INSTITUTIONAL DIMENSIONS
OF SCALING UP OF CLTS IN INDONESIA

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ABSTRACT
The study was focused on the institutional dimensions of the scaling up of CLTS. The key research question to be answered in the study is: What are the impacts of institutional arrangements on CLTS (speed of implementation, success of implementation and spread)? The study was conducted in three districts namely Pandeglang in Banten Province, Muara Enim in South Sumatera Province, and Sambas in West Kalimantan Province. The study found different incentives for different involving institutions. For the government institutions, the most important incentive was that CLTS supports them to achieve the objectives of their regular program. There is an indication of trade-off between level of institutionalization and the effectiveness of CLTS as community participation based approach. Fast spread of CLTS could produce lack of ownership among community members that could be a danger for the effectiveness and sustainability of CLTS. In order to function well in implementing CLTS, government institution required enabling environment related to the roles of health centres in particular. Health centres should be assigned greater authority in resource allocation, particularly: (1) to allocate the use of user fees collected from patients, and (2) to arrange proper assignment of village midwives depend on to villages need and midwives’ performance.

CLTS in Indonesia Context
Indonesia under Decentralisation Policy
Indonesia is a huge country with a population of more than 220 million. Administratively the country is divided into 33 provinces, 440 districts, 5,269 sub-districts and 69,919 villages. Not only big in size, but Indonesia is also very scattered with almost 14,000 islands. That gives a serious challenge for any institutions that want to cover the whole Indonesia in their activities. Practically, government is the only institution that has a potential to do that.

Decentralisation policy has been taking place since 2001 and devolved almost all of public service authorities (including health sector) to the local (district) government. Under the circumstances, by law, local (districts) governments are now responsible for water and sanitation issues. Before decentralisation, central government is the one that responsible for all sectors (including health and sanitation), while districts were only implementing agencies.

Every district is headed by a bupati (for regency or rural district) or a mayor (for city or urban district) who are directly elected by the community members. Also,

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1 The study is a collaboration between AKADEMIKA and Institute of Development Studies (IDS), University of Sussex, UK.
there are local parliaments (DPRDs) those the members are directly elected too. The two institutions (bupati/mayor and DPRD) are the key for formulating policies at district level, but the head of district is the one that responsible for implementation of the policies.

Health sector (including sanitation) at district level is handled by a health office (dinas kesehatan) under the head of district. There is a health office at province too, but that does not have direct link to the district health office.

The decentralisation policy gives authorities for districts to manage themselves, while provincial governments are in the position to represent central government. There is no direct connection between province and districts, but only coordination relationship. Also, the decentralisation policy implies no direct connection between ministry of health (at central level) with both provincial and district health offices. That is the significant difference to the situation before decentralisation era when district health office was under provincial health office and provincial health office was under the ministry of health (at central level).

**Milestones of CLTS in Indonesia**

The story of CLTS (community-led total sanitation) in Indonesia was started in middle of 2005 when the government of Indonesia launched CLTS in 17 villages in six provinces under Water and Sanitation for Low Income Communities (WSLIC) Project funded mostly by World Bank loan. In August 2006 the Ministry of Health declared CLTS as national strategy for the sanitation program. In September 2006, WSLIC 2 decided to change from revolving fund to CLTS in all (36) districts. At the same time, some NGOs started to adopt CLTS approach. During January to May 2007, in collaboration with the World Bank, the Government of Indonesia designed new sanitation program (PAMSIMAS/WSLIC 3) that includes CLTS (and sanitation marketing) in 115 districts. In that period, 160 villages achieved open defecation free (ODF) status.

July 2007 was also an important milestone of CLTS in Indonesia. At that time, the government (in collaboration with the World Bank) implemented project that adopt total sanitation approach namely Total Sanitation and Sanitation Marketing (TSSM). Also, ADB adopts CLTS approach in their sanitation program namely Clean Water, Sanitation and Health (CWSH) in 20 districts.

Generally speaking, CLTS approach has been successfully implemented in many villages through some projects in Indonesia. The big challenge is how to bring the implementation of the approach to the broader areas that would certainly need more than projects. Also, the quick adoption of CLTS as national strategy by the government has raised concerns on the level of understanding among the government officials at all level (central, provincial, district, village) about the CLTS concept.

**Challenge for Scaling Up**

It is quite clear that CLTS in Indonesia is characterized by the involvement of donor agencies through various water, sanitation and health (WSH) projects, as well as the NGOs. That could be a challenging situation, because scaling up of behaviour change is only possible in an environment free of external aid for
household toilet (Mukherjee, 2006), and the external aid is almost a “must” in a project.

Also, according to the World Bank (2006) they key challenge in Indonesia is the slow dissemination of the successful interventions, meaning that although the successful efforts have been demonstrated by a number of WSH projects, the sustainability and the spread of the successful approach to the broader areas across country are still left with big question mark. The problem is due not only to financial and capacity constraint, but also to the failure to stimulate self-sustaining adoption and expansion by the government at all level, districts government in particular. Since districts are the key institution with authority to handle health sector (including sanitation), that could be a challenging situation.

The involvement of government institutions is extremely crucial for the scaling up of CLTS. The government of Indonesia planned to scale up CLTS in 15 (out of 33) provinces in 2007-2011 (Ministry of Health, 2006). Actually the scaling up process has been taking place across district (indicated by the increasing number of districts interested in implementing CLTS) as well as within district (indicated by the increasing number of sub district or village implements CLTS). However, since CLTS is such approach that relies on community initiatives (instead of government interventions), a very crucial question for the scaling up process is: What kind of institutional arrangements suitable for the scaling up of CLTS (both within district and across district)? Such question is very crucial, because not every organisation is suitable for promoting CLTS (Kar and Chambers, 2008). Moreover, there are concerns about quality when good practices are scaled up (see Chambers, 2005).

The study was focused on the institutional dimensions of the scaling up CLTS, mainly to answer question: What are the impacts of prevailing institutional arrangements on CLTS with regard to its speed of implementation, success of implementation and spread?)

The study was conducted in three districts namely Pandeglang in Banten Province (where CLTS was initiated by international NGO), Muara Enim in South Sumatera Province (a WSLIC2 Project site with intensive roles of health centre), and Sambas in West Kalimantan Province (a CWSH Project with strong support from the head of district). The three districts were selected mainly because they are basically good in implementing CLTS. Different background of the three districts would give a chance to get a comparison of institutional aspects.

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<thead>
<tr>
<th>Table 1. Comparison among Three District Sites</th>
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<tbody>
<tr>
<td>Initator</td>
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<tr>
<td>Involvement of local government</td>
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<td>Involvement of province</td>
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<tr>
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**Involvement of Institutions**

*Institution Involved and Their Roles*

Implementation and spread of CLTS in Indonesia involve various institutions, both government and non-government institutions. The general picture of the institutions involved can be seen in Table-2.

**Central Government (Ministry of Health)**

Generally speaking, the two main roles of the ministry of health (in the decentralisation era) are signalling and formulating policy in health sector. Up to now, the ministry (and other ministries too) still acts as an executing agency because the decentralisation process is still in the transition and most of the districts (which actually has the authority) are still weak in term of capacity to take over the sector from central government.

Ministry of Health, particularly General Directorate of Disease Eradication and Environmental Health, is the key institution at central level in implementation of CLTS in Indonesia. Related to CLTS, in a national forum attended by representatives from provinces in 2006, the Minister of Health announced that CLTS was adopted as national policy to be implemented in all regions in Indonesia.

From the point of view of CLTS, national policy that was announced verbally (without official letter) could be positive or negative. In one hand, that gave a clear sign that CLTS approach was acceptable by central government and could be followed by provincial and district government without un-necessary pressure, but in the other hand, that kind of policy was not widely known and not strong enough to encourage all institutions at all level, especially for those need official policy. For example, one head of health centre in Pandeglang was completely unaware about the policy and questioning whether there was an official letter on that.

Beside in policy formulation, central government was also involved in delivering CLTS trainings, particularly trainings for provincial and district staffs, as well as monitoring the development of CLTS implementation across country. The monitoring was only done indirectly by compiling data from projects using CLTS approach under the ministry or relying on the reports from provincial and district...
health offices\(^2\), and at the same time expecting reports from NGOs those implementing CLTS. That situation has produced unavailability of reliable data on the development of CLTS implementation in Indonesia.

Recently, the Ministry of Health has established Technical Team for Community Based Total Sanitation or STBM (Sanitasi Total Berbasis Masyarakat). STBM is actually an “official” Indonesian term for CLTS. The technical team consists of Ministry of Health persons those are assigned to coordinate and implement CLTS under the ministry.

Working Group
Working group (kelompok kerja or pokja) is a typical institution that involves some different government agencies. According to the bureaucratic practices in Indonesia, one office cannot coordinate other offices at same (or higher) level. Ministry of Health (or Health Office at district level), for example, has no authority to coordinate Ministry of Education (or Education Office at district level), although everybody knows about the need for the coordination. The authority to coordinate other offices those actually at the same level is only owned by Bappenas at central level or Bappeda at district level. The general role of the working group is to try innovative or new ideas before being transferred to the technical ministries.

Related to CLTS, at central level there is a working group for drinking water and environmental health (Pokja AMPL) chaired by government official from Bappenas with members from ministry of health, ministry of home affairs, and ministry of public works. Actually, they are in the front row of promoting CLTS as well as training provincial and district officials, at least in the initial stage of CLTS implementation in Indonesia. However, as reflected by its name, the working group is not only working on CLTS.

Some provinces and districts have Pokja AMPL too. Provincial Pokja is under the governor and district Pokja is under the head of district. There is no direct connection among Pokjas at different level of government, although the formation of district or provincial pokjas is initiated by central Pokja AMPL.

Beside AMPL working group, there is a CLTS technical team (tim teknis) under the Ministry of Health. Unlike Pokja that does not work only for CLTS, the CLTS technical team is specifically established for CLTS. By design, the technical team was prepared to take care or anything about CLTS at the ministry.

Provincial Government and Provincial Health Office
Among the three research sites, the role of provincial government was only clearly seen in South Sumatera where the governor released special letter for all districts saying that they should implement CLTS gradually. Provincial Health Office followed up the letter by conducting trainings for all districts.

\(^2\) In the decentralization era, Ministry of Health does not have direct link to the provincial and districts health offices. To be discussed in other part of this report.
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<th>Institution</th>
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<th>Implementing</th>
<th>Monitoring</th>
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**Temporary (Project Based)
District and Sub-District Government
Responding the governor (of South Sumatera) letter, head of Muara Enim district released a decree to establish CLTS Technical Team to train the sub-districts. After being trained by district, interested sub-districts release a decree on sub-district technical team which not only train villages, but also implement CLTS at village level. Up to this study, there is no indication that other district in the same province was doing the same thing as Muara Enim. One of the key in Muara Enim is significant role of district health office and health centres to promote CLTS to the head of district.

District Health Office
Generally speaking, health office is the key institution at district level. The decision maker is the head of district, but she or he should get technical inputs from his or her staffs before making decision.

In this situation, the willingness of district to adopt CLTS was not only determined by provincial or central policy, but also by ability of district health office to convince the head of district. The case of Muara Enim as mentioned before is the clear example of the crucial role of district health office in influencing the head of district to make a “good” decision/policy on the CLTS.

Beside conducting training for sub-districts, in Muara Enim and Sambas, health office did the triggering too. That was not happened in Pandeglang, because CLTS was not adopted yet as local government’s policy. However, the “no reject” position of local government of Pandeglang so far is enough for everybody to implement CLTS there.

NGO
NGOs role in sanitation is not new in sanitation programs. For example, for SANIMAS (sanitasi masyarakat or community sanitation) project (funded by World Bank), local NGOs are always involved as local partner.

In three research sites, the role of NGO could only be seen in Pandeglang, where the international NGO (Project Concerns International or PCI) was the initiator of CLTS in 2006 and then continued by local NGO (Harfa3) since 2007 up to now. NGO was involved in every steps of CLTS implementation, except policy formulation that was the authority of the government.

It is important to note, that CLTS is not the only program of PCI, and for Harfa too. PCI used Posyandu Tumbuh Kembang (integrated post for early child care and development) as an entry point for its programs, and CLTS came later time. The balance between the two programs in the pilot villages depends on the local people’s need, and partly by the preference of program officer4.

Harfa is basically an institution for collecting and delivering zakat (similar to tax for moslem) which the goal is to improve the welfare of the poor and change their status from receiver to the contributor of zakat. In that context of social welfare

3 Harfa is the abbreviation of “harapan dhuafa” that literally means hope of the poor
4 One program officer was appointed for some pilot villages.
Harfa also has improving health program which CLTS is part of the health program. In the other words, CLTS is not the main program at Harfa.\(^5\)

However, in other regions some NGOs are involved through several CLTS or CLTS related projects. At least three other NGOs were identified namely: Gates Foundation, Plan International, and GTZ (in collaboration with German Bank for Reconstruction).

**Health Centre**

Health centres in Muara Enim are very active to promote, to train, to trigger, to work closely to the community, and to monitor CLTS. In Pandeglang, some villages were triggered by health centre, but not many, because in general the health centres there only supported the NGO CLTS works.

Meanwhile, the role of health centres in Sambas is not seen in four CLTS villages visited by the research team. One of the reasons is because health centre is not always available in sub-district in Sambas. Based on guess book in the village office, district health office officials and CWSH project officials were the ones that visited several time to the villages, while there was no indication of the appearance of health centre persons.

**Village Midwives**

The active roles of village midwives could only be seen in Muara Enim. There are at least two reason behind the limited role of village midwives in Pandeglang: (1) CLTS is still managed by NGO, and NGO hired specific facilitator for every CLTS village, village midwives only helped NGO facilitators, and (2) It is very rare for village midwives in Pandeglang to stay in their assigned village, that made them difficult to give an intensive interaction with local community (to be discussed more later in this paper). Meanwhile, all four villages those were visited do not have village midwives yet.

**Volunteer (Cadre)**

*Posyandu* cadres are women voluntarily help village midwives to manage the *posyandu* (integrated post for basic health care). They are all unpaid, or (in Pandeglang) given a very small money that usually they gave it back to support *posyandu* activities.

In the case of Pandeglang, where CLTS facilitators are NGO people, the cadres helped the facilitators to implement CLTS. In Muara Enim, they helped midwives, while in research sites in Sambas there was no role of cadres, mainly because there was no midwife available yet.

**Natural Leader**

There are some reasons why certain people were considered as natural leader, but the main thing is ability to give “something” to the community members. Sometimes it relates to materials, but usually not. In Indonesia, it is very often that religious leaders are considered as (informal) community leaders too.

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\(^5\) Harfa’s CLTS program is funded by an international NGO (Charitas). PCI helped Harfa to access the funding.
The role of natural leaders is very important, usually more important than the village formal leaders’ role, especially in implementing and monitoring CLTS. It can be said that without natural leaders, the implementation of CLTS would not be as good as expected. Meanwhile, in the case of formal leaders, that was great if they support CLTS, but “no reject” position (meaning they cannot give direct support, but let other people to manage the activities) was enough for facilitators to implement CLTS.

**Donor Agencies**

Basically, donor agencies support all level of governments to implement CLTS. The World Bank was involved along with AusAid through WSLIC2 Project in 36 districts beside its involvement through WSP in TSSM Project in 29 districts in East Java in collaboration with Bill and Melinda Gates Foundation as well as an ambitious project namely PAMSIMAS/WSLIC3 which is in progress to cover 110 districts in Indonesia. ADB is managing fund from Government of Dutch, Government of Canada and Government of UK in CWSH Project in 20 districts.

**Relation among Institutions**

Relations among institutions involved in CLTS are influenced very much by the whole institutional arrangement in the country, particularly after decentralisation policy took place in 2001 (please see Figure 2).

That kind of institutional relationship could influence the spread of CLTS to all districts, because in this case, the key institution to adopt (or not adopt) CLTS is district governments. But, it is the central government (not Ministry of Health) who has authority to “push” local government to adopt CLTS approaches. Sectoral policy released by technical offices (for example: Ministry of Health) is not strong enough to be a “must” for districts. In this case, Ministry of Home Affairs is more influencing than other departments. That is why the involvement of the ministry in the working group at central level is very crucial. Moreover, that reflects the situation that in the decentralised system, the role of central government to scale up CLTS is still very important. Without influence of central government, the decision to adopt CLTS is fully on the hand of head of districts.

As illustrated by Figure-2, the direct connection among local government, district health office, health centre and village midwives indicates that the chain is very important in the spread of CLTS, together with the chain that connects local government, sub-district government and village government. If the two chains work well and have a good coordination between them, ones could expect that the implementation and spread of CLTS in districts will work smoothly.

Anyway, the relations between parliament and government at all level should not be forgotten. The role of parliament is growing as part of transition in democracy practices in Indonesia. In some cases at district level, the parliaments are even politically stronger than local governments. That indicates, at least, that efforts to influence local government to adopt CLTS should not sideline the parliaments.

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6 Discussion about “pushed” scaling up for CLTS will come later in the other part of this paper.
The relation between NGO and local government in this study is also interesting to see. Institutionally, of course, there is no connection between NGO and the government. However, in the case of Harfa in Pandeglang, two District Health Office staffs (but not in the environmental health section) are also the key persons at the institution, even more one of them is the chairman of Harfa Pandeglang\(^7\). Up to now, the impact of such individual connection to the internalisation process of CLTS to be local government program (not NGO’s anymore), whether positive or negative, is not clear yet.

**Resource Allocation**

At the involving institutions, CLTS is taken care by certain people or section, but that people or sections do not work only for CLTS. At all government health institutions (Ministry of Health, Provincial Health Office, District Health Office and Health Centre), CLTS is put as part of environmental health program that covers not only CLTS related programs.

In the case of Muara Enim, where the district government gives authority to health centres to manage their fund, resource allocation at health centre level depended on the policy of the head of health centre. For illustration, for 2006/2007 Lembak Health Centre in Muara Enim has put environmental health program as the top

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\(^7\) Harfa headquarter is in Serang, the capital city of Banten Province, because by law, a managing zakat institution like Harfa should be at province level. However, Harfa Pandeglang is autonomous to headquarter with obligation only to report its activities.
priority among the health centre programs (the other programs were staff development, integrated services centre and out-patient services). In that case, most of time of health centre staffs in 2006/2007, sanitarians in particular, was allocated for CLTS. That allocation can be changed if the direction of the health centre program is changed by the head of the health centre.

Even for NGO, who is the main player in CLTS in Pandeglang so far, facilitators are the only actor those allocate 100 per cent of his/her time for CLTS. For higher level position than facilitators, NGO staffs have other responsibilities than facilitators. That was applicable both for international NGO (PCI) and local NGO (Harfa).

**Institutionalisation Dilemma**

Basically, the objective of institutionalization is to include CLTS as part of official government program/approach. Institutionalization is necessary for the spread of CLTS, because government is the only institution has ability to cover all areas across country (in this case: Indonesia). Without institutionalization, CLTS would only be implemented in limited areas, or even in the short term. However, in some other cases, rapid institutional take-up of CLTS has raised some dilemmas and challenges (Kar and Pasteur, 2005).

As mentioned before, up to now, most of CLTS activities in Indonesia are still based on projects, or as part of NGO activities. In that situation, at least two institutionalization processes have been taking place to scale up CLTS in Indonesia namely: (1) transfer process from project based activities to regular government program, and (2) transfer process from NGO to government, particularly local governments.

For the case of transfer of CLTS project activities to be government program, Muara Enim is an interesting case. As described before, South Sumatera Province/Muara Enim Regency is the only research site that has official policy in adopting CLTS. The head of district released a letter of formation of CLTS technical team that was enough as a sign that he supported CLTS to be implemented in his district. It is not a surprise if the spread of CLTS in there is much faster than in other sites.

However, the speed of spread of CLTS as a result of institutionalization is not without “cost”. Compared to Pandeglang and Sambas, regarding motivation to accept CLTS, “order from higher government” as a reason was clearer in Muara Enim. In contrast, CLTS in Sambas looked more “natural”, but the spread was quite slow. That phenomenon indicates the trade-off between the “quality” of CLTS (as a bottom up approach based on community need) and its speed to spread.

Also, the case of Tengguli Village in Sambas shows that sometimes inter-villages learning process through informal communication as indicated by WASPOLA (2007) did not happen easily. The next village of Tengguli did not adopt CLTS,

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8 In one interview, head of Lembak Health Centre said that there is a village that implement CLTS because of indirect “mental pressure” from the head of health centre who visited the village frequently.
although the villagers, as well as village government officials, could have seen what Tengguli villagers had been doing to have better sanitation. The finding was consistent to what has been discussed extensively by Deak (2008) that spread of innovation is not such a linear process. In this case, the initiative by external institution was needed to encourage certain villages to follow the successful villages (in implementing CLTS).

Generally speaking, top-down approach is not considered as a good thing for CLTS (see Kar and Chambers, 2008; Kar and Bongartz, 2005). That was justified in practice, because the top-down approach could produce a low quality of implementation of CLTS as illustrated by Muara Enim case. However, observation in the field suggested that if a bottom-up approach is strictly used, the spread of CLTS could be limited as illustrated by Sambas case. That is an indication that if spread of CLTS is still an objective, there is no choice to compromise with a top-down approach.

That was the analogue chase to the recommendation for CLTS to be flexible in some areas where subsidy of sanitation hardware cannot be avoided (Kar and Bongartz, 2006). The question then is up to what level the top down approach is still acceptable. Based on observation in the field, the acceptable top down approach cannot be deeper than sub-district level. Otherwise, the result would be counter-productive for CLTS. The use of instruction at village level or lower could produce outputs those are not much different to other approach that “corrected” by the idea of CLTS: fake or short term ODF status or even toilet building without ODF due to non-demand based situation.

Meanwhile, in the case of Pandeglang, transfer of ownership of CLTS from NGO to local government was too slow. Up to now, when CLTS has been there for more than two years, the impression of CLTS as “NGO’s program supported by local government”, instead of “local government program supported by NGO”, is still very clear. One of the keys is lack of political will from the Head of Pandeglang District to adopt CLTS9. In the longer term, that situation could be a danger for CLTS in Pandeglang. If nobody can convince the head of district, CLTS in Pandeglang would never more than NGO’s programs.

**Incentive, Reward and Sanction**
CLTS is an approach that heavily relies on demand from public. Under this circumstance, “motivation” becomes one of critical point in implementing CLTS. Whoever is involved, at any stage, must have motive or incentive to continuously maintain CLTS practice. Therefore, the fundamental question in the study is: Why they choose to be involved or implement CLTS?

*For Government Institutions*
For government institutions, the main reason in adopting CLTS was the fact that CLTS supported their own programs. This was clearly observed in South

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9 A rumour was mounting that the head of district does not like CLTS approach due to unseen role of government (covered by non-government’s role).
Sumatera Province\(^{10}\). The province is the only one (out of three observed provinces in the study) that had specific policy to enforce CLTS practice by issuing Governor Letter. From regulatory perspective, Governor Letter does not have strong enforceability. However, the Governor Letter had been adequate for Provincial Health Office in following up many programs to impose the implementation of CLTS.

The Governor Letter was issued due to provincial Health Office’s insistence in having “legal authority” to speed up CLTS implementation. Health Office cited CLTS practices encouraged environmental health programs. Public environmental health programs consisted of three components: (1) use of toilet, (2) clean water provision, and (3) healthy residence. CLTS was considered as “cheap” approach, since funding was only needed for assistance, monitoring and evaluation purposes.

Similar cases occurred at District Health Office, particularly in Muara Enim and Sambas\(^{11}\). CLTS was admitted because it was proven to support local Health Office, especially sanitation program (environmental health). Nevertheless, there was an important difference between these two local Health Offices. In Sambas, health office first adopted CLTS and then implemented it, whereas in Muara Enim, health office only adopted CLTS after observing successful implementation of CLTS in Lembak Sub District that was initiated by WSLIC project.

At sub-district level, Public Health Centre (Puskesmas) had been the primary institutions in exercising CLTS. The head of Health Centre in Lembak (Muara Enim) was aware that environmental health was one of its responsibilities. One of main indicators in public health programs was public coverage of toilet use. Upon receiving CLTS training, including opportunity to visit other districts that have adopted CLTS, the Head of Lembak Health Centre mulled CLTS an aid to carry out its public health programs. In other words, Lembak Health Centre acknowledged CLTS was an integral part of environmental health program within the institution.

On the contrary, health centres in Pandeglang regency did not consider CLTS as one of their responsibilities. Although they recognized CLTS as having a good approach, one head of health centre in Pandeglang believed CLTS was principally NGO activities. Health centres supported CLTS practices—as reflected in the health centre staffs involvement in many CLTS activities conducted by NGO. However, they did not perceive CLTS as part of their jobs since there were “no instructions”\(^{12}\). That was an indication that transfer of ownership process from NGO to local government (including health centre) was not complete yet.

There has been no strong indication that CLTS was able to create political incentive for government officials, particularly at village level. In many villages in

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\(^{10}\) That did not happen in Banten and West Kalimantan, although all governors heard the same declaration of adoption of CLTS by the minister of health. One of the key factors was the role of WSLIC officials at province that cannot be found in two other provinces (not WSLIC sites).

\(^{11}\) In other location (Pandeglang), Health Office had only “encouraged” CLTS, but not officially adopted it.

\(^{12}\) This case indicated that CLTS pledge as national program without formal policy was not effective from dissemination perspective.
Muara Enim where midwives had focal roles in CLTS implementation, almost every candidate endorsed by the midwives could win in village head local election. However, the case could not be replicated in Pandeglang. One village head candidate who was very involved in supporting the success of CLTS in his village lost an election as the study was conducted. The case in Pandeglang showed that CLTS did not provide enough “selling points” in political contest. The Muara Enim case could be perceived as triumph for village midwives’ personal influence, rather than CLTS’s.

Surely, the whole story could not be considered as CLTS’ “failure”. As an empowerment-based approach, CLTS had already been an achievement when local people are aware that they need good sanitation and are ready to dedicate their own resources to a healthy living. Successful CLTS is observed when general public believe in and are willing to make an effort on their own initiatives and led by local leaders (see Kar and Chambers, 2008). From this point of view, CLTS could serve as credit point for lower-level bureaucrats to their superiors. But, not vice versa as was demonstrated by Head of Lembak Health Centre’s “objection” (though never outspokenly stated) to claims by regency Health Office that CLTS in Muara Enim was a regency initiative. The Head of Lembak Health Centre considered the successful implementation of CLTS in Lembak as her initiative.

In some cases, CLTS does provide certain incentive for bureaucrats. There was credit point from the implementation of CLTS, but not from “below”, but from much higher-level bureaucrats. A token of appreciation from central government (Ministry of Health) was one of major factors in inducing local initiative to adopt CLTS practice. While local government had not explicitly mentioned this type of gratitude as their reason to implement CLTS, they seemed beaming proudly to obtain central government’s approval to their performance in exercising CLTS in their regions.

For Community
At CLTS-adopted villages, there were two groups: “innovator” group and “follower” group. While both considered toilet building was beneficial to them, they had different reasons in accepting CLTS. Or, at least they had different psychological characteristic. Innovator group accepted CLTS due to their own needs to having better sanitation for their environment. On the other hand, follower group accepted CLTS because they were invited or (at certain level) pressured by innovator group.

Innovator group had always existed in any adopted-CLTS districts, but in Pandeglang district, its existence had been formalised in a team, which was called

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13 This is very different, for example, compared to political incentive in managing football clubs by head of districts using public fund (which is very normal in Indonesia where football is very popular), because good achievement of football club would give political advantage for next election. (Now Indonesia has a regulation to prohibit local government budget allocation to football clubs).

14 The main task of district midwives was taking care of pregnant mothers and under five-year-old children. Midwives were very likely to be very “close” to local people as midwives’ works were tangible to them.
Tim Pemberantasan Tai/Waduk\textsuperscript{15} (Faeces Eradication Team) at village level—consisting of around five to eight people. The Team attempted to persuade other households to build toilet by selecting targets for each member of the Team based on their close relationships to the targeted households. Persuasive approach was conducted through various ways, including offering free massage service by one of team members who had the skill. For adamant households, the ultimate step was to build them toilet and hoped that they would be embarrassed. In Muara Enim, social sanction was directed towards these households in much-harder way which was by catapult their houses.

The case in Sambas Regency was different from the ones in Pandeglang and Muara Enim. As mentioned earlier, toilet building as part of CLTS implementation in Sambas was shared in a community (one toilet for approximately 5-10 households). Unlike in the former two locations, toilet building was coordinated by formal institutions, namely households group or RT (rukun tetangga)\textsuperscript{16}. To build communal toilet, every household has to contribute Rp 50,000,- or a bit more than five US dollar. For those who were not able to contribute that much, there was free-interest loans which could be repaid by instalments. In other words, “pressure” for public in adopting CLTS practice (toilet building) in Sambas was inserted in a more “formal” way.

Under the above circumstances, there was no surprise that only few households responded question “why built a toilet” with normative answers such as “want to live healthier”. Answers to the question varies from “because our elderly parents could not go to rice-field for toilet purpose”, or “because it was instructed to”, or “because we felt uncomfortable to others”, or simply no clear answers. These various answers were reflected in daily use of toilet by a household. There were some cases, minority in numbers, where members of a household that have built toilet still defecated in an open area (rice field, backyard or river)\textsuperscript{17}. These showed that CLTS success should not be measured only by coverage of toilet construction and/or toilet use by household, but should also taken into account whether people still defecate in open area\textsuperscript{18}.

Up to now, government has no reward system for regency, district or community who had successfully applied CLTS (with ODF status). In Muara Enim, local government initiated reward system based on bottom-up approach. The system would give community something they really need (ie: road, electricity, school building, etc) if the achieved ODF status. Another reward system was developed by PCI for CLTS-adopted districts based on public needs assessments such as CWSH project in Sambas. ODF-status districts/villages were rewarded facilities/public goods according to its needs, for example: clean water facility,

\textsuperscript{15} “Tai” and “waduk” are considered offensive terms for human excrement.
\textsuperscript{16} RT is the lowest government structure that comprises around 40 households.
\textsuperscript{17} Even in Pasirmulya District, Sindanglaya Village in Pandeglang Regency that was considered ODF-status district, some people still excreted in open area.
\textsuperscript{18} The main CLTS implementation indicator is ODF, but in practice, the most commonly-used indicators were building coverage and toilet use. These two indicators of public health programs had existed in every Puskesmas visited by research team in research locations. However, ODF status achievements in every district were available only at Lembak (Muara Enim) Puskesmas.
roads, electricity, etc. From idea perspective, the system was good (at least, compared to cash-based rewards) since it was based on public needs assessment and would benefit most from community. Unfortunately, when the system was put into practice, new problem emerged due to the fact that some public needs provision were not under local government authority. For instance, regular electricity provision was the domain of PLN (a state owned enterprise for electricity). Local government had difficulties to keep its promises unless they could provide non-regular electricity production which was not from PLN. Unfulfilled reward promises in one village would adversely affect motivation in other villages.

In Sambas, there were no rewards for village heads who had applied CLTS. According to local health office, this was due to concerns that local government would not be able to fulfil its rewards. Nevertheless, local government could facilitate provision of specific public goods for CLTS-adopted villages. For illustration, local community in Tengguli village had been long for telephone lines, therefore, local government encouraged certain telephone service provider (state owned enterprise) to build network tower in surrounding village. As of now, local people can enjoy telephone access in their village.

Besides government ability in fulfilling rewards, there are other reasons why reward system must be designed prudently. First, up to now, there was no verification system available to review ODF status of villages. A review could determine whether it was short-lived or sustained in longer period of time. Second, rewards were not aligned with basic principle of CLTS which was needs-based practice. If good sanitation is desirable, it does not need rewards to accomplish it. Third, a switching effect should be seriously considered. Rewards (and punishments) could also affect the level of other related activities. Rewarding one “good” thing can induce people to do less of other good things (Whitman, 2007).

For an Individual
Discussion on incentive/motivation for an individual was focused at CLTS champions at various levels. In the case of Muara Enim, CLTS seemed to come to the right person, that was the head of health centre in Lebak sub-district (please see Box 1). In this case, “champion” was in position to “look for” the right approach for their institution, and as they had strong determination to implement self-motivation principle, they immediately found and believed CLTS was the most appropriate approach. This had shown that search for “champion” could be done by initially identifying an individual who had and implement “self-motivation” principle in their life/jobs.

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19 In PCI case in Pandeglang and CWSH Project in Sambas, rewards had always been provided in the form of clean water facility. In both areas, many households still experience difficulties in clean water provision.
20 Self-motivation principle stated that the success or failure was determined more by inner motivation. External factors could only support, but not as key factors.
21 So far, “champion” naturally emerges. Considering champion’s central role in CLTS dissemination efforts, there should be special efforts to find “champion” (and not only depend on natural process).
Strong influence of health centre head had recently posed dilemmatic problems to CLTS spread and sustainability in Muara Enim. Ibu Agustin’s role in CLTS spread and implementation was as strong as ever. But on the other hand, she would not serve as head of health centre in Lembak sub district forever, and nobody knew where her next assignment would be. In a dialog in Lembak Health Centre, Ibu Agustin and district midwives who had been front runners in CLTS practice at Lembak sub district were not sure whether the practice would be maintained properly once Ibu Agustin had not been head of the Health Centre anymore and had been assigned to other jobs outside Health Office or to other location. Some village midwives explicitly mentioned that they were determined to work hard for CLTS “because of Ibu Agustin”.

As the head of health centre, Ibu Agustin always had priority program for her health centre at sub district level. When she was in her first year as Health Centre Head in 2001, her priority was internal improvement in her health centre. In the following years, she started to develop other programs including taking notice to the fact that some midwives were misplaced, and improving posyandu (integrated post for health service). In 2006/2007, priority program to be implemented was environmental health. At that time, Muara Enim (or specifically Lembak sub district) was one of WSLIC project area. Ibu Agustin was introduced to CLTS by WSLIC through training in East Java. Ibu Agustin immediately felt that CLTS (which had depended heavily on motivation of its users) was a perfect complement to environmental health program in her health centre’s working area.

Meanwhile, story on Ustdaz Encep was slightly different. He was a natural leader at kampong level. In religious community of Pasirmulya Kampong (Sindanglaya Village), Ustdaz Encep was a prominent person because he was praying teacher for children. The most interesting was that initially Ustdaz Encep was against CLTS— not because of its basic idea, but more because CLTS was brought to Pasirmulya Kampong by a foreign institution (PCI). From his parents, Ustdaz Encep was advised to be cautious of anything foreign—particularly if they are related to children. His attitude slowly changed, due to two things: (1) observing clear result from PCI programs, when his child who was previously considered malnourished was taken care of and the child’s condition was improved, and (2) PCI had carried out personal approach and conveyed that PCI’s key mission in relation to CLTS was to “encourage people to have healthy living”. Gradually, supported by open minded attitude of Ustdaz Encep, PCI approach was successful as it resulted in Ustdaz Encep’s recognition of CLTS and even making him one of “champion” to influence or invite other people to adopt CLTS in Pasirmulya Kampong.

There was a rumor that Ibu Agustin would be assigned to an important position in Health Office Muara Enim. But in a dialogue with research team, she revealed her plan to move outside Muara Enim.
Actually Ibu Agustin had sought to prepare successors among her staffs in Lembak Health Centre—especially sanitarians (environmental health staffs). It had been quite successful since two former sanitarians were already promoted as head of health centre in other sub districts. It was expected that they would implement CLTS in their new sub districts—just like in their previous Lembak sub district. However, it did not happen as expected. The reason is not clear yet, but at least this fact demonstrated that there was “something” in Ibu Agustin that could not be easily replicated.¹²³

Meanwhile, the case of Pandeglang showed that some champions could be the people who have already seen that CLTS had brought good impacts on the livelihood of the villagers or for themselves. Moreover, some of them could be the opponents of CLTS previously.

Based on the case, CLTS supporters should not be frustrated by public figures who are against CLTS at the beginning of the process. As long as they were sincere and open-minded for discussion, there were always possibilities to accept CLTS practice—even to further promote them as CLTS champions in their respective districts.

**Lessons for Enabling Environment**

*Village Midwives Assignment*

An important principle in scaling up is to ensure that the system should be able to run without any sophisticated inputs (Narendranath, D., 2007). That means project-approach that hired specific persons or built new specific organisations for CLTS is not suitable institution for the scaling up of CLTS. Instead, the use of existing persons and organisations is recommended.

In the earlier part of the report, it had been explained that one of key factors in successful CLTS spread in Muara Enim was the positive role of health centres and village midwives which was a result of enabling environment. One of crucial factors in CLTS successful implementation, particularly in its introduction stage, was the existence of facilitators in answering various questions, encouraging public, coordinating with local opinion leaders, etc.

One of the cases was in Pandeglang, where PCI as CLTS initiator recruited a facilitator who worked and stayed in the assigned village. When the local NGO (Harfa) was appointed to continue PCI works, they did not require the facilitator to stay in the assigned village. Then, it became apparent that CLTS implementation was not as intense as when it was managed by PCI. This showed

¹²³ In a conversation, Ibu Agustin said that if she had a will, then she would not stop until it was accomplished.
that the existence of facilitator with close proximity to community members was very crucial.

For village midwives, they were instructed (by law) to reside in the assigned village in order to work effectively. In Lembak sub district (Muara Enim), all village midwives stayed in their designated village, just as stipulated in the regulation. Therefore, village midwives could play similar function as PCI facilitator in Pandeglang. However, in Pandeglang, only very few village midwives lived in the assigned village. In Sambas, village midwives’ roles in CLTS villages were nowhere to be seen—although midwives resided in 142 villages (out of 186 villages).

Learning from those cases, it was imperative that necessary condition that village midwives must reside within the village should be satisfied if CLTS was to be adopted with village midwives’ involvement (as hired hand of health centres). In areas where number of village midwives were in fact adequate, there should be enforcement so it is mandatory for midwives to live in the designated village. Weak (or no) enforcement would result in less influential role of midwives as facilitator in CLTS implementation, and the function should be replaced by other individuals who resided in the village.

There were other problems related to village midwives’ role that needs to be resolved—not only by requiring them to live in the assigned village. Community characteristics of one village were different from other village. Midwives could work effectively when they were able to adjust themselves to and have good interaction with local people. Since midwives had different characteristics and personalities, there were at least two things that need to be considered to in assigning a midwife to an appropriate location: (1) ability to identify local characteristics in every village, and (2) authority to assign village midwives in suitable locations according to the midwives’ characteristics. Both were existed in Lembak Health Centre (Muara Enim). The Head of Lembak Health Centre had an ability to identify public characteristics in every (18) villages under her authority. At least, she knew villages that had “unique” characteristics and needed to be assisted by midwives with specific characteristics. In case where village midwives were assigned in a unsuitable (to the midwives’ characteristics) location, the Head of Health Centre could relocate them to a more suitable area. The authority could also be extended to performance-related case, so that the Head of Health Centre had powerful authorization to enforce village midwives to work well, including in CLTS implementation.

Resource Allocation Authority
An authority to allocate resources (funds) was an important factor in health centre involvement. One of health centre activities was providing curative treatment to the public for a small user charge. In Muara Enim, these fees were solely managed

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24 Besides that, currently there were 50 people being trained as village midwives with scholarship facility.

25 The term “specific” was related to communication style, for example: there was a village with direct (to-the-point) and tough way of communication (compared to other villages), thus required “strong” midwife who was able to communicate smartly.

26 Village midwives assignment was secured by Decree of Head of District Health Office
by the health centres to finance their own programs/activities, and were only required to report the amount of revenue and its detail use to the local government\textsuperscript{27}. With this arrangement, health centres would not find any difficulties in funding CLTS-related visits to some villages provided that environmental health program (CLTS) was included as its priority program. Decision to include CLTS as priority program would not mean anything if there was no adequate fund to implement it or if the health centres did not have authority to allocate resource according to its priority program\textsuperscript{28}.

From three study locations, only Muara Enim had an authority to allocate resources. In Pandeglang and Sambas, head centre had to transfer all its revenues to local government as part of local revenue (pendapatan asli daerah) before acquiring its operational budget “allowance” through local budget (APBD). Such as difference was a no surprise, since in current decentralization era, local government had authority to regulate these things.

It should be noted that health centres did not have specific budget to fund CLTS-related visits. At Health Office level, similar thing happened. There was budget allocation for training purposes, but only available for planned training activities. Funding for CLTS-related visits was usually taken from monitoring and evaluation budget (which was not specific for CLTS). Health Centre (and/or Health Agency) had not always needed to allocate specific fund for CLTS-related visits. However, CLTS implementation would be much improved if health centres (and/or Health Office) allocated special budget for this particular purposes, or if they had authority to allocate resources to meet what they need.

\textit{Inter-Sector Cooperation}
Sanitation (including CLTS) involves many sectors such as: health, education, public works, etc. Therefore, inter-sector cooperation was needed to implement CLTS as government program—with certain sector took charge as leading sector. Improper institutional arrangement would hinder execution of sanitation program (including CLTS), or at least would make it loose its cross-sector characteristics. The existence of working group (Pokja) AMPL and CLTS Technical Team as discussed in earlier part of the Report was an effort to deal with cross-sector involvements.

Nevertheless, working group or technical team was not the only alternative to sort out inter-sector coordination problem. At central government level, Coordinating Ministry for Public Welfare could work as connecting point to sanitation program with cross-sector approach. At provincial or regency level, there was Provincial/District Secretariat who could also do similar function at local level. These institutions even had an “advantage” due to its permanent status, thus, provided sustainability guarantee while working group and Technical Team only had ad hoc status. On the other hand, as mentioned briefly in earlier part of the report, working group was more effective to carry out innovative programs or approach before it was adopted as “formal” policy. In addition to that, working

\textsuperscript{27} In several locations (outside study locations), similar mechanism was applied to local government-owned hospital.
\textsuperscript{28} Although CLTS was known as “inexpensive” approach, it still needed adequate funding, especially to conduct training and public visits (for triggering, mentoring, monitoring, etc.).
group also had better chances to form more solid teams since its members were representatives from established institutions.

Solution to this, perhaps, would be a combination between two types of cross-sector institutions—a working group and permanent coordinating institution (and was already established). The existence of working group was necessary at initial stage and more of a short-term in nature, at least until CLTS pilot project ended. When government decided to adopt CLTS for all regions, it would be better to assign CLTS implementation to permanent institution that had coordination function. Assignment to a certain technical institution (such as Ministry of Health or Health Office) could be also be done, taking into account the consequences of losing cross-sector characteristics unless there was some bureaucratic flexibility that allowed Ministry of Health or Health Office to take on coordinating responsibility with other Ministry/Office without the existence of special unit/institution.

**Beyond Sanitation: Flexible Working Hours**

As discussed in the previous parts, flexible bureaucracy is needed for an effective CLTS implementation. However, some evidences in the field indicate that not only CLTS need flexible bureaucracy, but to some degree, CLTS was able to make the bureaucracy more flexible and “friendly” to the community.

To implement CLTS, District Health office staffs (village midwives and health centre staffs in particular) have been familiar with a flexible working hour arrangement, especially in early stages of CLTS. Household visit to invite them to build toilet could be done more effectively in the evening when the head of household was already back from daily activities. Moreover, when building the toilet, local people were happy to be observed by village midwives, and that sometimes happened out of normal working hours. That means that as facilitator, village midwives, sanitarian and head of health centre should be ready to work anytime.

Although that looks simple, a flexible working hours is not easy to apply. First, because there is no government regulation saying that they should do that, meaning that there would not be a sanction for village midwives and sanitarians if they were not willing to do. Second, there is no financial incentive to do that, or of any, the amount is so small. Under the circumstances, only persons with high commitment and good understanding on how CLTS should be implemented are willing to work “anytime”.

**Learning Opportunities**

CLTS has also been a chance for local governments to learn each other. That was happened at least in the case of interaction between Pandeglang and Muara Enim that was facilitated by international NGO (please see Box 2).

Learning process was also happened within district. In Sambas, some village officials from Sagu Village and Semanjak Village visited Tempanan Hulu Village

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29 If a team consisted of non-individual members, technical institutions often sent different persons for different events. Thus, cross-sectoral cooperation would be in jeopardy.
(one of CLTS villages) without outside facilitation to learn about CLTS. Even Sambas Health Office knew about the visit only after the two visiting villages requested to be triggered by the Health Office\(^\text{30}\). That evidence indicates that inter-village/district visit as part of process CLTS spread does not always need facilitation for outside institution. The more important thing than the facilitation is dissemination of information about CLTS implementation to other villages/districts.

**Box 2. Inter-District Learning Process**

When the head of Lembak Health Centre (Muara Enim) was invited to train Pandeglang staffs, she used that chance to learn about “posyandu tumbuh kembang” (integrated post for early child care and development)\(^1\) that relatively new for her. After coming back from the visit, the Head of Lembak Health Centre implement the concept in her working area. In short, Pandeglang learn about CLTS from Muara Enim, Muara Enim learns about “posyandu tumbuh kembang” from Pandeglang.

However, it is important to note that inter-district/village visit is not always identical to the learning process. It is not rare, that visiting districts/villages did not take any action to follow up the visit. Eventually, that is back to the issue of motivation among the participants of the visit.

**Conclusions**

The spread of CLTS in Indonesia faced a challenge of shifting CLTS position from project-based activities into government regular program. CLTS could potentially produce incentive for government institution since CLTS supports the accomplishment of health programs conducted by government institutions at all level. Nevertheless, this potential benefit may not materialize because it will also depend on level of knowledge, interpretation and attitude of key officials in government institutions. Therefore, the spread of CLTS must be initiated by intensive information dissemination within government bureaucracy in order to give clear picture on basic idea of CLTS and how CLTS could be back health program achievements, particularly in the area of environmental health.

Although the institutions developed by CLTS projects seemed to functioned well, they may not imply that similar approaches could be applied across regions in spreading stage. Project-based institutions were effective, but they need plenty of inputs. This is because these institutions were specifically created and tended to be differed from existing institutions. The spread of CLTS had better performed by existing institutions – without establishing a new one. A recommended institution is community health centre (puskesmas) with sanitarian and village midwives as front-runner in undertaking facilitator function at village level. The biggest challenge is availability of village midwives and their willingness to live in their assigned village. As discussed before, only by staying continuously in their village that these midwives could function well as facilitator.

\(^{30}\) In Sambas, triggering was done by District Health Office.
An enabling policy environment is needed to support health centres’ function in implementing and spreading CLTS. The health centres should be given more authority to allocate their resources, particularly in: (1) using user fees collected from patients, and (2) determining assignments of village midwives based on village need assessment and their performance. In addition, another necessary condition, namely a flexible (at least, to some extent) bureaucracy system, should be present in order to cope with different field situation.

Rewarding ODF status achievement should be considered carefully since it may trigger off dilemmas due to inadequate verification system and inability of government officials to provide rewards. There is also as possibility of an adverse impact of reward to community initiatives that should also be taken into account, including switching effect in the form of negative impact to other things (non-CLTS).

Regarding that CLTS is a community-based approach this study indicated that there was a trade-off between level of institutionalisation and effectiveness. Quick spread could result in low sense of belonging among members of community – which could threaten sustainability and effectiveness of CLTS. On the other hand, pure bottom up approach that gives full authority to members of community to spread CLTS practices would result in more natural CLTS implementation. The approach is more likely to produce sustainable outcome, but the spread of CLTS would only progress slowly. Therefore, the spread of CLTS could be carried out by compromising top-down approach with participatory approach in implementation stage at village level to align with CLTS basic principles.

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