	43	61	104	14	16	30	16	17	33

Table 22: Distribution of respondents reporting the decision of households to built a latrine by choice levels

Decision to build a latrine by its type (first choice)		Decision to build a latrine by its type (other choice)										
		Flush or Pour Flush Toilet	Pit Latrine	Composting toilet	Not interested in building toilets / latrines / WC/No funds	WC ever built by the gov.	Permanent latrine and has a closet	Toilets, septitank, pipes, tiles water tub	Ordinary toilets without ceramics oe simple with zinc roof	Others	None	Total
Other	Flush or Pour Flush Toilet	93	3	0	0	0	0	0	0	0	1	97
	Pit Latrine	0	0	0	0	0	0	0	0	0	0	0
	Composting toilet	0	0	0	0	0	0	0	0	0	0	0
	Not interested in building toilets / latrines / WC/No funds	0	0	0	0	0	0	0	0	0	3	3
	WC ever built by the government	2	0	0	0	0	0	0	0	0	0	2
	Permanent latrine and has a closet	39	0	0	0	0	0	0	0	0	0	39

	Toilets, septitank, pipes, tiles water tub	5	0	0	0	0	0	0	0	0	0	5
	Ordinary toilets without ceramics oe simple with zinc roof	13	2	2	0	0	0	0	0	0	0	17
	Others	2	0	0	0	0	0	0	0	0	1	3
	None	0	0	0	0	0	0	0	0	0	1	1
	Total	154	5	2	0	0	0	0	0	0	6	167

Table 22: Distribution of respondents reporting the decision of households to built a latrine by choice levels

Decision to build a latrine by its type (first choice)		Decision to build a latrine by its type (other choice)										
		Flush or Pour Flush Toilet	Pit Latrine	Composting toilet	Not interested in building toilets / latrines / WC/No funds	WC ever built by the gov.	Permanent latrine and has a closet	Toilets, septitank, pipes, tiles water tub	Ordinary toilets without ceramics oe simple with zinc roof	Others	None	Total
Other	Flush or Pour Flush Toilet	93	3	0	0	0	0	0	0	0	1	97
	Pit Latrine	0	0	0	0	0	0	0	0	0	0	0
	Composting toilet	0	0	0	0	0	0	0	0	0	0	0
	Not interested in building toilets / latrines / WC/No funds	0	0	0	0	0	0	0	0	0	3	3
	WC ever built by the government	2	0	0	0	0	0	0	0	0	0	2
	Permanent latrine and has a closet	39	0	0	0	0	0	0	0	0	0	39
	Toilets, septitank, pipes, tiles water tub	5	0	0	0	0	0	0	0	0	0	5
	Ordinary toilets without ceramics oe simple with zinc roof	13	2	2	0	0	0	0	0	0	0	17
	Others	2	0	0	0	0	0	0	0	0	1	3
	None	0	0	0	0	0	0	0	0	0	1	1
	Total	154	5	2	0	0	0	0	0	0	6	167

Table 23: Average cost to build a latrine as per knowledge of the respondent by province, district, gender and income quantiles (in million Indonesian Rupiyah)

Sex	Income Quintiles	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M.Garai	E.kang	Keerom	
M	Highest quintile	8.000	3.100	3.000	4.060
	2nd highest quintile	6.000	3.500	0.000	4.333
	Medium quintile	5.167	2.000	6.000	4.708
	2nd lowest quintile	5.750	0.000	0.000	5.750
	Lowest quintile	3.000	1.500	3.967	3.311
	Total	5.441	2.755	4.100	4.322
F	Highest quintile	8.000	2.833	2.000	3.700
	2nd highest quintile	5.333	2.950	7.000	4.350
	Medium quintile	5.364	3.500	4.500	5.000
	2nd lowest quintile	5.286	0.000	4.000	5.000
	Lowest quintile	0.000	1.833	4.250	3.214
	Total	5.455	2.733	4.300	4.450
Total	Highest quintile	8.000	2.967	2.500	3.880
	2nd highest quintile	5.600	3.225	7.000	4.343
	Medium quintile	5.275	2.750	5.000	4.870
	2nd lowest quintile	5.455	0.000	4.000	5.231
	Lowest quintile	3.000	1.700	4.080	3.269
	Total	5.449	2.743	4.211	4.393

Table 24: Distribution of respondents reporting their awareness regarding available options to receive any assistance (loan, financing, gifts/grants, Construction Material/inkind support etc.) to build the latrine by province, district and gender

Sex	Aware of any available options to receive any assistance	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M.Garai	E.kang	Keerom	
M	Yes	0	0	2	2
	No	32	12	14	58
	Don't know	11	2	0	13
	Total	43	14	16	73
F	Yes	2	4	0	6
	No	43	9	15	67
	Don't know	16	3	2	21
	Total	61	16	17	94
Total	Yes	2	4	2	8
	No	75	21	29	125
	Don't know	27	5	2	34
	Total	104	30	33	167

Table 25: Distribution of respondents reporting their action of plan in case of having extra money by province, gender and preference

Preference	Action if have extra money	Other								
		Province								
		Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
		M	F	Total	M	F	Total	M	F	Total
FIRST	Pay debt	4	8	12	16	9	25	15	14	29
	Buy the necessity for my children	30	42	72	25	26	51	45	57	102
	Buy food/ household appliances for my family	109	123	232	29	22	51	48	41	89
	Buy various items (TV, VCD/DVD/motor cycle, mobile phone, fixed phone, vehicle, computer etc.)	1	0	1	8	8	16	7	4	11
	Renovate the house	2	2	4	71	64	135	32	28	60
	Build/Renovate the Toilet	7	11	18	22	21	43	25	28	53
	Put into saving account	8	4	12	13	27	40	4	5	9
	Other	4	5	9	0	1	1	1	5	6
	None	0	0	0	0	0	0	0	1	1
	Total	165	195	360	184	178	362	177	183	360
SECOND	Pay debt	7	10	17	5	5	10	1	3	4
	Buy the necessity for my children	65	95	160	33	23	56	34	35	69
	Buy food/ household appliances for my family	31	30	61	42	42	84	51	79	130
	Buy various items (TV, VCD/DVD/motor cycle, mobile phone, fixed phone, vehicle, computer etc.)	2	1	3	23	11	34	23	13	36
	Renovate the house	8	8	16	38	49	87	46	36	82
	Build/Renovate the Toilet	14	24	38	19	27	46	12	10	22
	Put into saving account	10	12	22	24	21	45	8	6	14
	Other	28	15	43	0	0	0	2	1	3
	None	0	0	0	0	0	0	0	0	0
	Total	165	195	360	184	178	362	177	183	360
THIRD	Pay debt	16	35	51	20	21	41	15	9	24
	Buy the necessity for my children	42	33	75	30	23	53	14	18	32
	Buy food/ household appliances for my family	18	17	35	31	46	77	28	33	61
	Buy various items (TV, VCD/DVD/motor cycle, mobile phone, fixed phone, vehicle, computer etc.)	2	6	8	26	15	41	28	18	46
	Renovate the house	12	17	29	33	27	60	44	58	102
	Build/Renovate the Toilet	31	39	70	16	16	32	18	12	30
	Put into saving account	19	21	40	28	30	58	27	32	59
	Other	25	27	52	0	0	0	3	3	6
	None	0	0	0	0	0	0	0	0	0
	Total	165	195	360	184	178	362	177	183	360

Table 26: Distribution of respondents reporting action taken to dispose of babies stool by province, district and gender

Sex	Action taken to dispose of babies stool	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M.garai	E.kang	Keerom	
M	Thrown in toilet facility/latrine	112	57	92	261
	Thrown in the bushes/field/animal pen river/beach/drain	25	8	39	72
	Not disposed of/left on the ground	3	1	4	8
	Buried in yard/field	86	2	29	117
	Thrown in garbage/rubbish bin	2	38	14	54
	N/A household does not have young children this age	20	85	43	148
	Use pampers	0	0	0	0
	Directly washed his/her pants	1	0	0	1
	Others	1	1	0	2
	None	0	3	10	13
	Total	165	184	177	526
F	Thrown in toilet facility/latrine	133	45	91	269
	Thrown in the bushes/field/animal pen river/beach/drain	24	11	33	68
	Not disposed of/left on the ground	1	0	4	5
	Buried in yard/field	109	0	14	123
	Thrown in garbage/rubbish bin	1	27	14	42
	N/A household does not have young children this age	21	100	55	176
	Use pampers	0	0	1	1
	Directly washed his/her pants	0	0	0	0
	Others	0	0	1	1
	None	0	0	8	8
	Total	195	178	183	556
Total	Thrown in toilet facility/latrine	245	102	183	530
	Thrown in the bushes/field/animal pen river/beach/drain	49	19	72	140
	Not disposed of/left on the ground	4	1	8	13
	Buried in yard/field	195	2	43	240
	Thrown in garbage/rubbish bin	3	65	28	96
	N/A household does not have young children this age	41	185	98	324
	Use pampers	0	0	1	1
	Directly washed his/her pants	1	0	0	1
	Others	1	1	1	3
	None	0	3	18	21
	Total	360	362	360	1082

Communication Channels

Table 1: Distribution of households reporting participation in meeting about sanitation and visit of government official regarding construction of a latrine by province, district and Sex

Sex	Participation in meeting and visit of government official	Others			Total
		Province			
		NTT	SS	PP	
		District			
		M.garai	E.kang	Keerom	
M	Yes	30	49	35	114
	No	128	117	124	369
	Don't know	7	18	18	43
	Total	165	184	177	526
F	Yes	38	37	29	104
	No	142	122	140	404
	Don't know	15	19	14	48
	Total	195	178	183	556
Total	Yes	68	86	64	218
	No	270	239	264	773
	Don't know	22	37	32	91
	Total	360	362	360	1082

Table 2. Distribution of households received sufficient information helpful to construct a latrine by province, district and Sex

Sex	Received sufficient information	Others			Total
		Province			
		NTT	SS	PP	
		District			
		M.garai	E.kang	Keerom	
M	Yes	27	40	25	92
	No	3	9	9	21
	What did you miss? Please specify.	0	0	1	1
	Total	30	49	35	114
F	Yes	35	27	23	85
	No	3	10	6	19
	What did you miss? Please specify.	0	0	0	0
	Total	38	37	29	104
Total	Yes	62	67	48	177
	No	6	19	15	40
	What did you miss? Please specify.	0	0	1	1
	Total	68	86	64	218

Table 3: Distribution of households able to recall three key messages learned/practice in the participated meeting by province, district, and Sex

Sex	Recall three key messages learned in the meeting	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M.garai	E.kang	Keerom	
M	Yes	25	8	4	37
	No	3	28	13	44
	Don't know	2	13	18	33
	Total	30	49	35	114
F	Yes	35	1	6	42
	No	2	27	12	41
	Don't know	1	9	11	21
	Total	38	37	29	104
Total	Yes	60	9	10	79
	No	5	55	25	85
	Don't know	3	22	29	54
	Total	68	86	64	218

Table 4: Distribution of households reporting the sources of information to get information about hygiene and toilet by province and Sex

Sources of information to get information	Other								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	M	F	Total	M	F	Total	M	F	Total
Television	44	42	86	56	66	122	137	137	274
Newspaper/Tabloid, Magazine	0	0	0	7	6	13	2	1	3
Print Materials	2	1	3	6	7	13	6	5	11
Neighbours/Friends	35	38	73	47	41	88	50	57	107
From School Children in the family	9	14	23	9	4	13	21	25	46
Family members/relatives	44	67	111	82	69	151	53	66	119
Local authority (head of village, RT/RW)	117	145	262	152	147	299	68	64	132
Religious leaders	6	11	17	20	18	38	12	6	18
Government health workers (sanitarians, midwives, cadres, etc.)	127	163	290	121	100	221	110	119	229
Others	2	2	4	0	0	0	12	11	23
Don't know	52	48	100	20	29	49	20	23	43
Total	438	531	969	520	487	1007	491	514	1005

Table 5: Distribution of households reporting trusted/preferable source of information by province and Sex

Sources of information	Other								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	M	F	Total	M	F	Total	M	F	Total
Television	43	37	80	58	57	115	133	135	268
Internet	0	0	0	0	0	0	0	0	0
Newspaper/Tabloid, Magazine	1	1	2	5	7	12	3	2	5
Neighbours/Friends	34	36	70	41	44	85	49	56	105
From School Children in the family	8	16	24	9	10	19	23	23	46
Family members/relatives/self	46	65	111	83	62	145	46	66	112
Local authority (head of village, RT/RW)	116	148	264	157	146	303	77	68	145
Religious leaders/organisations	5	12	17	26	27	53	11	5	16
Government & other health workers and other organisations	127	162	289	124	116	240	111	117	228
Posyandu	0	0	0	0	0	0	0	0	0
Others	2	2	4	0	0	0	14	11	25
Don't know	52	46	98	18	25	43	21	24	45
Total	434	525	959	521	494	1015	488	507	995

Table 1: Distribution of respondents reporting existence of any sanitation association (forum, active volunteers, or other organised group) involved in promoting sustainable sanitation by province, district and Sex

Sex	Existence of sanitation association	Others			
		Province			Total
		NTT	SS	PP	
		District			
		Manggarai	Enrekang	Keerom	
M	Yes	7	66	16	89
	No	92	68	128	288
	Don't know	66	50	33	149
	Total	165	184	177	526
F	Yes	18	65	28	111
	No	102	57	129	288
	Don't know	75	56	26	157
	Total	195	178	183	556
Total	Yes	25	131	44	200
	No	194	125	257	576
	Don't know	141	106	59	306
	Total	360	362	360	1082

Table 2: Distribution of respondents reporting most active groups taking part in meetings and action planning by province and Sex

Mostly Active Groups	Other								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	M	F	Total	M	F	Total	M	F	Total
Men	7	18	25	56	50	106	15	23	38
Women	6	18	24	41	40	81	12	24	36
Girls	0	0	0	7	3	10	1	2	3
Boys	0	0	0	1	0	1	1	3	4
People from Poor households	1	1	2	1	0	1	8	10	18
Elderly people	0	1	1	0	0	0	7	11	18
Village leader	6	16	22	4	3	7	8	13	21
People with disabilities	0	1	1	0	0	0	0	0	0
People from Minority groups	0	0	0	0	3	3	0	0	0
Religious people	4	15	19	1	2	3	0	0	0
Professional/Workers (sanitarian, teacher)	0	4	4	4	2	6	0	0	0
Don't know	0	0	0	1	2	3	0	0	0
Total	24	74	98	116	105	221	52	86	138

Table 3: Distribution of respondents reporting action plan to achieve ODF (post-triggering planning and actions) in the community by province, district and Sex

Sex	Action Plan to achieve ODF	Others			
		Province			Total
		NTT	SS	PP	
		District			
		Manggarai	Enrekang	Keerom	
M	Yes	17	48	29	94
	No	79	99	107	285
	Don't know	69	37	41	147
	Total	165	184	177	526
F	Yes	28	46	35	109
	No	80	89	112	281
	Don't know	87	43	36	166
	Total	195	178	183	556
Total	Yes	45	94	64	203
	No	159	188	219	566
	Don't know	156	80	77	313
	Total	360	362	360	1082

Table 4: Distribution of respondent reporting the result in case of someone found defecating in the open by province and Sex

Result, if someone found defecating in the open	Other								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	M	F	Total	M	F	Total	M	F	Total
Financial penalty	0	0	0	0	3	3	1	2	3
Legal penalty	0	0	0	0	0	0	1	3	4
Community members scorn / punish	0	1	1	21	19	40	19	22	41

Nothing happens	149	173	322	155	153	308	153	149	302
Others	16	22	38	8	3	11	3	8	11
None	0	0	0	5	3	8	0	1	1
Total	165	196	361	189	181	370	177	185	362

Table 5: Distribution of respondents ever seen any map or sign in the community to stop open defecation

Sex	Ever seen any map or sign in the community to stop open defecation	Others			
		Province			Total
		NTT	SS	PP	
		District			
		Manggarai	Enrekang	Keerom	
M	Yes	10	38	4	52
	No	126	117	146	389
	Don't know	29	29	27	85
	Total	165	184	177	526
F	Yes	22	30	8	60
	No	142	114	154	410
	Don't know	31	34	21	86
	Total	195	178	183	556
Total	Yes	32	68	12	112
	No	268	231	300	799
	Don't know	60	63	48	171
	Total	1080	1086	1080	3246

Table 6: Distribution of respondents reporting that community verified as ODF verified or not by province, district and Sex

Sex	Community verified as ODF verified	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M.garai	E.kang	Keerom	
M	Yes	17	37	18	72
	No	70	87	79	236
	Don't know	78	60	80	218
	Total	165	184	177	526
F	Yes	29	29	19	77
	No	72	76	86	234
	Don't know	94	73	78	245
	Total	195	178	183	556
Total	Yes	46	66	37	149
	No	142	163	165	470
	Don't know	172	133	158	463
	Total	360	362	360	1082

Table 7: Distribution of respondents reporting the period (Years-Months) of ODF verification by province, district and Sex

Sex	Other							
	G1. Name of Province							
	Nusa Tenggara Timur (NTT)		South Sulawesi		Papua		Total	
	Manggarai		Enrekang		Keerom			
	Y	M	Y	M	Y	M	Y	M
M	4	6	10	5	7	2	8	5
F	4	6	11	5	8	4	8	5
Total	4	6	10	5	8	3	8	5

Table 8: Distribution of respondents reporting way of getting ODF verification by province and Sex

How the community was got ODF verification	Other								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	M	F	Total	M	F	Total	M	F	Total
Participation of a large number of households members in the process	12	27	39	32	28	60	15	16	31
A checklist was used for verification with clear verification criteria	12	28	40	3	1	4	2	0	2
A large OD areas around the village were visited for the verification process	11	22	33	10	3	13	2	2	4
Involvement of actors other than community members (media, government officials, neighbouring communities etc.) in verify	0	1	1	0	0	0	0	0	0
The participation of other parties besides the community (media, government agencies, local communities)	16	25	41	13	16	29	1	1	2
Total	51	103	154	58	48	106	20	19	39

Table 9: Distribution of respondents having knowledge that community received any reward/incentive for achieving the ODF status by Province, district and Sex

Sex	Have knowledge that community achieved any reward/incentive in respect of ODF status	Others			Total
		Province			
		NTT	SS	PP	
		District			
		M.garai	E.kang	Keerom	
M	Yes	0	11	2	13
	No	10	20	14	44
	Don't know	7	6	2	15
	Total	17	37	18	72
F	Yes	0	5	2	7
	No	21	22	15	58
	Don't know	8	2	2	12
	Total	29	29	19	77
Total	Yes	0	16	4	20
	No	31	42	29	102
	Don't know	15	8	4	27
	Total	46	66	37	149

Table 10: Distribution of respondents reporting the type of reward/incentive awarded to the communities by province and Sex

Type of reward/incentive awarded to community	Other								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	M	F	Total	M	F	Total	M	F	Total
Public recognition	0	0	0	4	2	6	0	0	0
Financial rewards	0	0	0	1	1	2	0	0	0
In-kind or material support	0	0	0	7	3	10	1	0	1
Other incentives or rewards	0	0	0	0	0	0	1	2	3
Clothes	0	0	0	0	0	0	1	2	3
Total	0	0	0	12	6	18	3	4	7

Table 11: Distribution of respondents reporting anyone came to them for encouraging to build/keep using/improve the toilet after ODF verification by province and Sex

Did anyone came to encourage to build/keep using/improve the toilet?	Other								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	M	F	Total	M	F	Total	M	F	Total
Yes from a sanitation	0	0	0	5	2	7	1	1	2
Yes from a PKK member	0	0	0	1	0	1	0	0	0
Yes from a village officer	0	0	0	7	3	10	0	0	0
Midwife	0	0	0	1	1	2	1	1	2
Total	0	0	0	14	6	20	2	2	4

Table 12: Distribution of respondents reporting their involvement in maintaining/sustaining the ODF status

Sex	Weather the community members involved in maintaining sustaining the ODF status	Others			Total
		Province			
		NTT	SS	PP	
		District			
		Manggarai	Enrekang	Keerom	
M	Yes	0	8	1	9
	No	0	2	0	2
	Don't know	0	1	1	2
	Total	0	11	2	13
F	Yes	0	2	1	3
	No	0	0	0	0
	Don't know	0	3	1	4
	Total	0	5	2	7
Total	Yes	0	10	2	12
	No	0	2	0	2
	Don't know	0	4	2	6
	Total	0	16	4	20

Table 13: Distribution of respondents reporting their knowledge regarding place of availability of sanitary materials and supplies for constructing toilet be purchased by province and Sex

	Other

Place of availability of sanitary materials and supplies to be purchased	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	M	F	Total	M	F	Total	M	F	Total
Within or nearby your community/dusun	52	64	116	3	2	5	0	0	0
At village/desa level	79	97	176	10	14	24	6	6	12
At sub-district level	100	114	214	111	92	203	109	120	229
At district level	95	107	202	110	108	218	130	124	254
Don't know	1	0	1	6	3	9	4	5	9
Total	327	382	709	240	219	459	249	255	504

Table 14: Distribution of respondents reporting the sufficient report to poor households by province, district and Sex

Sex	Sufficient support to poor households	Others			
		Province			Total
		NTT	SS	PP	
		District			
		Manggarai	Enrekang	Keerom	
M	Yes	1	33	5	39
	No	15	2	12	29
	Don't know	149	149	160	458
	Total	165	184	177	526
F	Yes	1	24	4	29
	No	23	2	15	40
	Don't know	171	152	164	487
	Total	195	178	183	556
Total	Yes	2	57	9	68
	No	38	4	27	69
	Don't know	320	301	324	945
	Total	360	362	360	1082

Diarrhea Knowledge

Table 1: Distribution of respondents reporting the ways to protect their children against diarrhea by province and gender

Ways adopted to protect young children	Other											
	Province											
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua			Total		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Boil or treat your water	106	134	240	111	116	227	129	135	264	346	385	731
Use latrines/dispose faeces of children in latrines	143	160	303	93	89	182	72	71	143	308	320	628
Wash hands with soap and water	126	159	285	106	103	209	85	105	190	317	367	684
Cook food well	56	69	125	12	12	24	59	77	136	127	158	285
Store food properly/ cover the food	24	32	56	29	22	51	26	30	56	79	84	163
Buy food from a clean place/ not buying food from random place	26	27	53	21	23	44	22	25	47	69	75	144
Wash fruits and vegetables with potable/safe water	2	7	9	4	4	8	21	28	49	27	39	66

There is nothing you can do, it's a normal part of life	0	2	2	7	1	8	4	5	9	11	8	19
Adopt hygienic style	0	0	0	0	0	0	1	0	1	1	0	1
Wash hands after defecation	0	0	0	0	0	0	0	0	0	0	0	0
Use clean water	0	0	0	0	0	0	0	0	0	0	0	0
Provide medicine	1	0	1	0	0	0	0	0	0	1	0	1
Others	2	1	3	0	0	0	1	0	1	3	1	4
Do not know	8	12	20	1	1	2	9	7	16	18	20	38
Total	494	603	1097	384	371	755	429	483	912	1307	1457	2764

Table 2: Distribution of respondents reporting that their children under age of five victimized of diarrhea (3 or more watery stools within 24 hours or same day) by province district and gender

Sex	Children under age 5 had diarrhea	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M.garai	Enrekang	Keerom	
M	Yes	10	5	6	21
	No	66	25	64	155
	Don't know	1	0	0	1
	Total	77	30	70	177
F	Yes	17	0	5	22
	No	84	24	60	168
	Don't know	0	1	2	3
	Total	101	25	67	193
Total	Yes	27	5	11	43
	No	150	49	124	323
	Don't know	1	1	2	4
	Total	178	55	137	370

Table 3: Distribution of respondents reporting that their children under age of five victimized of diarrhea (3 or more watery stools within 24 hours or same day) by province district and income quintiles

Income Quintiles	Children under age 5 had diarrhea	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M.garai	Enrekang	Keerom	
Highest quintile	Yes	0	0	2	2
	No	7	19	27	53
	Don't know	0	0	0	0
	Total	7	19	29	55
2nd highest quintile	Yes	2	3	1	6
	No	19	13	24	56
	Don't know	1	0	0	1
	Total	22	16	25	63
Medium quintile	Yes	15	1	2	18
	No	74	13	8	95

	Don't know	0	0	0	0
	Total	89	14	10	113
2nd lowest quintile	Yes	9	0	0	9
	No	45	0	4	49
	Don't know	0	0	1	1
	Total	54	0	5	59
Lowest quintile	Yes	1	1	5	7
	No	5	1	55	61
	Don't know	0	1	1	2
	Total	6	3	61	70
Total	Yes	27	5	10	42
	No	150	46	118	314
	Don't know	1	1	2	4
	Total	178	52	130	360

Handwashing

Table 1: Distribution of respondents reporting the time of hands washing by province and gender

Usually wash hands	Other											
	Province											
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua			Total		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Before cooking	28	97	125	46	60	106	52	95	147	126	252	378
Before eating	152	185	337	166	157	323	162	171	333	480	513	993
Before eating	110	138	248	128	115	243	125	138	263	363	391	754
Before feeding a baby/child	23	41	64	23	15	38	15	26	41	61	82	143
After cleaning the feces from a baby/child	25	50	75	9	20	29	11	16	27	45	86	131
After defecation	137	168	305	110	112	222	71	84	155	318	364	682
After work/returning home from work	140	163	303	47	32	79	95	88	183	282	283	565
Others	0	0	0	0	0	0	0	1	1	0	1	1
Don't know	0	0	0	0	0	0	0	0	0	0	0	0
Do not wash hands	2	0	2	0	0	0	0	0	0	2	0	2
Total	617	842	1,459	529	511	1,040	531	619	1,150	1,677	1,972	3,649

Table 2: Distribution of respondents sharing the reasons to wash their hands (motivatives to wash hands) by province and gender

Reasons to wash hands	Other											
	Province											
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua			Total		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
To prevent the spread of disease	154	194	348	129	115	244	124	143	267	407	452	859
To be clean	156	192	348	161	151	312	153	153	306	470	496	966
To smell good	10	24	34	47	32	79	39	42	81	96	98	194

To get rid of dirt/smell/sticky things on my hands	47	78	125	52	48	100	24	28	52	123	154	277
Religious reasons/beliefs	1	0	1	3	1	4	2	0	2	6	1	7
Was told it was the right thing to do	6	8	14	6	6	12	2	0	2	14	14	28
Because that's what everyone does	5	0	5	1	5	6	1	2	3	7	7	14
Others	0	0	0	0	0	0	0	0	0	0	0	0
Don't know	0	0	0	0	0	0	0	0	0	0	0	0
Total	379	496	875	399	358	757	345	368	713	1123	1222	2345

Table 3: Distribution of respondents reporting the items to be used to wash their hands by province and gender

Item usually use to wash hands	Other											
	Province											
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua			Total		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Water	163	187	350	148	139	287	173	181	354	484	507	991
Soap	102	129	231	141	133	274	149	153	302	392	415	807
Powdered or liquid detergent	62	84	146	6	8	14	52	60	112	120	152	272
Ash	0	0	0	0	1	1	1	0	1	1	1	2
Dirt/sand/mud	0	1	1	0	0	0	0	0	0	0	1	1
Others	0	0	0	0	0	0	2	0	2	2	0	2
Do't know	165	195	360	184	178	362	176	183	359	525	556	1081
Total	492	596	1,088	479	459	938	553	577	1,130	1,524	1,632	3,156

Table 4: Distribution of respondnets reporting use of soap to wash their hands by province and gender

Reasons to wash hands with soap	Other											
	Province											
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua			Total		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
When they are visibly dirty	108	130	238	127	119	246	143	159	302	378	408	786
When they smell or are sticky	60	83	143	86	77	163	68	72	140	214	232	446
Before cooking	37	84	121	40	47	87	51	78	129	128	209	337
Before eating	103	126	229	83	60	143	76	92	168	262	278	540
Before feeding a baby/child	15	29	44	10	14	24	7	17	24	32	60	92
After defecation	111	124	235	69	68	137	22	35	57	202	227	429
After cleaning a baby that has defecated	22	41	63	5	12	17	8	15	23	35	68	103
Use every time I wash my hands	10	19	29	11	6	17	8	12	20	29	37	66
After work	82	98	180	9	3	12	37	41	78	128	142	270
Others	0	0	0	0	0	0	1	0	1	1	0	1
None	0	1	1	0	0	0	0	0	0	0	1	1
Total	548	735	1,283	440	406	846	421	521	942	1,409	1,662	3,071

Table 5: Distribution of respondents reporting reasons for not washing their hands by province and gender

Reasons for not washing hands	Other											
	Province											
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua			Total		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
No/insufficient water to wash hands	2	0	2	0	1	1	0	0	0	2	1	3
No soap available to wash hands	0	0	0	0	1	1	0	0	0	0	1	1
No ash available to wash hands	0	0	0	0	1	1	0	1	1	0	2	2
Don't understand the purpose/not important	0	0	0	0	1	1	0	0	0	0	1	1
Don't have time to	0	0	0	0	1	1	0	0	0	0	1	1
Don't know when to	0	0	0	0	1	1	0	0	0	0	1	1
Total	2	0	2	0	6	6	0	1	1	2	7	9

Rotate Statement

Table 1: Distribution of respondents giving their opinion that most people in this community do not have a toilet in their house by province, district and respondent's gender

Sex	Opinion that most of the people do not have a toilet	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M.garai	E.kang	Keerom	
M	Strongly Disagree	9	37	14	60
	Disagree	44	91	123	258
	Neither Agree nor Disagree	25	24	11	60
	Agree	80	30	25	135
	Strongly Agree	7	2	4	13
	Total	165	184	177	526
F	Strongly Disagree	11	35	7	53
	Disagree	56	87	120	263
	Neither Agree nor Disagree	35	27	16	78
	Agree	89	26	39	154
	Strongly Agree	4	3	1	8
	Total	195	178	183	556
Total	Strongly Disagree	20	72	21	113
	Disagree	100	178	243	521
	Neither Agree nor Disagree	60	51	27	138
	Agree	169	56	64	289
	Strongly Agree	11	5	5	21
	Total	360	362	360	1,082

Table 2: Distribution of respondents giving their opinion that most poor households in this community do not have a toilet in their house by province, district and respondent's gender

Sex		Others

	Opinion that most of poor households do not have a toilet	Province			Total
		NTT	SS	PP	
		District			
		M.garai	E.kang	Keerom	
M	Strongly Disagree	2	20	17	39
	Disagree	31	81	107	219
	Neither Agree nor Disagree	23	30	16	69
	Agree	99	50	34	183
	Strongly Agree	10	3	3	16
	Total	165	184	177	526
F	Strongly Disagree	6	13	7	26
	Disagree	32	75	112	219
	Neither Agree nor Disagree	42	43	13	98
	Agree	108	39	48	195
	Strongly Agree	7	8	3	18
	Total	195	178	183	556
Total	Strongly Disagree	8	33	24	65
	Disagree	63	156	219	438
	Neither Agree nor Disagree	65	73	29	167
	Agree	207	89	82	378
	Strongly Agree	17	11	6	34
	Total	360	362	360	1,082

Table 3: Distribution of respondents giving their opinion that a lot of people think that it is to expensive to have a toilet in their house by province, district and respondent's gender

Sex	A lot of people think that it is to expensive to have toilet in their house	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M.garai	Enrekang	Keerom	
M	Strongly Disagree	5	22	17	44
	Disagree	82	86	95	263
	Neither Agree nor Disagree	14	34	20	68
	Agree	55	34	44	133
	Strongly Agree	9	8	1	18
	Total	165	184	177	526
F	Strongly Disagree	9	14	15	38
	Disagree	93	82	96	271
	Neither Agree nor Disagree	18	34	29	81
	Agree	67	42	37	146
	Strongly Agree	8	6	6	20
	Total	195	178	183	556
Total	Strongly Disagree	14	36	32	82
	Disagree	175	168	191	534

	Neither Agree nor Disagree	32	68	49	149
	Agree	122	76	81	279
	Strongly Agree	17	14	7	38
	Total	360	362	360	1,082

Table 4: Distribution of respondents giving their opinion that in the community it is acceptable to defecate in the open by province, district and respondent's gender

Sex	In the community its acceptable to defecate in the open	Others			Total
		Province			
		NTT	SS	PP	
		District			
		M.garai	Enrekang	Keerom	
M	Strongly Disagree	21	31	27	79
	Disagree	133	87	116	336
	Neither Agree nor Disagree	5	36	17	58
	Agree	3	28	17	48
	Strongly Agree	3	2	0	5
	Total	165	184	177	526
F	Strongly Disagree	39	34	22	95
	Disagree	146	87	119	352
	Neither Agree nor Disagree	8	27	21	56
	Agree	0	26	20	46
	Strongly Agree	2	4	1	7
	Total	195	178	183	556
Total	Strongly Disagree	60	65	49	174
	Disagree	279	174	235	688
	Neither Agree nor Disagree	13	63	38	114
	Agree	3	54	37	94
	Strongly Agree	5	6	1	12
	Total	360	362	360	1,082

Table 5: Distribution of respondents giving their opinion that It's embarrassing when people can see others defecating in the open by province, district and respondent's gender

Sex	It's embarrassing when people can see others defecating in the open	Others			Total
		Province			
		NTT	SS	PP	
		District			
		M.garai	Enrekang	Keerom	
M	Strongly Disagree	0	0	15	15
	Disagree	4	24	93	121
	Neither Agree nor Disagree	0	23	20	43
	Agree	128	93	46	267
	Strongly Agree	33	44	3	80
	Total	165	184	177	526
F	Strongly Disagree	2	0	14	16
	Disagree	9	16	95	120

	Neither Agree nor Disagree	1	25	17	43
	Agree	130	85	51	266
	Strongly Agree	53	52	6	111
	Total	195	178	183	556
Total	Strongly Disagree	2	0	29	31
	Disagree	13	40	188	241
	Neither Agree nor Disagree	1	48	37	86
	Agree	258	178	97	533
	Strongly Agree	86	96	9	191
	Total	360	362	360	1082

Table 6: Distribution of respondents giving their opinion that most people feel ashamed to not have a toilet in their house by province, district and respondent's gender

Sex	Most people feel ashamed to not have a toilet in their house	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M.garai	Enrekang	Keerom	
M	Strongly Disagree	1	4	17	22
	Disagree	5	25	95	125
	Neither Agree nor Disagree	9	24	18	51
	Agree	123	90	43	256
	Strongly Agree	27	41	4	72
	Total	165	184	177	526
F	Strongly Disagree	1	2	16	19
	Disagree	6	26	86	118
	Neither Agree nor Disagree	16	29	21	66
	Agree	156	81	58	295
	Strongly Agree	16	40	2	58
	Total	195	178	183	556
Total	Strongly Disagree	2	6	33	41
	Disagree	11	51	181	243
	Neither Agree nor Disagree	25	53	39	117
	Agree	279	171	101	551
	Strongly Agree	43	81	6	130
	Total	360	362	360	1082

Table 7: Distribution of respondents giving their opinion that in the community Open defecation is acceptable when water is not available for toilet by province, district and respondent's gender

Sex	Open defecation is acceptable when water is not available	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M.garai	Enrekang	Keerom	
M	Strongly Disagree	11	24	22	57
	Disagree	134	91	118	343
	Neither Agree nor Disagree	15	29	18	62
	Agree	4	38	19	61
	Strongly Agree	1	2	0	3
	Total	165	184	177	526

F	Strongly Disagree	22	26	23	71
	Disagree	140	84	125	349
	Neither Agree nor Disagree	26	26	11	63
	Agree	7	39	24	70
	Strongly Agree	0	3	0	3
	Total	195	178	183	556
Total	Strongly Disagree	33	50	45	128
	Disagree	274	175	243	692
	Neither Agree nor Disagree	41	55	29	125
	Agree	11	77	43	131
	Strongly Agree	1	5	0	6
	Total	360	362	360	1082

Table 8: Distribution of respondents giving their opinion that many people don't want to build a toilet in their house because it smells by province, district and respondent's gender

Sex	Many people don't want to build a toilet	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M.garai	Enrekang	Keerom	
M	Strongly Disagree	19	27	16	62
	Disagree	140	104	134	378
	Neither Agree nor Disagree	3	22	14	39
	Agree	3	30	13	46
	Strongly Agree	0	1	0	1
	Total	165	184	177	526
F	Strongly Disagree	35	34	22	91
	Disagree	150	100	122	372
	Neither Agree nor Disagree	5	20	21	46
	Agree	5	23	18	46
	Strongly Agree	0	1	0	1
	Total	195	178	183	556
Total	Strongly Disagree	54	61	38	153
	Disagree	290	204	256	750
	Neither Agree nor Disagree	8	42	35	85
	Agree	8	53	31	92
	Strongly Agree	0	2	0	2
	Total	360	362	360	1082

Table 9: Distribution of respondents giving their opinion that people in the community do not mind if their daughters married a person who do not have a toilet in his house by province, district and respondent's gender

Sex	People don't mind if their daughters married a person who do not have a toilet	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M.garai	Enrekang	Keerom	

M	Strongly Disagree	2	5	23	30
	Disagree	53	96	114	263
	Neither Agree nor Disagree	62	44	15	121
	Agree	44	38	25	107
	Strongly Agree	4	1	0	5
	Total	165	184	177	526
F	Strongly Disagree	6	10	20	36
	Disagree	65	92	109	266
	Neither Agree nor Disagree	55	41	31	127
	Agree	62	34	23	119
	Strongly Agree	7	1	0	8
	Total	195	178	183	556
Total	Strongly Disagree	8	15	43	66
	Disagree	118	188	223	529
	Neither Agree nor Disagree	117	85	46	248
	Agree	106	72	48	226
	Strongly Agree	11	2	0	13
	Total	360	362	360	1082

Table 10: Distribution of respondents giving their opinion that there is no relationship between defecating in the open and people having diarrhea by province, district and respondent's gender

Sex	There is no relationship between defecating in the open and people having diarrheal	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M.garai	Enrekang	Keerom	
M	Strongly Disagree	13	12	25	50
	Disagree	136	101	129	366
	Neither Agree nor Disagree	4	38	8	50
	Agree	11	31	15	57
	Strongly Agree	1	2	0	3
	Total	165	184	177	526
F	Strongly Disagree	25	14	31	70
	Disagree	149	95	116	360
	Neither Agree nor Disagree	6	28	17	51
	Agree	14	41	18	73
	Strongly Agree	1	0	1	2
	Total	195	178	183	556
Total	Strongly Disagree	38	26	56	120
	Disagree	285	196	245	726
	Neither Agree nor Disagree	10	66	25	101
	Agree	25	72	33	130
	Strongly Agree	2	2	1	5
	Total	360	362	360	1082

Table 11: Distribution of respondents giving their opinion that most people think it is unnecessary to wash their hands WITH SOAP by province, district and respondent's gender

Sex	It is unnecessary to wash their	Others	
		Province	Total

	hands WITH SOAP	NTT	SS	PP	
		District			
		M.garai	Enrekang	Keerom	
M	Strongly Disagree	11	23	21	55
	Disagree	143	103	132	378
	Neither Agree nor Disagree	3	23	11	37
	Agree	7	33	12	52
	Strongly Agree	1	2	1	4
	Total	165	184	177	526
F	Strongly Disagree	14	27	30	71
	Disagree	168	95	119	382
	Neither Agree nor Disagree	6	19	16	41
	Agree	6	36	18	60
	Strongly Agree	1	1	0	2
	Total	195	178	183	556
Total	Strongly Disagree	25	50	51	126
	Disagree	311	198	251	760
	Neither Agree nor Disagree	9	42	27	78
	Agree	13	69	30	112
	Strongly Agree	2	3	1	6
	Total	360	362	360	1082

Observation Hand Washing

Table 1: Distribution of respondents reporting place of washing hands by the family members by province, district and gender

Sex	Place of washing hands by family members	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M.garai	Enrekang	Keerom	
M	Within 10 paces of the toilet facility (inside or outside)	70	98	84	252
	Within 10 paces of the kitchen/cooking place	67	74	39	180
	Elsewhere in home or yard	1	11	48	60
	Outside of yard	1	0	4	5
	No specific place	24	1	1	26
	Not allowed to observe	0	0	1	1
	None	2	0	0	2
	Total	165	184	177	526
F	Within 10 paces of the toilet facility (inside or outside)	80	81	69	230
	Within 10 paces of the kitchen/cooking place	85	78	58	221
	Elsewhere in home or yard	1	15	38	54
	Outside of yard	0	0	16	16
	No specific place	28	2	1	31
	Not allowed to observe	1	0	0	1
	None	0	2	1	3
	Total	195	178	183	556
Total	Within 10 paces of the toilet facility (inside or outside)	150	179	153	482

	Within 10 paces of the kitchen/cooking place	152	152	97	401
	Elsewhere in home or yard	2	26	86	114
	Outside of yard	1	0	20	21
	No specific place	52	3	2	57
	Not allowed to observe	1	0	1	2
	None	2	2	1	5
	Total	360	362	360	1082

Table 2: Distribution of repondents reporting the availability of water at the place of washing hands by province, district and gender

Sex	Availability of water at the place for washing hands	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M.garai	Enrekang	Keerom	
M	Water is not available	11	4	16	31
	Water is available	154	180	161	495
	Total	165	184	177	526
F	Water is not available	17	2	12	31
	Water is available	178	176	171	525
	Total	195	178	183	556
Total	Water is not available	28	6	28	62
	Water is available	332	356	332	1020
	Total	360	362	360	1082

Table 3: Distribution of respondents reporting the presence of soap or detergent at the place of washing hands by province, district and gender

Sex	Presence of soap or detergent at the place of washing hands	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M.garai	E.kang	Keerom	
M	Water only	20	20	25	65
	Soap and water	100	145	105	350
	Powdered or liquid detergent and water	45	9	46	100
	Ash	0	10	1	11
	None	0	0	0	0
	Total	165	184	177	526
F	Water only	21	18	17	56
	Soap and water	117	144	122	383
	Powdered or liquid detergent and water	57	8	44	109
	Ash	0	8	0	8

	None	0	0	0	0
	Total	195	178	183	556
Total	Water only	41	38	42	121
	Soap and water	217	289	227	733
	Powdered or liquid detergent and water	102	17	90	209
	Ash	0	18	1	19
	None	0	0	0	0
	Total	360	362	360	1082

able 4: Distribution of respondents reporting usual way of washing hands by province and gender

Usual way of washing hands	Other											
	Province											
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua			Total		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Water only	129	150	279	84	71	155	134	130	264	347	351	698
Soap and water	112	147	259	163	158	321	153	164	317	428	469	897
Powdered or liquid detergent and water	49	59	108	16	9	25	64	54	118	129	122	251
Ash	0	0	0	1	1	2	0	1	1	1	2	3
Dirt/sand/mud	0	0	0	1	0	1	0	0	0	1	0	1
Shook hands to dry	30	44	74	1	0	1	0	0	0	31	44	75
Used visibly clean cloth to dry	21	21	42	3	2	5	0	1	1	24	24	48
Used visibly dirty cloth to dry	6	3	9	0	1	1	0	0	0	6	4	10
Cannot demonstrate (lacks resources to demonstrate)	6	10	16	0	0	0	0	0	0	6	10	16
Unwilling/Refused to demonstrate	1	2	3	0	0	0	0	0	0	1	2	3
Total	354	436	790	269	242	511	351	350	701	974	1028	2002

Social Norms

Table 1: Distribution of households reporting the frequency of using toilet by household members by province, district and gender

Sex	Frequency of using toilet	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M.garai	E.kang	Keerom	
M	Never	7	5	2	14
	Rarely	4	2	0	6
	Sometimes	12	4	3	19
	Often	41	68	7	116
	Always	101	105	165	371
	Total	165	184	177	526
F	Never	5	3	1	9
	Rarely	3	0	9	12
	Sometimes	15	0	4	19

	Often	54	68	11	133
	Always	118	107	158	383
	Total	195	178	183	556
	Never	12	8	3	23
	Rarely	7	2	9	18
Total	Sometimes	27	4	7	38
	Often	95	136	18	249
	Always	219	212	323	754
	Total	360	362	360	1082

Table 2: Distribution of households reporting out of 10 households, how many members per households are using toilet by province, district and gender

Sex	Household members using toilet out of 10 households	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M.garai	E.kang	Keerom	
M	Nobody uses toilet in hoousehold	0	0	0	0
	Only one household	0	0	2	2
	Two households	1	0	8	9
	Three households	1	0	10	11
	Four households	0	2	10	12
	Five households	11	11	16	38
	Six households	15	4	19	38
	Seven households	21	13	17	51
	Eight households	39	36	23	98
	Nine households	4	26	20	50
	Ten households	73	92	52	217
	Total	165	184	177	526
F	Nobody uses toilet in hoousehold	0	0	0	0
	Only one household	0	1	2	3
	Two households	0	0	10	10
	Three households	1	1	11	13
	Four households	1	5	11	17
	Five households	11	10	26	47
	Six households	7	4	13	24
	Seven households	26	10	22	58
	Eight households	50	33	23	106
	Nine households	10	13	29	52
	Ten households	89	101	36	226
	Total	195	178	183	556
Total	Nobody uses toilet in hoousehold	0	0	0	0
	Only one household	0	1	4	5
	Two households	1	0	18	19
	Three households	2	1	21	24
	Four households	1	7	21	29
	Five households	22	21	42	85
	Six households	22	8	32	62
	Seven households	47	23	39	109
	Eight households	89	69	46	204
	Nine households	14	39	49	102
	Ten households	162	193	88	443
	Total	360	362	360	1082

Table 3: Distribution of respondnets reporting they belive that the people in the village should use a latrin by province, district and gender

Sex	Belief of the respondent to use the toilet by people	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M.garai	E.kang	Keerom	
M	Yes	165	183	176	524
	No	0	1	1	2
	Total	165	184	177	526
F	Yes	194	174	183	551
	No	1	4	0	5
	Total	195	178	183	556
Total	Yes	359	357	359	1075
	No	1	5	1	7
	Total	360	362	360	1082

Table 4: Distribution of respondents reporting that they belive that the people in village should use a latrine by province, and gender

Reasons that people should use a latrine	Other								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	M	F	Total	M	F	Total	M	F	Total
Because it is the right thing to do	121	144	265	182	173	355	157	166	323
Health Envirenment related reason	94	104	198	0	1	1	18	15	33
Personal Preference	24	25	49	1	0	1	2	1	3
External pressure	0	0	0	0	0	0	0	1	1
Others	101	111	212	1	1	2	20	17	37
None	0	0	0	0	0	0	0	0	0
Total	340	384	724	184	175	359	197	200	397

Table 5: Distribution of respondents reporting that he/she thnks that how many out of 10 people should use a latrine because it is the right thing to dy by province, district and gender

Sex	People out of 10 should use a latrine	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M.garai	E.kang	Keerom	
M	Nobody uses toilet	0	1	1	2
	Only one person	1	0	1	2
	Two persons	7	0	10	17
	Three persons	8	0	10	18
	Four persons	7	0	10	17

	Five persons	11	9	13	33
	Six persons	21	16	20	57
	Seven persons	14	10	32	56
	Eight persons	32	40	21	93
	Nine persons	2	16	28	46
	Ten persons	62	92	31	185
	Total	165	184	177	526
F	Nobody uses toilet	1	4	0	5
	Only one person	0	1	2	3
	Two persons	7	0	13	20
	Three persons	5	1	14	20
	Four persons	5	2	8	15
	Five persons	16	14	21	51
	Six persons	17	5	17	39
	Seven persons	21	14	27	62
	Eight persons	39	28	27	94
	Nine persons	4	16	23	43
	Ten persons	80	93	31	204
	Total	195	178	183	556
Total	Nobody uses toilet	1	5	1	7
	Only one person	1	1	3	5
	Two persons	14	0	23	37
	Three persons	13	1	24	38
	Four persons	12	2	18	32
	Five persons	27	23	34	84
	Six persons	38	21	37	96
	Seven persons	35	24	59	118
	Eight persons	71	68	48	187
	Nine persons	6	32	51	89
	Ten persons	142	185	62	389
	Total	360	362	360	1082

Table 6: Distribution of respondents reporting the result of defecation in open, if happened by province and gender

Result of defecation in open	Other								
	Province								
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua		
	M	F	Total	M	F	Total	M	F	Total
Financial penalty	0	0	0	0	3	3	1	2	3
Legal penalty	0	0	0	0	0	0	1	3	4
Community members scorn / punish	0	1	1	21	19	40	19	22	41

Nothing happens	149	173	322	155	153	308	153	149	302
Others	16	22	38	8	3	11	3	8	11
None	0	0	0	5	3	8	0	1	1
Total	165	196	361	189	181	370	177	185	362

Observation Sanitation

Table 1: Distribution of respondents reporting the location of toilet facility being used by family members by province, district and gender

Sex	Location of toilet facility	Others			Total
		Province			
		NTT	SS	PP	
		District			
		M.garai	E.kang	Keerom	
M	In own dwelling/attached to own dwelling	79	77	82	238
	In own courtyard	40	93	78	211
	Someone else's yard	2	0	0	2
	Other people's farm	1	0	0	1
	Outside the yard a bit away from home	0	0	1	1
	Refused/Not able to observe	43	14	16	73
	Total	165	184	177	526
F	In own dwelling/attached to own dwelling	83	76	74	233
	In own courtyard	49	86	91	226
	Someone else's yard	0	0	0	0
	Other people's farm	1	0	0	1
	Outside the yard a bit away from home	0	0	0	0
	Refused/Not able to observe	62	16	18	96
	Total	195	178	183	556
Total	In own dwelling/attached to own dwelling	162	153	156	471
	In own courtyard	89	179	169	437
	Someone else's yard	2	0	0	2
	Other people's farm	2	0	0	2
	Outside the yard a bit away from home	0	0	1	1
	Refused/Not able to observe	105	30	34	169
	Total	360	362	360	1,082

Table 2: Distribution of respondents reporting the kind of toilet being used by their families by province and gender

Kind of toilet	Other											
	Province											
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua			Total		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Flushed to piped sewer system	69	66	135	71	57	128	76	80	156	216	203	419
Flushed to septic tank	22	17	39	84	72	156	85	85	170	191	174	365
Flushed to pit latrine	13	15	28	18	35	53	35	25	60	66	75	141
Flush, don't know where	1	0	1	0	1	1	0	1	1	1	2	3
VIP latrine	1	3	4	0	0	0	0	3	3	1	6	7
Pit latrine with slab (concrete, wood/bamboo)	20	27	47	0	0	0	13	19	32	33	46	79
Pit latrine without slab/open pit	17	26	43	0	0	0	14	17	31	31	43	74
Composting toilet	14	15	29	0	0	0	0	0	0	14	15	29
Toilet using bamboo	1	0	1	0	0	0	0	0	0	1	0	1
Refused/Not able to observe	165	195	360	184	177	361	177	183	360	526	555	1,081
Total	323	364	687	357	342	699	400	413	813	1,080	1,119	2,199

Table 3: Distribution of respondents reporting the access to adequate water to meet the needs of flushing in toilet by province, district and gender

Sex	Access to water to meet the needs of slushing in the toilet	Others			
		Province			Total
		NTT	SS	PP	
		District			
		M.garai	E.kang	Keerom	
M	Yes	63	168	116	347
	No	12	1	17	30
	Don't know	0	1	2	3
	Total	75	170	135	380
F	Yes	61	158	112	331
	No	12	3	20	35
	Don't know	0	1	1	2
	Total	73	162	133	368
Total	Yes	124	326	228	678
	No	24	4	37	65
	Don't know	0	2	3	5
	Total	148	332	268	748

Table 4: Distribution of respondents reporting that the path to latrine is walked on by province, district and gender

Sex	Path to latrine is	Others			
		Province			Total
		NTT	SS	PP	
		District			

	walked on	M.garai	E.kang	Keerom	
M	Yes	95	127	111	333
	No	27	43	50	120
	Total	122	170	161	453
F	Yes	102	129	119	350
	No	32	33	47	112
	Total	134	162	166	462
Total	Yes	197	256	230	683
	No	59	76	97	232
	Total	256	332	327	915

Table 5: Distribution of respondents reporting visibly used anal cleansing material by province, district and gender

Sex	Visibly used anal cleansing material	Others			Total
		Province			
		NTT	SS	PP	
		District			
		M.garai	E.kang	Keerom	
M	Yes	55	154	78	287
	No	67	16	83	166
	Total	122	170	161	453
F	Yes	67	140	74	281
	No	67	22	92	181
	Total	134	162	166	462
Total	Yes	122	294	152	568
	No	134	38	175	347
	Total	256	332	327	915

Table 6: Distribution of respondents reporting their obervation regarding the availability of water for pour flush by province, district and gender

Sex	Availability of water for pour flush	Others			Total
		Province			
		NTT	SS	PP	
		District			
		M.garai	E.kang	Keerom	
M	Yes	102	153	126	381
	No	20	17	35	72
	Total	122	170	161	453
F	Yes	114	151	133	398
	No	20	11	33	64
	Total	134	162	166	462
Total	Yes	216	304	259	779
	No	40	28	68	136
	Total	256	332	327	915

Table 7: Distribution of respondents reporting their observation regarding detection of feces in the pit using flashlight by province, district and gender

Sex	Detected feces in	Others	
		Province	Total

	pit using flashlight	NTT	SS	PP	
		District			
		M.garai	E.kang	Keerom	
M	Yes	59	69	61	189
	No	63	101	100	264
	Total	122	170	161	453
F	Yes	61	58	62	181
	No	73	104	104	281
	Total	134	162	166	462
Total	Yes	120	127	123	370
	No	136	205	204	545
	Total	256	332	327	915

Table 8: Distribution of respondents reporting their observation that the slab is wet by province, district and gender

Sex	Slab is wet	Others			Total
		Province			
		NTT	SS	PP	
		District			
		M.garai	E.kang	Keerom	
M	Yes	78	98	91	267
	No	44	72	70	186
	Total	122	170	161	453
F	Yes	87	115	91	293
	No	47	47	75	169
	Total	134	162	166	462
Total	Yes	165	213	182	560
	No	91	119	145	355
	Total	256	332	327	915

Table 9: Distribution of respondents reporting their observation regarding the smell by province, district and gender

Sex	Smelly	Others			Total
		Province			
		NTT	SS	PP	
		District			
		M.garai	E.kang	Keerom	
M	Yes	65	10	73	148
	No	57	160	88	305
	Total	122	170	161	453
F	Yes	78	9	70	157
	No	56	153	96	305
	Total	134	162	166	462

Total	Yes	143	19	143	305
	No	113	313	184	610
	Total	256	332	327	915

Table 10: Distribution of respondents reporting their observations regarding the toilet by province and gender

Observations	Other											
	Province											
	Nusa Tenggara Timur (NTT)			South Sulawesi			Papua			Total		
	M	F	Total	M	F	Total	M	F	Total	M	F	Total
Path to latrine is walked on	95	102	197	127	129	256	111	119	230	333	350	683
Visibly used anal cleansing material	55	67	122	154	140	294	78	74	152	287	281	568
If Pour Flush water is available	102	114	216	153	151	304	126	133	259	381	398	779
Detected faeces in pit using flashlight	59	61	120	69	58	127	61	62	123	189	181	370
Slab is wet	78	87	165	98	115	213	91	91	182	267	293	560
Smelly	65	78	143	10	9	19	73	70	143	148	157	305
Total	454	509	963	611	602	1,213	540	549	1,089	1,605	1,660	3,265