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WATER AND SANITATION
FOR HEALTH PROJECT

CARE

WASH Field Report No. 284

**CARE INDONESIA: INCREASING COMMUNITY PARTICIPATION
AND DEVELOPING A BASIC STRATEGY
FOR HYGIENE EDUCATION IN RURAL WATER AND SANITATION PROGRAMS**

Prepared for the USAID Mission to Indonesia
and CARE

under WASH Task No. 118

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by

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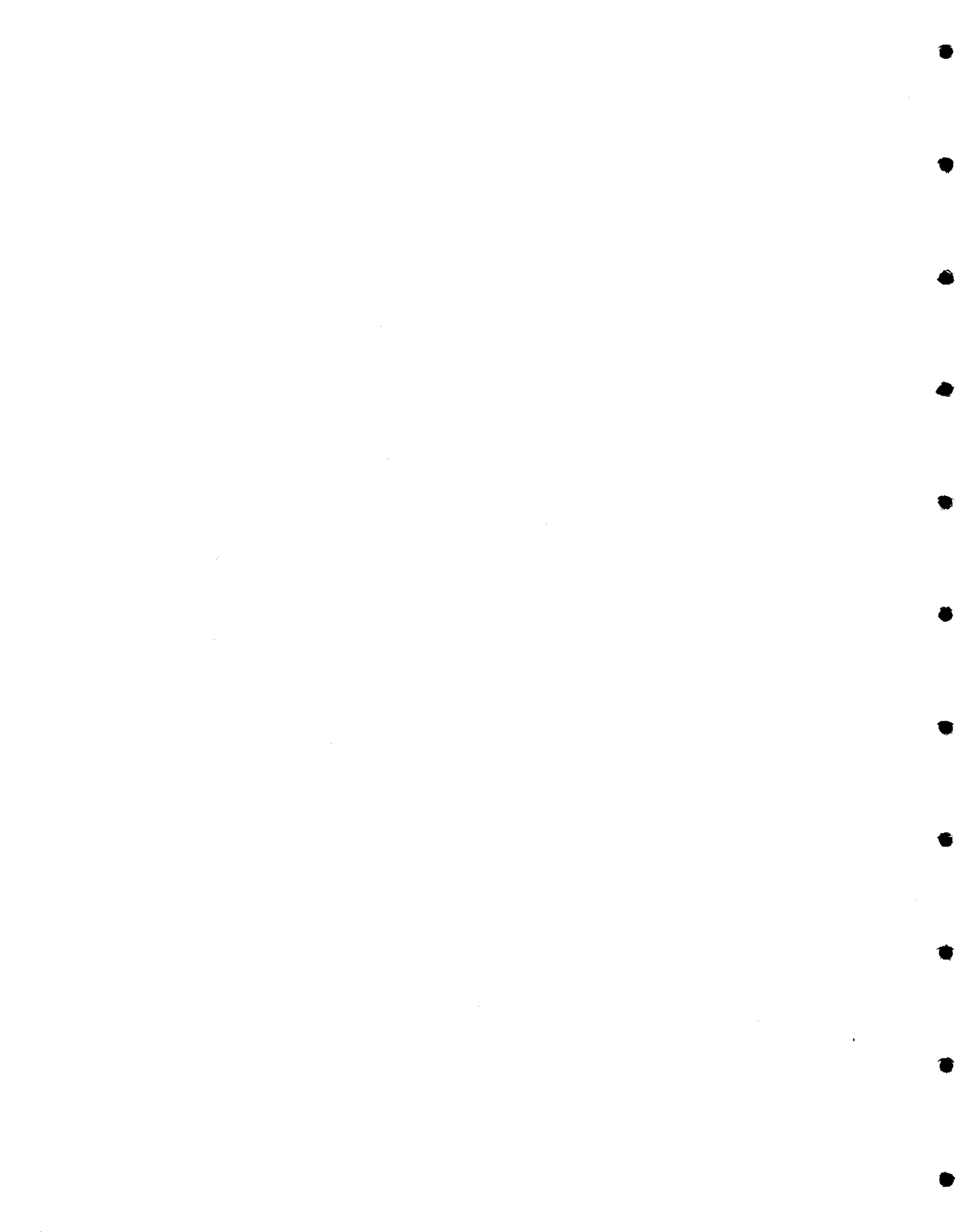
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ACRONYMS

CSFW	Community Self-Financing in Water
FO	field officers
GOI	Government of Indonesia
<i>kader</i>	voluntary health worker
NTB	Nusa Tenggara Barat
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
<i>Panitia</i>	village water committee
PHC	Public Health Care
<i>Posyandu</i>	village integrated health post
SRCD	Sulawesi Rural Community Development
WASHES	Water and Sanitation for a Healthier Environmental Setting



EXECUTIVE SUMMARY

This activity, conducted collaboratively by CARE Indonesia and WASH, was designed to assess and revise current hygiene/health education strategies in CARE's three water projects: Sulawesi Rural Community Development (SRCD), Water and Sanitation for a Healthier Environmental Setting (WASHES), and Community Self-Financing in Water (CSFW) in Java and Nusa Tenggara Barat (NTB). The team, consisting of CARE and WASH staff, spent three weeks in November 1989 meeting with project staff and observing field conditions. In collaboration with staff at each site, the team developed a comprehensive approach to community management. Because the approach and strategy used in hygiene education for a water project cannot be isolated from the overall management approach of that project, the team reviewed and made recommendations for strengthening the overall community management approach in each of the project sites. A strategy for hygiene education is integrated within this overall framework.

The objectives of CARE Indonesia's three projects in water and sanitation are to provide adequate access to water and expand coverage. The water projects are promoting primarily gravity-fed water systems, with a lesser emphasis on rain-water catchments and pumps. Other aspects of the projects include water-sealed latrines, garbage pits, animal pens, and house drainage (Sulawesi). The emphasis of the hygiene education program was on diarrhea-related messages, proper water storage, and sanitation. The educational program is conducted through village voluntary health workers (kaders) and managed by the health section of the water committee. The investment in the training of kaders is questioned.

The SRCD project began implementing its hygiene education component about seven months ago, while the WASHES and CSFW projects began hygiene education three months before the CARE/WASH review.

The following recommendations are made to strengthen the current program:

1. Improve the community management aspects of the infrastructure. This can be done by:
 - Improving site selection processes,
 - Making more of an effort to ensure that the appropriate people are selected to be on the village water committees (panitia) and striving to have the water committee institutionalized within the local village government,
 - Clearly outlining the roles and responsibilities of project and panitia,
 - Continuing to develop the quality of the operations and maintenance capability of the support communities, and
 - Providing wider technology options to the village representatives.

2. Develop more detailed criteria to determine whether a community is better suited to the WASHES or CSFW project.
3. Expand the training capability at provincial and headquarters levels. Ensure training is more task-oriented. Train field officers (FOs) to be better facilitators and strengthen the ability of water committees (panitia) to be trainers of community members.
4. Focus the basic hygiene strategy on sanitation and simple hygiene interventions. The hygiene messages should be based on current sanitation problems, behaviors, and beliefs identified by the village health committee.
5. Expand the messengers for health messages to include the most effective community "gatekeepers", for example, teachers and religious leaders. Emphasis should be placed on involving the village health committees more in determining needs, prioritizing interventions, and developing work plans.

Chapter 1

INTRODUCTION

Rural water supply and sanitation have been CARE Indonesia's primary programming focus since the 1980s. This assessment focuses on all three of CARE's water and sanitation projects in Indonesia: Water and Sanitation for a Healthier Environmental Setting (WASHES), Sulawesi Rural Community Development (SRCD), and Community Self-Financing of Water (CSFW).

In cooperation with the provincial governments, the WASHES project has constructed approximately 70 piped water systems and 250 rainwater catchment tanks and has installed 50 handpumps. Since 1987 SRCD has installed 119 gravity-fed water systems. CARE programs all focus on assisting rural communities develop their capability to understand, implement, and maintain their own water and sanitation systems.

During the past eight years, CARE Indonesia has been struggling to incorporate a suitable health/hygiene component into the existing water programs. In 1984, the first effort was made by CARE to develop a health component in the WASHES project. One community organizer was hired in West Java. For one year, the community organizer conducted community awareness meetings and focused on promotion of Posyandu (village integrated health post) and kader (volunteer health worker) activities at each target site. This approach was difficult to sustain and its actual impact was questionable. An evaluation was not conducted. In 1985, a Child Survival I Grant was secured. This child survival project was designed to be implemented at each water site and stressed immediate short-term results requiring CARE field staff to be highly operational.

Though the first phase of the child survival project was considered successful, it was determined that even greater potential impact might be possible over the long term if CARE changed the strategy and clustered project sites. As a result, continuing to combine the two projects proved to be impossible. The overall change in the child survival strategy and local political constraints associated with the WASHES project resulted in a separation of the two project activities into different locations.

These changes again left the WASHES project without a health component. In 1987, a great deal of mission energy was focused on community self-financing of water; health education was not considered a major priority at that time. It was not until mid-1988 that a third plan was prepared to provide WASHES with a suitable health component. The final health components developed in both the WASHES and SRCD programs were redesigned with the senior CARE staff in each of the field offices. General guidelines were prepared with the objective of developing the communities' capabilities to improve their own health status.

The basic educational approach was to target mothers or caretakers of children under five years of age and provide educational services through village kader on the causes and prevention of diarrheal diseases. A second approach was to be employed that would be directed toward the community as a whole in an effort

to improve basic village sanitation practices. Specifically, the goal was to improve community understanding and awareness of the need for selected sanitation and water use practices. This strategy was to be managed by local village leaders with the intention of increasing the targeted leaders' abilities to organize, implement, and monitor their own local health interventions.

The health component within the WASHES projects has just started to be implemented in two villages in each of the following three provinces: West Java, East Java, and Nusa Tenggara Barat (NTB). In July 1989, the WASHES senior staff participated in the development of a Detailed Implementation Plan (DIP). The actual implementation of the health component interventions began in early September after one week of training for the field officers was completed.

A specific strategy for incorporating a health/hygiene component into the CSFW project had not been developed at the time the technical assistance was provided.

The health component in the SRCD was revised in early 1989 and is being implemented in 10 sites. The CARE staff have received approximately three weeks of in-service training and are active in the selected villages.

The health component of the SRCD program was launched in 1980 with a simple pamphlet distribution at project sites on sanitary living, clean water benefits, and pest control. Occasional health talks by sub-district health personnel were arranged for the villagers.

Through a series of consultancies in 1982-83, an approach and training materials were developed for the provision of complete primary care services for South, Central, and Southeast Sulawesi. The approach consisted of the field officers training nutrition kader and school teachers in the villages and working closely with Posyandu and Puskesmas staff to provide water/sanitation, environmental health, immunization, nutrition, family planning, ORT, and first aid education.

After the new approach was tested in one site in South Sulawesi, the chief representatives in each province were to develop their own health care plans for Phase I sites. They were to be assisted by proposed health education field officers, one per province. In 1986, Dian Desa, an Indonesian NGO, conducted an evaluation of the SRCD program and concluded that the sanitation and health component had been executed in a "casual and listless manner, with marginal impact."

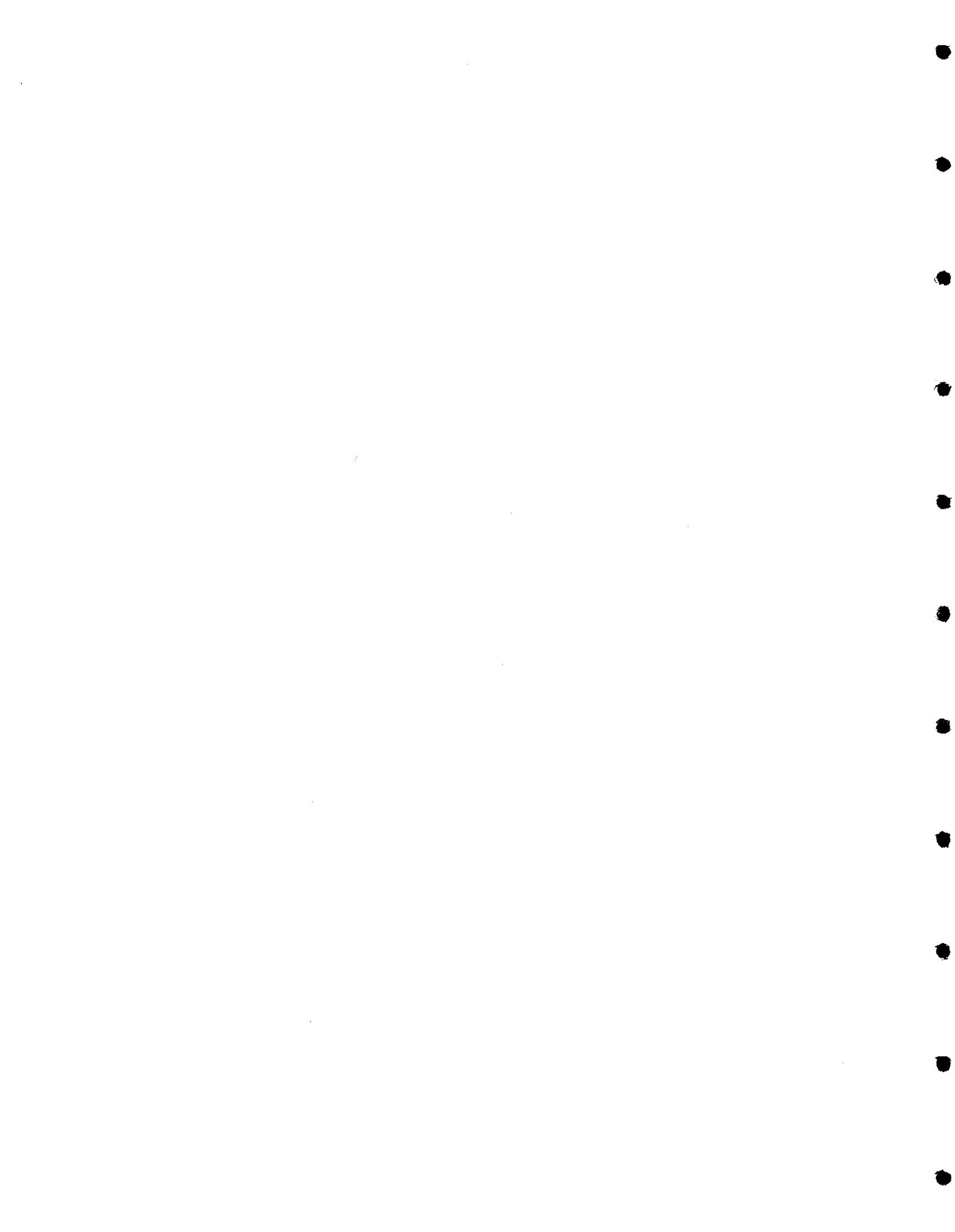
In 1987, four part-time doctors were hired to coordinate health activities according to the strategy outlined in MYP 87-90. Field officers and kader training programs were continued and reinforced. Monitoring and evaluation tools were designed, and a plan of supervision was initiated.

Though the SRCD field staff received related in-service training, they were frequently forced to work independently and the construction aspect of the water component became their dominating concern. In mid-1988, a detailed implementation plan that revised the focus of the health activities was again prepared. Rather than promote all the Posyandu services as well as kitchen gardens, latrines, and animal pen construction, it was decided that activities

would be directed toward reducing the severity of diarrhea, continuing construction of latrines, and incorporating basic sanitation education. In addition, pilot activities were planned in order to develop other components (e.g., nutrition) that could later be incorporated into the health section.

In 1989, a health support officer was hired to implement the new strategy in FY 1990 sites and to coordinate all health activities for the SRCD program. A field officer training program was initiated in February. Training emphasis was placed on the role of the field officer as facilitator in encouraging community participation in all phases for both the water and health components of the program.

By September 1989, twelve sites in South Sulawesi and eight sites in Central Sulawesi had received preparation and training in the new health strategy and in strengthening community participation processes. This included preliminary surveys of both target groups, field officers' training, community committee training, kader training, and monitoring.



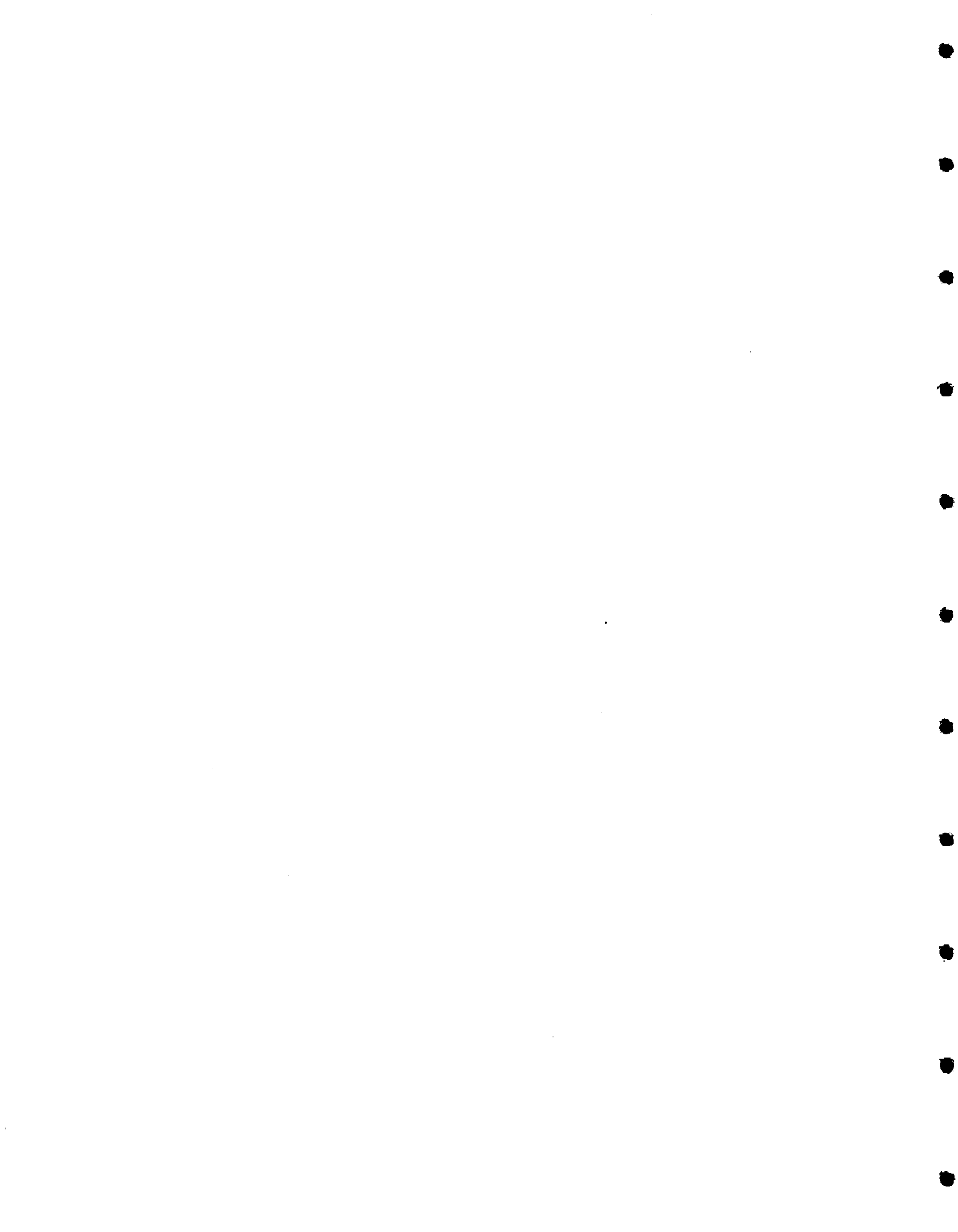
Chapter 2

TECHNICAL ASSISTANCE METHODOLOGY

To meet the scope of work objectives, the team consisting of WASH staff Dr. May Yacoob, CARE Assistant Country Director Dr. Frederick Henning, and CARE Regional Technical Advisor for PHC Dan O'Brien met in Jakarta for a three-day team planning session, visited project sites, and worked with local CARE staff in the provinces of South Sulawesi, NTB, and East Java.

During the four- to five-day trips to each project region, extensive interviews and observations were conducted in the target communities. The team, with assistance from translators, conducted two- to three-hour meetings with community leaders responsible for the water projects in each village, women, users of the water facilities, and health kaders. Extensive group discussions were also held with the CARE field office staff responsible for actual village contacts and implementation of project activities at the village level.

Following field site visits, the team met for one or two working days with all the senior project staff responsible for the water programs in each field office. During these meetings, findings and recommendations were jointly prepared and strategies for increasing community participation and integrating hygiene education were explored thoroughly.



Chapter 3

FINDINGS

The following findings and recommendations are not meant to imply that current strategies are inappropriate. In fact, CARE Indonesia has done a commendable job of decentralizing construction, getting high participation from communities in construction, and getting systems built at low cost. What follows are simply gaps in the current processes that, when filled, can make all three projects into water projects with community management capability as their central objective.

3.1 Disseminating Hardware: Operations--Maintenance

The three water projects, WASHES, CSFW, and SRCD, have been successful in disseminating "hardware", mainly by building gravity water systems, installing pumps, and constructing rainwater catchment facilities. Building latrines, drainage works, and garbage pits is also part of the project package. There is an effective system for reporting progress on the acquisition of hardware by villagers. There is also every reason to believe that the hardware in place, specifically the water systems, is being maintained by the respective village committees. Monitoring of water systems, however, is related more to delivery and less to management. Limited spot-checking by the technical assistance team indicates that collection of user fees may be erratic. Provisions for major breakdowns in the systems are also insufficient

3.2 Community-Based Institutions

The "Panitia" (Pembangunan Sarana Air Bersih)--the water development committee--that is to be trained by the project staff is not a permanent community committee. This committee dissolves soon after construction is completed. Another committee called "Badan Pengelola Sarana Air Bersih" (the water management committee), usually made up of many of the same members as the earlier committee, is appointed and trained to manage and maintain the system. It was claimed that most communities prefer this approach of separating the development committee from the management committee.

3.3 SRCD, WASHES, and CSFW Hygiene Education

Each of the project areas visited--South Sulawesi, NTB, and East Java--varies in its perception of where and how hygiene and health fit within a water project. South Sulawesi has tested the health strategy recently developed and was able to identify where and how the changes could be implemented. NTB was in the process of analyzing its strategy to determine how it has been doing business and to begin reformulating its approach. East Java has accepted the health component but has not yet understood how the pieces will fit together.

3.4 The Question of Subsidy

The WASHES project has gained the reputation of being able to generate 50 percent or more of water system construction costs from community members. Negotiations for subsidy levels frequently are based on the field officers' ability to make a "deal" with the community. At present, the primary determinant of subsidy levels is the ability of the communities to negotiate for as much subsidy as possible and that of the field officers to negotiate for a minimum amount. An economic survey that gives an indication of ability and willingness of communities to pay for water is being implemented at all sites. It is anticipated that the results of this survey will assist the management staff and communities to determine a fair level of subsidy if, in fact, any is required. Currently, much of the field officers' time is spent persuading communities to contribute financially to water projects.

3.5 Gravity System Bias

The strength of the project in the sites visited is primarily the installation of gravity-fed systems. The selection of new communities is largely influenced by the availability of a spring rather than by the need for water or the financial capability of the community to support the technology.

3.6 Attitudes and Perceptions

Roles and responsibilities between CARE and the community are often not spelled out up front. CARE staff do not regard themselves as entering negotiations with communities as two equal parties. Rather, the field officers regard it as their responsibility to bring the communities up to a higher standard and believe that village leaders cannot be expected to perform many important functions. The field officers' attitudes should be changed so that they have a more positive development approach.

3.7 Technical Quality Control

The field officers and their supervisors have the only technical capability in many of the provinces at present. From time to time, problems in the technical design of systems occur. The ability of the local field staff may not always be adequate to provide needed technical solutions or quality control. The issue of quality control is likely to become increasingly important as communities pay for their own systems. Cutting corners and jeopardizing quality for costs may become a problem.

3.8 Competing for Resources

Village community resources are not unlimited. Communities are being asked to pay for the construction of facilities, for the time and expenses involved in receiving training, and for sanitation packages. When communities do not

understand why these interventions are a part of a package in water projects, their primary interest frequently is only in the construction of systems.

In addition, as competition for financial resources in rural communities becomes more intense, the type of water facilities advocated becomes very important. Appropriate technology as well as the cost must be thoroughly explained to the community members, i.e., gravity flow as opposed to rainwater catchment.

3.9 Training and Training Methodologies

The backbone of community water and sanitation projects lies in the strength of their training capability. Training based on specific tasks and on experiential learning methodologies is currently being implemented in SRCD only. WASHES and CSFW tend to provide one-shot "workshop" training lasting 3-7 days two or three times in the course of an entire cycle. Training in health and hygiene is supported by local clinic (puskesmas) nurses or physicians and by other prominent government officials. CARE's role is to facilitate training opportunities, and, whenever possible, upgrade the quality of training in an effort to ensure continued sustainability of the activities. Frequently, training techniques include lectures that do not require participant participation. CARE staff need to become more proficient facilitators and must learn how to be better trainers themselves. At present, in the training sessions conducted, CARE staff have few improvements or alternative training techniques to offer.

3.10 Role of Field Officers

The implementation of community projects is still highly dependent on the field officers' drive and support. Their positions are more those of technical experts rather than facilitators of community-based institutionalization. The field officers' work time is not closely supervised nor are the outputs of the field officers' community meetings clearly defined. Field officers spend much of their time problem-solving in communities rather than monitoring and facilitating progress.

3.11 Broad-Based Participation: Involvement of Women

Community water committees (panitia) are primarily made up of men who are village leaders. The health sections of the committees are the only committee sections that may include women. The field officers accept the village committees' composition as a given. They do not see their role in negotiating a committee composition that is more broad based and includes candidates capable, both in skills and time, of carrying out committee duties. This, no doubt, contributes to the lack of sustained interest cited as a problem with several committees.

3.12 Health Messages and Messengers

Health and hygiene messages are pre-planned. Information on diarrhea, how to make oral rehydration solutions, and sanitation hardware construction are provided as one package. Mothers in Sulawesi with young children are viewed as an important target group. The kaders appointed by the village leaders are trained as the primary messengers. In almost all the sites visited, many of the kaders are young women of marriageable age with some literacy skills. Because kaders frequently lack the experience of marriage and child-bearing, they have not yet entered into the category of women with knowledge who command a level of respect. Field officers frequently complain that villagers do not respect the kaders and, as a result, the messages they provide are not respected or treated seriously. In some interactions observed by the technical team, the kaders were sent to do housework or the mothers already were aware of the information being provided. Other issues regarding kaders include a high attrition rate and low motivation due to lack of compensation. In general, the project determines the messages and messengers rather than allowing the communities and situation to dictate the most effective approach.

3.13 Environmental Sanitation Needs

The three project areas appear to vary greatly in their social and economic abilities and the need for sanitation. Environmental sanitation conditions and household behaviors seemed to be much better in sites visited in the SRCD project area than in the area in NTB served by WASHES. In SRCD and East Java, latrines are accepted and are used by community members.

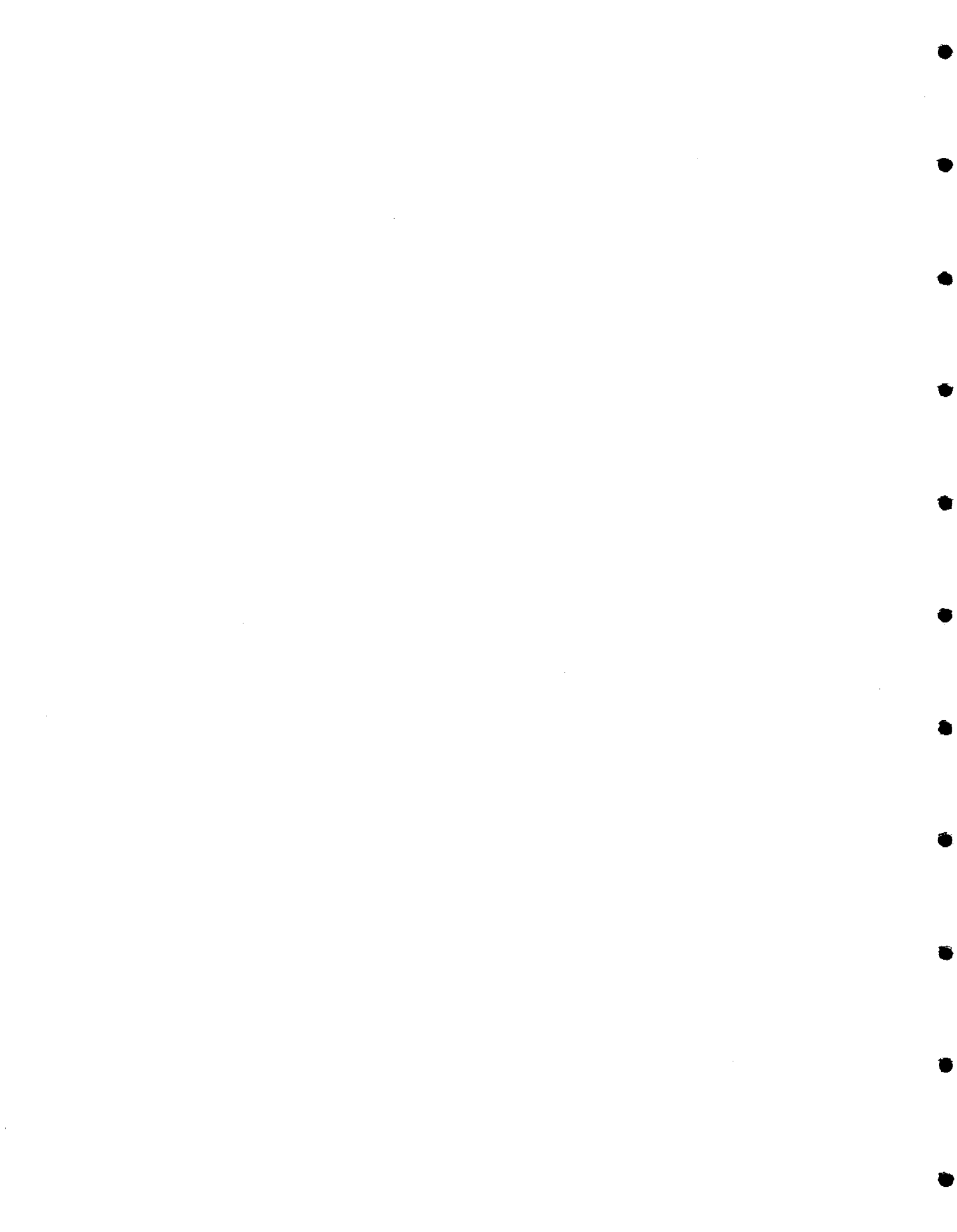
3.14 Government Involvement

CARE's strength and success in working with grass roots communities are very important and contribute to the organization's effectiveness. Government officials are included in some activities, but the purpose and expected results of their participation are not always clear. The perception of some government officials seems to be that CARE is a reputable "contractor" for water projects and is therefore best left alone to do its work.

3.15 Other Findings

- Panitia membership is often weak as a result of a hurried selection process.
- There is no effort yet to address the issue of chickens in household kitchens. They have been shown to be an important factor in transmitting diarrhea.
- Grey water was usually not disposed of properly in many communities in Java and NTB.
- Disposal of baby feces is a problem in many communities.

- Latrine technology options are required.
- There is a need for training personnel in each of the provincial offices.



Chapter 4

RECOMMENDATIONS

The team suggests that the objectives of the projects be refocussed from construction to community capacity-building.

WASHES and SRCD, and to a lesser extent CSFW, will need to make a conscious decision either to cut down on numbers of systems or build in the flexibility to extend the time frames for project cycles. This strategy choice will be necessary until the processes for community capacity-building rather than construction is more firmly in place and better understood by project staff. Initially, field officers should have two or three sites and should receive close supervision, continuous training, and clear instruction as to expected outputs from meetings with community members.

4.1 Long-Term Management Operations, and Maintenance

Communities cannot undertake major repairs of systems. However, dependence on CARE as the paternal figure, always available to step in, needs to be reduced. During the project cycle, the management skills of community members must be strengthened. Systems for regular fee collection and saving for eventual system replacement must be instituted. A provincial roving team of a technician and a community organizer could be trained by CARE and placed within the government structure. Alternatively, private sector technical capability could be identified, trained, and provided with appropriate tools and spare parts to undertake repairs that are beyond the means of community committees.

Other specific recommendations in this area are:

- Use the results of the operation and maintenance survey currently being designed to adjust qualitatively community management processes. Review the overall functioning of systems and the communities' ability to solve problems.
- Assist in selection of panitia membership.
- Negotiate and sign a contract detailing work responsibilities with committees in each village.
- Enhance CARE's own ability to conduct more comprehensive feasibility studies (social, technical, political, health, and economic) to 1) select sites and 2) improve negotiation procedures with communities.

4.2 Defining Hygiene in Water Projects

Hygiene education will need to be narrowed down to focus on environmental sanitation in all three projects. It is recommended that causes, treatments, and prevention of diseases, including diarrhea, should be included based on need. For example, if in the course of implementing an environmental sanitation program there is an outbreak of diarrhea, then its cause and the need for ORS preparation should be explained by the Puskesmas staff with only facilitation by CARE field officers. It is acceptable to promote ORT during the project cycle, but efforts should be made to ensure that ORT does not become the center of the educational approach. Instead, the educational strategy should focus on the communities' identified needs and the availability of existing resources.

4.3 Sustainability

Project staff and field officers need to understand how to develop community capability to manage and properly utilize resources. The ability to understand the concept of sustainability and the field level activities required to make it happen varies greatly from one project region to another. Training and sharing of experiences among project participants should be strengthened. Training should focus on how water systems, hygiene education, and community participation fit together as a total package. The training should also emphasize that the entry into a CARE/community partnership is based on a relationship between equals rather than patronization.

4.4 Expanding Empowerment

Participation and empowerment merely in constructing a water system and paying for it are not sufficient. The current objectives of WASHES and CSFW need to be broadened to include fostering the ability of communities to identify negative behaviors affecting community health and seek out solutions. Self-help projects are not a new concept in rural Indonesia. A review of past experiences, their application, and transferability to the management of water and sanitation resources should be consciously used.

4.5 Relationship between WASHES and CSFW

A more thorough economic survey needs to be included when the technical water feasibility study is being done. This is necessary to determine whether the community will be assisted by WASHES or CSFW and the percentage of subsidy needed. This will help in developing a coherent strategy for determining how much subsidy, if any, is needed in a particular community. Furthermore, communities' seeking to expand existing systems built by WASHES or the government seems to provide a foundation for future CSFW activities. In addition, as communities move along this continuum from WASHES to CSFW, there should be room for a "modified" CSFW implementation approach.

4.6 Expanding Technology Choice

CARE needs to base its site selection on the need for water rather than availability of springs. As more communities become CSFW, the question of technology options that are within the means of communities to operate and maintain will become increasingly important. Similarly, alternative latrine technology, e.g., pit, VIP, should be offered in addition to the current water-sealed latrine.

4.7 Demand Creation

CARE needs to explore more efficient ways to create demand for its WASHES/CSFW services. Although government and communities jointly participate in community development plans, there is every indication that field officers have to spend time generating business. Media or public education campaigns should be explored to create an awareness of the type of service CARE is providing.

4.8 Expand Staffing

It is recommended that CARE hire in-house trainers for each provincial office. In addition, part-time technical capability is needed to ensure quality control of systems and respond to any technical complications that surface.

4.9 Task-Oriented Training and Strategy

More time, effort, thought, and resources must be spent in training at all levels. Task-oriented training based on activities being implemented at the community level should be the heart of the training strategy. Methodologies based on experiential learning will mean more frequent training. The effectiveness of the training will also be based on the ability and the need of the community. The role of the field officer must change from implementor to facilitator. Instead of getting community tasks done, the field officers need to work with communities and accept the communities' decisions, for example, unwillingness to participate in the project. Committees, not field officers, should be used to gather and analyze data and develop workplans.

4.10 Strengthening the Participatory Process: Women and Committees

Water committees need to understand the vested interest of women in ensuring that water systems function effectively. Slowly and with great sensitivity, field officers need to ensure that women participate on the committees. If women are given responsibilities in fee collection and care of the reservoirs, they should be paid. Women's opinions and preferences in the location of reservoirs, washing areas, and latrines should be actively solicited. Field officers need to assist the community to select the best people to participate on the water committee. The roles and responsibilities of the community and CARE should be clearly outlined and formalized. As a first step, water committees can collaborate with a women's social group in each community.

Ideally, the results of this collaboration should be institutionalized and the water committee or panitia given more responsibility for managing existing water and health projects. This would increase management capacity to undertake future projects.

4.11 Messengers and Messages

The health section on the water committee should be expanded to include a wider range of important community members with access to various community groups. A teacher, a traditional birth attendant, a religious Imam, and a traditional healer should be part of this committee. They will each have access to a specific target group in the community. The dissemination of their messages will create a net in which all community members are included.

The messages should be identified by the committee as part of a workplan they participated in developing. These messages will be based on community behaviors identified by the committee.

4.12 Improve Government Participation

Long-term sustainability of projects will require a more conscious effort on the part of CARE to involve the government. The participation of government personnel in training activities, their understanding of why they are participating, and the expectation of specific outputs from them will help build their capacity to continue managing developmental projects in their respective areas.

Chapter 5

STRATEGIES

Based on the findings and recommendations, strategies for community project cycles were developed for SRCD in Sulawesi and WASHES and CSFW in NTB and East Java. The technical assistance team worked closely with managers and field staff in each province to put together the strategies. This process consisted of the following six steps.

- Review of current project activities, especially those relating to sanitation and hygiene, conducted by project staff in CARE's provincial office.
- Visits to project sites to interview government officials and community residents and to observe project activities.
- Interviews with the projects' field supervisors.
- Development of a flow chart depicting the projects' current major activities and decision points.
- Discussion of findings and recommendations resulting from the visits to project sites.
- Modification of the flow chart based on findings and recommendations.

This process varied slightly for the East Java office. During the discussion of findings from the field visit, project staff felt that the current project strategy is sufficiently effective and that modification was not necessary. Therefore, the findings and any resulting recommendations to modify the strategy for WASHES and CSFW in East Java have not yet been incorporated into the existing project strategies. The technical assistance team has, however, strongly suggested that CARE-Jakarta senior management review the overall findings and recommendations of this report along with the strategies developed for projects in Sulawesi and NTB with the East Java project staff. The technical assistance team believes project strategies being implemented in East Java would benefit from qualitative adjustments aimed at strengthening community management processes.

The focus of the new strategies for Sulawesi and NTB is on strengthening the project committees, formalizing the roles and responsibilities of the committees and CARE, involving the committees and community in identifying problems and developing solutions, and improving training at all levels. The key to successful implementation of the strategies is well-prepared and skilled field staff. Therefore, in addition to the strategies at the community project cycle level, a training strategy has been worked out. It has been designed to be flexible and responsive to the needs of the field officers so they, in turn, are

able to respond to the needs of the communities and where they are in the project cycle.

Listed below are the primary steps in the strategies developed by project staff in each province. They are organized by provincial office and correspond directly to the flow charts appearing in the appendix. In addition, the training strategy and its specific modules are outlined.

5.1 SRCD in South Sulawesi

During the course of developing the strategy, SRCD staff decided to focus on site selection, the formation of the committee, the negotiation of a contract with the committee, and the process for developing sanitation and hygiene activities. Therefore, other activities related to the project such as construction and finance are not listed. Staff intend to upgrade community management around the sanitation and hygiene activities and apply the lessons learned to the other sections at a later date.

STEPS

Surveyor and FO conduct technical, social, economic, political, and health feasibility study. These are short assessments designed to gather sufficient information to make decisions about entering the community.

DECISION POINT: Based on the feasibility study, the decision is made whether to enter or not enter the community.

FO requests site priorities for water systems from GOI.

FO identifies formal and informal leaders and other influential people in the community.

FO contacts district and sub-district GOI and local health centers to explain the project. The purpose is to orient the government officials to the project and to begin to establish linkages.

FO meets with the community leaders (formal and informal) to explain the project approach and the criteria for selecting a committee. The FO and community leaders set a date for a community meeting.

FO explains the project to the community at the meeting. Special emphasis is given to the selection of the committee and the importance of having members that represent various groups in the community. For example, school teachers, religious leaders, traditional birth attendants, traditional healers, and elected officials are suggested as possible members. The FO recommends that the community take some time to think about the committee and who the members should be.

The community leaders form the water and health committees. It is important that the FO leave the community and give it time to think about the committee's membership. The committee should consist of influential people in the

community, including women. It should also have sub-committees or sections for health, construction, finance, and others if desired.

Field officers and committee begin to negotiate. Together the field officers and committee members discuss and clarify their specific roles and responsibilities in the project. The negotiation process is likely to take several meetings.

DECISION POINT: Based on the results of the negotiation, the decision is made whether to continue to work with the community.

FO and committee sign a contract. The purpose of the contract is to formalize the roles and responsibilities they agreed upon and to symbolize the beginning of a partnership.

FO trains the health section of the committee to conduct a needs assessment and baseline survey in the community- a simple, informal data collection activity to investigate some of the water-related health problems and corresponding behaviors in the community.

Health section conducts the needs assessment and baseline survey in the community. FO and health section analyze the needs assessment and baseline survey data. During this activity, water-related health problems and behaviors are prioritized.

FO and the health section develop the workplan to address the priority problem(s) and behaviors. Specific messages and ways to deliver them are developed. Special attention is given to the target groups for the messages and the corresponding "gate-keepers" for these groups.

Health section implements the workplan. FO trains the health section in how to monitor and adjust the workplan. Simple monitoring tools like those used during the needs assessment and baseline survey are developed. The health section determines when it will monitor the activities and meet to make adjustments if they are necessary.

Health section continues to implement, monitor, and adjust the work plan.

5.2 WASHES and CSFW in NTB

Unlike SRCD staff, project staff in NTB decided to develop community management processes for each of the project's components: technical, financial, and health. Even though each component is developed, it would be wise for project staff to begin to build community management processes into the health component since it is the newest. Once experience is gained with this component, the same management processes can be built into the other areas.

STEPS

FO investigates the community for felt needs and for the health, social, and political situation. FO also determines technical feasibility for water system options.

DECISION POINT: Based on information from the community investigation, the decision is made whether or not to work with the community.

FO meets with formal and informal community leaders to explain the project and water system technology options. Technology options are based on the technical feasibility data ascertained during the community investigation. The FO also begins to negotiate concerning potential members of the committee with the community leaders. The FO emphasizes the importance of having committee members who represent various water user groups in the community.

Community leaders make a formal request in writing to CARE for the project.

FO verifies that the site meets the necessary criteria.

Community leaders select the committee. This is based on the suggestion of the FO and what he or she was able to negotiate. Also, the sections of the committee are formed. They most often will include health, technical, and finance.

FO meets with the committee to present and discuss cost estimates for the different types of water system technologies that are feasible for that community.

DECISION POINT: Based on the technology options and their costs, the committee decides on the type of water system(s) it wants.

FO and the committee begin to negotiate their specific roles and responsibilities that will be necessary to implement the project. The negotiation is likely to take several meetings. Also part of the negotiation is the total cost of the water system and how much money and other resources each party will contribute.

DECISION POINT: Based on the negotiation process, the decision is made on whether to continue to work with the community. The assessment of the negotiation process is based on the community's level of motivation, ability, and willingness to contribute resources, and overall readiness to undertake the project.

FO (representing CARE), a government representative, and the committee (representing the community) sign a contract which formalizes the roles and responsibilities of each party.

FO trains the technical section in how to conduct the technical survey which is determined by the type of water system technology.

FO trains the financial section in how to conduct the economic assessment (survey). This assessment is intended to be simple and based on several basic economic indicators.

FO trains the health section in how to conduct the health needs assessment. Like the economic assessment, the health needs assessment is based on several basic indicators associated with water-related health problems and their behaviors.

The technical, economic, and health sections conduct the corresponding surveys with the help of the FO.

The surveyor and FO design the water system and develop the budget. This is done in the CARE office.

FO and financial section analyze and tabulate the data from the economic assessment. The purpose of this activity is to involve the financial section in the analysis so they learn by doing.

DECISION POINT: Based on the economic status of the community and the type of feasible water system required, CARE determines to what level the community can afford to pay for the water system (i.e., 100 percent community self-financed or some level of subsidy).

FO and health section analyze and tabulate the data from the health needs assessment. In addition, priority water-related health problems and associated behaviors are identified.

FO presents the water system design and budget to the technical committee. The design is discussed and the technical section has the opportunity to modify it where technically feasible. Also the budget is discussed and compared to the earlier estimates. The technical section may wish to hold a community meeting to discuss the design options with other community residents affected by the decisions.

FO trains the technical section in how to develop a technical workplan. The plan is developed during the training. Specifically, the section determines what construction will take place and in what order. The FO facilitates the process. Part of the workplan will include task-specific training for whatever is being constructed (i.e., tanks, pipelines, standpipes, wells, handpumps).

FO trains the financial section on resource mobilization and management issues. Ideas for raising money and the corresponding record-keeping are covered. As a result of this training, the financial section develops a workplan to collect and manage resources.

FO trains the health section in how to develop and disseminate messages based on the results of the health needs assessment. The output of the training should be a workplan including specific messages, target groups for these messages, and appropriate "gate-keepers" for these groups.

Technical, economic, and health sections implement their workplans.

FO trains each section in how to monitor and adjust its activities to ensure smooth and effective implementation.

Each section continues to implement, monitor, and adjust its activities.

FO trains the technical committee in how to operate and maintain the water system as it is being constructed. This is in preparation for post-construction O&M activities.

Technical section begins to implement O&M activities to ensure proper functioning of the water system. This may include tank cleaning, minor pipe repairs, checks and adjustments for water flow, greasing parts, and so forth.

5.3 WASHES and CSFW in East Java

The following strategy was developed by project staff in East Java and represents what is currently being implemented. Although the staff felt the strategy did not need further refinement, the technical assistance team believes some qualitative adjustments could be made to strengthen community management processes.

STEPS

CARE reviews the list of potential sites for water projects based on inputs from GOI, field officers, and direct community requests. FO contacts the GOI sub-district office to confirm the proposed site. The site is taken from the priority list above. FO and sub-district staff visit the proposed site to assess the water potential and suggest the kind of water system technology.

FO conducts a community meeting. During the meeting, felt needs of the community are identified, technical training is planned, and persons who will participate in the technical survey are identified. FO conducts technical training and survey. For a gravity flow water system, this would consist of training in determining elevations and distances. This is considered on-the-job training. In FY 1990, this survey will consist of an economic assessment in addition to the technical survey. Surveyor designs the water system and prepares the budget. FO conducts community meeting (with leaders and general public) to present and discuss the water system design and budget. During this meeting, the design and budget can be modified by the community as long as it is technically feasible. Also, the amount the community will contribute to the water system construction is negotiated. The negotiation process may take up to four or five meetings with community leaders before it is settled. Community leaders and FO select the committee. During the formation of the committee, the FO suggests its organizational structure. Usually, this consists of the technical, financial, and warehouse sections. In FY 1990 a health section will be added.

FO and health section conduct the health baseline survey. The FO also works with the section to analyze and tabulate the results. FO trains the entire committee in specific management issues. The training lasts from three to seven days and includes around 30 participants.

The financial section begins to mobilize resources for water system construction. This usually entails collecting money and payment in kind such as materials. The materials are then sold by the committee to raise additional money. This is an on-going process. The technical section begins to construct the water system once enough money is collected. If the water system is gravity-flow, the first thing often built is the captation tank. As more money is collected, the second structure is built and so forth.

FO contacts the local government to identify how it can contribute to training the different sections. For example, the health center staff often train the health section in various health messages and how they can be delivered.

FO and health center staff train health section on specific health messages and other activities. The health section implements and monitors the health activities.

FO monitors the collection of resources, construction of the water system, and health activities.

FO and the technical section establish the operations and maintenance committee. This is done once the water system has been constructed. FO and health section conduct the final health survey (evaluation). This is done approximately six months after health activities begin.

5.4 Training for the Field Officers

The approach to training the field officers should be task specific. The idea is to train the field officers in a specific task in a short period of time. The training may be formal or informal. In turn, the field officers train the committees in the same or a related task. The time interval between the FO training and the committee training should be minimized.

The strategies mentioned above are for a typical project cycle in a given community. Since communities progress at different rates, they are likely to be at different stages in the project cycle at any one time. Therefore, training for the field officers will have to be flexible and creative in order to give them the skills they will need to transfer to the committees using the task-specific training approach.

The technical assistance team and CARE-Jakarta senior management intend to develop a training package consisting of task-specific modules. This training strategy will begin with a 10 day workshop covering the specific skill areas in the project cycle the FO will need in order to work with the committees.

Modules will then be developed for each skill area covered in the workshop. When a community reaches a particular stage in the project cycle for which the FO needs the corresponding skill area, that module is used to train the FO. If enough field officers need a specific skill, they can be trained together. If not, more informal one-on-one training can be conducted by a supervisor.

The training strategy could include modules on the following topics:

Introduction to the training approach and how to use the modules

How to conduct a feasibility study (social, technical, health, political, and economic)

How to select the committee and its sections with community leaders

How to negotiate and sign a contract with the community

How to train the health section to conduct a needs assessment, analyze the results, prioritize needs, and develop an effective workplan

How to train the health section to develop specific health messages and to deliver them

How to train the finance section to conduct an economic assessment, analyze the data, and use the results to develop a workplan to collect and manage resources

How to train the finance section to manage the resources

How to train the technical section to conduct the technical study and develop a workplan to begin and supervise construction

How to train the technical section to construct the water system

How to train the various sections to monitor and adjust the workplans

How to train the O&M committee to collect and manage user fees, maintain the water system and sanitation facilities, solve problems, and use external resources to repair major breakages

APPENDIX A

People Met and Organizations Visited



APPENDIX A

People Met and Organizations Visited

The following individuals were interviewed in the process of developing this report:

South Sulawesi

1. Brian Jones Coordinator SRCD
2. Jopie Sinanu Assistant Coordinator
3. Hildy Haiplik Health Officer
4. Lahmuddin Siddiq Project Manager
5. Razak Thaha Msc. Technical Assistant Health
6. Sundari Djamaluddin Technical Assistant Health,
Tana Toraja

Nusa Tenggara Barat (NTB)

1. Muljanto Chief Representative
2. Maury Miloff Assistant Chief Rep.
3. Margaret Newens Support Health Officer
4. Ikin sodikin WASHES Project Officer
5. Kuswanto Village Primary Health Care Project Officer
6. Yulietty Setianingsih: Management Trainee

East Java

1. Maja M. Suhud Chief Representative
2. M.K. Lilik WASHES Project Officer
3. Jen Jerus Rusalam Village Primary Health Care Project Officer
4. Nurhidayati Community Organizer
5. Yanti T. Laksana Management Trainee

Jakarta

- | | | |
|----|---------------|-------------------------|
| 1. | Iskandar | Deputy Country Director |
| 2. | Dr. Mary Judd | Coordinator CSFW |
| 3. | Budi Rahardjo | Management Trainee |

The following are villages that the technical assistance team visited and groups contacted.

Places

Contacts

South Sulawesi

1. Sinjai, District of Sinjai

1. Village Leader
2. Health Kader

Nusa Tenggara Barat

1. Penjor, District of West Lombok
2. Bentek, District of West Lombok

1. Village Leader
2. Water Development Committee Leader
3. Technical and Health Kaders
4. Mothers
5. Staff of Provincial Public Work Office
6. Staff of Provincial Planning Board
7. Staff of West Lombok District Health Office

East Java

1. Bangunsari, District of Pacitan
2. Wonoanti, District of Pacitan

1. Village Leader
2. Water Development Committee Leader
3. Technical and Health Kaders
4. Mothers
5. Pacitan District Head
6. Bandar Sub-district Head
7. Secretary of Pacitan District
8. Head of Pacitan Planning Board
9. Head of Pacitan Health Office

APPENDIX B

Scope of Work



APPENDIX B

SCOPE OF WORK

Dr. May Yacoob
Dan O'Brien

OBJECTIVE

The objective of this technical assistance is to review CARE Indonesia's strategy for implementing a health component within the existing Water and Sanitation for a Healthier Environmental Setting (WASHES), Sulawesi Rural Community Development (SRCD) and Community Self-Financing Water (CSF/W) projects. It is expected that the technical team will examine the detailed implementation plans, visit existing or potential sites, provide specific written feedback on the findings and a list of specific recommendations for possible improvements.

It is important to note that the health component is a new endeavor within these projects and this technical assistance is not designed to evaluate the activities rather it is meant to reinforce current plans and identify possible weaknesses before the health component is operational.

SITES

The health component within the WASHES project will be or has just started to be implemented in two villages in each of the following three provinces: West Java, East Java and NTB. The WASHES senior staff in July 89 participated in the development of the DIP. The actual implementation of the health component interventions began in early September after one week training for the Field Officers was completed.

The health component in the SRCD is being implemented in 10 sites. The CARE staff have received approximately three weeks of inservice training and are fully active in the selected villages.

BACKGROUND

WASHES

In 1984, it was recognized by CARE that a health component was needed in the WASHES project. One community organizer was hired in West Java. The community organizer for one year conducted in each target site, community awareness meetings focused on promotion of Posyandu (village integrated health post) and kader (volunteer health worker) activities. This approach was difficult to sustain and actual impact was questionable. An evaluation was not conducted. In 1985, a Child Survival I Grant was secured. This Child Survival I project's design was to be implemented in each water site and stressed immediate short term results requiring CARE field staff to be highly operational.

CARE staff organized and trained kader to promote and conduct a wide range of primary health care activities. The underlining assumption of this project design was that after one year of intensive support, villages would become animated and village kader would remain active serving as effective adjuncts to the public health program, requiring only periodic support from the local health centers. After one year, the program would become sustainable and CARE field personnel could move on to other villages.

It has become evident to CARE, that kader require substantially more support than originally anticipated. Local health centers are neither sufficiently staffed, equipped nor motivated to provide necessary back-up support. In addition, because of CARE's operational role, village leaders tended to depend on the CARE field staff, with the expectation that CARE would independently implement and maintain the project. Consequently, it was concluded unlikely that improvements at the village level achieved through the present model could be sustained after CARE's withdrawal. Furthermore, CARE's involvement in 48 villages as originally planned would have a beneficial effect in these communities, but on the whole, it would be inconsequential to the national need.

Though the first year of the Child Survival project was considered successful it was determined that even a greater potential impact might be possible over a long term if CARE adopted a facilitator's role rather than concentrating on the direct implementation of health care activities.

This change in strategy left the WASHES project again without a health component. Combining the two projects proved to be impossible. In 1987, a great deal of mission energy was focused on community self-financing of water. And it was not until mid 1988 that a third plan was prepared to provide WASHES with a suitable health component.

SRCD Program

The original health component within the SRCD program was designed in 1983. The focus was on supporting the Posyandu. The field officer stationed in the village was to assist the kader and if possible the community leaders implement the standard Posyandu services.

Though the SRCD field staff received related inservice training they were frequently forced to work independently and the construction aspect of the water component became a dominating influence. In mid 1988, a health component detailed implementation plan was prepared that revised the focus of the health activities. Rather than promote all the Posyandu services as well as kitchen gardens, latrines and animal pen construction it was decided to direct activities towards reducing the severity of diarrhea, construction and use of latrines and water use. In addition pilot activities were implemented in order to develop other components, (i.e. nutrition) that could later be incorporated into the health section.

MAJOR ISSUES

The following is a list of the major areas that CARE Indonesia would appreciate assistance.

WASHES HEALTH COMPONENT

1. What are the strengths and weaknesses of the detailed implementation plan?
 - a. objectives
 - b. messages
 - c. strategy
 - d. target group
 - e. supervision
 - f. community training aids
 2. The work load of the Field Officers (involved in WASHES and Community Self-Financing of Water) must be explored and if required alternative management approaches suggested.
 3. Simple monitoring instruments need to be explored and, if needed, designed.
 4. Determine how the health component can best be implemented within the CSF/W project, is it worth the effort?
 5. Sustainability of the current planned project activities needs to be discussed and possible alternatives identified.
 6. Future health component directions, especially those related to the CSF/W project and technical assistance that might be required, needs to be identified.
 7. Determine how the WASHES and CSF/W health component can best fit into or complement the Posyandu program.
- * It is expected that a summary report outlining specific recommendations will be provided by the team.

SRCD HEALTH COMPONENT

1. What are the strengths and weaknesses of the current health detailed implementation plan. Major issues to be addressed by the technical assistance team:
 - Health messages
 - Target groups
 - Planned activities and time frames - realistic and, logical
 - Health component appropriately integrated with water activities
 - number, suitability, clarity, presentation
 - appropriateness, feasibility

- Training aids - appropriateness and use
- Supervision standard - review procedures used
- frequency
- * Evaluation processes - when, how, alternative,
 methods

Recommendations, time frame and approach for improvements in any of the above areas is welcome.

2. Does the project have adequate staff to meet the technical managerial and operational needs of the project.

3. Do indicators need refinement? Does the project need to conduct surveys? Example:

- Baseline surveys - initial community survey
- community survey checklist
- ibu Balita survey

4. Determine future activities for next five year period:

- pilot sites - objectives and possible design
- additional health components required

5. Relationship or fit of the SRCD health component activities within the village Posyandu program needs to be explored.

6. Sustainability of current activities. What are the project activities which should be sustained after CARE withdraws from the villages?

* It is expected that the TA team will provide a written description on the current SRCD health component include how it might be improved and developed over the next five years.

END PRODUCT OUTLINE

Executive Summary

1. Introduction
 - 1.1 Background
 - 1.2 Methodology
 - 1.3 Goals and objectives of the TA
2. Description of Hygiene Component
 - 2.1 WASHES
 - 2.2 CSFW
 - 2.3 SRCD
3. Findings
 - 3.1 Successful starts
 - 3.1.1 Objectives
 - 3.1.2 Messages
 - 3.1.3 Strategies
 - 3.1.4 Target group
 - 3.1.5 Supervision
 - 3.1.6 Training guides
 - 3.2 Areas to be improved
 - 3.2.1 Objectives
 - 3.2.2 Messages
 - 3.2.3 Strategies
 - 3.2.4 Target group
 - 3.2.5 Supervision
 - 3.2.6 Training guides
 - 3.3 Specific Issues (SOW)
4. Recommendations
 - Training
 - Supervision
 - Strategy
5. Strategy(ies)
6. Lessons learned from the TA Review

Appendices

PURPOSE

To develop and recommend the most feasible, sustainable, and effective hygiene/health education strategies for WASHES, SRCD, and CSFW projects for current and future programming.

OUTLINE

Outline 3 specific and practical hygiene/health education strategies & processes for specific field level activities so that communities will develop the capability to identify and undertake other behavior change related to health activities in the future.

AREAS OF INQUIRY

1. What are processes that take place in the 3 projects in water?
2. What does training consist of - for how long, who, how?
3. How does training get transferred to the community? Is there a transferal from the committees to the communities?
4. What are the existing community structures and how do they work?
5. What are indigenous PVOs doing in these communities?
6. What are household-specific hygiene problems and practices?
 - a. Water use
 - b. Food/hygiene
 - c. Cultural differences
7. What goes on in terms of environmental sanitation? Garbage, gray water, waste water, animal pens? Are there other environmental/health programs within the past 2 years?
8. What are the other programs in the area?
9. What is interaction between field staff and committees?
10. How are decisions made?
 - a. Community level
 - b. Household level
11. Supervision in field offices, esp. Sulawesi.
12. What is economic profile of the districts?
13. Village voluntary workers (kader) profile.



APPENDIX C

Project Cycles in Sulawesi, West Java, and NTB



PROJECT CYCLE IN A COMMUNITY IN SULAWESI

1. CONDUCT TECHNICAL SURVEY (FOR BANK OF SITES)
2. CONDUCT ORIENTATION WORKSHOP FOR FIELD OFFICERS
3. FEASIBILITY STUDY
 - TECHNICAL
 - SOCIAL
 - ECONOMY
 - POLITICAL
4. CONTACT GOVERNMENT TO REQUEST PRIORITY

DECISION POINT: ENTER/NO ENTER

5. IDENTIFY FORMAL/INFORMAL LEADERS (INFLUENTIAL)
6. CONDUCT WORKSHOP, I.E., NEGOTIATION WITH COMMUNITY

DECISION POINT: TECHNICAL OPTIONS

7. CONTACT GOVERNMENT AND EXPLAIN THE PROJECT (INCLUDING DISTRICT/SUB-DISTRICT HEALTH OFFICES (PUSKESMAS))
8. TRAIN THE FIELD OFFICERS:
 - DEMONSTRATION
 - COMMUNITY MEETING
 - PANITYA FORMATION AND TRAINING
9. CONTACT TOMA:
 - EXPLAIN THE PROJECT
 - SET UP MEETING
10. CONDUCT (BY FIELD OFFICER) COMMUNITY MEETING AND EXPLANATION
11. CONDUCT FIELD OFFICERS WORKSHOP FOR NEGOTIATION PROCESS
12. COMMUNITY FORMS "PANITYA" (GOOD MIX)
13. BEGIN PROCESS WORK WITH PANITYA ABOUT STRATEGY, ROLES/RESPONSIBILITY

DECISION POINT: CONTINUE OR LEAVE THE COMMUNITY

14. NEGOTIATE CONTRACT WITH PANITYA
15. FIELD OFFICERS TRAIN HEALTH SUB-COMMITTEE ON NEEDS ASSESSMENT
16. CONDUCT NEEDS ASSESSMENT PLUS BASELINE SURVEY
17. CONDUCT WORKSHOP FOR FIELD OFFICERS TO ANALYZE DATA AND DEVELOP SANITATION/HYGIENE PROGRAM
18. SHARE SURVEY RESULTS WITH PANITYA
19. PANITYA DEVELOPS WORKPLAN
20. IMPLEMENT ACTION PLAN
21. CONDUCT WORKSHOP FOR FIELD OFFICERS ON MONITORING AND EVALUATION
22. CONTINUE TO IMPLEMENT MONITOR AND ADJUST PLAN
23. PANITYA (SUB-COMMITTEE) ORGANIZES FOR:
 - LATRINES/DRAINAGE
 - SYSTEM
 - EDUCATION
 - GARBAGE DISPOSAL
24. COLLECTING MATERIALS (CEMENT, SAND, ROCK, TOILET BOWL, ETC.) AND DESIGN
25. BEGIN BUILDING THE SANITATION FACILITIES
26. BUILDING THE SPRING CATCHMENT TANK, STORAGE TANKS, PUBLIC TANKS
27. DIGGING THE TRENCH LINE
28. INSTALL THE PIPE LINE
29. TRAIN THE PANITYA (BY FIELD OFFICER) FOR THE INSTALLATION
30. COMMUNITY MEETING FOR BPAB AND MONTHLY USER FEE
31. BPAB TRAINING:
 - ADMINISTRATION/ACCOUNTING
 - TECHNICAL