

HEALTHY PARTICIPATION, HEALTHY PEOPLE:

A Review of Social Accountability Initiatives in Indonesian Policies and Programs

DISCUSSION PAPER

October 2018

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Health, Nutrition and Population (HNP) Discussion Paper

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Health, Nutrition and Population (HNP) Discussion Paper

Healthy Participation, Healthy People: A Review of Social Accountability Initiatives in Indonesian Policies and Programs

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Abstract:

As social accountability (SA) initiatives in Indonesia continue to grow, evidence shows that mechanisms to engage citizens to monitor service provision and provide constructive feedback on large-scale programs in the public sector still need improvement. SA, or citizens' ability to hold governing actors and their partners accountable for their actions and commitments, is recognized as a fundamental right and an indispensable means of strengthening national health systems. The Government of Indonesia's commitment to improve basic service delivery to poor and vulnerable populations represents an opportunity to apply SA approaches to improve the access and quality of health services.

This report aims to inform efforts to improve SA in Indonesia's health sector, particularly maternal and child health services. It gives an overview of common approaches to building social accountability, using examples from other comparable low- and middle-income countries, to extract lessons learned. It then analyses Indonesia's national regulatory and policy framework related to SA initiatives in the health sector. Next, it reviews Indonesian initiatives that have included SA components in order to identify programmatic opportunities, challenges, and remaining gaps for improving SA in Indonesia's health sector. Finally, it provides evidence-based recommendations for future SA policy and programming initiatives in Indonesia.

Three common thematic SA approaches emerged from this review. These include: building awareness among communities, creating voice, and empowering action. This report finds that SA initiatives that include all three elements through multiple mechanisms are more likely to succeed. Programs need to develop comprehensive approaches that fit local contexts, accommodate multi-sector partnerships, and account for existing power dynamics and risks associated with increased decision-making authority. Efforts to prepare service providers and local officials to solicit routine citizen feedback on services, and to work with citizens to develop solutions that work for everyone, should be mainstreamed into *all* health system strengthening programs.

Keywords: Social Accountability, Citizen Engagement, Health Policy Framework, Indonesia

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This report serves as an important checkpoint on Indonesia's use of social accountability initiatives particularly in the health sector, and a contribution to the growing body of work on social accountability globally.

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PART I – INTRODUCTION

The number of social accountability initiatives in Indonesia is growing, yet the country still has limited experience in using them to improve the monitoring and implementation of large-scale public sector programs that offer basic services. A few examples include the new national health insurance program (*Jaminan Kesehatan Nasional* or JKN), the Family Hope Program (a household conditional cash transfer program), community health centre (*Puskesmas*) accreditation, the multi-sectoral community nutrition program, and the village fund. Several current regulations and policies on basic health service delivery and local government management recognize the role of social accountability (SA) in improving the quality of (and access to) health services. However, this regulatory environment also faces cultural challenges, such as the traditional view among government officials that citizen participation is an unwelcome intrusion into government affairs (Buehler, 2011). SA approaches provide an opportunity to overcome such limitations, and to scale up and institutionalize community participation mechanisms in an effort to improve basic service quality.

This report consists of three interlinked components that aim to inform efforts to improve SA in Indonesia’s health sector, particularly maternal and child health services. It first gives an overview of common approaches to building SA, using examples from other comparable low- and middle-income countries, to extract lessons learned. It then analyses Indonesia’s national regulatory and policy framework related to SA initiatives in the health sector. Next, it provides a more in-depth review of Indonesian initiatives that have included SA components in order to identify programmatic opportunities, challenges, and remaining gaps for improving SA in Indonesia’s health sector. Finally, it provides evidence-based recommendations for future SA policy and programming initiatives in Indonesia.

PART II– SOCIAL ACCOUNTABILITY

Systems of accountability are essential for maintaining checks and balances in governance relationships. Governing bodies usually have internal mechanisms that monitor performance and maintain accountability to the public. Horizontal accountability involves different government branches or departments overseeing one another. The public can also hold public officials accountable, most notably by voting for elected officials, which is an example of vertical accountability. In many countries, internal government failure to guard against problems such as poor service quality or the misallocation of resources has made it important to increase investments in a third approach to accountability. SA refers to citizens' ability to hold governing actors and their partners accountable for their actions and commitments, particularly when these commitments are neglected or if other forms of accountability are insufficient. SA approaches refer to:

The broad range of actions and mechanisms beyond voting that citizens can use to hold the state to account, as well as actions on the part of government, civil society, media and other societal actors that promote or facilitate these efforts (Malena and McNeil, 2010).

In the process of monitoring and improving state functions, SA approaches also aim to empower and mobilize citizens to undertake their own actions to hold the state accountable. While citizen action is a critical condition for improving SA, these actions require considerable skill, resources, commitment, and time, and may expose citizens to a number of risks. SA initiatives therefore usually consist of multiple efforts to build citizen and community capacities in accordance with local requirements. These initiatives typically begin with efforts by civil society organizations (CSOs) and other development partners to improve citizens' ability to access (and make sense of) information related to their rights and entitlements in order to build awareness of grievances and galvanize action (Malena and McNeil, 2010). SA initiatives then often invest in developing the ability of citizens – and citizens' groups – to voice demands and provide feedback on state functions. SA initiatives often facilitate dialogues, planning sessions, and other forms of engagement between citizens and the state. SA approaches seek to ensure the representation of the whole community, especially marginalized groups, when drafting demands or making decisions.

SA approaches can be applied to improve the responsiveness of a range of state functions, from governance to public service delivery, including maternal and child healthcare. For strengthening service delivery, there are several different approaches that can be applied that include addressing management, incentives, or demand side barriers. The objective of the SA approach, however, is to improve the relationship between key actors, including decision makers, frontline workers who deliver services, and citizens (the end users). Governance in service delivery consists of the rules, incentives, and accountability mechanisms that affect these relations and facilitate the efficient and responsive delivery of quality services (Ringold, Holla, Koziol, & Srinivasan, 2011). Service systems become more responsive to the population's needs when decision makers and providers are supported and incentivized to improve the quality of services, which may include empowerment through training and resources,

and the flexibility to adapt to local needs and contexts. In order to contribute to good governance, citizens should be empowered to hold both decision makers and providers accountable for their obligations, promises, and conduct in service delivery.

Another critical element of SA is the response of the state and its partners to citizen action. This may consist of actions that aim to address citizen concerns, such as policy change, improved transparency, or increased budget allocations; it may also involve tactics that seek to undermine citizen action, such as publishing misinformation or repressing protestors. CSOs and development partners often work with state actors directly to cultivate SA through advocacy, technical assistance, capacity building, or participatory planning.

Social Accountability in the Health Sector

The health sector has a long tradition of promoting transparency, participation, and inclusiveness that predates the concept of SA. For instance, the Alma Ata Declaration of 1978 states that primary healthcare “requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care, making fullest use of local, national and other available resources; and to this end develops through appropriate education the ability of communities to participate”(WHO, 1978). In 1997, the Jakarta Declaration on Leading Health Promotion into the 21st Century stated priorities that emphasized investments in health that reflect the needs of all population groups, as well as increased community capacity and empowered individuals, and called for transparency and public accountability (WHO, 1997).

More recently, the UN Secretary-General’s Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030), a critical supporting document for the Sustainable Development Goals and the Every Mother Every Child movement, included SA as a key element of its Accountability Framework. Moreover, the Five-Point Call to Action, led by the World Bank, US Agency for International Development, and the World Health Organization, and endorsed by dozens of global health actors, called for the promotion of governance “with citizens’ and community’s participation for accountability” in health sector activities at all administrative levels (Measurement and Accountability for Results in Health, 2015). Underlying all of this support is the notion that SA is both a fundamental right and an indispensable means of strengthening national health systems.

The Government of Indonesia is now in a position to promote SA approaches as part of its Medium Term National Development Plan 2015–19 (2015). Within this strategic plan, three pillars contribute to a policy framework to reduce poverty and inequalities: 1) a comprehensive social protection system, 2) basic services for the poor and vulnerable, and 3) sustainable livelihoods. As part of the second strategy, the government aims to improve basic services through a frontline approach that will improve the accountability of service providers at the frontline and address government responsiveness via the inclusive participation of communities and citizens. The government’s commitment to focus on improving basic service delivery to poor and vulnerable populations represents an opportunity to apply SA approaches to improve the access and quality of maternal and child health services.

PART III – METHODS:

Three related searches were conducted for this review in peer-reviewed and grey literature¹ in English or Bahasa Indonesia for: 1) programs and studies in low- and middle-income countries, 2) domestic programs and studies from Indonesia, and 3) national policies from Indonesia. These are described separately below.

The final set of papers was selected from peer-reviewed articles, program reports, technical reports, and meeting notes published between 2000 and 2016 that described or reviewed SA mechanisms, tools, or approaches that applied to a primary health care system, maternal and child health services, or where a health component was part of the program implementation.

Programs and Studies from Low- and Middle-income Countries

Articles on SA related to health service delivery were identified using the Web of Science and Medline databases. Search terms included “social accountability,” “citizen engagement,” “civil engagement,” and “civil society engagement.” The search was refined by including the terms “health,” “maternal health,” and “developing countries.” Specific program information was identified by reviewing the reference lists of published review articles. Titles and abstracts of papers identified in these searches were reviewed and potential papers were read to decide on the final sample.

Domestic Programs and Studies from Indonesia

An initial set of Indonesia-specific studies was identified in the above-mentioned search. Additional published reports and grey literature were identified through:

- A search of the internal resources library at the Center on Child Protection and Wellbeing
- Contact with colleagues at the World Bank, UNICEF, the Australian Department of Foreign Affairs and Trade, and The Asia Foundation, among others
- A manual search of the institutional websites of key national actors in Indonesia’s governance and health sectors

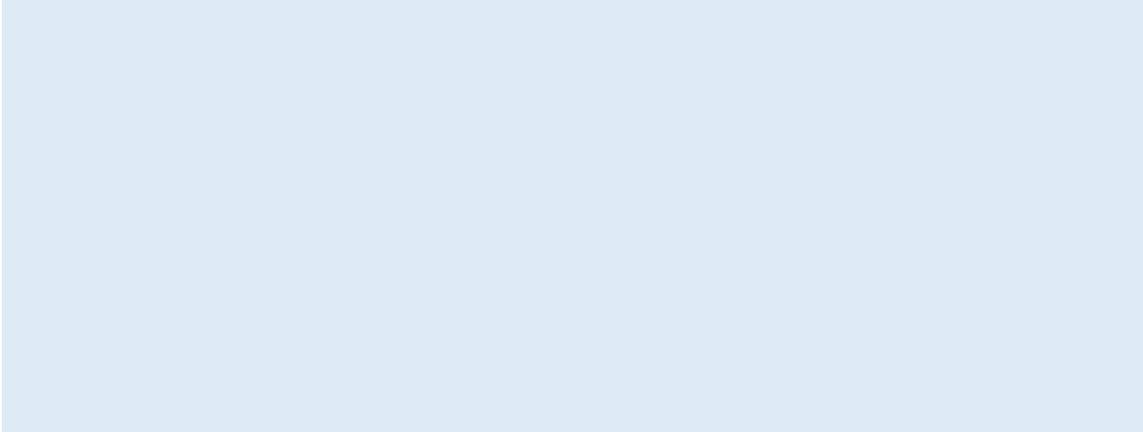
The review of Indonesian domestic programs focused on literature from programs and studies related to health and maternal and child health services; however, it also included publications for which health may not have been the primary focus but rather one component of the SA initiative. While neither the Indonesia-specific nor the international search was exhaustive, the focus was on the use of SA measures within public health services located in low- and middle-income countries, with a particular interest in Indonesia.

Domestic Policy Review from Indonesia

¹ documents from government, academia, industry, and business that are not controlled by commercial publishers

Current regulatory and legal documents relevant to Indonesia's health sector were analysed in order to review the legal frameworks that govern the implementation of accountability initiatives. The preliminary literature review on SA provided a list of key terms that were used to identify relevant regulations, including major acts (*undang-undang*) and relevant implementing regulations. The list of legal bases and references cited in each policy document were also reviewed.

The review focused on active national policies that are either specific to the health sector or have governance implications for the health sector. While this review included a broad selection of national acts, it was limited to ministerial regulations, since they have a stronger institutionalization effect and are more legally binding than ministerial decrees or circulation letters. Policies that have been repealed, amended, or otherwise inactivated were not included in the search, unless doing so was critical for interpreting the current policies. Judicial rulings and commentaries were also excluded from the analysis, as well as ministerial regulations specific to other sectors that have no bearing on SA in the health sector. Finally, international commitments and subnational policies related to SA in Indonesia were not analysed.



PART IV – CASE STUDIES: USING THE SOCIAL ACCOUNTABILITY APPROACH IN THE HEALTH SECTOR IN LOW- AND MIDDLE-INCOME COUNTRIES

Despite the great diversity of objectives, designs, tools, and implementation arrangements among the various programs that use SA components across low- and middle-income countries, a set of three common thematic approaches emerged. These approaches, described in more detail below, are often used in conjunction, or build on each other, often to greater effect (Fox, 2015). In practice, SA can be thought of as a process that is supported by components or mechanisms that fit the local context (Salamon, Geller, and Sokolowski, 2014). This process should also be two-way in that mobilizing citizens to generate constructive feedback needs to be met by the actions of public sector institutions.

Awareness: Information and Education

Community members often have insufficient education regarding their rights and the services entitled to them. In India, for example, despite focused attention since 2005 by the National Rural Health Mission, many women still have a relatively low awareness of maternal health services. A civil society alliance of organizations has begun to increase awareness by organizing public hearings and rallies; its partners have generated large crowds of women to engage in public discussions about women's health and accountability gaps (Papp, Gogoi, and Campbell, 2013). While this method may not be culturally appropriate in all contexts, Indian women have benefitted from sharing their individual struggles with one another, potentially shifting mindsets on a large scale (Papp et al., 2013). These events create unique communication opportunities between women, health care providers, and public officials. Yet some local organizers and participants acknowledge that longer-term efforts to develop women's agency and confront deeply rooted patriarchal norms will be necessary to create sustainable accountability (Papp et al., 2013).

Awareness and knowledge of their rights to basic services may also increase community participation in constructive discussions with service providers and public officials. In Ethiopia, an evaluation of the Protection of Basic Services Program found that increased awareness among community members of their rights to basic services led to better engagement in subsequent program meeting activities (Tadesse, Swain, Afeta, and Bultosa, 2010). As community members begin to understand how to identify and articulate problems related to service delivery, service providers, in turn, begin to value feedback from community members, resulting in more effective dialogue.

A three-state, community-based information campaign was conducted in India that measured the impact of information on learning and other school outcomes. In villages where parents and communities received information on their roles, responsibilities, and entitlements for their children, the frequency and attendance of Village Education Committee meetings increased significantly (Pandey, Goyal, and Sundararaman, 2009). This suggests that community members were receptive to information about roles and responsibilities, and that this increased understanding led to greater participation. However, the impact of the campaign on learning achievements among children was modest, suggesting that more sustained intervention efforts may be required.

Voice: Monitoring and Feedback Mechanisms

SA efforts that disseminate information and raise awareness among communities regarding their rights to basic health services are important, but many researchers and practitioners agree that this step is often insufficient to improve service delivery on its own (Fox, 2015; Joshi, 2014). SA approaches that also promote citizen engagement with health service providers and government officials in the interest of improving service delivery are more effective. On the one hand, citizens may act as a “watchdog” over policy implementation in the health sector by holding policy makers accountable to their promises and catching any discrepancies in funding allocations (Slevin and Green, 2013). On the other hand, citizens are also present at the point of service, which makes their feedback on and perceptions of service delivery valuable for measuring the performance of health providers. Therefore SA approaches may be collaborative between citizens and service providers, or citizens might take a more adversarial approach to emphasize accountability as in the oversight example above. Several mechanisms have been used to engage citizens in activities that monitor service delivery, provide feedback, and even take part in planning and resource allocation.

Local residents in Zimbabwe monitored revenues from an AIDS tax that was intended to help cover the costs of patients affected by HIV/AIDS, and discovered that patient experiences did not agree with the reporting from the National AIDS Council (Slevin and Green, 2013). In response to on-going shortages of antiretroviral drugs (ARV), citizens organized and demanded greater transparency in the use of tax funds, an effort that was eventually supported by the Zimbabwe Lawyers for Human Rights. In response to demonstrations, the National AIDS Council republished financial information and held multi-stakeholder meetings that included representatives of people living with HIV to discuss program gaps. These meetings also resulted in quarterly monitoring of ARV clinic assessments and quarterly meetings with news media (Bhat et al., 2016).

Since public services are often not prepared to monitor citizens needs and demands, much less respond to them, another effective approach is to develop a monitoring and feedback mechanism. Communities can monitor service delivery through an instrument like citizen report cards. In Tajikistan, citizens were invited to voice their concerns about maternal and child health services, which were taken into account in the development of a local report card. Implementers found that citizens were very capable of articulating and prioritizing concerns that could be used as report card indicators. Service providers agreed with citizen assessments of the areas that were identified as requiring improvement. When feedback from the report cards was sensitive, however, community members became worried about the reactions of health providers. Previous studies in Indonesia have reported similar findings of fear or reluctance to report on sensitive issues related to community maternal mortality audits and referral mechanisms for child protection violations (D'Ambruso, Izati, Martha, Kiger, and Coates, 2013; Stark, Bancroft, Cholid, Sustikarini, and Meliala, 2012). This is a challenge for initiatives that provide community feedback, because the fear of reprisal from providers and the risk of hurting the patient-provider relationship is a source of concern for community members. Citizens suggested that an external actor should facilitate this role in order to protect patient-provider relationships (Bauhoff, Tkacheva, Rabinovich, and Bogdan, 2016).

Engaging community members together with health providers and village leaders to share responsibility for monitoring service usage and outcomes may produce greater transparency and active dissemination of information, but can also increase follow-up action. In India and Timor Leste, for instance, community members and service providers created a simple monitoring tool to display the number of births and vaccinations on a poster in order to disseminate information to the local community, including health workers, volunteers, and caregivers. Increased awareness of the importance of vaccinations created a sense of shared responsibility that motivated community members to cooperate to improve vaccination rates (Jain, Taneja, Amin, Steinglass, and Favin, 2015). The Quality Assurance Partnership Committees in the Philippines also promoted collaboration in monitoring efforts. Committees of community members and health workers were formed to collectively address the accountability of service providers. Community members on these committees channelled feedback from health service users collected by surveys and suggestion/complaint boxes (Brinkerhoff & Wetterberg, 2015). A study in Kenya, however, described the challenges associated with health committees, including the varied education levels of community members that can make technical dialogues more difficult. Poorly defined committee roles can lead to mistrust and even conflict between community members and service providers (Goodman, Opwora, Kabare, and Molyneux, 2011).

SA initiatives that incorporate multiple program components often prepare an enabling environment for program activities. For example, conducting discussion activities, like forums – where citizens, health providers, and public officials collaborate to design standards and monitoring instruments prior to implementation – has been effective for creating a collaborative environment and removing barriers to participation. The Partnership Defined Quality (PDQ) program introduced by Save the Children has been implemented in several countries including Nepal, Armenia, and Afghanistan (Hoffmann, 2014). PDQ prepares community members for monitoring exercises by building support, jointly defining quality, and positioning citizens and service providers as “allies.” Community members involved in this approach described increases in health service utilization and improvements in service quality. Similarly, in Uganda a randomized field experiment examined a community monitoring process of health clinics in which community members and health workers undertook preparatory steps before implementing a monitoring plan (Björkman and Svensson, 2009). Initial meetings helped to focus community members and health workers on cooperating to achieve improvements in service quality. To help with the dissemination of monitoring results, interlocutors, or external agents with negotiating capacity, were involved in the negotiations between health providers and the community, especially regarding the expected actions of providers. Achievements included improved health outcomes, such as a reduction in infant mortality, an increase in outpatient services, and an overall improvement in service quality (Björkman and Svensson, 2009).

Empowerment: Citizen Training, Mobilization, and Participation

Building the capacity of citizens and governing bodies is an important component of SA initiatives. Strengthening citizen voice often requires training in addition to information about entitlement to services. At the same time, governing counterparts may also need to strengthen their capacity to respond to and address feedback from citizens. Lastly, service providers must have the technical capacity to carry out services in a professional and safe manner. Preparing each actor by identifying their roles and responsibilities

helps enable each to participate fully in SA initiatives. In the steps outlined here, SA approaches are usually collaborative in nature between citizens, government counterparts, and service providers. It may also be important, however, to balance more adversarial strategies in order for dialogue and feedback to take place.

The Quality Assurance Partnership Committees in the Philippines succeeded in building capacity among community members in addition to conducting monitoring activities (Brinkerhoff and Wetterberg, 2015). At some program sites, citizens were empowered to engage with decision makers to advocate for community concerns, specifically meeting with provincial-level leaders. This was interpreted as a sign of learning and improved agency.

In Uganda, the Community and District Empowerment for Scale-up (CODES) program introduced citizen report cards to facilitate community empowerment in efforts to improve coverage of child survival interventions. The report cards in this study were created using data collected from facilities that included services and utilization, supplies, and resources in order to help citizens develop strategies for improvement. The report cards were considered essential to the program's success: factual information from the report cards provided a foundation on which community members could base their input and demands during dialogues with local leaders and health providers (Katahoire et al., 2015). In Afghanistan, community scorecards were introduced to engage community members and service providers in improving patient-centred services. Scorecards are monitoring tools that combine the social audit approach with the citizen report card to monitor and evaluate services; they empower communities to actively participate in dialogues to improve services. In Afghanistan, the scorecard process involved multi-stakeholder meetings to develop action plans, and community members from different segments of the population were invited, especially those from under-represented and marginalized groups. Implementers reported the need to carefully balance community members' expectations with the limited capacity of service providers to respond to demands (Edward et al., 2015).

Health service charters present another tool to empower communities to act on their grievances and ideas for service improvement. These charters are visible announcements commonly drafted by patients and providers, which detail the services offered at a health facility. This information may include service-related costs, waiting times, and facility hours. At a minimum, charters offer a baseline for citizens to assess the services they receive and hold providers accountable. In practice, however, citizens do not always take action when providers do not uphold the terms of the charter. One study in rural Kenya measured community members' perceptions of health facility charters (Atela, Bakibinga, Ettarh, Kyobutungi, and Cohn, 2015). Among service users that read the service charters, a relatively high percentage (84 percent) felt that the information presented was useful for making service-related decisions. However, citizens were still reluctant to engage service providers directly when inconsistencies occurred, due to cultural norms and hierarchies in the health care system that suggest village leaders and elders should handle such issues.

Capacity building also involves building networks among different groups within communities, for example between poor and non-poor citizens, and with different levels of governing and non-governing bodies. Since the "state" and "citizenry" are not homogenous, effective strategies link different governing actors who share a willingness

to collaborate and pursue reforms, and bridge educational or socio-economic divides within civil society (O'Meally, 2013). The CORE group, for example, is an established network of organizations focused on collaborative action and learning to improve maternal and child health in underserved populations in developing countries (CORE Group, 2015). The CORE secretariat model seeks to promote constructive networks by connecting civil society and government partners through the exchange of ideas to solve important health problems. The model promotes knowledge transfer and problem solving that pursues common goals, rather than those of a single organization. Several child health programs have benefitted from sharing technical and financial resources from CORE Group member organizations (Levenger and McLeod, 2002).

Service providers may also need to build their capacity. In Uganda, CSOs supported a shift in national policy for health workers to use misoprostol to treat postpartum haemorrhages. CSOs – including Venture Strategies Innovations, Programme for Accessible Health Communication and Education, and Ipas – assisted the Ministry of Health in developing clinical guidelines and providing health workers with training on the drug's use. CSOs thus played an important role in building capacity among service providers as they adjusted to a change in national policy (Atukunda, Brhlikova, Agaba, and Pollock, 2015).

The different SA approaches described in this section cover three important aspects for engaging citizens in the process of improving basic service delivery – awareness, monitoring and feedback, and empowerment. The case studies reported here suggest that a combination of these approaches may increase the effectiveness. When citizens possess greater awareness of service delivery, for example, they are more likely to have the confidence to engage in mechanisms like providing feedback or serving on committees alongside service providers. Monitoring instruments like report cards can also be used to facilitate feedback from service users and service providers. With any of these approaches, however, there are risks that deserve consideration to protect citizens rights and maintain relationships with service providers.

PART V – SOCIAL ACCOUNTABILITY IN INDONESIAN POLICIES:

Compared to other countries, Indonesia has a very high level of civic engagement; thus SA is not new. A much higher percentage of Indonesian citizens (84 percent) claims membership in formal organizations compared to other Southeast Asian countries like Malaysia (61 percent) and Thailand (51 percent) (Lussier and Fish, 2012). Community practices, like *Musrenbang* (a type of planning meeting), involve citizens in planning and development with their neighbours and local leaders. As the country continues to decentralize, the provision of basic government services like healthcare is increasingly managed at lower administrative levels. Various aspects of SA have been incorporated into existing policy and regulatory frameworks. This section discusses national laws, regulations, and other policy mechanisms that are gradually providing Indonesian citizens with a greater ability to monitor their government, contribute to decisions that affect them, and influence the planning and execution of public services, with a particular focus on health.

Table 1. Overview of Relevant Laws and Regulation

Laws/Regulations	Themes	Dimensions of Social Accountability	Accountability type
Public Service Law (Law No. 25 of 2009)	Public service	Enhancing citizen's voice by ensuring all service units have SOPs, service charters, complaint and feedback mechanisms, and accessible information (type 1 and 2)	Horizontal and vertical accountability
Health System Law (Law No. 36 of 2009)	Health system and service	Involvement of communities in providing services and monitoring the service delivery (type 3)	Horizontal accountability with a brief mention of community's monitoring
The Law on Village No. 6 of 2014	Village governance and fund	Securing community's voice in village decision-making, planning, implementation, and monitoring (type 3)	Horizontal and vertical accountability
Public Information Law (Law No. 14 of 2008)	Access to public information	Ensuring citizen's access to acquire information from public institutions (type 1)	Horizontal accountability (through Commission on Public Information)
PerMenKes 65/2013 on Guidelines for the Implementation of Community Empowerment in Health Sector	Community empowerment	Encouraging community-driven development and participation in health-related decision-making (type 3)	Vertical accountability
PerMenKes	Nutrition	Engaging community in	Horizontal

Laws/Regulations	Themes	Dimensions of Social Accountability	Accountability type
23/2014 on Nutrition Improvement Efforts		Dissemination of information and education in regards to activities to improve nutrition status (type 3)	accountability
PerMenKes 25/2014 on Child Health	Child health	Empowering elements of community (health cadres, school committee, students committee, community-based rehabilitation) to take active role in increasing children's health status (type 3)	Horizontal accountability
PerMenKes 97/2014 on services pre-, during, and post pregnancy, family planning, and sexual health	Maternal health	Reaffirming the partnership between health service unit and the community (type 3)	Horizontal accountability
PerMenKes 66/2014 on Child Growth and Development Monitoring	Child health	Reaffirming the partnership between health service unit and the community (type 3)	Horizontal accountability
PerMenKes 78/2014 on Congenital Hypothyroid Screening	Child health	Reaffirming the partnership between health service unit and the community (type 3)	Horizontal accountability
PerMenKes 75/2014 on Community Health Centers (<i>Puskesmas</i>)	<i>Puskesmas</i> ' organization	Ensuring minimum standard of <i>Puskesmas</i> ' facilities, procedures, and services (type 1) Encouraging community's role as stakeholders in public health efforts (type 3)	Horizontal accountability
PerMenKes 46/2015 on Accreditation of <i>Puskesmas</i> , primary health clinics, private practice, and dental private practice	<i>Puskesmas</i> ' accreditation	Ensuring all primary clinics including <i>Puskesmas</i> have client agreement on service standards, operating hours, and cost installed as well as complaint and feedback mechanism (type 1) Ensuring all of the information above is accessible to community and clients (type 2)	Horizontal and vertical accountability
PP 65/2005 and PerMenKes 43/2016 on	Minimum Service Standard of	n/a	Horizontal accountability

Laws/Regulations	Themes	Dimensions of Social Accountability	Accountability type
Minimum Service Standard	Healthcare		

Public Service

The Indonesian Government has issued several laws designed to improve the quality of basic services in Indonesia, most notably the Law on Public Service No. 25 of 2009² (Public Service Law), led by the Ministry of Bureaucratic Reform (KemenPAN ARB). This law aims to govern the interactions, expectations, rights, responsibilities, and discretions between all parties involved in service delivery, including between users (citizens) and service providers. The Public Service Law does not provide an exhaustive list of services under its authority, though it does mention health service as an example (Article 5 and elucidation of Articles 4 and 7). Neither the law nor its main implementing government regulation (*Peraturan Pemerintah* or PP 96/2012)³ details the technicalities of the service standards with which each service provider or “*Penyelenggara*” must comply. Instead, they outline the procedural instruments that service providers must install in all their service units (*organisasi penyelenggara*) in order to deliver quality services and the process to develop these instruments (see also Buehler, 2011).

In general, the Public Service Law sets out the responsibilities of service units (providers and their staff) and what service users are entitled to. It stipulates that all service providers (*Penyelenggara*) have to create standards of service, standard operating procedures (SOPs) for each type of service, and monitoring and evaluation mechanisms, as well as complaint-handling mechanisms. The providers are obligated to involve the community in developing all these mechanisms in a non-discriminatory manner. In addition, communities have the right to monitor the implementation of service standards, to report complaints whenever these standards are not met, and to have those complaints redressed. The regulation also defines violations of those standards and sets out sanction procedures for implementers, as well as mechanisms for communities to complain to higher levels of government, including ombudsman and the House of Representatives.

As part of the implementation of Public Service Law, since 2013 Ombudsman conduct an assessment of government institution’s compliance to some dimensions mandated by the Law. In 2016, Ministry of Health scored the highest mark among 25 ministries being reviewed. The assessment covers aspects of client-friendly services such as existence of clear service procedures and requirements, time and cost certainty, and complaint handling mechanisms, all of which must be accessible to clients. It didn’t cover the quality of the procedures and services, and the client’s satisfaction (Ombudsman RI 2016)⁴

² Undang-Undang Nomor 25 Tahun. 2009 Tentang Pelayanan Publik.

³ Peraturan Presiden Nomor 96 Tahun. 2012 Tentang Pelaksanaan Undang-Undang Nomor 25 Tahun 2009 Tentang Pelayanan Publik.

⁴ Ombudsman RI 2016. “Hasil Penilaian Kepatuhan Terhadap Standar Pelayanan dan Kompetensi Penyelenggara Pelayanan Sesuai Undang-Undang Nomor 25 Tahun 2009 Tentang Pelayanan Publik (Compliance Assessment on Public Service Standard and Competence according to Law No. 25 of 2009 on Public Service), Jakarta, Indonesia.

In 2008, the government passed Law No. 14 of 2008 on Access to Public Information (Public Information Law). The Public Information Law affirms citizens' access to information from government organizations, including State-Owned Enterprises and it specifies the types of information that should be published publicly and the procedures to obtain such information. The objectives of this law are very much in keeping with some SA's dimensions. The Law in particular aims to guarantee a citizen's right to understand the formulation of policy or program and how decisions are made as well as the reasons behind them. The Law is also envisioned to encourage citizens' involvement in public decision-making and to help create a transparent, accountable, effective, and efficient government. It does not only guarantee citizens' access to public information but also their rights to attend public hearings as well as to disseminate all public information they have acquired.

The Law specifies three types of information that should be released to the public.⁵ The first category is information that must be published regularly, at least once every 6 months using accessible means and language. This information includes government institutions' activities and performance, as well as information pertaining to their financial reports. The second is information that should be available at any time. This includes all of the institutional decisions and their considerations, all policies and their supporting documents, all project plans, annual estimation of spending, agreement with other institutions, any public speech by the officials, and institutional work procedures related to the services they provide to public. The final category is information that has to be made available as necessary, especially in an emergency situation.

Health Sector

Several policies outline the conduct and procedures of health services. The Law on National Health System No. 36 of 2009⁶ (Health System Law) lays the legal foundation for Indonesia's healthcare system, in which all efforts to advance health systems and deliver health services are jointly conducted by the central and local governments citizens (including individuals and organizations). This includes surveillance efforts, nutrition, maternal health, and mental health services. The law also stipulates that the central and local governments can, but are not obliged to, involve communities in monitoring the implementation of health services, but it does not explain how this should be implemented. While the law acknowledges the general role of the community (*masyarakat*) in all aspects of health services, it does not stipulate the responsibilities of public and private (that is, for-profit) actors. Nor does it detail the different mechanisms that these actors can use to hold the government accountable. Furthermore, the Law does not mandate formulation of implementing regulations for community's involvement. The main accountability mechanisms set out in this law and its implementing regulations are internal mechanisms among different levels of government in the health sector.

At the operational level, several key Ministry of Health regulations (*Peraturan Menteri Kesehatan* or PerMenKes) include provisions to create a supportive environment within the health sector for community participation. Various implementing regulations for the

⁵ The Law puts limit to what kind of material that public can access. It excludes material that can jeopardize the state, any information that is related to individual rights, materials that might distort fair competition among private sector, and information that hasn't been filed or documented.

⁶ Undang-Undang Nomor 36 Tahun 2009 Tentang Sistem Kesehatan Nasional.

Health System Law, such as PerMenKes 66/2014 on Child Growth and Development Monitoring and PerMenKes 78/2014 on Congenital Hypothyroid Screening, incorporate elements of community participation and reaffirm the partnership between health providers and the community.

Nutritional improvement targets described in PerMenKes 23/2014⁷ lay out the shared responsibility between the government and the community for both capacity development and information dissemination. There is even a description of how the community should contribute to program development and play a role in monitoring and evaluating nutrition programs. PerMenKes 25/2014,⁸ pertaining to child health, encourages the involvement of relevant elements in the community such as health cadres, school committee, and the children and teenagers themselves. PerMenKes 97/2014,⁹ covering services for pre-, during, and post pregnancy specifies community's role in areas such as provision of transportation and transit homes, maternal class, and mitigation planning against complication.

PerMenKes 75/2014 on Community Health Centres¹⁰ advances the government's commitment to improving and ensuring higher standards of health services by establishing the minimum requirements for community health centres (*Puskesmas*). This set of requirements covers physical infrastructure, administrative procedures, human resources, and corresponding levels of training that must be available, and the services that must be provided. This regulation emphasizes the importance of accreditation (once every three years) to verify and monitor the quality of *Puskesmas*; this accreditation is conducted by an independent body appointed by the Ministry of Health. The regulation briefly mentions community participation as part of the public (community) health effort by *Puskesmas* in rural areas. However, according to articles 33 and 45 of this regulation, *Puskesmas* still rely on internal, top-down monitoring as the main mechanism for accountability: *Puskesmas* submit their planning to Dinas Kesehatan (district-level health departments), which then provides supervision and monitoring. Article 45 of PerMenKes 75/2014 furthermore stipulates that professional organizations can be involved in monitoring the implementation of *Puskesmas* services.

In 2015, the Ministry of Health issued PerMenKes 46/2015,¹¹ which detailed the assessment criteria and elements of accreditation for *Puskesmas* and other healthcare facilities, including primary health clinics and private practices. This regulation is explicit in its efforts to modernize *Puskesmas* and, similar to the Public Service Law, it aims to make *Puskesmas* more attuned to the needs and priorities of their communities. PerMenKes 46/2015 stipulates the need to have a community/client agreement on service standards and operating hours, an internal code of conduct, and complaint-handling mechanisms. All the information regarding services (for example, schedule,

⁷ Peraturan Menteri Kesehatan Nomor 23 Tahun 2014 Tentang Upaya Perbaikan Gizi.

⁸ Peraturan Menteri Kesehatan Nomor 25 Tahun 2014 Tentang Upaya Kesehatan Anak.

⁹ Peraturan Menteri Kesehatan Nomor 97 Tahun 2014 Tentang Pelayanan Kesehatan Masa Sebelum, Hamil, Masa Hamil, Persalinan, dan Masa Sesudah Melahirkan, Penyelenggaraan Pelayanan Kontrasepsi, Serta Pelayanan Kesehatan Seksual.

¹⁰ Peraturan Menteri Kesehatan Nomor 75 Tahun 2014 Tentang Pusat Kesehatan Masyarakat.

¹¹ Peraturan Menteri Kesehatan Nomor 46 Tahun 2015 Tentang Akreditasi Puskesmas, Klinik Pratama, Tempat Praktik Mandiri Dokter, dan Tempat Praktik Mandiri Dokter Gigi.

type of services, complaint mechanisms, operating hours) has to be made accessible on the communication board, through sensitization events (*sosialisasi*) and other media. PerMenKes 46/2015 instructs *Puskesmas* and district health offices to consult communities on the types of services they prefer. In this process, communities should be able to provide feedback on several aspects of service delivery, such as the quality of staff responses to user complaints, the clarity of the information communicated, provider performance, and quality of services. *Puskesmas* are also required to set up an internal audit mechanism for finance and overall performance. This commitment to increasing the accountability and responsiveness of health service units is also echoed in the recent Ministry of Health Strategic Plan (*Renstra*) of 2015–2019 that includes improving the ministry's response to community complaints as one of its performance targets.

Nevertheless, similar to the Public Service Law, PerMenKes 46/2015 does not stipulate which mechanisms providers should use to address community feedback; nor does it regulate community participation in *Puskesmas*' financial and budgetary decisions. PerMenKes 46/2015 also follows PerMenKes 75/2014 in its reliance on internal accountability mechanisms: all staff primarily answer to the head of *Puskesmas*, who then reports to the district health office. The accreditation indicators include a routine performance evaluation that must be conducted against targets set by the district health office and submitted to this office (points 1.3.1 and 1.3.2). The regulation does not mention the community's role in these routine performance evaluations, although it states that community feedback should be solicited to improve services. Nor is there a provision to channel community feedback directly to the district health office. SA mechanisms, such as community feedback and complaint handling, are not institutionalized within *Puskesmas*' internal accountability mechanisms.

The Public Service Law, PP 96/2012, and PerMenKes 46/2015 are mainly concerned with the procedural aspects of service delivery and how the state, through its public service units, can be held accountable to citizens for perceived service quality. While there appears to be a significant policy gap concerning how health service units can be held accountable to health outcome targets, this law and regulation have also created significant policy space for community voice and feedback. PerMenKes 46/2015, for example, mandates *Puskesmas* to encourage community participation through empowerment activities, not only to formulate service priorities, but also to provide input on the implementation of standards and to participate in improving service quality. The regulation encourages *Puskesmas* to utilize several methods, such as surveys and direct involvement in community deliberation forums (*musyawarah* and *forum desa* are explicitly mentioned). It also recognizes that the community has a right to monitor and advocate for changes in health services through existing empowerment forums.

PerMenKes 65/2013¹² outlines the concept of community empowerment and details some of its applications in health services. The regulation recognizes community empowerment as a strategy to encourage community-driven development and participation in all health-related decision-making processes. PerMenKes 65/2013 stipulates that any effort to empower communities must observe 10 principles, including accountability, equal participation, transparency, voluntariness, and decentralization. It

¹² Peraturan Menteri Kesehatan Nomor 65 Tahun 2013 Tentang Pedoman Pelaksanaan dan Pembinaan Pemberdayaan Masyarakat Bidang Kesehatan.

also emphasizes the significant role that facilitators, CSOs, and health cadres play in mobilizing and building community capacity to advocate for their interests and needs.

Decentralization

The provision of health services has been delegated to the district government level. The Minimum Service Standards (*Standar Pelayanan Minimum* or SPM) provide one avenue for the central government to ensure that all citizens benefit from a minimum threshold of quality basic services, including healthcare, while recognizing that decentralization gives local governments the flexibility to apply these standards in accordance with the local context. The Law on Local Government No. 32 of 2004 and No. 23 of 2014¹³ (Local Government Law) mandate the formulation of SPM indicators by relevant ministries. The implementing regulation of the 2004 Local Government Law, PP 65/2005,¹⁴ tasks the Ministry of Home Affairs with coordinating relevant ministries to develop SPM for specific services, including health. PP 65/2005 also stipulates that SPM should cover standards for monitoring, and the line ministries are responsible for technical supervision of the implementation by district governments through sectoral agencies (SKPD). The evaluation is hierarchical: the provincial government evaluates the district, and the central government evaluates the province. Local government planning processes and instruments, such as the local Medium Term Development Plan and SKPD's Strategic Plan (*Renstra*), should primarily refer to, and reflect, all of these indicators.

PerMenKes 43/2016 recognizes the need to set a minimum service standard to ensure all citizens regardless of their residential district can access a certain threshold of health care amid a decentralized health governance. It also sets output targets for these minimum services, such as 100 percent immunization coverage for infants under one year old. There were some observations regarding the inconsistencies between the Public Service Law and the creation of SPM mandated by the Local Government Law. The Public Service Law stipulates that all public services, including those outsourced to the private sector, need to have a standard of services, while the Local Government Law only mandated SPM for obligatory functions of local government (Buehler, 2011). Health services, however, fall into both categories: public service and obligatory function of local government. A closer comparison between regulations pertaining to the SPM and the Public Service Law also point to complementary roles. The SPM regulates what type of services a health service unit should provide, as well as its achievement or coverage target. The Public Service Law and Permenkes 46/2015 set out guidance and required procedures on how to deliver those services.

The recent SPM did not mention any community empowerment programs listed in previous SPM (PerMenKes 741/2008). As a central government instrument in a decentralized governance system, the primary accountability for SPM lies internally in the relationship between central and local governments; the central government is the principal and the local government is the agent. Neither PP 65/2015 nor PerMenKes 43/2016 regulates external accountability between the government and citizens, except

¹³ Undang-Undang Nomor 32 Tahun 2004 Tentang Pemerintahan Daerah was replaced by Undang-Undang Nomor 23 Tahun 2014 Tentang Pemerintahan Daerah. Both laws mandated government to formulate SPM for a set of basic services, including health services.

¹⁴ Peraturan Pemerintah Nomor 65 Tahun 2005 tentang Pedoman dan Penerapan Standar Pelayanan Minimal.

by acknowledging that communities can use SPM to gain control over government performance in health services and to access information on annual SPM targets.

PerMenKes 46/2015 (discussed in the previous section) recommends that *Puskesmas* consider district SPM and other top-down guidelines from district health offices or the Ministry of Health when developing centre service standards and performance indicators. None of these regulations specifies what to do if a community's priorities conflict with the SPM.

The Law on Village No. 6 of 2014 (the Village Law)¹⁵ presents several opportunities to increase communities' role in governance and decision making. This law recognizes the village as an autonomous political entity via the devolution of governance and budgetary authority through the village apparatus and communities. The Village Law is designed to encourage and mobilize communities to participate in decision making, and to improve public services for these communities through the disbursement of village funds. Activities to improve community access to quality basic services are mentioned as priorities for village budget allocation, and the law explicitly mentions health as a basic service, along with education and basic infrastructure (elucidation of Article 74). The recent *Renstra* of 2015–2019 also recognizes opportunities to utilize village funds to promote investment in community health efforts and empowerment.

The Village Law grants villages the autonomy to create budgets and carry out local development projects. It also specifies the rights of communities over the village's governance and development agenda. These include the right to obtain information from the village government, to give feedback and voice aspirations in decision-making processes (including for village regulations and budgetary allocations), to oversee service management, and to enjoy equal and just services. Village government, in turn, is obligated to inform and involve village communities in the implementation of village development plans, and to redress any complaints that arise. Participation from citizens and collaboration between villages is expected for planning, implementation, facilitation, and oversight of the village development agenda. Citizens are to be actively involved through community discussions (*musyawarah desa*) and representation in the village parliament (*Badan Permusyawaratan Desa*). However, the Village Law stipulates that all village priorities should be aligned with those of the district, provincial, and national governments. As of 2017, the details to operationalize the Village Law and village funds are still under deliberation, and will be implemented through further regulations.

Indonesian government spending on the health sector in the years prior to the program was relatively low, even compared to other Asian nations: in 2014 it was approximately 3.6 percent of GDP, or 41.4 percent of total health costs; private and out-of-pocket payments accounted for the remainder (WHO, 2016). Of this percentage, the biggest proportion of central government health expenditure is on Indonesia's unified health insurance program, *Jaminan Kesehatan Nasional* (JKN). In 2017, 46 percent of MoH's budget was spent on JKN (MoH, 2018). Due to the financial support required to maintain the JKN, Jokowi's administration increased government spending on health by 21.4 percent in 2015, and later in 2016 by 42.8 percent, which was the first time state spending on health reached the 5 percent required by the National Health System Law (Negara, 2016).

¹⁵ Undang-Undang Nomor 6 Tahun 2014 Tentang Desa.

The Law No. 24/2011 stipulated that JKN be delivered by Social Security Administrative Bodies on Health (*Badan Penyelenggara Jaminan Sosial* or BPJS Kesehatan)¹⁶ to the entire population. If universal coverage is realized in 2019 –according to government target- Indonesia will become the largest single-payer health system in the world (Fossati, 2016). Given the size of this endeavour, it is imperative to have an effective and accessible complaint handling mechanism. The Law mandated the formation of a supervisory council (*Dewan Pengawas*), as an internal monitoring body. The supervisory council consists of 7 professional members representing government (2 member), workers (2 members), employers (2 members), and community (1 member). The members are appointed by the President for 5 years. The supervisory body is responsible of monitoring the implementation of BPJS policies and programs, providing advice and recommendations, and enacting BPJS annual plan and budget. The Law also mandates BPJS to submit annual program and financial report –after being audited by a public accountant- to the President. An executive summary of the report must be published to public through electronic mass media.

Since its roll-out in 2014, JKN has been marred with complaints and mismanagement. Government has responded by improving the policies and regulations, including substantial efforts in disseminating correct information and improving the complaint handling mechanism. It now has a 24-hour call centre to dispense information and receive complaints. Recently, MoH issued a regulation No. 4 of 2016 on Clinical Advisory mandates the formation of Clinical Advisory Council (*Dewan Pertimbangan Medik*) at national and provincial level. The Council's tasks include investigation of medical frauds, providing medical advice for costing and procedures adjustment (including subsidized drugs), and mediating clinical conflict.

Since 2011, Indonesia is also a partner of the Open Government Initiative (OGI), an international movement to encourage transparency, public participation, and accountability in government activities; the corresponding action plan for 2016–2017 describes the challenges still faced by the Indonesian Government, as well as strategies to achieve a more open and accountable government. The current action plan addresses three main challenges: 1) limited access to public information (by promoting public institution information accessibility and disclosure), 2) limited channels to facilitate public participation (by encouraging greater public participation in government administration), and 3) sub-optimal public service quality (by taking steps to improve responsiveness to citizens' needs and aspirations) (Open Government Indonesia). One of the flagship mechanism that came out of OGI is LAPOR! (see subsection “LAPOR” in this report).

Relationships between Different Types of Accountability

Horizontal, vertical, and social accountability are closely interlinked. Horizontal accountability, which includes the internal mechanisms that different government entities use to hold each other responsible for adhering to their mandate, may (sometimes negatively) influence health providers' responsiveness to communities that demand changes. After reviewing 71 health interventions in low-and middle-income countries, Berlan and Shiffman (2012) concluded that, when providers were accountable to actors

¹⁶ Undang-Undang Nomor 14 Tahun 2011 Tentang Badan Penyelenggara Jaminan Sosial

other than the citizens who use health services, those providers were less likely to be responsive to citizens' demands. For instance, oversight mechanisms that measured health provider performance reflected the preferences for quality of care of the government officials who designed the mechanisms, whereas local citizens may assess quality of care differently, particularly regarding access to care, provider–patient relationships, and system inefficiencies (Blendon, 2001).

Therefore, horizontal accountability mechanisms, while important for system monitoring, do not necessarily encourage provider responsiveness to citizen preferences, unless citizens are given meaningful opportunities to contribute to those mechanisms.

Horizontal accountability mechanisms appear to be the main tools used in Indonesia, yet they are rarely explicitly connected to SA mechanisms. The Health System Law relies on internal accountability mechanisms, monitoring of *Puskesmas* is conducted through a top-down mechanism, and PerMenKes 46/2015 relies on a hierarchical reporting system. These policies mention (but often do not clearly define) channels for citizen feedback to improve the quality of health services; they do not include formal guidelines for implementation or redress. For those community participation mechanisms that have been put forward in the existing national policy framework, such as community monitoring and complaint handling, it mostly remains unclear how they should influence horizontal accountability mechanisms, like provider performance evaluations or *Puskesmas* accreditation. One way of ensuring that the community's voice is embedded in such horizontal mechanisms is to appoint a community representative in the accreditation body and/or create a pre-and-post accreditation advisory team. Involving community members in health committees has already been accomplished with careful attention to description of roles and responsibilities and ability to influence decisions (Molyneux et al., 2012).

The hierarchical character of many public health systems and accompanying accountability mechanisms also affects the level of provider responsiveness to citizen feedback. In a descriptive review, Cleary et al. (2013) examined accountability mechanisms in district health systems from low- and middle-income countries, specifically focusing on the connection between these mechanisms and responsiveness to patients and citizens. In addition to provider capacity, they found that organizational culture and relationships between providers and supervisors played equally important roles in the effectiveness of internal accountability mechanisms (Cleary, Molyneux, and Gilson, 2013). Management styles that allow increased decision space, and supportive practices like mentoring, were contrasted with more authoritarian practices frequently used in hierarchical systems. Likewise, a study that examined horizontal accountability through the functions of supervision and disciplinary action in India found that a hierarchical organizational culture perpetuated several unproductive managerial practices (George, 2009). Instead of using accountability measures to create a supportive environment that prioritizes innovation and citizen needs, these measures could be “misus[ed] to offload responsibility and victimize lower level health department personnel as scapegoats, efforts to seek accountability are distorted and unjust organizational hierarchies are maintained” (George, 2009, 216).

Balancing horizontal accountability mechanisms with SA initiatives that promote local community involvement is challenging, especially for setting local budgets and priorities. Cleary et al. (2013) reported on several studies in which national

priorities shaped local budgets, despite efforts by local health committees and community representatives to influence the budget process. In Tanzania, for example, the district-level Council Health Management Team was required to reconcile local data with national priorities. According to one team member, "...even though we identify our own district priorities at the end of the day we must observe the national priorities" (Maluka, 2011). Similarly, a study in Kenya that examined a planning and budgeting process involving community participation in the government sector discovered that national priorities took precedence in annual work plans (O'Meara, Tsofa, Molyneux, Goodman, and McKenzie, 2011).

Indonesia's Village Law takes steps to grant authority to local village governments and their communities for development planning and budget setting. The implementing regulations (PerMenKes) seem to further support citizen involvement in more specific areas (such as maternal health). However, some articles in the law suggest that national and provincial priorities will still guide these processes. Supervision and guidance for village authorities, for example, should come from provincial and district government officials (Articles 112–115).

Nonetheless, government workers must be trained on their new responsibilities associated with the Village Law. There is evidence that government employees at the sub-district (*kecamatan*) level, an ideal point of administrative contact for villages, are poorly prepared to deal with new inquiries and demands from villages (Kusumaningrum, Bennouna, Siagian, & Agastya, 2015; SMERU, 2015).

The level of community participation in SA initiatives, and especially health providers' responsiveness to this participation, may be influenced by whether the initiative identifies community members as "citizens" or "clients." A study comparing four districts that implemented the Kinerja program in Indonesia (described in further detail below) reported different patterns of community participation during initiatives to improve health service delivery at *Puskesmas* (Anna Wetterberg, Hertz, & Brinkerhoff, 2015). It found that a more "citizen-centred" approach led to increased levels of empowerment, on-going participation, and a partnership between community members and providers. However, a "client-centred" approach was characterized by the use of community feedback simply as a tool for improving service delivery, which resulted in less citizen empowerment (Anna Wetterberg et al., 2015). Both approaches reported improvements in services, suggesting changes in providers' and officials' levels of responsiveness. Molyneux et al. (2012) reviewed several studies of community accountability mechanisms and found that most experienced difficulties in involving community members, including resource imbalances between community members and health providers that can affect engagement between them (Molyneux et al., 2012).

PART V – USING THE SOCIAL ACCOUNTABILITY APPROACH IN INDONESIA’S HEALTH SECTOR

Indonesians were actively participating in community development projects long before the recent wave of SA initiatives. Even before *reformasi*, the National Planning Agency under President Suharto launched an ambitious anti-poverty program that issued block grants to poor villages. This program, called *Inpres Desa Tertinggal* (Program for Left-behind Villages), was designed to help citizens seek their own pathways out of poverty (Guggenheim, 2006). The World Bank went on to fund a number of large-scale community-driven programs, including the Village Infrastructure Project, the Kecamatan Development Program, and the National Community Empowerment Program (PNPM). This section reviews a component of PNPM that focused on health services (Generasi), as well as another example of an early, large-scale program that featured initiatives to build SA in the health sector – *Desa SIAGA*. It then provides a brief overview of more recent SA initiatives in Indonesia that are relevant to the health sector. A number of these programs include SA initiatives in other basic services and development objectives, which are beyond the scope of this review.

Each of these SA initiatives is considered separately in order to illustrate their diverse designs and results. While several programs use similar SA tools, each has unique aims, theory of change, scope, and limitations. The section concludes with a discussion of how these programs fit within the thematic framework of awareness, voice, and empowerment introduced in Section two.

PNPM Generasi

The Healthy and Smart Generation component of PNPM Generasi (2007–2012) illustrates how citizens can participate directly in decision making related to strengthening health service provision. This community-driven development program issued yearly block grants to villages to improve education and maternal and child health outcomes by providing facilitation and incentives, and empowering communities to decide how to allocate the funds. As long as the community met 12 health and education targets, it qualified for the subsequent year’s block grant. If the community exceeded the targets, it qualified for a performance bonus. Trained facilitators and volunteers also organized focus group discussions, inter-village meetings, and consultation workshops to enable community members to identify bottlenecks within the program and share lessons learned on an on-going basis. The final evaluation of the program implementation found that, compared to control areas, program areas had improved on a number of health-seeking behaviours, including more frequent weight checks and participation in parenting and pre-natal classes even after eight years of implementation (Olken and Sacks, 2018). Program areas also saw increased numbers of cadres at community health posts and increased participation in health education meetings, though there were mixed results concerning the quality of health services. Although women and other marginalized groups were formally represented in the meetings, male village elites often dominated the decision-making process discussion (Febriany, Toyamah, Sodo, and Budiayati, 2011).

Desa SIAGA

The Indonesian Maternal and Newborn Health (MNH) Project (1999–2004) provides a notable early example of ministries and their partners formulating creative solutions to communications challenges across Indonesia to raise awareness of citizens' rights to health. The project engaged government service providers, CSOs, journalists, researchers, branding companies, and entertainers like Lis Dahlia to popularize safe motherhood practices, effectively pioneering a new family-centred approach to building demand for quality health services. In addition to educating women and men to reduce the risks associated with pregnancy, the project's 'SIAGA' (ALERT) campaigns, including *Desa SIAGA* (ALERT Village), *Bidan SIAGA* (ALERT Midwife), and *Wartawan SIAGA* (ALERT Reporter), taught Indonesians around the country to expect high-quality reproductive healthcare from the Ministry of Health and its partners, and to participate actively in improving those healthcare systems (Hill, Goeman, Sofiarini, & Djara, 2014).

In order to form a *SIAGA* village, trained organizers engaged community members in *Identifikasi Masyarakat Partisipatif*, a participatory appraisal method, to account for local beliefs and values about childbirth, and to identify available resources, stakeholders, and traditional mechanisms for community organizing. Using this method, *SIAGA* villages developed community systems to monitor healthy pregnancies, provide financial support and transportation to pregnant mothers in need, and to organize a blood donation system. A 2004 impact evaluation of *Desa SIAGA* found that the program increased knowledge about a range of pregnancy risk factors among mothers, fathers, midwives, and influential community members compared to baseline and control groups; program participants were also more aware of community support schemes for safe pregnancy, and mothers were more likely to use antenatal care (Sood, Chandra, Palmer, and Molyneux, 2004).

Since the end of the MNH Project, the *SIAGA* model has been replicated numerous times, with support from a diverse array of ministries and bilateral donors. These modified *SIAGA* programs have increasingly emphasized the value of community empowerment, and in 2009 German Technical Cooperation supported the production of guidelines for implementing community empowerment within the national *Desa SIAGA* program (Strengthening District Health Systems, 2009). These guidelines call for regular village- and district-level meetings to convene multiple stakeholders in order to improve program monitoring and enable community members to use program data to continue strengthening services and attracting resources. Some observers have concluded that the program is sustainable because it enables communities to recognize the value of this empowerment (Hill et al., 2014). This community empowerment component is now part of a 2010 Ministry of Health decree¹⁷ that makes local governments responsible for supporting *Desa SIAGA* (Hill et al., 2014).

Citizen Voice and Action

Citizen Voice and Action for Government Accountability and Improved Services (CVA) began implementation in Indonesia in 2014 with funding from the World Bank. WahanaVisi, with support from World Vision, is the primary implementer. The program aims to improve district and local planning for maternal, newborn, and child health

¹⁷ 1529/Menkes/SK/X/2010

services in three districts in Eastern Indonesia. CVA operates at multiple levels, enhancing information exchange, coordination, and cooperation among communities and village, sub-district, and district governments. One of its approaches is to recruit village facilitators to help prepare citizens to interact with local government counterparts, such as service providers.

At the beginning of program implementation, a civic education component aims to improve community knowledge of the services that the government is responsible for providing to citizens. This includes information about service standards, health indicators, and facility details to prepare citizens to engage in evidence-based discussions (Hoffmann, 2014). CVA also promotes the use of community scorecards, which are filled out by both service providers and community members; the collected information offers a constructive opportunity to learn from different perspectives and address areas for improvement. No evaluation of CVA has yet been made available, and it remains to be seen how the program will impact its target population.

ACCESS II

The Australian Community Development and Civil Society Strengthening Scheme (ACCESS) Phase II was funded through AusAid, and implementation took place in four provinces in Eastern Indonesia from 2008 to 2014. The program aimed to build and empower local constituencies to be more capable of interacting with local government and articulating their demands. ACCESS also facilitated the connection between citizens and governing counterparts through the use of local CSOs and village cadres. The target policy areas included health service delivery, education, and the fair distribution of resources for local development.

An impact evaluation in 2013 found that ACCESS II program beneficiaries enjoyed increased access to information on health services and their citizen rights (Australian Community Development and Civil Society Strengthening Scheme Phase II [ACCESS II], 2013). As part of the evaluation, a community impact assessment found that almost two-thirds (62.4 percent) of citizens in program areas felt more informed about village programs, about half (49.3 percent) felt that they could participate in community meetings, and a little under half (47.2 percent) had improved perceptions of service delivery. However, these findings are based on non-probability sampling, and should be interpreted with caution (ACCESS II, 2013). As a result of capacity building by ACCESS and partnering CSOs, average citizens were reportedly more capable of participating in important aspects of local governance, such as public planning, which were traditionally reserved for select community members. Respondents also reported feeling that the government was more responsive and willing to address citizens' input regarding service delivery. Nevertheless, the evaluation found a few instances in which participation in the local planning process continued to be limited to a select group of individuals. Even where planning was more inclusive, localities often struggled to align their budgets with village plans. Notwithstanding these limitations, however, over two-thirds (70 percent) of survey respondents felt that the benefits of their involvement in the program outweighed their time and resource investments.

Of course, not all program gains were distributed equally among program sites. The impact evaluation found that the local capacity of CSOs and village cadres was an important factor in determining the degree of improvement in citizen empowerment.

Since these organizations and individuals acted as the primary agents interacting with communities and government personnel, the intensity and quality of the activities they conducted often determined the success of community empowerment efforts (ACCESS II, 2013).

LOGICA2

The Local Governance Innovations for Communities in Aceh Phase II (LOGICA2), funded by AusAid, was conducted in Aceh Province. Similarly to ACCESS, LOGICA2 was an extension of a successful initial program phase. This second program phase commenced in early 2010, ended in 2014, and focused on two aims simultaneously: empowering local citizens and building capacity in governing systems and personnel. The capacity-building interventions targeted government at the district and provincial levels. LOGICA2 aimed to improve service delivery in the health and education sectors.

LOGICA2 was successful in increasing the knowledge of communities (particularly village cadres) of their rights to basic social services as well as the responsibilities of government systems to provide these services, according to a 2012 progress report (Suhirman, Suryaningati, and Kelly, 2012). Community members gained awareness of the right to advocate for better service provision with various authorities, including the village office, service units, and district-level agencies. For some community members, possessing a new level of awareness motivated them to take an interest in more active accountability steps.

Representing all community groups when identifying community needs and demands is an important aspect of SA approaches. One of LOGICA2's strengths was that a higher percentage of women engaged in village-level discussions about local development, which increased the likelihood that the needs of women and children would be addressed in village development plans. LOGICA2 reportedly achieved a female representation of 85 percent among the voluntary village cadres, and more than two-thirds of these women maintained their active involvement in village planning forums (*Musrenbang*) and on local school and health committees (Suhirman et al., 2012).

Although LOGICA2 delivered important benefits to communities and local governments with respect to empowerment and capacity building, some observers believe that the second phase was too ambitious in its objectives relative to the program timeline. The 2012 progress report, for example, noted limitations in the degree of government responsiveness it was able to achieve. The report attributed this limitation partly to the program planners having underestimated the complexity of changing the local government while simultaneously empowering the community (Suhirman et al., 2012). The report noted that the program made several incorrect assumptions in its design phase, did not implement a rigorous monitoring and evaluation plan capable of informing course corrections, and did not adequately engage the donor, AusAID, in policy discussions and negotiations that could have enhanced program effectiveness and sustainability.

Kinerja

The Kinerja program, led by RTI International and funded through the US Agency for International Development (USAID), ran from 2010 to 2015 in four Indonesian provinces

with the aim of improving public service in three areas: health, education, and business licensing. Program implementation focused on strengthening governance measures between local citizens and governing counterparts, but employed interventions that were based on existing policies as much as possible. While program interventions targeted services at the district and village levels, Kinerja worked with local organizations to build capacity and promote greater sustainability. This model presented some challenges because baseline local capacity varied, and organizations required different types and levels of technical assistance and training in key areas.

One of the program's notable interventions was the multi-stakeholder forums with citizens and local government counterparts to raise citizens' awareness of, and stimulate demand for, better services. These forums also increased citizens' capacity to oversee the implementation of services and actively engage with their local governing officials, for example to develop service charters (Kinerja, 2015). These charters reportedly enhanced service delivery by improving staff attitudes and attendance, increasing the accountability of midwives, and increasing the availability of doctors (Anna Wetterberg et al., 2015). Three of four program districts visited during an evaluation published in 2015 had successfully passed health regulations with help from Kinerja. Subsequent interviews, however, found that these regulations had not always affected service provider performance below the district level, owing to on-going challenges with disseminating new information to these lower administrative levels (Kinerja, 2015).

Many of Kinerja's health-related activities targeted maternal health services at the *Puskesmas* level. Feedback mechanisms were implemented to give local communities a channel for complaints or recommendations for the local service providers. SOPs were also promoted at the *Puskesmas* level to address complaints and institutionalize best practices. While these SOPs reportedly contributed to some improvements in provider behaviour, they had little noticeable impact on the use of services at the time of the endline evaluation (Kinerja, 2015). One notable policy change involved the head of a *Puskesmas* cancelling a contract with a formula milk company in order to promote breastfeeding, in response to demands from a citizen oversight board; the change also coincided with new district-level regulations.

Analyses of two national survey datasets (*Susenas* and *Riskesdas*) found that while both treatment and control groups enjoyed improvements in a number of health indicators during the program period – including assisted childbirth, exclusive breastfeeding, and use of public health facilities – individuals in treatment districts did not have significantly better health outcomes than those in control districts by the end of the program. Individuals in intervention districts were less likely to use health services than those in treatment districts, though this may be a result of measurement error due to challenges in evaluating the program (Kinerja, 2015).

LAPOR

Through Open Government Indonesia (OGI), the national government operates LAPOR, an online complaint-handling portal that is integrated with over 70 government institutions. Using the LAPOR website, hundreds of individuals report complaints or queries directly to the relevant institution every day, though the system has not been rolled out in most local governments (Basu, 2015; Dhiratara, 2013). Ideally, the system would expand across the country and each complaint would be addressed within a

certain number of days, after which the relevant institutions would routinely analyse the complaints and develop new policies and practices to prevent future complaints across administrative levels. Most analyses of LAPOR data are a few years old, and therefore may not reflect the system's current performance; over 300,000 reports were made in 2013, and a similar number was predicted to be made in 2014 (Mahendra, Pratiwi, & Prawesti, 2014). Of a subsample of 62,527 such reports made before May 2013, the highest number (19 percent) were related to bureaucratic reform and governance, followed by infrastructure (17 percent), and education (15 percent). The government had resolved 53 percent of these reports, while 25 percent were still under investigation, and the remaining 22 percent had not been processed. According to OGI, in 2014 MoH has developed a complaint and feedback mechanism called SIAP and MoH has started to link it with LAPOR! (OGI 2015).

UPIK

The Special Administrative Capital of Yogyakarta became a pioneer in mediating the connection between state actors and citizens shortly after decentralization. With support from municipal leaders and Swisscontact, the Unit for Information and Complaint Services (*Unit Pelayanan Informasi dan Keluhan* or UPIK) was created to facilitate communication between the government and citizens for complaints and grievances. A 2015 report found that 4,006 messages were relayed through UPIK in 2014, and that 97.5 percent of these reports were followed up on, although other sources have reported lower complaint-handling rates (Fatonie, Pellini, Smidt, & Apriliyanti, 2016). UPIK received a score of 68.5 on responsiveness in a 2014 public satisfaction survey, and its operators gave the system's follow-up procedure a score of 71.7, both of which were slight improvements on the previous year. In 2015, public services accounted for a third of all complaints – the largest complaint category.

UPIK has already sustained three mayoral periods and has become an institutional fixture in the municipal government, and has been mentioned in the Municipal Annual Work Plans for the past three years (Fatonie et al., 2016). Strong leadership was an important factor in its early stages; addressing capacity among government personnel to receive and respond to information from citizens cultivated political will and state accountability.

EMAS

Expanding Maternal and Neonatal Survival (EMAS) is a five-year USAID-funded program to improve emergency maternal and newborn health services in six provinces. EMAS is focused on two primary objectives: upgrading emergency clinical services and improving the efficiency and effectiveness of referral systems. To accomplish these objectives, the EMAS program works with government agencies, CSOs, public and private health care providers, and citizens.

In terms of accountability initiatives, EMAS introduced civic forums (*Forum Masyarakat Madani*) to empower communities to develop an active voice and hold maternal newborn health facilities accountable for quality emergency care. These forums were comprised of CSOs that were recruited based on their interest and capacity to support MNH issues. The community links to the civic forums were voluntary maternal and child health motivators (MKIA) who represented women and their families in the program villages.

Civic forums were focused on three primary roles. First, these forums provided channels for feedback that included activities such as drafting service charters, collecting MNH service feedback through voluntary MKIAs, and public monitoring (community scorecards). Second, EMAS implemented an electronic citizen feedback mechanism called “Citizen Gateway” that allowed service users to submit feedback through SMS on the quality of care at hospitals and *Puskesmas*. Program staff supported health workers to systematically receive, monitor, and respond to feedback from service users. Finally, EMAS also developed technical working groups (*Pokjas*) that acted as multi-stakeholder oversight committees. These groups were made up of public officials, health providers, and citizens with the goal of sharing governance responsibilities and promoting cooperation. The primary roles of the *Pokja* included advocating at the local and district levels for financial resources and policy changes that support maternal and neonatal health services.

An independent midterm evaluation of EMAS, drawing on 200 key informant interviews and a desk review, found that each of these civil engagement mechanisms was valid, but that “there may be too many pieces to the current approach to allow focus on success of the most important parts” (Wasisto, Budiharsana, Koblinsky, & Barlett, 2014). The evaluation reported that there was high variability in the effectiveness of *Pokjas*. While many successfully advocated for increased investments in maternal and neonatal health, some reportedly focused too heavily on garnering support for their own functions, rather than on maternal health outcomes. As for civic forums, the evaluation found members to be enthusiastic and energetic, but concluded that they often lacked subject matter knowledge, and needed more clarity on their roles, and general support. Finally, the evaluation found that citizen report cards and other client feedback mechanisms “may not yield substantial pay-off and may dilute the limited capacity of EMAS” (Wasisto, Budiharsana, Koblinsky, and Barlett, 2014). Nevertheless, community feedback did lead to significant policy change on occasion: in one district, feedback prompted the Social Security Administrative Bodies (BPJS) and the agency charged with administering the national health insurance (JKN) to modify regulations for covering newborns at the national level (EMAS, 2016a). The program’s final two years have yet to be assessed.

Discussion of Programs

Awareness: Information and Education

The *Desa SIAGA* program and its various iterations creatively adapted the central message from ministries and partners to resonate with citizens. This program, which still continues in a new form, is a strong reminder of the benefits of engaging a range of partners to build effective messaging and create demand for quality health services. Since *Desa SIAGA* began, several more programs have continued to improve awareness of citizens more locally, like CVA and ACCESS II in eastern Indonesia and LOGICA2 in Aceh. CVA introduced civic education activities in which CSOs and government officials provide citizens with the opportunity to learn about their rights and the service standards and accountability systems that are in place to secure them. ACCESS II and LOGICA2 both included information dissemination activities aiming to stimulate community-led advocacy efforts to improve governance and public services. Participating citizens in both programs became significantly more confident as they learned more about their rights to services, and LOGICA2 also had considerable

success increasing the representation of women in this process (ACCESS II, 2013; Suhirman et al., 2012). Multi-stakeholder forums and civic forums used by Kinerja and EMAS, respectively, were key means of generating awareness among citizens. In addition to providing an opportunity to improve awareness among participants, forums create an important space for dialogue to take place between citizens, health providers, and local leaders, who represent the various interests of the community.

Voice: Monitoring and Feedback Mechanisms

Providing a channel for citizens to voice their feedback (both positive and negative) about public service delivery is an important part of accountability measures. Several programs across Indonesia have experimented with citizen monitoring and citizen feedback. Two mechanisms, LAPOR and UPIK, use technology to accommodate citizen complaints about government services. These mechanisms allow citizens to submit their feedback electronically, after which it is delivered to the appropriate department. UPIK has reportedly been effective in responding to citizen feedback. Meanwhile, the USAID-funded Kinerja (2010–2015) program supported *Puskesmas* to establish their own complaint-handling mechanisms (Kinerja, 2015). ACCESS supported the establishment of 232 community complaint centres across 15 districts, at which individuals provided feedback about basic services; volunteers supported by the program would ensure that the grievances were addressed (ACCESS II, 2013).

In an effort to facilitate more representative feedback across all segments of the population, programs such as ACCESS, LOGICA, and Kinerja have also actively sought patient input through structured client feedback, including complaints surveys and citizen report cards (ACCESS II, 2013; Kinerja, 2015; Suhirman et al., 2012). CVA effectively employed community scorecards to capture feedback and concerns from both community members and service providers. While such surveys and reporting mechanisms require significant financial and human resources investments, they can represent some of the voices that are least heard by government officials, especially in contexts where it is not customary to openly criticize the authorities. By producing population-based estimates of citizens' experiences and perceptions of public services, these tools offer useful insights for policy makers and health centre management, and provide communities with evidence to improve their policy advocacy efforts.

Empowerment: Citizen Training, Mobilization, and Participation

Empowering citizens through capacity-building activities gives community members the tools and confidence to interact productively with state actors. The multi-stakeholder forums implemented by Kinerja described above are also noteworthy: they bring citizens and local governments together to draft service charters and develop action plans that effectively institutionalize measures to improve service standards. During the program, 61 service charters were developed with *Puskesmas* across Kinerja's 20 partner districts (Kinerja, 2015). These activities cultivated a culture of cooperation between community members and their local governments, a precedent that has since been replicated beyond the program areas. Similarly, EMAS drafted service charters through its civic forums to publicize standardized maternal and neonatal health services that should be available at facilities. *Pokjas* were influential across EMAS districts in advocacy activities securing budgets and increased funding for maternal and neonatal health; these groups

were also influential in advocating policy changes that support maternal and neonatal health (EMAS, 2016b).

Another common approach is to develop citizen skills that enable them to contribute to SA. Kinerja, for example, trained 281 citizen journalists and supported a fellowship program, journalism festivals, and other public events to incentivize their continued professional development. During the program, these journalists developed 1,106 media products, including articles and documentary videos (Kinerja, 2015). Other programs train volunteers to participate in existing government systems, such as village health post (*Posyandu*) cadres, or to facilitate community group discussions and planning meetings. Programs such as ACCESS also invest in strengthening citizens' organizational capacities as part of community mobilization efforts. This involves promoting networking among different groups to support knowledge sharing and coalition building, as well as improving CSO management and governance systems, and mainstreaming gender and social inclusion principles to secure accountability for all segments of the citizenry (ACCESS II, 2013). The ultimate goal of these efforts is to prepare citizens to work together on SA initiatives beyond the scope of the initial program.

CVA focused on the initial step of building community members' capacity. Civic education activities with trained facilitators informed community members of their rights to minimum service standards, and provided knowledge on roles and responsibilities during implementation of the SA approach. This knowledge enabled community members to engage in critical discussions with service providers during multi-stakeholder meetings. CVA accepts this enabling step as essential to empowering communities to advocate for service provider accountability. One important challenge for facilitators and community members is to address the range of public policy and legal understanding among community members (Wahana Visi, 2014).

PART VI – RECOMMENDATIONS:

On Policies

1. **Supporting the development and provision of more detailed policy guidance and technical assistance to subnational governments on linking social and horizontal accountability mechanisms** could help secure citizens' role in critical health sector strengthening efforts, from informing service provider performance reviews to influencing budget allocation decisions. While Indonesia's national policy framework provides a strong foundation for SA in the health sector, it lacks detailed guidance on the incentives and procedures needed for service providers and local officials to address citizen feedback effectively. The current paradigm in the policy framework still views community participation as a way to pool resources in implementing activities rather than as an indispensable aspect of service delivery governance.

Despite the importance of the private sector in Indonesia's healthcare system, national policies providing for SA in this sector have insufficient detail on the roles, responsibilities, and accountability obligations of private, for-profit actors relative to public service providers and citizens. Addressing this gap in the national SA framework would help ensure that all healthcare providers are accountable to the patient population, while also promoting private–public partnerships that can enhance citizen voice and improve health outcomes.

2. **Recognizing the emergence of new modalities of fiscal transfer, especially the Budget Allocation for Specific Purposes (*Dana Alokasi Khusus* or DAK) and village funds (*Dana Desa*), SA initiatives in health should focus on the requirements and prioritization of those transfers, and linking them with horizontal accountability mechanisms in public financial management.** DAK is usually allocated to help local governments achieve national priorities as set out in the Annual Government Workplan (*Rencana Kerja Pemerintah* or RKP). In 2016, DAK for the health sector focused on reducing maternal mortality, infant mortality, and malnutrition, as well as on achieving equitable family planning services, among other priorities. According to Permenkes 43/2016, DAK will be allocated based on a local government's capacity to meet SPM targets. When SA initiatives have the same focus as DAK priorities and are based on adequate information on the DAK received by their districts, citizen awareness, voice, and empowerment can be geared towards ensuring that local governments adhere to their stated health goals.

The Village Law and the distribution of village funds also present opportunities to stimulate SA in health services. This modality can be set with a particular focus on community empowerment and participation as recognized by a number of policies detailed above as well as the Ministry of Health's Strategic Plan 2015–2019 (*Rencana Strategis* or *Renstra Kesehatan*). The village funds can be utilized to increase a community's capacity to identify its own health needs and to make expenditure decisions on relevant health services. The central government can facilitate this process by institutionalizing key health priorities (reducing maternal mortality, infant mortality, and malnutrition, and equitable family planning services)

into the Village Law's implementing regulations, manuals for village facilitators, and village-level accountability mechanisms by making sure that these will be complimentary to DAK and other existing fiscal streams. The on-going World Bank assessment of the village funds accountability system will offer more insights on salient avenues to pursue these opportunities.

3. **The minimum service standards in health can be an effective tool for operationalizing SA in the patient-provider relationship.** Greater support for citizen capacities to engage meaningfully and confidently with health planners and providers to improve service quality would go a long way towards ensuring that this SPM mechanism is realized to its maximum potential. Investments in citizen capacities, however, are often only as effective as the state's capacities and willingness to engage with citizens. Efforts to prepare service providers and local officials to solicit routine citizen feedback on services, and to work with citizens to develop solutions that work for everyone, should be mainstreamed into *all* health system strengthening programs – not just those focused on governance or SA. Preparing local governments in this way must go beyond creating standards and conducting trainings; providers and officials must be incentivized to work with citizens and to improve their services while being given reasonable assurances that negative feedback will not threaten their job security. SA is by necessity a complex process that requires the alignment and harmonization of all stakeholders at the policy, strategic, and operational levels.

On Programs

1. **Undertake a comprehensive approach.** Initiatives are more productive when they deploy multiple SA approaches to support citizen action and responses from the public service partners. Furthermore, these approaches are more effective when they are adapted to the specific needs, preferences, and constraints of the local population and implementing partners (ACCESS, 2013; Fox, 2015; Kinerja, 2015; Suhirman et al., 2012). Policy initiatives can reinforce programmatic gains by institutionalizing solutions and securing an environment that enables long-term SA (ACCESS, 2013; Fox, 2015; Kinerja, 2015). This institutionalization can provide both a legal framework to support solutions with proven track records, and transparent standards of service based on available evidence and local preferences. This process is more likely to formalize successful performance monitoring mechanisms beyond the pilot phase and create budgetary space to incubate on-going innovation.
2. **Promote links between SA and horizontal accountability.** Citizen feedback on services ("social accountability") can inform internal government performance evaluations, and thus make the government's internal accountability process more transparent to citizens and open additional channels for citizens to report directly to policy makers (Grandvoinnet, Aslam, and Raha, 2015). Such links may also enhance transparency around budgetary provision toward citizens, ensuring that citizens understand (and are able to monitor) the existing channels that finance service delivery (Grandvoinnet et al., 2015).
3. **Cultivate intersectoral, multi-group partnerships.** Programs are more effective when they aim to strengthen cooperation and coordination by engaging all segments of the local population, together with citizen's groups, academic institutions, and

multiple elements of government including service providers, local authorities, and policy makers across administrative levels (ACCESS, 2013; Kinerja, 2015; Suhirman et al., 2012). The diversity of partners helps enhance the credibility of capacity-building projects and investments at the community and government levels, and increases the likelihood that the results will endure beyond the program period (Kinerja, 2015). Cultivating trustworthy and productive relationships with diverse partners may require multiple stages of program implementation and may be facilitated by stakeholder mapping and political economy analysis. Existing programs also tend to overlook the need to improve the capacity of frontline service providers to influence policy makers or elected officials, which is especially important when the providers' responses to community grievances and aspirations depend on government decisions.

4. **Be sensitive to existing power dynamics within the community and civil society.** Social initiatives that give locally appointed councils, forums, and facilitators decision-making authority without taking local power dynamics into account risk elite capture and social and gender exclusion – which can disempower the very populations targeted by SA initiatives (Fox, 2015). The emphasis on patients as a core concerned group, for example, may overlook other parts of the community that have no access to services. However, efforts to include marginalized segments of the population risk exacerbating social tensions and undermining programmatic legitimacy. These risks reinforce the need for a variety of approaches, and for engagement with diverse stakeholders, such as higher-level officials, provincial CSOs, and media organizations, which can provide counterweights to local elites. Engaging multiple stakeholders can also reduce the risk that program implementers and other external actors will override the community's interests (Lodenstein, Dieleman, Gerretsen, and Broerse, 2016).
5. **Be patient: results take time to materialize, and when they do it is hard to attribute changes to specific programs, especially over the short term.** Community members and leaders should manage their expectations accordingly. Monitoring and evaluation teams can be incorporated into the early stages of program development to ensure that program evaluation strategies are sensitive enough to program targets (Kinerja, 2015); these evaluations should include both quantitative and qualitative data. An impact evaluation of Kinerja noted that randomized control trials might not be suited to such large-scale and complex programs due to both political and logistical constraints (Kinerja, 2015). In the short and medium term, investments that focus on changing the perceptions that government officials' perceptions of citizen involvement, and increasing providers' capacity to earn and nurture trusting relationships with multiple stakeholders, may enhance the sustainability of SA initiatives (Lodenstein et al., 2016).
6. **Contextualize all programs.** SA initiatives may not apply across all contexts; program designs must take into account the politics, economy, culture, and regulatory environment of program areas, and remain flexible to the emerging needs and preferences of local populations (Fox, 2015; A. Wetterberg, Brinkerhoff, and Hertz, 2016). Province and district regulations are particularly important for ensuring that national SA policies are implemented in ways that are appropriate to the local context. This context dependency also highlights the critical need to invest in the

capacities of service providers, officials, and different elements of civil society at the local level to encourage them to develop their own SA initiatives.

APPENDICES

Abridged Case Studies

Problem-driven Analysis	Scope	Drivers	Roles of Parties involved	Sources of Funding
<p>Lack of awareness among mothers regarding the risks of childbirth and entitlements to health services.</p> <p>Location: Orissa, India</p>	State level (Province equivalent)	<p>Generating Demand: increasing awareness, agency, opportunities for women to confront people in power, changing mindsets among women;</p> <p>Leveraging intermediaries to legitimize demands from women</p> <p>Sensitizing leaders and health providers to change mindset</p>	<p>Civil society alliance (volunteers) organize public hearings</p> <p>Government leaders and health care providers facilitated by civil society alliance</p>	Civil Society Alliance
<p>Improve the delivery and quality of public basic services</p> <p>Location: Ethiopia</p>	Town level	<p>Engaging citizens and civil society organizations with activities that use social accountability tools</p>	<p>Civil Society Organizations raise awareness of rights, responsibilities, and entitlements to basic services</p>	Multi-Donor Trust Fund
<p>Physical resources alone are not sufficient to improve delivery of quality services.</p> <p>Location: India</p>	Village level	<p>Empowering stakeholders by providing information may stimulate demand for quality services.</p>	<p>Research Study Information campaign targeting parents of elementary school children.</p>	Nike Foundation
<p>Holding government accountable for program planning and management of resources for AIDS Levy</p> <p>Location:</p>	National Level	<p>Civil Society (activists) held demonstrations;</p> <p>Formal petition filed against government by Human Rights Lawyers</p>	<p>CSOs play role of government watchdog</p>	N/A

Zimbabwe				
Monitoring performance of primary care service providers Location: Tajikistan	Province level	Engaging community members to participate in public reporting on performance of service providers	Citizens provide feedback to health service providers through report card	World Bank
Lack of understanding and demand for Vaccine services Location: Timor Leste, India	District and Village level	Engaging community members, health providers, and village leaders to share responsibility for monitoring services/outcomes	Citizens and health care providers create vaccine monitoring instrument	Millennium Challenge Corporation
Improving government health service quality with community input Location: Philippines	Province level	Improving effectiveness of service delivery	Joint community– provider committees to engage citizens to improve service quality	Donor-funded
Low coverage for safe motherhood services Location: Nepal, Armenia, Afghanistan	Community or District level	Collaboration between providers and community in defining, implementing, and monitoring the quality improvement process	Partnership between users and providers of services	Local resources
Weak primary health care services, lack of information among community members Location: Uganda	Community level	Empowerment of community members and providers through interface meetings to produce action plans and monitoring instruments	Research Study Providers and community members create action plan	Jan Wallander's and Tom Hedelius' Research Foundation
Low coverage and quality of child survival interventions. CODES	District level	Communities are empowered through dialogues and citizen report cards	Provider and community members conducted LQAS, Bottle-	United States Fund for UNICEF

Location: Uganda			neck analysis, Causal analysis, Continuous Quality Improvement (CQI), Community Dialogues based on Citizen Report Cards and U reports	
Increase the responsiveness, sustainability, and efficiency of health services Location: Kenya	District level	Providers commit to provision of services according to service charter. Community is empowered by knowing rights and services offered.	Health care providers and community members	Gates Cambridge, Peterhouse Cambridge, APHRC, and CNHR

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As social accountability (SA) initiatives in Indonesia continue to grow, evidence shows that mechanisms to engage citizens to monitor service provision and provide constructive feedback on large-scale programs in the public sector still need improvement. SA, or citizens' ability to hold governing actors and their partners accountable for their actions and commitments, is recognized as a fundamental right and an indispensable means of strengthening national health systems. The Government of Indonesia's commitment to improve basic service delivery to poor and vulnerable populations represents an opportunity to apply SA approaches to improve the access and quality of health services.

This report aims to inform efforts to improve SA in Indonesia's health sector, particularly maternal and child health services. It gives an overview of common approaches to building social accountability, using examples from other comparable low- and middle-income countries, to extract lessons learned. It then analyses Indonesia's national regulatory and policy framework related to SA initiatives in the health sector. Next, it reviews Indonesian initiatives that have included SA components in order to identify programmatic opportunities, challenges, and remaining gaps for improving SA in Indonesia's health sector. Finally, it provides evidence-based recommendations for future SA policy and programming initiatives in Indonesia.

Three common thematic SA approaches emerged from this review. These include: building awareness among communities, creating voice, and empowering action. This report finds that SA initiatives that include all three elements through multiple mechanisms are more likely to succeed. Programs need to develop comprehensive approaches that fit local contexts, accommodate multi-sector partnerships, and account for existing power dynamics and risks associated with increased decision-making authority. Efforts to prepare service providers and local officials to solicit routine citizen feedback on services, and to work with citizens to develop solutions that work for everyone, should be mainstreamed into *all* health system strengthening programs.

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