January 2015 No. 2015-01

International Development Group Working Paper Series

Social Accountability in Frontline Service Delivery: Citizen Empowerment and State Response in Four Indonesian Districts

Anna Wetterberg
Jana C. Hertz
Derick W. Brinkerhoff

A working paper of the
Governance and Economic Development Division
International Development Group,
RTI International

3040 East Cornwallis Road
P.O. Box 12194
Research Triangle Park, North Carolina 27709-2194
USA

RTI INTERNATIONAL

International Development Group Working Paper Series

Social Accountability in Frontline Service Delivery: Citizen Empowerment and State Response in Four Indonesian Districts

Anna Wetterberg
Jana C. Hertz
Derick W. Brinkerhoff

Governance and Economic Development Division
International Development Group (IDG),
RTI International
3040 East Cornwallis Road
Post Office Box 12194
Research Triangle Park, NC 27709-2194
919-541-6343
awetterberg@rti.org

January 2015
No. 2015-01

The following IDG working papers are available:

- *No. 2013-01: Strengthening Local Councils in Uganda*
- *No. 2013-02: The Political Economy of Adopting Public Management Reforms: Patterns in Twenty Indonesian Districts*
- *No. 2013-03: Capacity Development for Local Organizations: Findings from the Kinerja Program in Indonesia*
- *No. 2014-01: Strategies for Improved Delivery of Basic Services: A Concise Framework and Selected Cases*
- *No. 2014-02: Does Better Governance Improve Service Delivery? Evidence and Lessons Learned from the Guinea Faisons Ensemble Project*
- *No. 2014-03: From Supply to Comply: Gauging the Effects of Social Accountability on Services, Governance, and Empowerment*

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABBREVIATIONS AND TERMS

Bappeda	Badan Perencanaan Daerah, district planning agency
BPS	Badan Pusat Statistik, Central Statistics Agency
Bupati	district executive for kabupaten, usually translated as regent
CHS	complaints handling survey
CSO	civil society organization
DFID	Department for International Development [UK]
Dinas Kesehatan	District Health Office
DPRD	Dewan Perwakilan Rakyat Daerah, local legislative assemblies/regional parliament
HDI	Human Development Index
IDS	Institute of Development Studies
INDO-DAPOER	Indonesia Database for Policy and Economic Research
IO	intermediary organization
ISO	International Organization for Standardization
kabupaten	regency, usually refers to a rural area
kota	municipality, usually refers to an urban area
LBI	Local Budget Index
LPSS	Local Public Service Specialist
MMR	maternal mortality rates
MSF	Multi-Stakeholder Forum
PNPM	Program Nasional Pemberdayaan Masyarakat, National Program for Community Empowerment
puskesmas	subdistrict primary health center
SA	social accountability
SC	service charter
SMS	short message service
TNP2K	Tim Nasional Percepatan Penanggulangan Kemiskinan, National Team for the Acceleration of Poverty Reduction
USAID	United States Agency for International Development
Walikota	district executive for kota, usually translated as mayor

ABSTRACT

Frontline public services are the point at which service providers and citizens interact. Social accountability (SA) tools engage citizens in identifying shortcomings to improve frontline service delivery. Such tools have been criticized as mere widgets; decontextualized technical interventions that do little to transform the system of service provision or state-society relations. However, there has been increasing effort to understand the contexts and political processes through which accountability is negotiated to find the best fit between SA tools and local circumstances.

To identify factors associated with continued commitment to SA, we examined the Kinerja program's implementation of SA tools in Indonesia, drawing on sixty interviews with providers, clients, and local officials at fifteen primary health centers in four districts. Kinerja works in twenty districts to improve services through a complaints survey, a multi-stakeholder forum, and a service charter negotiated between citizens and providers.

We found that healthcare providers and local governments demonstrated responsiveness to citizens not only in contexts that we characterize as conducive, but also in less favorable contexts. However, providers' commitments to SA were often weaker than citizens'. Further, state actors showed varying emphasis in their commitments to SA. Some saw citizens as ongoing partners in improving service delivery, while others used SA to identify priorities for improvement without further active citizen engagement. While both models resulted in service enhancements and replication of SA approaches, longer-term sustainability will be undermined without citizen engagement and where providers' and citizen's expectations for SA are not aligned.

Bureaucratic reforms and the Village Law could facilitate continued commitment to SA in Indonesia, but there have also been signs of reduced support for SA tools and of new limitations on democratic processes. This policy context puts Indonesia at a pivotal juncture, with risks of falling back into old patterns and losing the hard-won momentum for service improvements through SA.

ACKNOWLEDGMENTS

Financial support for this study was provided by an RTI independent research and development grant, RTI's Fellows Program, IDG's Executive Vice President's office, and IDG's Governance and Economic Development Division. We thank the Kinerja program's staff and the collaborating Indonesian government and local organization partners for support for data collection in Indonesia. The authors gratefully acknowledge access to data and documentation for the districts studied and provided by the U.S. Agency for International Development's (USAID's) Kinerja Program (Cooperative Agreement No. AID-497-A-10-00003; see http://www.kinerja.or.id). Ellen Lohr-Hinkel and Gail Hayes provided helpful editing and layout support. The views expressed are solely those of the authors.

INTRODUCTION

Frontline public services are the point at which service providers and citizens interact, in settings such as health clinics, schools, social welfare bureaus, or registrar offices. The quality of those interactions influences service utilization, citizen satisfaction, trust in government, and ultimately service outcomes. In international development, frontline public service delivery often lies at the intersection between sectoral and governance programs. Addressing public service needs and solving service delivery problems have traditionally fallen within the sphere of government, where solutions have focused on modifying administrative processes, increasing public sector capacity, introducing supportive policies, and designing improved technical interventions. A rising chorus of criticism of these supply-side methodologies has faulted them for not doing enough to gauge and respond to citizens' needs (Brinkerhoff & Wetterberg, 2013). In response, demand-side approaches engage citizens to address these shortcomings. Proponents of concentrating on the demand side maintain that citizen input can help by identifying gaps in service delivery at the front lines, and by raising the voices of service users, the demand side can contribute to stronger service provider accountability (e.g., Agarwal & Van Wicklin, 2012). An extensive literature has emerged and continues to grow, which examines citizen engagement in service provision and the dissemination of social accountability (SA) tools (see Gaventa & Barrett, 2010, 2012; O'Meally, 2013; Tembo, 2013).

Most donor-supported SA interventions, implicitly or explicitly, incorporate a linear theory of change that SA directly connects citizen voice, enabled by SA tools, to increased accountability, leading to government and provider responsiveness (Rocha Menocal & Sharma, 2008). However, this causal chain model has been increasingly subject to challenge, both practically—in terms of what works and what does not—and conceptually, regarding why expected outcomes have not been reliably achieved. In response, two key issues in applying SA tools and methods arise. The first concerns the conditions under which these tools and methods effectively communicate citizen needs and support holding frontline service providers accountable for meeting them. The second is the extent to which their use persists beyond initial introduction (by donors and country actors) and, further, is sustainable over time. On the frontlines of service delivery, both issues remain understudied (Molyneux, Atela, Angwenyi, & Goodman, 2012).

This paper contributes to filling this gap. We examine the application of SA tools and associated processes in Indonesia, where the United States Agency for International Development's (USAID's) Kinerja program has been implementing service delivery improvements that combine demand- and supply-side interventions for the past four years in 20 districts, starting in 2010. We assess four districts' experience with three SA tools applied in the health sector: (1) a user complaints survey (referred to as a complaints handling survey, or CHS); (2) a service charter (SC), an agreement negotiated between citizens and providers at primary health centers (*puskesmas)* to specify provider responsibilities and identify areas for improvement; and (3) a multi-stakeholder forum (MSF), a committee formed to channel citizens' concerns and feedback to providers and local government officials. We explore the contextual and Kinerja-specific factors that influence continued commitment (or lack thereof) to SA tools and principles, and examine the extent to which citizens and providers perceive that SA has led to changes in service delivery. Regarding sustainability, we investigate changes in the attitudes of providers, citizens,

and local government officials across the four districts and note which of the SA tools introduced by Kinerja have been sustained. The empirical base for our study comes mainly from field interviews in the spring of 2014 with puskesmas staff, MSF members, district government officials, intermediary organizations (IOs), and Kinerja staff.

The paper begins with a brief literature review and the development of an analytic framework for assessing SA tools and processes. It next provides an overview of Kinerja's SA interventions and the theory of change that outlines the expected results paths. The paper then turns to the findings from the four districts, where the discussion seeks to illuminate the SA dynamics and offer insights into the "what and why" of citizen engagement in health provider accountability. Finally, the paper offers some observations, recommendations, and conclusions related to SA and frontline service delivery.

SOCIAL ACCOUNTABILITY

Accountability may be defined as "constraints on the exercise of power by external means or internal norms" (Chandler & Plano, 1988, cited in Freedman & Schaaf, 2013, p. 104). Where accountability actors are located within a particular governance system influences how these constraints function. One broad categorization distinguishes between institutions and actors located within the state and those located outside. Accountability within the state refers to state institutions that curb abuses by other public agencies and branches of government. External actors include individual citizens, media, civil society organizations (CSOs), and the private sector in various activities that seek to articulate demands, investigate and denounce wrongdoing, enforce standards of conduct, and provide commentary on the behavior and actions of public officials and agencies. In democracies, external actors can exercise electoral accountability, but may also rely on both collaboration with the state – through, for example, participatory budgeting and citizen-providers committees – and confrontation (through actions such as demonstrations and lawsuits) to hold public actors to account (Bukenya et al., 2012; Brinkerhoff with Azfar, 2010).

SA has become the shorthand term to refer to the role that citizens play, through various collective action tools and processes, to constrain the state's use of power (O'Meally, 2013). SA needs to connect in some manner to state institutions to influence behaviors, norms, and incentives for officials, service providers, and citizens (Freedman & Schaaf, 2013). SA varies in terms of its power to hold providers and officials to account. To capture this variation, Fox (2007) delineates a spectrum ranging from opaque transparency to hard accountability, as illustrated in Table 1. Following his reasoning, merely sharing information (on government decisions or, in our case, experiences with service delivery) fails to explain what decisions or actions will be taken in response, thus resulting in opaque or fuzzy transparency that does not reflect changes in behavior. Clear transparency, in contrast, details officials' responsibilities and how resources will be spent and thus moves closer to the accountability pole of the range. Citizens' right to demand answers can produce a soft version of accountability. However, such limited accountability does not include sanctions for failure; "answerability without consequences falls short of accountability" (Fox, 2007, p. 668). It is only when officials and providers are sanctioned for shortcomings in the fulfillment of their responsibilities that hard accountability is evident.

Table 1. Social accountability actions ranging from transparency to accountability

Transparency		Accountability	
Opaque	**Clear**	**Soft**	**Hard**
Dissemination and access to information			
• State shares information only			
	Institutional answerability		
	• Citizens can request information • State specifies response to shared information	• Ongoing monitoring • Making demands to enforce legal standards	
			Sanctions, compensation, and/or remediation
			• Invoking formal grievance procedures • Holding demonstrations to protest against poor service quality

Source: Adapted from Fox (2007) and Joshi & Houtzager (2012).

SA efforts differ in their origins. Cornwall and Coelho (2007) distinguish *invited* spaces for citizen participation—provided by the state, often prompted by donors—from those that citizens have *claimed* through their own efforts. Tools for creating such invited spaces have proliferated over recent decades, and the specific interventions that Kinerja uses, summarized below, represent only a small selection of the available options. SA approaches vary in the scope of involvement that they afford citizens, from those that rely on individual citizens to report their experiences with service provision (such as the CHS used by Kinerja, which aggregates individual user experiences) to others where citizens collaborate to express needs (for instance, the SC, for which a group of local community representatives negotiate with service providers on improvements) (Joshi & Houtzager, 2012).

Tools that invite participation have, in recent years, been criticized as mere widgets: decontextualized technical interventions following standardized implementation protocols that do little to transform the system of service provision or state-society relations (Freedman & Schaaf, 2013; Joshi & Houtzager, 2012). Studies have shown that invited spaces can have positive impacts on both democratic and socio-economic development outcomes (Gaventa & Barrett, 2012). However, there has been an increasing emphasis on understanding the contexts and political processes through which accountability is negotiated such that the intended benefits result. This shift emphasizes finding the best fit between SA tools and local circumstances, rather than identifying best practices that are universally relevant ends in themselves (Freedman & Schaaf, 2013; Molyneux et al., 2012; O'Meally, 2013). Best fit approaches call for revisiting the assumptions underlying SA theories of change and recognizing the complexity and variation within individual contexts (Joshi, 2014; Rocha Menocal & Sharma, 2008).

A range of perspectives on contextual variables exists, with the political economy angle being perhaps the most prevalent (see Fritz, Kaiser, & Levy, 2009; Wild, King, Chambers, & Harris, 2012). O'Meally (2013) focuses specifically on SA, and outlines six contextual domains that influence SA's effectiveness and sustainability. We present the domains most relevant to our research in Table 2, which also incorporates several factors that Agarwal and Van Wicklin (2012) flag as important.[1] Three observations relevant for this study emerge from the table. First, citizen mobilization for collective action related to SA will depend upon their capacities and willingness to undertake the necessary activities to pursue it effectively. Second, the state's political and bureaucratic institutions, structures, and processes influence incentives for citizens' engagement in SA and for state actors to respond to such efforts (Agarwal & Van Wicklin, 2012; Joshi & Houtzager, 2012). Third, differing histories and configurations of state-society relations, including elite bargains, influence possibilities for achieving results from SA interventions.

Table 2. Contextual domains influencing social accountability effectiveness and sustainability

Contextual domain	Subdimensions
Civil society	Technical and organizational capacity Capacity to build alliances across society Capacity to build alliances/networks with the state Authority, legitimacy, and credibility of civil society with citizens and state actors Willingness of civil society to challenge accountability status quo Capacity of citizens to engage in SA Willingness of citizens to engage in SA
Political society	Willingness of political/elected elites to respond to and foster SA Willingness of state bureaucrats to respond to and foster SA State and political elite capacity to respond to SA Democratization and civil society enabling environment The nature of the rule of law The capacity/willingness of political parties to support SA
State-society relations	The character and form of the social contract History of state-citizen bargaining (long- and short-term) State-society bridging mechanisms (formal and informal) The nature and depth of state-society pro-accountability networks

Source: Adapted from O'Meally (2013) and Agarwal & Van Wicklin (2012)

We apply the soft-hard accountability continuum from Fox (2007) and note the distinction between invited and claimed spaces. Taking a holistic perspective that looks beyond the technical aspects of SA interventions to include considerations of context, we explore a selection of the factors presented above in Table 2 to the extent our data allow. We look for interactions among the various actors relevant to frontline service delivery that can help to explain both service and governance outcomes by

[1] O'Meally's additional domains are intra-society relations, inter-elite relations, and global dimensions. While important, we expect these domains to have a less direct effect on the SA interventions that are the focus in our study.

"considering the unfolding of dynamic interactions over time that reshape both states and citizens" (Joshi & Houtzager, 2012, p. 146).

KINERJA'S SOCIAL ACCOUNTABILITY INTERVENTIONS

It is important to summarize the SA interventions that are our focus and to discuss Kinerja's underlying theory of change. It should be noted that Indonesia's legal and administrative framework is broadly supportive of citizen engagement in service delivery. Complaints surveys are legally mandated (Permenpan 13/2009 for the Improvement of Quality in Service Delivery with Civic Participation), although they are not consistently implemented. Indonesia is highly decentralized; through a series of reforms launched initially in 1999, the majority of authority for fiscal and legislative decisions, as well as service delivery, were transferred to the district level (Brinkerhoff & Wetterberg, 2013).

USAID has a long history of supporting decentralization reforms in Indonesia, and the Kinerja program is the most recent manifestation of that commitment. The program provides support to districts to improve service delivery and works with local governments, civil society, and service providers on specific interventions in health, education, and local economic development, which are chosen for their alignment with national policy priorities and/or demonstrated effectiveness. Kinerja also includes a series of cross-sectoral interventions that are designed to create incentives for improved local service delivery performance, by giving citizens a more effective voice in public service delivery, supporting performance management systems in local governments, and increasing competition through benchmarking, competitive awards, and public information.

Kinerja follows a series of steps to involve citizens, service providers, and local sectoral agencies to plan and carry out the SA tools (Table 3). Also facilitating the process are project staff (particularly the Local Public Service Specialist, LPSS) based at the district level and an intermediary organization (IO)—a university or CSO tasked with providing technical assistance. Early on, citizens form a Multi-Stakeholder Forum (MSF) to represent their views. The MSF members are involved in designing and implementing the Complaints Handling Survey (CHS) which is a means both to raise citizens' awareness of their rights and to encourage them to advocate for better services. Problems identified through the CHS are then used as input to the Service Charter (SC). By identifying shortcomings and negotiating solutions, the CHS and SC combined are intended to provide a mechanism for holding puskesmas and schools accountable for their level of service delivery. After the implementation of the CHS and SC:

> *The expected result…is the introduction of a complaint handling system that provides the means to identify complaints, analyze them, and find solutions. The findings of the surveys are used as evidence-based advocacy to demand better public services, and help to raise awareness on problematic issues to related stakeholders, especially CSOs, local governments, and DPRDs* [Dewan Perwakilan Rakyat Daerah, *local legislative assemblies*]. *It is expected that local governments will include the implementation of Complaint Handling Surveys in their annual budgets…for the coming year. (Kinerja, 2011, p. 19).*

This quote encapsulates Kinerja's theory of change, which incorporates the following causal chain. The introduction of SA tools will lead to changes in (1) norms for provider behavior (proactive identification of problems and appropriate response), (2) citizens' access to and use of information (evidence-based advocacy aimed at providers, CSOs, local government, and legislators), and (3) local government's priorities (shifting budget allocations). These changes will then contribute directly to improving service delivery at frontline sites. Cumulatively over time, these shifts in service delivery, and the accompanying increases in accountability, will trigger an increase in the state's responsiveness to citizens and the latter's expectations of the former, ultimately reinforcing more democratic state-society relations.

Table 3. Steps for implementing Kinerja's SA tools

	Step	Actors involved
1	**Preparation.** This step includes building political commitment among stakeholders, including a memorandum of understanding with the *Bupati* (district executive, usually translated as regent), who agrees to address outcomes of the survey, from sharing tools and adapting them to the specific context of the region, to training of stakeholders, and to allocating resources.	District executive *(Bupati/Walikota)* Kinerja staff IO Sectoral agencies
2	**Multi-stakeholder workshop.** These focus on raising citizens' awareness of their rights, building formal commitments among stakeholders, adopting or adapting tools to the local context, and formulating action plans.	Citizen groups IO Service providers Sectoral agencies
3	**Complaints handling survey.** This activity is implemented through interviews with the service delivery units and their users to identify complaints related to effectiveness, responsiveness, efficiency, human resources, and logistics, as well as other aspects of the service unit.	MSF IO
4	**Complaints analysis and formulation of follow-up actions.** In this step, the causes and consequences of complaints are analyzed strategically to identify root causes. Strategic solutions to improve service delivery will be formulated. A service charter between service users and the service delivery unit, the *Dinas Kesehatan* (District Health Office) and District Education Office, and district government is developed to document agreements made on planned improvements and the schedule for their implementation. Actions that are beyond the authority or capacity of the service delivery units are formulated as technical recommendations for the district head.	MSF IO Service providers Sectoral agencies District government
5	**Service charter signing:** The Service Charters and technical recommendation are signed publicly and witnessed by the district head, DPRD and other related stake holders to encourage accountability.	MSF IO District head DPRD Media
6	**Follow-up of service charters**. Progress on the implementation of service charters and technical recommendations are monitored by an independent MSF and its progress published in local media. The MSF meets regularly with district authorities, e.g., local parliamentarians in the DPRD, the Bupati, and *Bappeda* (district planning agency) and lobbies for the timely implementation of the reforms. Citizen journalists and local media create wider public awareness and report on the service charter implementation.	MSF Media District government

Source: Adapted from Kinerja (2011).

STUDY METHODOLOGY

We chose four districts in Aceh and West Kalimantan for this research, based on their performance[2] during Year 1 (2011–2012) implementation, as assessed by Kinerja's national office staff: Kota Banda Aceh; Kabupaten Bener Meriah; Kabupaten Sambas; and Kota Singkawang. In each of these districts, Kinerja's Year 1 reform package focused on improving service delivery in the health sector. In Banda Aceh, Singkawang, and Bener Meriah, we visited all three puskesmas that had participated in Year 1 implementation in each district. In Sambas, we visited three Year 1 puskesmas, as well as three that carried out similar interventions in Year 2 (2012–2013) supported by district government funding. To capture a range of experiences within each district's institutional context, we visited both sites where Kinerja project staff reported that SA tools were well implemented and others where implementation went less well. In total, we collected data at 15 sites. To avoid identification of individual sites, we refer to them by pseudonyms. The letters at the beginning indicate the district in which the puskesmas is located (for example, BA refers to Banda Aceh and SAM refers to Sambas).

During February–March 2014, we conducted 60 semi-structured group and individual interviews with MSF members, puskesmas staff, district officials, Kinerja staff, and staff from IOs. Interview guides included questions about context, Kinerja implementation, replication, and outcomes. To allow for triangulation, the same question guides were used with all respondents. Interview data were supplemented with Kinerja project documents and monitoring data, as well as secondary data from other sources (noted where relevant in the tables below). The interviews were coded with ATLAS.ti software (primarily by the first author, with selective checks on coding patterns by the second author), using a deductive and inductive set of codes to allow for content analysis.

We use a comparative case analysis at the site- and district-levels (15 puskesmas and 4 districts). In Gerring's (2004, p. 343) typology of case studies, our analysis can be characterized as Type II, as it breaks the primary unit (Indonesia) into sub-units (districts and puskesmas) that are subjected to synchronic covariational analysis. Limiting the comparative analysis to a single country holds national policies, including decentralization, constant, but the cross-district and cross-site analysis allows for local variation in the factors of interest. Given that the data come from only four districts, however, the findings are not representative of Indonesia as a whole.

[2] We recognize the possible bias created by selecting on the dependent variable. Because our study involved an ongoing project, we were unable to collect baseline data; resource limitations precluded the inclusion of non-project communities. We caution readers against generalizing from our sample to the rest of Indonesia, but offer instead interpretations of positive deviance as indicators of promising avenues for improving governance and service delivery outcomes.

SOCIAL ACCOUNTABILITY FINDINGS: EXPLORING THE CAUSAL CHAIN

Background: context for Kinerja SA interventions

The four research districts that are the focus of our study implemented the same Kinerja health and SA reforms. However, these districts varied considerably in terms of prior context, including general socio-economic indicators, past health performance, and norms for social accountability.

Socio-economic indicators

Table 4 presents selected indicators of the socio-economic context for the four districts[3] of the study: Sambas, Bener Meriah, Banda Aceh, and Singkawang. Of the four, Sambas—located in the province of West Kalimantan on the island of Borneo—is the most populous and least urban. The other predominantly rural district in our study—Bener Meriah, in Aceh on the island of Sumatra—has roughly a fifth of Sambas' population. However, Bener Meriah is quite poor, with a quarter of the population below the poverty line. Bener Meriah stands in sharp contrast to Banda Aceh, the provincial capital, where slightly under 10% of the population is poor. In fact, in 2010, Banda Aceh and Bener Meriah were the richest and poorest districts, respectively, in Aceh province. The West Kalimantan districts (Sambas and Singkawang) are wealthier than their Aceh counterparts, with both districts below the national average poverty rates for urban and rural areas.

Although the West Kalimantan districts have a smaller proportion of poor residents, the Aceh districts generally outperform them on social service indicators. Human Development Index (HDI) scores are at or above the national average in Aceh, as are rates for medically assisted births. The percentage of medically assisted births is directly relevant to the Kinerja health reforms, which aim to encourage exclusive breastfeeding and increase deliveries by medical staff. Sambas is the lowest-performing of the four districts in terms of medically assisted births, with the rate of such births even falling below the national average.[4] Rural Bener Meriah's rate is also below that of urban Banda Aceh. The relatively lower rates of medically assisted births in the two rural districts suggest that Kinerja's reforms may be of greater urgency to officials and citizens there than in the two urban districts.

[3] In Indonesia, *kabupaten* refers to regencies or rural districts; *kota* is the term used for municipalities or urban districts. In this paper, we refer to both kabupaten and kota as districts.
[4] Note, however, that both Sambas and Bener Meriah are performing above their respective provincial averages for medically assisted births (62% for West Kalimantan; 87% for Aceh).

Table 4. 2011 socio-economic indicators, by district

Province	Aceh		West Kalimantan		
District *(Formal District Designation)*	**Banda Aceh** *(Kota)*	**Bener Meriah** *(Kabupaten)*	**Sambas** *(Kabupaten)*	**Singkawang** *(Kota)*	**National average***
Total population	229,532	125,732	502,496	191,264	-
Percentage of population in urban area*	100	20	18	69	-
Percentage of population below poverty line	9	26	9	6	9 (urban) 16 (rural)
Human Development Index (HDI)	78	72	66	69	72
Percentage medically assisted births	100	94	74	89	80

* Data from 2010
Source: DAPOER 2011 data (World Bank, 2014) and BPS (2011).

Existing norms for SA: district-level reforms

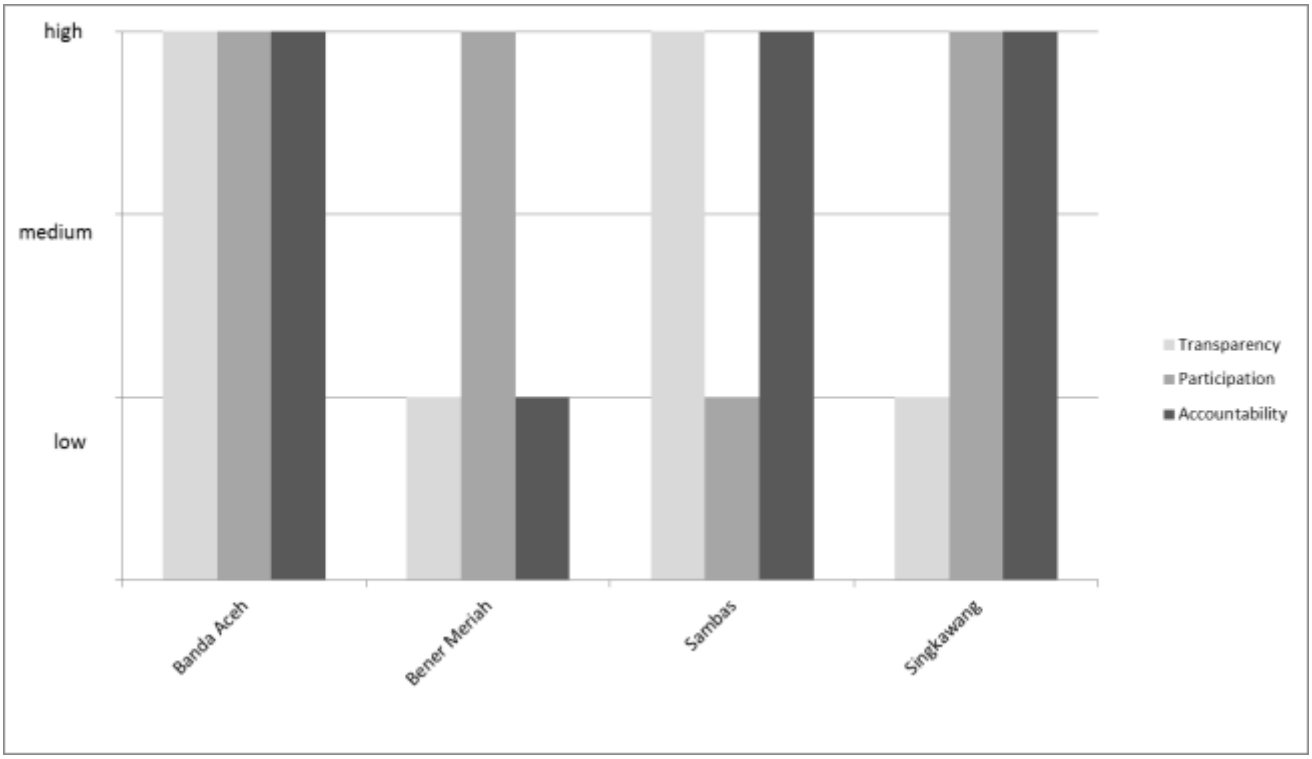
Another contextual factor that could affect sustained SA efforts is local officials' attitudes towards citizen engagement (O'Meally, 2013). Figure 1 shows 2011 data from the Local Budget Index (LBI), which gauges the extent to which principles of transparency, participation, and accountability have been integrated into four stages of local budget processes (planning, discussion, implementation, and public accountability).[5] Here, we use the LBI scores for each district as a measure of the local government's willingness to foster social accountability.[6]

All four districts had made some efforts to improve transparency, participation, and accountability, but only Banda Aceh had made substantial progress on all three measures. Singkawang had improved participation and transparency, but in the past, the local government there had shown little interest in accountability reforms. Bener Meriah had focused on improving participation, with less attention to transparency or accountability. In contrast, Sambas officials had incorporated transparency and accountability principles in budgeting processes, but had not focused on participation.

Given these past experiences with SA, we might expect the best fit with Kinerja's SA tools in Banda Aceh. Because policymakers in the district have shown a prior willingness to pass related reforms, they might be more interested than counterparts in other districts in supporting citizens' efforts to hold healthcare providers accountable at the front lines.

[5] The methodology relies on scoring 101 items (44 for transparency, 15 for participation, 20 for accountability, and 22 for gender equality) based on availability, adequacy, and quality of key budgeting documents and activities in the health, education, and public works sectors. Each item is given equal weight in calculations of an overall index, as well as a separate index for each of the four domains of interest. We use the LBI indexes for transparency, participation, and accountability in this analysis.
[6] Due to lack of comparable data for all districts, we could not include political factors that may influence local officials' commitments to SA. For an analysis of such factors in other districts where Kinerja is active, see Wetterberg and Brinkerhoff (2013).

Figure 1. Prior policy reforms conducive to social accountability, by district



Source: Adapted from Local Budget Index (SekNas Fitra & The Asia Foundation, 2012).

Existing norms for SA: site-specific attitudes[7]

In addition to the general district context, the prior experiences with SA efforts at each puskesmas site may also shape implementation and sustainability of Kinerja's interventions. Table 5 presents data on three variables that could signal contexts that are either particularly conducive or, conversely, inhospitable to Kinerja's interventions.

First, mechanisms for channeling complaints to the puskesmas existed at 11 of our 15 study sites before Kinerja's work began. However, these pre-existing invited spaces were rarely effective; only 4 of the 11 reported mechanisms were in use.[8] The others were most often complaints boxes posted at the puskesmas, but rarely or never utilized by patients.

Second, for just over half of the health centers studied, prior provider-user relations were characterized as antagonistic. Functioning bridging mechanisms through which community members could communicate with the puskesmas were reported at only one puskesmas (in Banda Aceh). In general, respondents reported either no ongoing relationship at all between providers and users — especially in Bener Meriah, where neither citizens nor provider reported prior interaction—or, more often, an antagonistic relationship in which community members feared repercussions if they approached the puskesmas with any concerns.

[7] To avoid identification of individual sites, we use pseudonyms rather than their names (see Table 5). The letters at the beginning of the pseudonym indicate the district in which the puskesmas is located.
[8] Effective complaints mechanisms included complaints boxes and an SMS reporting system.

Table 5. Context for social accountability, by site and district

Site	Existing complaints mechanisms	Existing provider-user relations	Past SA effort
Banda Aceh			
BA1	not effective		X
BA2	effective	functioning	
BA3	not effective	antagonistic	X
Bener Meriah			
BM1			
BM2	effective		
BM3	effective		X
Sambas			
SAM1	effective		X
SAM2		antagonistic	X
SAM3	not effective	antagonistic	X
SAM4		antagonistic	
SAM5	not effective	antagonistic	X
SAM6	not effective	antagonistic	X
Singkawang			
SIN1		antagonistic	
SIN2	not effective		
SIN3	not effective	antagonistic	

Source: Authors' ratings, based on interviews

Finally, at about half the sites, interview respondents reported cases of prior citizen efforts at holding service providers accountable, indicating past initiatives to claim space for citizens. In every district at least one site reported an instance of prior social accountability, except for Singkawang where no such efforts were mentioned. However, most of the reported prior efforts were instances of individuals or small groups complaining about service delivery problems (e.g., midwife not at her post in the village, problems with referrals) either to puskesmas staff or to village government officials. At only one site in Banda Aceh did these efforts involve collective action to communicate dissatisfaction with the puskesmas.

Overall, these variables paint a picture in which citizens' and providers' experience is one of weak and moribund channels of communication. Even when provided, invited spaces for accountability are rarely effective. However, despite citizens fearing repercussions for complaints, they do show some willingness to claim space for SA. Further, there is a small subset of puskesmas (one in Banda Aceh, two in Bener Meriah, and one in Sambas), where past complaints mechanisms have been effective and where Kinerja's SA tools might further strengthen citizens' ability to hold providers to account.

Implementation of Kinerja SA interventions

The prior section outlined contextual factors that potentially influence the sustainability of frontline SA. Given the varying contexts, below we characterize selected aspects of how the Kinerja SA interventions were implemented at each study site.

Prior research has shown that the composition of user committees, such as the MSF, are directly related to accountability and service delivery outcomes (Molyneux et al., 2012). Thus, it is important to understand whether the MSF was created only in the course of Kinerja implementation or whether it was built upon existing structures that could enhance SA efforts through existing trust and network ties.

At all the study sites, MSF members were individuals who had prior experience with community engagement. Some members held formal positions (village heads), were community leaders (in women's groups, religious organizations), or had acted as community extensions of government programs (village health cadres, volunteer social workers). Exact combinations of MSF members varied across sites, as did the extent to which they had collaborated previously, as shown in Table 6. At most of the sites with available information, MSF members had not worked together previously. MSFs with prior collaboration experience (two in Banda Aceh, one in Bener Meriah, and one in Singkawang) could be expected to more effectively implement the CHS and negotiate the SC, given existing connections between members that would also be anticipated to contribute to the sustainability of SA interventions.

The MSF's efforts could be tempered, however, by low provider receptiveness to the SA tools. During the first year of Kinerja's implementation, staff working across the project's districts reported considerable resistance from service providers. Some puskesmas staff tried to "correct" CHS results, and others publicly expressed anger at the delineation of shortcomings identified (Kinerja, 2012). At other sites, however, service providers seemed more willing to collaborate. Provider resistance was likely to have influenced attitudes towards replication and broader changes towards citizen engagement. If the implementation was challenging, we would expect more reluctance on the part of government officials and providers to commit to sustaining such practices.

Table 6 also shows interview data related to how Kinerja's CHS mechanisms were implemented at each site. At nine of 15 sites, providers reacted negatively to the presentation of survey results, with responses ranging from surprise and disbelief to shock and anger over the type and number of complaints from the community. These reactions underscore the relatively confrontational nature of CHS in contexts where providers are inexperienced with receiving client feedback. Notably, none of the Bener Meriah puskesmas reacted negatively, but instead accepted the survey results. One puskesmas in each of the other districts accepted the survey without a negative reaction; all of these had some prior familiarity with user surveys.[9]

[9] The BA2 and SIN3 sites had both been ISO certified prior to Kinerja's start. ISO certification designates the puskesmas as meeting a set of management standards (for more information, see http://www.iso.org). As part of the ISO experience, they had conducted regular satisfaction surveys. SAM5 is a Year 2 site; staff at this puskesmas said they had heard about the CHS from colleagues at Year 1 puskesmas and, therefore, were not surprised by the survey results.

Table 6. Factors related to implementation of Kinerja SA reforms, by site and district

Site	MSF members had previously collaborated	Negative provider reaction to CHS results	Provider expressed concerns about CHS methodology	SC points remaining to address[10] (2014)
Banda Aceh				
BA1		X	X	0/11
BA2	X		X	0/11
BA3	X	X	X	3/16
Bener Meriah				
BM1	n.a.			1/9
BM2	X			0/11
BM3	n.a.			0/14
Sambas				
SAM1	n.a.	X	X	n.a.
SAM2		X	X	n.a.
SAM3		X	X	5/28*
SAM4		X	X	2/10*
SAM5				n.a.
SAM6		X	X	5/17*
Singkawang				
SIN1		X	X	2/59
SIN2		X	X	2/67
SIN3	X		X	10/78

Notes: N.a. indicates no data available. * indicates data from 2013
Source: Authors' interviews and Kinerja monitoring data.

At the majority of sites (11 out of 15), puskesmas staff also reported concerns over the validity of the CHS methodology or the way that it had been implemented. At two of these sites (SAM3 and SAM5), staff balanced these negative perceptions with positive ones, recognizing the utility of the methodology. Consistent with their neutral reception of the survey results, puskesmas staff in Bener Meriah had no concerns about the survey methodology. Reactions to survey results were generally aligned with perceptions of the CHS methodology.

In spite of providers' skepticism towards the CHS methodology and results, all sites made substantial progress on completing the SC according to Kinerja monitoring data. The types of complaints covered and SC details varied considerably, but each puskesmas was able to address all but a handful of the points negotiated for SC inclusion, based on the CHS results (Table 6). At some sites, all points had

[10] The percentage indicates the proportion of SC points that the puskesmas had made no attempt to address (most points were recorded as completed, but some were still in process). Monitoring approaches differed somewhat across districts (categorization of points, classification of effort), so the most comparable way to assess completion was to count points where there had been no effort to address.

been completed. The level of SC completion does not appear to relate to MSF composition or to provider perceptions of and reactions to the survey.

Changes in service provision

A core assumption of Kinerja's theory of change is that strengthening citizens' abilities to demand better services will lead to improved service delivery. This section explores this link in the causal chain, using interview data based on codes related to changes in service delivery (including access to service delivery), demand for services (defined as increase in number of patients), and medical outcomes.

In spite of challenges during implementation at some sites (Table 6), high rates of SC completion translated into widely held perceptions of service delivery improvements (Table 7). Either MSF or puskesmas respondents at 14 of the 15 sites reported some change in service delivery, and at 12 sites both types of respondents agreed that there had been improvements. Reported changes include small physical improvements (such as addition of chairs in the waiting room and beautification), reduction in wait times, changed hours of operation, better staff attitudes and service orientation, increased attendance and accountability of midwives in rural posts, increased availability of doctors, better availability of medicines, better records management and registration processes, and differentiated and customized services for women and the elderly. Ongoing or unresolved complaints included general problems with midwives' absenteeism, lack of cleanliness and maintenance, women continuing to distrust midwives' skills and judgment, staff rudeness, and parking problems.

Based on these data, there is some evidence that SA interventions resulted in perceived public service delivery improvement. Notably, there were very few differences in perception between MSF members and puskesmas staff about service delivery improvement, which contrasts significantly with the reported results of differences in perception about higher levels of accountability (discussed below). Of the four districts, however, respondents from Banda Aceh sites stand out as reporting fewer and generally more modest improvements in service delivery.

In response to questions about changes in service delivery, some respondents also volunteered other shifts in services. Respondents noted increases in access to services at 4 of the 15 sites and cited a decrease in access at one site (the decrease reported was not attributed to Kinerja interventions, but rather to communal conflict). Changes in access cited include expanded home services for women (including provision of birthing equipment and assisted delivery), more attention to high-risk pregnancies, separate services for older patients, and extended hours.

In addition, there were some perceived changes in demand for services and some perceived changes in medical outcomes, although referenced at a much lower rate than changes in service delivery. Changes in demand for services were defined as an increase in the number of patients. Respondents perceived increases in demand at 7 of the 15 sites. Types of changes include citizens seeking services outside of assigned jurisdiction, citizens going to the puskesmas instead of directly to the hospital, number of visits/visitors increased, and decline in births assisted by traditional birth attendants.

Interviewees mentioned changes in medical outcomes at two puskesmas. One puskesmas respondent reported improvements in 2012 (no maternal deaths, only two cases of infant malnutrition, and

100% use of medical personnel at births), attributed to Kinerja interventions. In the other puskesmas, there was reference to a reported decline in maternal mortality rates.

Table 7. Perceived changes in services reported by puskesmas and MSF, by respondent, site, and district

Site	Direction of change	Changes reported
Banda Aceh		
BA1 puskesmas		None
BA1 MSF	Modest improvement	New queue numbers reduced wait times somewhat. MSF provided potted plants to beautify health center.
BA2 puskesmas	Improvement	Reduced wait times after more staff added at front desk. New filing system eliminated complaints about lost medical records.
BA2 MSF	Modest improvement	More chairs in waiting room. MSF provided potted plants to beautify health center. Puskesmas is cleaner.
BA3 puskesmas	Modest improvement	Midwives instructed to leave note if they leave post. Rude front desk staff have been moved.
BA3 MSF		None
Bener Meriah		
BM1 puskesmas	Improvement	Working hours changed to extend hours of service delivery. Doctors now on standby. Midwives stay at their post.
BM1 MSF	Improvement	Better availability of medicines. Staff are more responsive. Hours are more reliable. Better organization of services.
BM2 puskesmas		None
BM2 MSF		None
BM3 puskesmas	Improvement	More medicine and medical equipment available. Better organization of services. Improved information dissemination through MSF. New system to track midwives' locations.
BM3 MSF	Improvement	Reallocation of staff and change in shifts to extend hours of operation. More anti-worming medicine available. Better organization of services. Friendlier and more service-oriented staff.
Sambas		
SAM1 puskesmas	Improvement	Better staff discipline. Extended hours of operation.
SAM1 MSF	Modest improvement	Enforced change in working hours.
SAM2 puskesmas	Improvement	Extended hours of operation. Midwives required to inform puskesmas if they leave post.

Site	Direction of change	Changes reported
SAM2 MSF	Improvement	Puskesmas stopped midwives' illegal payments. Extended hours of operation.
SAM3 puskesmas	Improvement	Added staff to expand hours of operation. Staff no longer allowed to ask patients to cover transport. Midwife's presence in village is monitored. Ambulance refurbished.
SAM3 MSF	Improvement	Extended hours for emergency unit. Midwife stays in village. Separate birthing room designated at puskesmas.
SAM4 puskesmas	Improvement	Improved staff timeliness. Extended hours of operation. Ambulance refurbished. Electricity provided for village health post. Separate birthing facility built at puskesmas.
SAM4 MSF	Improvement	Extended hours of operation. Improved staff attitudes. Ambulance service provided.
SAM5 puskesmas	Improvement	Extended hours of operation. Staff are more disciplined. Effort to reduce wait times. Separate registration desk for older patients. Advance preparation for high-risk pregnancies.
SAM5 MSF	Improvement	Extended hours of operation. Friendlier staff. Much better organization at registration desk. Older patients receive special services. Better staff discipline.
SAM6 puskesmas	Modest improvement	More information provided through posters, brochures, posting of fees. Addition of fans, filing cabinets.
SAM6 MSF	Modest improvement	Staff are more disciplined and friendlier.
Singkawang		
SIN1 puskesmas	Improvement	Enforced working hours. Improved service at registration window. Better organization.
SIN1 MSF	Improvement	Small physical changes. More staff at registration desk. Better organization. Enforced working hours.
SIN2 puskesmas	Improvement	Equipment provided for village health posts. Extended hours of operation. Midwives on call 24 hours. Reorganization of birthing facility.
SIN2 MSF	Improvement	Friendlier staff.

Site	Direction of change	Changes reported
		Better organization. Better information on services and rules for access.
SIN3 puskesmas	Improvement	Improved system for post-partum visits. Birthing equipment provided for village health posts. Improved staff discipline.
SIN3 MSF	Improvement	Reduced wait times. Special waiting room for pregnant women. Small physical improvements. Improved staff discipline.

Source: Authors' interviews.
Note: Blank cells indicate no changes reported.

Changes in perceptions and practices related to SA

In addition to shifts in service delivery, the research sought to assess broader changes in citizen perceptions and practices related to SA and in officials' and providers' responsiveness to citizen engagement. Such shifts could lead to effects on services other than those targeted by Kinerja and in the general interactions between citizens and state actors. Through an extensive study that mapped cases of citizen engagement, Gaventa and Barrett (2010, 2012) developed a typology of such outcomes, illustrated in Table 8. The typology recognizes that effects may be both positive and negative (see also Cornwall & Coelho, 2007; Holland, Ruedin, Scott-Villiers, & Sheppard, 2012). For example, when mobilized citizens do not garner any response to their efforts, they may feel *more* disempowered. In some cases, officials could respond to citizen actions by not becoming more open to input, but rather by punishing active citizens through denial of service. Such potential for negative outcomes must be recognized alongside any positive effects.

Table 8. Outcomes of citizen engagement

Outcomes	Positive	Negative
Construction of citizenship	Increased civic and political knowledge Greater sense of empowerment and agency	Reliance on knowledge intermediaries Disempowerment and reduced sense of agency
Practices of citizen participation	Increased capacities for collective action New forms of participation Deepening of networks and solidarities	New capacities used for "negative" purposes Tokenistic or "captured" forms of participation Lack of accountability and representation in networks
Responsive and accountable states	Greater access to state services and resources Greater realization of rights Enhanced state responsiveness and accountability	Denial of state services and resources Social, economic, and political reprisals Violent or coercive state response
Inclusive and cohesive societies	Inclusion of new actors and issues in public spaces Greater social cohesion across groups	Reinforcement of social hierarchies and exclusion Increased horizontal conflict and violence

Source: Gaventa & Barrett (2012)

In their study, which covers both "invited" and "claimed" spaces for engagement, Gaventa and Barrett (2010) found the highest levels of positive impacts for construction of citizenship, along with the least progress in developing inclusive and cohesive societies. The highest level of negative outcomes was in the area of state response. Notably, invitations to participate in formal processes were less likely to produce positive outcomes and accounted for a greater proportion of negative outcomes than other modes of citizen engagement.[11] When such invitations did provide benefits, they contributed most to the construction of citizenship, but also to practices of citizen participation and responsive and accountable states (Gaventa & Barrett, 2010, p. 348). We use these same categories in assessing the effects of citizen engagement at our research sites, shown below in Tables 9 and 10.

Site-level changes

Table 9 shows sites at which interview respondents reported changes subsequent to Kinerja's SA tools related to each of the outcomes identified by Gaventa and Barrett. Our results suggest relatively strong positive effects on the construction of citizenship, with respondents at 9 of the 15 sites (from every district) reporting some gains in this area (Table 9). These improvements usually consisted of MSF members feeling empowered to express their views about service quality, or gaining information about service delivery, which they could then monitor. However, we also found the highest levels of negative effects in the same category. The empowerment effects were often diminished by MSF's frequent reliance on intermediaries (such as Kinerja staff or local CSOs involved with the program) to communicate their views or insist on their rights as citizens. At only two sites (BM3 and SIN2) were positive effects reported independently, while four sites reported only negative effects on the construction of citizenship. All sites in Banda Aceh and Sambas reported high reliance on knowledge intermediaries, suggesting that MSFs' gains in these districts are unlikely to be sustained.

Although citizens less often reported gains in participatory practices, all three sites in Bener Meriah reported positive outcomes in this area, mainly through expansion of MSF networks beyond the village level. In this district, MSFs also connected with district officials and leveraged these connections to give feedback on service delivery and to organize advocacy efforts. Two of the Singkawang MSFs also reported similar widening of their networks, but these gains did not extend to the district level. In contrast, none of the six Sambas sites reported gains in practices of citizen participation.

Positive outcomes in terms of responsive and accountable states (10 of the 15 sites) were comparable in frequency to those for construction of citizenship and were also present in every district. Sambas sites showed consistent gains in this area, with only one exception (SAM6) where the puskesmas head saw no benefits from efforts to improve services and was, therefore, reluctant to make further investments. Examples of positive changes included puskesmas heads taking initiatives to address problems that were not directly under the health center's control (such as arranging for electrical connections, identifying alternative funding sources to pay for improvements, and working with village government to provide needed equipment); recognition of the value of community complaints, and reported awareness of the need to be responsive to patient needs. At one site in particular (SAM4), the

[11] In particular, voluntary associations were a more important source of positive outcomes (Gaventa & Barrett, 2012).

head had become highly focused on improving service quality and attracting more patients through improved and expanded services.

Table 9. Broader effects of citizen engagement on relations with providers, by site and district

Site	Construction of citizenship		Practices of citizen participation		Responsive and accountable states		Inclusive and cohesive society	
	Positive	Negative	Positive	Negative	Positive	Negative	Positive	Negative
Banda Aceh								
BA1	X	X	X	X		X	X	
BA2	X	X			X		X	
BA2		X			X	X		
Bener Meriah								
BM1	X	X	X			X		
BM2			X		X	X	X	
BM3	X		X		X		X	
Sambas								
SAM1		X			X			
SAM2		X		X	X			
SAM3	X	X			X	X		
SAM4	X	X			X			
SAM5	X	X		X	X		X	
SAM6		X		X		X		
Singkawang								
SIN1	X	X	X					X
SIN2	X		X		X		X	
SIN3								

Source: Authors' interviews.

For responsive and accountable states, there were also two types of negative effects reported, which were relatively mild in terms of Gaventa and Barrett's categories (Table 8). First, providers at several sites ignored user feedback on the grounds that citizens lacked understanding, information, or skills to appropriately assess the situation. For example, there were numerous examples of providers discounting a high-frequency CHS complaint because "respondents answered even though they do not know about [a particular service]."[12] In other cases, puskesmas staff acknowledged the legitimacy of an issue raised by citizens, but responded only by saying that it was beyond the providers' control to address it. One instance was the complaint that midwives charged women for contraceptives that should be free. Providers responded that they were powerless to affect these problems as contraceptives were provided by

[12] Interview: Dinas Kesehatan, Sambas, March 5, 2014.

the family planning agency.[13] While less overtly hostile than outright violence, reprisals, or denial of service when citizens complain, such provider passivity directly impedes service improvements.

Finally, there were relatively few changes in societal inclusiveness or cohesiveness, but when these did occur, they were generally positive. These gains all involved inclusion of new actors and issues in public spaces, with government actors inviting citizen involvement in processes that had been previously reserved for the state. Puskesmas in both Bener Meriah (BM3 and BM2) and Singkawang (SIN2) recognized the value of involving citizen groups to improve effectiveness of service delivery and outreach efforts: "[The SA tools] showed us we were not close enough to the community. … Even if [the tools are] not facilitated, we will bring people to meetings to discuss problems. We think this is good for us and has set an example. It would be a shame if it declined."[14]

District-level changes

In terms of broader outcomes, clear distinctions exist at the district level. Both in Banda Aceh and Singkawang, changes were very limited (Table 10). In Banda Aceh, the health technical agency had made some effort to include citizens by communicating program information to the district-level MSF. In Singkawang, participation in the district-level MSF had been sustained beyond Kinerja's implementation, with some advocacy to relevant government actors for health problems, but these activities have relied heavily on the CSO that facilitated the Kinerja SA tools.

In contrast, a number of positive changes were reported at the district level both in Bener Meriah and in Sambas. In Bener Meriah, these shifts—in citizens' enhanced participation, greater interest from legislators and planning officials in citizen engagement, and openness to collaborating with civil society in multiple ways—signaled broad agreement on the legitimacy and utility of citizen engagement. Some legislators were open to meeting with citizens and incorporated their input in policies. A planning agency official saw citizens' input as vital: "Criticism is like vitamins; they help to improve our system."[15] Although the district health agency was not convinced of the need for direct citizen feedback, health officials recognized the need to work with civil society organizations for effective program implementation: "If it is just the *Dinas* on its own, the program will not get very far."[16]

Combined with the consistent positive changes in practices of citizen participation at the puskesmas level (Table 9), the changes in Bener Meriah suggest that, subsequent to Kinerja's facilitation of invited spaces for citizen engagement, there are *further opportunities for citizens to claim space*. We are not suggesting that Kinerja is responsible for the greater openness towards citizen engagement in this district. Recall that Bener Meriah had made high levels of progress on participatory reforms prior to Kinerja's work in the district (see Figure 1). In contrast to the other districts, Bener Meriah also had some effective complaints mechanisms and no report of antagonistic prior relations between users and providers (Table 6). During Kinerja implementation, none of the Bener Meriah providers reacted negatively to CHS results or expressed concerns about the methodology, of which staff at almost all other puskesmas were skeptical. These patterns suggest a context and provider attitudes that were more

[13] Interview: Puskesmas SIN3, March 8, 2014.
[14] Interview: Puskesmas SIN2, March 11, 2014.
[15] Interview: Bappeda, Bener Meriah, March 3, 2014.
[16] Interview: Dinas Kesehatan, Bener Meriah, March 3, 2014.

receptive to citizen engagement than the other sites in our study. The use of the CHS and the SC, plus the MSF's work under the program, appear to have strengthened community members' capacities to engage government actors (both at puskesmas and at district levels) and capitalize on these actors' relatively open attitudes to citizen engagement to enhance responsiveness.

Table 10. Broader effects of citizen engagement on relations with district actors, by district

District	Construction of citizenship	Practices of citizen participation	Responsive and accountable states	Inclusive and cohesive society
Banda Aceh	No change	No change	No change	Technical agency informs district MSF of programs, but acknowledges MSF weakness.
Bener Meriah	No change	Citizens gained organizing and advocacy experience that resulted in ongoing connections to legislators.	Legislator and planning agency see need for citizen input to improve services. Technical agency does not see need for citizen communication.	Broad support (technical agency, planning agency, and DPRD) for including different civil society actors (MSF, CSOs) in state processes.
Sambas	No change	No change	Changes in district procedures to encourage puskesmas responsiveness District head, planning agency, technical agency support responsiveness at all puskesmas in district.	Planning agency has contracted CSO to implement accountability tools at all puskesmas.
Singkawang	No change	District MSF continues monthly meeting and advocates at technical agency, but remains reliant on Kinerja IO.	No change	No change

Source: Authors' interviews.

In Sambas, the combination of changes at the district and puskesmas level suggest a different pattern of responsiveness to citizens, which surprisingly does not prioritize citizen empowerment. At the puskesmas level, gains in citizen empowerment were dampened by high dependence on intermediaries to sustain these improvements (Table 9). Note also that there were no reports of enhanced citizen participatory practices at the puskesmas level. Recall also that prior provider-user relations in this district were often antagonistic and existing complaints mechanisms rarely effective (Table 5). Kinerja implementation generally aligned with the contextual variables; Sambas MSFs did not have a history of prior collaboration and providers had consistently negative reactions to the CHS results and methodology.

In spite of the low levels of citizen empowerment and participation as well as the negative provider reactions, there were reports of increased responsiveness at all but one of the puskesmas in Sambas. Such changes were encouraged by an emerging commitment from district-level actors who, during the course of Kinerja's first year of implementation, came to see the SA tools as a means of improving service delivery. Senior district officials made it clear after observing the results of Year 1

implementation that the Kinerja tools would become the district's model for improving puskesmas services, contributing to the local government's goal of improving the district's poor performance on health indicators (see Table 4).[17]

After year 1, the Sambas local government decided to implement a scaled-back version of Kinerja's programs in all 27 puskesmas in the district. In addition, the district leadership and officials at the planning and health agencies voiced support for the specific tools used in Kinerja and provided concrete incentives for puskesmas to use them to increase responsiveness. For example, a district health agency official was initially skeptical of the program, but became supportive after seeing that it changed puskesmas staff's "mindsets and performance." These results provided the confidence to reward puskesmas that implement SA tools by giving them greater financial autonomy, permission to provide additional services, and staff promotions. A planning agency official noted how local regulations had been changed to facilitate greater flexibility at puskesmas that implement Kinerja interventions. Puskesmas that complete the program are also given more attention from other district agencies to address infrastructure needs (roads, delivery rooms). Several respondents noted that puskesmas have started to compete for patients by providing better services.[18] The head of the most service-oriented puskesmas in the district pointed to three stages of changes that supported improvements at his health center: "Before, we had the commitment to make things better, but we were pulled further by Kinerja. Then new district regulations and provision of financial autonomy helped further. Now there is a Ministry of Administrative and Bureaucratic Reform pilot project in Sambas about bureaucratic reforms… once it is going, it will cover all services, not just the puskesmas….Now we don't have to think about meeting targets, now we just try to make services comfortable so that more patients will come."[19]

Although district actors clearly supported responsiveness at the facility level, they did not show a general interest in engaging citizens. They supported further investment in SA tools because it has helped to improve performance of puskesmas staff, but they did not perceive a broader relevance for citizen engagement. In parallel, weak MSFs in this district, highly dependent on intermediaries, had not gained skills to claim space on their own. In this district, *Kinerja's SA tools did not expand opportunities for citizens to claim space—as they appeared to in Bener Meriah—but did result in additional instances of invited space.*

Sustainability and replicability of social accountability interventions

The ultimate aims of the theory of change are sustained increases in responsiveness to citizens and improvements in service delivery that result from institutionalized accountability processes at multiple levels, from the health facility to the district. In this section, we characterize and compare short-term direct effects of the sustained elements of Kinerja interventions in terms of their contribution to accountability. Interview data were culled to create a profile for each puskesmas and each district, with information comparing the sustainability of the three main SA interventions (CHS, SC, and MSF) at the puskesmas and district levels. Then the data were analyzed again to compare the views of MSF members about the role of citizens with those of providers, at the site and district levels. Our reasoning here is that

[17] Interviews: (1) District officials, Sambas, March 5, 2014, and (2) CSO, Sambas, March 4, 2014.
[18] Interviews: (1) MSF SAM6 and SAM2, March 5, 2014 and (2) Puskesmas SAM4, March 6, 2014.
[19] Interview: Puskesmas SAM4, March 6, 2014.

the chances for replication and sustainability of citizen engagement in accountability are increased to the extent that the views of citizens and state actors align about citizen engagement.

Mechanisms/external means of accountability

***Complaint handling surveys*.** There were no reported plans to repeat CHS at any of the puskesmas visited. However, CHSs were being replicated in two new puskesmas in Bener Meriah and district-wide (covering 27 puskesmas) in Sambas. In areas where the CHS was not replicated, supply-side satisfaction surveys (completed by puskesmas without citizen input to design) were generally seen as replacements for the demand-side CHS conducted by MSFs in Kinerja-supported puskesmas.

Service charters. SCs were also generally not sustained; only two sites (both in Sambas) reported that work continued on SC points. Similarly to the CHSs, the SCs were also replicated in two new puskesmas in Bener Meriah and district-wide (covering 27 puskesmas) in Sambas.

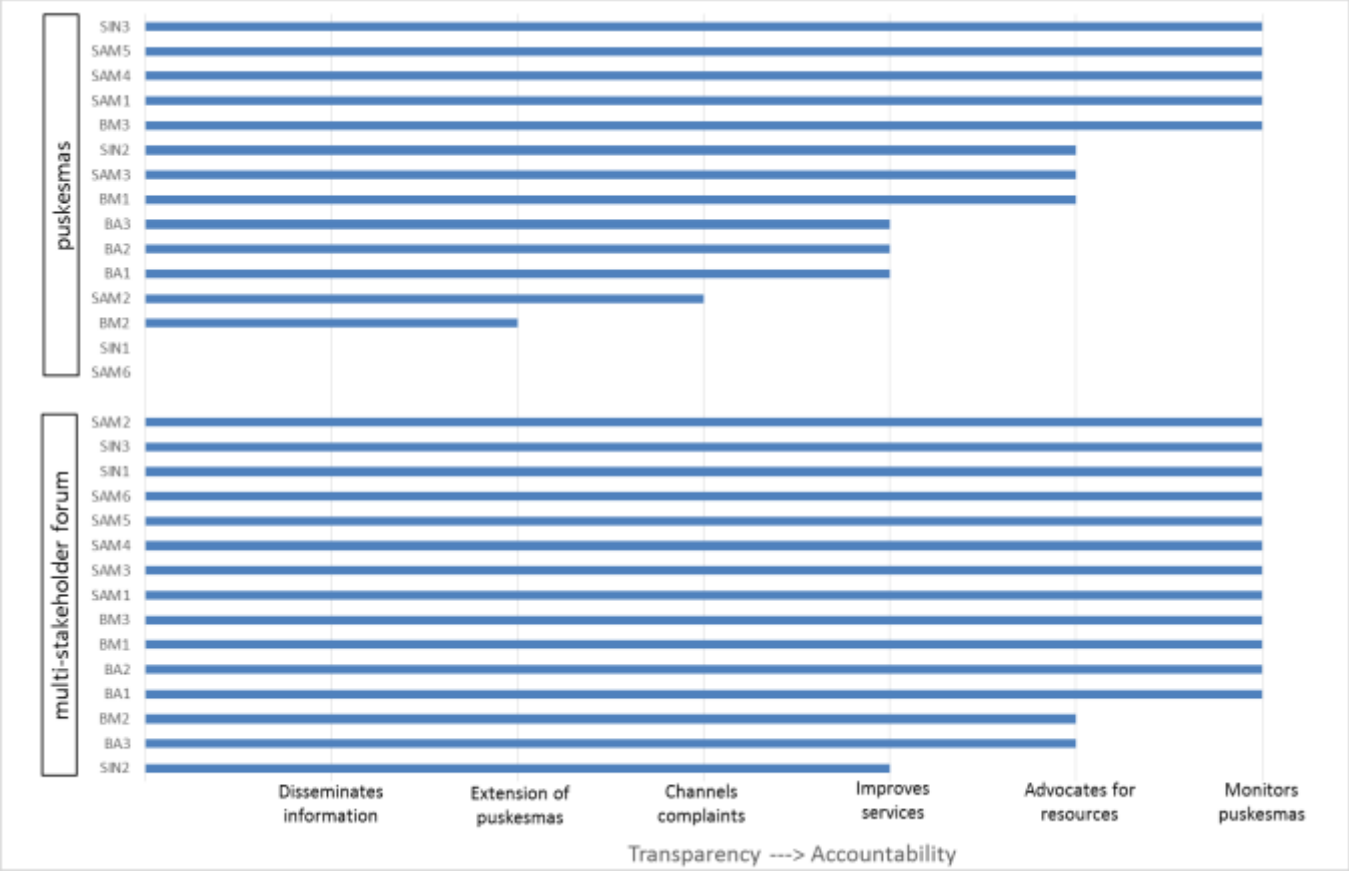
***Multi-stakeholder forum*.** Interviews with MSF members indicated variable sustainability. Some MSF activities continued in puskesmas in Bener Meriah and in all three puskesmas in Singkawang, where the IO had instituted a monthly savings fund (*arisan*) for MSF members from across the district.

Norms/internal means of accountability

For the analysis of norms or internal means for accountability, we categorized the interview data related to perceptions of the MSF's role at each site and ranked them along Fox's transparency-accountability spectrum as a gauge of SA norms after Kinerja's SA interventions (Table 1). The revised categories that form the horizontal axis of Figures 2 and 3 below are, from left to right:

1. MSF disseminates information/program from puskesmas;
2. MSF is an extension/partner/bridge to puskesmas;
3. MSF channels complaints/needs to puskesmas (actual and aspirational);
4. MSF involved in addressing complaints/improving services;
5. MSF advocates and lobbies for resources (actual and aspirational); and
6. MSF disciplines, monitors, and/or controls puskesmas (actual and aspirational).

Figure 2. Highest transparency-accountability level for MSF reported by puskesmas staff and MSF members, by respondent

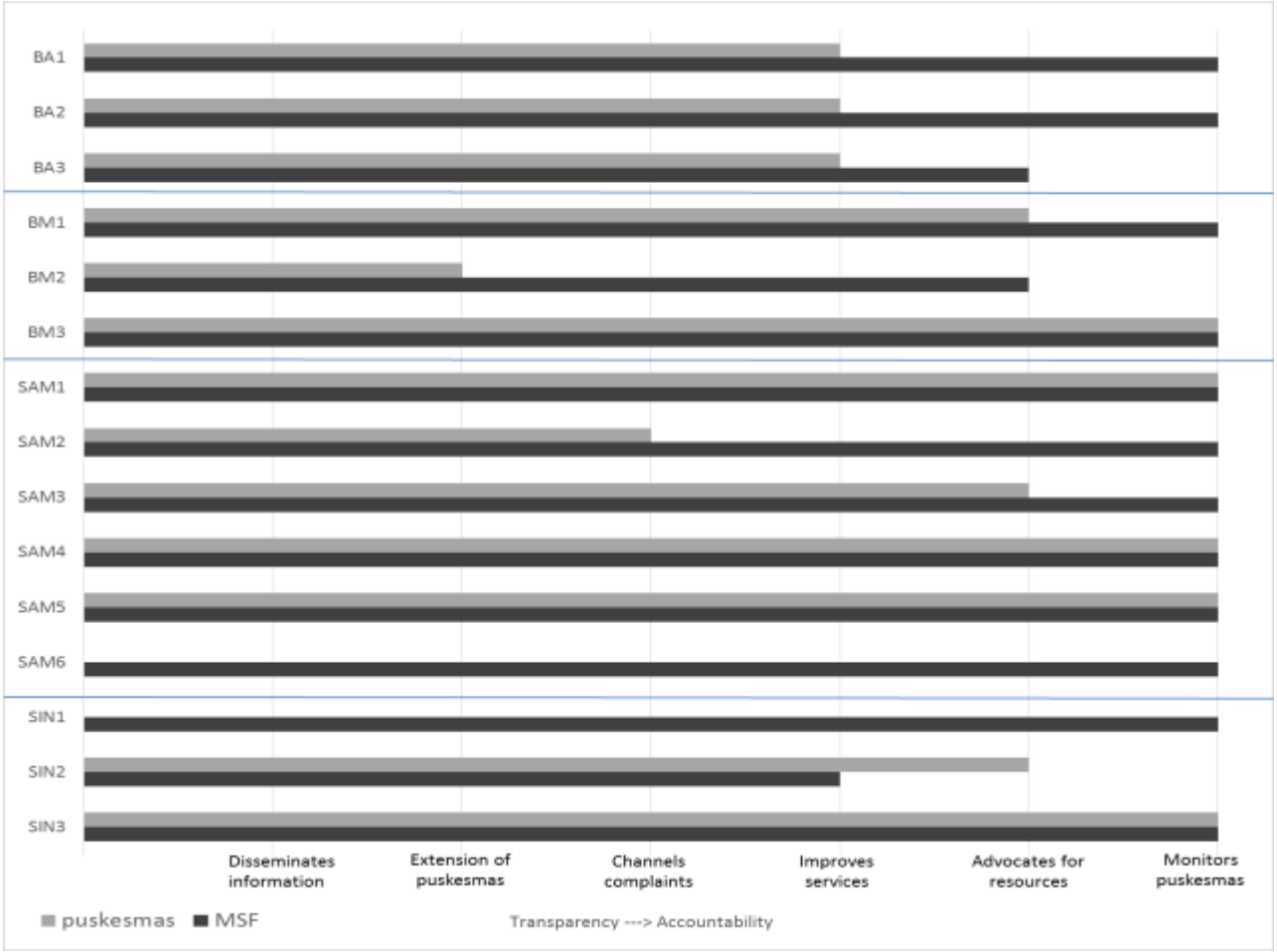


Source: Authors' interviews.

The interviews with puskesmas staff showed widely varying views on the MSF's role (Figure 2). At five sites, providers reported that the MSF could monitor service delivery, indicating an openness to social accountability. Respondents at the other sites saw a weaker role for citizens, however, reporting MSF involvement closer to the transparency end of the spectrum and two sites (SIN1 and SAM6) reporting no role for the MSF. In contrast, almost all MSF members interviewed (12 of the 15) saw serving as a facility performance monitor as an appropriate MSF role. The range of responses was smaller than that for providers', with all MSF respondents reporting roles for citizens towards the accountability end of the range. Cumulatively, Figure 2 shows a strong contrast in the perceptions of the MSF members compared to those of puskesmas staff.

Figure 3 presents the same data as Figure 2, reorganized by site and district to look more closely at the variation between sites. At five sites *both* MSF members and puskesmas providers mentioned the highest level of MSF accountability. These include three sites in Sambas, one in Bener Meriah, and one in Singkawang. Notably, Banda Aceh did not have any sites with both puskesmas and MSFs reporting high levels of accountability. In contrast, at the two sites where puskesmas staff did not mention any role for the MSF (not even the lowest levels of transparency were recognized), the MSF reported the highest level of accountability, indicating incongruence in these two sites, both located in West Kalimantan.

Figure 3. Highest transparency-accountability level for MSF reported by puskesmas staff and MSF members, by respondent, site, and district



Source: Authors' interviews.

To better understand the contextual factors influencing accountability, we compare the five sites recognized both by puskesmas and MSFs as having the highest levels of accountability, with the two sites having no puskesmas recognition of a role for the MSF (from Figure 3). The findings are displayed in Table 11 below. The results show there were variable pre-existing conditions in the sites with congruent recognition of MSF accountability. For example, BM3 puskesmas in Bener Meriah had effective prior complaint mechanisms, existing provider-user relations, and neutral or positive reactions to the CHS. At the other end of the spectrum, SAM4 puskesmas in Sambas had ineffective prior complaint mechanisms, antagonistic provider-user relations, and negative reactions to CHS results, including concerns about the CHS methodology. However both BM3 and SAM4 puskesmas mentioned the role of the MSF at the highest levels of accountability. These findings suggest the SA interventions triggered positive outcomes in different contexts and point to the salience of "micro-contexts," defined as local factors that impact upon the particular implementation trajectories of SA interventions (Joshi, 2014).

For example, among the local factors in BM3 puskesmas was positive leadership from the puskesmas head, who recognized the importance of social accountability and used the complaint survey

and other social accountability mechanisms (e.g., an SMS hotline) to improve the responsiveness of the health center. The puskesmas head commented, "After the complaint survey, we learned about many different types of complaints that we did not know about before, such as availability of anti-worming medicine, oxygen was not available for use by midwives, midwives were not at their duty station, or midwives did not perform their birthing/delivery duties very well. When we learned about the complaints, we addressed them by providing additional medicines and equipment and worked with the midwives to address the complaints associated with them."[20]

The puskesmas head's actions improved citizen satisfaction, resulting in greater financial autonomy, awards, and increased demand for services. She commented, "We obtained financial autonomy. The Dinas Kesehatan transfers funds directly to the puskesmas and we can manage our own funds. Our doctors can make their own decisions about the quantity and kinds of medicines to meet our patients' needs. This is a big change. Before if we needed something as simple as a piece of paper we had to go to the Dinas Kesehatan but now we do not have to do that." She also mentioned, "There are two puskesmas that requested support and they came to visit our puskesmas to ask about how we made reforms. We receive questions from other puskesmas as well, since our puskesmas has received awards."

In contrast, the puskesmas head at SAM6, one of the puskesmas with no recognition of MSF accountability and low completion rates of service charter improvements, was not committed to increased accountability and did not see the benefit of improved responsiveness. He said that he did "not see any benefits" in response to the charter. The low completion rates in this puskesmas could also be attributed to lack of initiative. The puskesmas head spent time documenting poor conditions in village health posts (unclean floors, water available only from collected rainwater, many materials stored under birthing tables that allow germs to collect), but only to protect himself: "If there is no decline in infant and maternal mortality, I can explain this is part of the problem."[21] When asked whether he could involve the MSF to improve services in the health outreach posts, he said that unless there are village funds to pay for it he would not be supportive.

[20] Interview: Puskesmas, BM3, March 4, 2014.
[21] Interview: Puskesmas, SAM6, March 5, 2014.

Table 11. Comparison of contextual factors for high and low accountability sites

Site	Existing complaints mechanisms	Existing provider-user relations	MSF members had previously collaborated	Negative provider reaction to CHS results	Provider expressed concerns about CHS methodology	SC points remaining to address (2014)
High accountability sites						
BM3	effective		n.a.			0/14
SAM1	effective		n.a.	X	X	n.a.
SAM4		antagonistic		X	X	2/10*
SAM5	not effective	antagonistic				n.a.
SIN3	not effective	antagonistic	X		X	10/78
Low accountability sites						
SAM6	not effective	antagonistic		X	X	5/17*
SIN1		antagonistic		X	X	2/59

Notes: N.a. indicates no data available. * indicates data from 2013
Source: Authors' interviews and Kinerja monitoring data.

DISCUSSION OF FINDINGS AND RECOMMENDATIONS FOR PRACTICE

Here we return to the issues related to the theory of change for SA that underpin Kinerja's approach to improving local service delivery performance. We address the influence of context on the causal chain, the various patterns of commitment to SA and the consequent implementation of SA interventions, and the prospects for sustainability.

To reinforce and continue to build towards effective citizen demand for service improvements, our findings demonstrate the need to not only change provider attitudes to engender responsiveness to citizen feedback, but also to continue to strengthen citizen engagement to sustain accountability. The specifics of further investments are critical to increasing the prospects for sustainability. Based on our findings, we also make recommendations for practitioners and policymakers, who are working to support and sustain SA.

Influence of context

The study corroborates the salience of each of the three main contextual domains summarized in Table 2. In the civil society domain, citizens' willingness to engage in SA were important for the implementation of all three of Kinerja's SA tools and mechanisms: the CHS, SC, and MSF. Our findings offer some support for the influence of past history of efforts to claim space for accountability (social mobilizations, active associations), as well as other invited initiatives (complaints mechanisms.) These efforts appear to have laid the groundwork for Kinerja's technical assistance at some sites. In addition, the implementation of the first round of the CHS and SC has influenced the subsequent partial replication of the approach. Even if prior efforts have not been successful, other research has shown that change is more likely to result from multiple types of citizen engagement (Cornwall & Coelho, 2007; Gaventa & Barrett, 2010).

In the political society domain, the enabling environment for citizen engagement and the willingness of state bureaucrats to support SA, combined with the rule of law, stand out. These are influenced by a set of national legal mandates that seek to change state-society relations through increased transparency, participation, and accountability; for example, the requirement that service delivery agencies conduct regular citizen feedback through CHS and that sectoral services meet prescribed minimum service standards (Wetterberg & Brinkerhoff, 2013). The history of state-society engagement is affected by the incentives that local sectoral agencies offer to providers to commit to SA and by varying power differentials between technical agencies and providers, as well as the willingness and ability of citizens to engage (Holland et al., 2012).

Although each of the contextual domains associated with SA are salient, the effects are not consistent. Among the study's more striking findings is that some health facilities successfully implemented the Kinerja-supported SA tools and demonstrated responsiveness to service users both in positive and in negative contexts (see Table 11). Kinerja districts were chosen randomly; as a result, the contextual factors varied widely, as did their anticipated impact on SA. However, the data from our study indicated there was no clear pattern of contextual factors among the five sites with common perceptions of SA between citizens and providers. Similarly, broader changes resulted in districts with both more and less conducive contexts (Tables 5 and 6). We interpret this finding as attesting to the importance of micro-contexts in influencing the dynamics of SA theories of change, confirming Joshi's (2014) analysis of micro-level drivers of citizen engagement in accountability.

To be clear, our argument is not against the importance of contexts for understanding the dynamics of SA. On the contrary, contextual variables, particularly at the micro level, are likely to be critical to understanding the series of events and interactions between local factors that led up to SA outcomes. However, information about these variables is unlikely to be readily available, and their effect on the direction of change is difficult to predict. Our study provides some hints about micro-level drivers such as particular individuals in leadership positions, who show a demonstrated commitment to SA and to improving service delivery and facility performance. Our findings also argue for investing in SA in both seemingly "conducive" and "resistant" contexts. Because pre-existing conditions did not neatly align with outcomes, even micro-contextual data—if they are available—will not clearly identify sites where SA commitments are most likely to take root. While not arguing for a random selection (see below), our findings suggest encouraging SA in a broad range of contexts.

Recommendation 1: Use contextual data as a guide, but be prepared for unexpected outcomes

The apparent importance of micro-contexts leads us to re-examine the value of gathering detailed macro-contextual information to guide and tailor programmatic decisions for SA interventions. The contextual factors in Table 2 are all relatively macro-level, and as such are indicative rather than predictive of SA applications and outcomes. Significant investments of time and resources are required to collect information on all contextual indicators, without necessarily gaining substantially in *a priori* understanding of the viability of SA. We, therefore, recommend that practitioners use available contextual data to guide decisions about where to introduce SA interventions, but avoid large investments in time and resources to gather additional information on context. Data-gathering efforts should be focused on

micro-contexts (Joshi, 2014) as opposed to completing depictions of macro-contexts (O'Meally, 2013), which have less direct effects on SA.

Commitments to social accountability: citizen-centered and client-centered

Across our research sites, we note two distinct patterns of commitment to SA subsequent to Kinerja's interventions. These two patterns, citizen centered and client centered, differ in emphasis on citizens' use of information and advocacy for continued service improvement, which were anticipated to strengthen in Kinerja's theory of change. The two patterns are explained in more detail below.

Citizen-centered social accountability

At some research locations, there was a *citizen-centered* pattern in which state actors demonstrated commitment to *SA as a means of involving citizens as partners in improving service delivery*. In Bener Meriah, there were consistent reports of improved practices of citizen participation at the puskesmas level, as well as support for citizen input and involvement for feedback and policy input at the district level (Tables 9 and 10). SIN2 was the only puskesmas at which staff perceived a stronger role for citizens in ensuring accountability than MSF members themselves reported (Figure 3). In these locations, the empowerment of citizens to gather and provide information was valued as a critical component of improving services.

In the citizen-centered pattern, social accountability was linked to enhancing involvement of citizens as partners in improving service delivery. This emphasis aligns well with the project's theory of change and also fits with other efforts to improve decentralized governance in Indonesia's nascent democracy. The country's largest poverty alleviation program, *Program Nasional Pemberdayaan Masyarakat* (PNPM), is centered on principles of participation, transparency, and accountability and has been demonstrated to strengthen involvement of non-elites, including women and the poor, in identifying local needs and allocating community funds (McLaughlin, Satu, & Hoppe, 2007; Pokja Pengendali PNPM, 2012). The Village Law (Undang-Undang No. 6/2014 tentang Desa) also emphasizes community empowerment through participatory village deliberations, as well as transparent planning and financial processes and public accounting for use of development funds.

Although this citizen-centered version of commitment to SA clearly emphasized empowerment, there is some indication that, at least at the district level, the commitment to SA extended only to soft accountability (see Table 1). Officials were open to input and collaboration and often recognized the right of citizens to monitor, but there was little explicit discussion of sanctions for providers who failed to respond to citizens' feedback.

Client-centered social accountability

In contrast to *citizen-centered* SA, other locations presented a *client-centered pattern*. Here, state actors made substantial changes in response to Kinerja interventions, but placed much less emphasis on empowering citizens to insist on accountability and demonstrated weak recognition of citizens' rights to be involved in improving service delivery. Although service delivery improvements prompted changes in provider behavior, often reinforced by local government support for improved services, these changes did

not produce the anticipated strengthening of citizens' roles in ensuring quality services; this feedback loop in the theory of change did not work as anticipated in these locations.

In client-centered patterns, *SA was adopted as an instrument to improve services, by increasing provider responsiveness to clients*. The clearest case of this pattern is Sambas,[22] where district officials demonstrated strong commitment to replicate Kinerja's tools across the district and provided clear rewards (and some sanctions) to ensure puskesmas staff's responsiveness to problems were identified through the tools. These actions facilitated changes in attitudes at the health center level; recall that four of the six puskesmas in this district reported the two highest levels of MSF roles (Figure 3). However, there were no broader improvements in empowerment or participation in this district, and gains at the site level were highly dependent on Kinerja actors (Tables 9 and 10). Rather than building citizens' capacities to gather information and use it to advocate for service improvements, SA tools were seen as a *means of identifying priorities for providers, so that they could improve services for clients*. In a variant on New Public Management-style, performance-based incentives, providers were rewarded for applying these tools and demonstrating improvements; while MSFs clearly had the right to provide input, there was little concern with the quality of citizen involvement or desire for further interactions. The district's strong commitment to SA was reflected in reinforced changes in provider behavior and in local government priorities, without the emphasis on citizen empowerment seen in other locations.

This pattern fits well with Indonesia's current push for improving the professionalism and effectiveness of the civil service through bureaucratic reforms. The Civil Service Law (Undang-Undang No. 5/2014 tentang Aparatur Sipil Negara), which was signed into law in January 2014, emphasizes the civil service's capacity to deliver public services to improve the people's welfare and also requires civil servants to take responsibility for their performance. In fact, Sambas has been selected as a pilot site for implementing bureaucratic reforms stemming from this law, which district actors and puskesmas staff who were interviewed for this study saw as reinforcing the changes in attitudes and practices prompted by their experience with Kinerja's SA tools.

Although the changed orientation of providers and officials has been impressive in Sambas, focusing only on client satisfaction as a means of increasing provider responsiveness to improve service governance and quality, without emphasis on involving citizens, misses the broader aims of SA. Without strengthening citizens' voice, "overcoming systemic shortcomings and bringing about collective improvements by means of active citizenship in sustainable service improvements [become] secondary considerations" (Brewer, 2007, p. 554).

However, this concern should not detract from the unexpected outcome that a commitment to SA has taken hold at all. In contrast to Bener Meriah, where SA tools reinforced conducive contextual factors, both at site and district levels, few would have expected Sambas to develop a commitment to requiring SA tools at all puskesmas. Instead, SA interventions in this district overcame antagonistic provider-user relations and the shortage of functioning complaints mechanisms, as well as negative receptions from providers, to result in service improvements and providers' and officials' changed

[22] Puskesmas BA2 in Banda Aceh also fits this pattern.

attitudes. Sambas is thus an instructive illustration of how micro-contextual factors influence SA outcomes.

Especially notable is that district officials were actually paying attention to developments at the puskesmas level and responding with changes in policy and programming. Many districts take a top-down approach, passing programs and resources down to subdistricts and villages without monitoring their use or appropriateness (McLaughlin et al., 2007; Wetterberg, Dharmawan, & Jellema, 2013).[23] Further, their responses consisted not only of changed requirements and directives, but of tangible incentives associated with hard accountability (Table 1).

In sum, both the citizen- and client-centered commitments to SA resulted in service improvements through provider responsiveness. Generating a response from providers and officials is the crux of SA in Indonesia (Lewis, 2013), where a number of studies have shown that citizens are willing to complain *if* they are able to do so without fear of repercussions (Gaduh, 2010; Olken, 2007). However, if citizens receive no response, this enthusiasm can reasonably be expected to temper. Although the two patterns differed in emphasis, both demonstrated notable shifts in providers' and officials' perceptions of the validity of community feedback on service delivery.

Recommendation 2: Demonstrate utility of citizen engagement through collaboration on shared problems to increase provider responsiveness

We recommend facilitating collaboration to address recognized, shared problems as a means of increasing providers' willingness to engage with citizens and of strengthening user committees. When puskesmas staffs' perceptions of SA activities were relatively well-aligned with citizens' views, it was often because the clinicians and administrators had collaborated with user committees on solving a problem that was important to both sets of actors.

For example, one puskesmas in West Kalimantan struggled with high maternal mortality rates (MMR) for many years. One of the perceived obstacles was the firmly held local belief in a remote community that births should be accompanied by traditional birth attendants. To address the high MMR, the user committee met with members of the remote community to learn why they were reluctant to work with midwives or to use the puskesmas facilities. Community members perceived that puskesmas practices contradicted local customs, thus complicated pregnancies were rarely referred to the puskesmas for further assistance. The user committee worked with the puskesmas to change how the birthing facility was set up to accommodate local beliefs and to ensure that puskesmas staff treated patients with respect. As a result of these changes, the MMR was significantly reduced. Further, providers recognized the user committees' role as a bridge between the community and the puskesmas and continued to collaborate on addressing common priorities.

Again, identification of shared problems requires mechanisms that allow citizens to communicate and discuss concerns with providers, underscoring the need for formal SA efforts. These mechanisms enable providers to see citizens not only as patients, but also as potential allies in addressing priority

[23] In our study, such behaviors were observed in Singkawang, where district actors showed little interest in the changes in service delivery taking place at the puskesmas level.

problems. In addition, SA efforts should provide space for providers to identify issues with which they could use the community's help to engender mutual benefit.

Recommendation 3: Leverage civil service/administrative reforms to provide institutional incentives and sanctions for provider responsiveness.

In our interviews, several of the puskesmas respondents reporting higher SA activity also noted that they had benefited from equipment, promotions, additional services, and financial autonomy after demonstrating responsiveness to client needs. For example, two administrators were promoted to puskesmas head for performing well during the implementation of CHSs and SCs. Financial autonomy to manage revenues and make purchases was extended to several puskesmas that showed good performance on Kinerja implementation. Several puskesmas respondents noted that their health centers had been given more attention for district budgetary allocations (roads, in-patient services) because they had successfully completed SA activities. In West Kalimantan, two puskesmas heads enforced staff attendance by applying local regulations for deducting pay.

The Civil Service Law provides both for principles of accountability and responsiveness (Chapter II) and for mechanisms for performance assessment and associated rewards and sanctions (Chapter VIII, Section 3) that could help to institutionalize incentives for SA. According to the Law, district supervisors should have the authority to evaluate the performance of frontline service providers, sanctioning and rewarding them accordingly (Articles 72–82). These legal provisions are opportunities to increase provider responsiveness through performance assessment, rewards, and sanctions. In particular, as noted earlier, providing incentives for providers to directly engage with citizens would contribute to further empowerment gains.

Recommendation 4: Ensure that invited spaces directly engage providers with citizens

To generate a response from providers, SA interventions must include formal efforts to engage citizens (such as direct involvement in survey design and implementation and SC negotiations that were part of Kinerja's interventions) through opportunities to identify emerging issues, discuss them with providers, and advocate for responses from district officials. The study results indicated that formal SA mechanisms (such as the CHS and SCs) provided data and a reason for citizens to interact with puskesmas staff outside the often hierarchical patient-provider relationship. Although sometimes contentious, discussions of survey results and charter negotiations were often the first opportunities that citizens had to provide direct input to service quality. Invited spaces that do not involve citizens in identifying and prioritizing problems in direct collaboration with providers (such as complaints boxes, SMS) have rarely been effective. In contrast, open discussion of problems and how to address them, while often contentious, are difficult for providers to ignore. To increase the likelihood of responsiveness, providers must be required to listen to community concerns, even if such engagements are confrontational.

Especially where SA commitments are client-centered, it is critical to continue support for direct citizen engagement. Because empowerment gains have been weaker in such areas, citizens might not insist on direct engagement if providers shift to less participatory SA tools. District officials must,

therefore, ensure that incentives will encourage direct engagement with citizens, rather than provide only tokenistic SA.

Moving beyond widgets: sustainability of citizen-state relations for accountability

If, as a measure of sustainability, we focus only on the degree to which Kinerja's SA tools were replicated, results are not particularly encouraging. We found no puskesmas repeating CHSs and SCs, although Bener Meriah had committed to introducing them at two additional puskesmas, and Sambas was planning to replicate tools at all puskesmas in the district. However, these data were collected after one year of interventions, and it may have been too soon to expect repeated implementation of the SA tools at the same sites.

More importantly, even after only one year, our respondents did report changes in interactions within society, triggered by the interventions across a range of micro-contextual variables, which shape prospects for sustaining SA. At the puskesmas level, aligned citizen and provider attitudes towards SA increases the likelihood of sustainable SA interventions and hard accountability (Figure 3). If both have similar expectations of the role that citizens should play, providers will be relatively open to feedback and monitoring.

Recall, however, that we often found significant divergence of perceptions of the MSF as a mechanism to support social accountability. The puskesmas staff and MSFs agreed at lower levels of accountability, such as for information dissemination, but disagreed at higher levels of accountability, such as in facility monitoring. This divergence indicated that multi-stakeholder members felt more empowered to hold puskesmas accountable for performance than puskesmas staff were willing to recognize or accept.

In the long term, such disjuncture could be problematic for sustainability at the puskesmas level. Lack of alignment does not preclude SA, but there is an inherent problem of lack of responsiveness from providers, who see a smaller role for MSFs than the latter do for themselves. If MSFs make demands, but puskesmas do not recognize citizens' rights to demand better services, discount their feedback as uninformed or unimportant, or see criticisms as threatening, the feedback mechanism will be one-sided and not result in the desired public service delivery improvements. A lack of responsiveness could eventually lead to disempowerment and backsliding on the SA and service delivery gains (Gaventa & Barrett, 2012).

At the district level, empowerment gains, seen at sites with citizen-centered commitments to SA, may prompt efforts to improve other services. After they have established a role for themselves in influencing how health services are delivered, citizens may insist on providing feedback on other types of public services. Where they have connected with receptive district officials, as in Bener Meriah, citizens may rely on these allies to push for responsiveness from other providers.

With the client-centered pattern, however, sustainability may be problematic if SA tools become routinized over time and their original intent to involve citizens at multiple stages become lost. The technical steps may be decoupled from their original intent, performed only as myth and ceremony to legitimate the executing actors (Holland et al., 2012; Meyer & Rowan, 1977). For example, providers may shift to feedback mechanisms that lack the thorough community engagement of the original tools.

Citizens in such districts have not made empowerment gains that would enable them to insist on involvement in improving service delivery. If the state stops inviting space for SA, citizens have not gained the skills to claim it on their own.

Recommendation 5: Go beyond enumerating progress on SA tools' implementation as a gauge of sustainability

To understand the effects of SA efforts, practitioners need to measure shifts in provider responsiveness and levels of engagement by citizens rather than (or in addition to) completion rates of SA interventions. Although indicators such as MSF formalization, SC completion, and plans to replicate tools may be related to broader changes (as replication plans were in Bener Meriah and Sambas), the variations in commitment to SA and prospects for sustainability are not captured by such indicators. At the site level, there was no relationship between (non-existent) plans for replication and changes in service delivery and responsiveness.

Practitioners and policymakers may gain a better understanding of the prospects for sustainability by gauging SA in terms of larger shifts in citizen and state responsiveness rather than narrowly measuring the causal linkages between interventions and public service delivery outcomes. McGee and Gaventa (2011) reinforce this notion in the promotion of power analysis frameworks and tools, while Joshi (2014) suggests instead to assess progress through causal chains. Similarly, our findings suggest that SA interventions can trigger larger shifts in citizen-state relations in a variety of contexts and that second-order shifts may be more indicative of sustainability than replicability of specific interventions.

We recommend a learning approach to implementation of SA and public service delivery initiatives. Monitoring and evaluation efforts should capture the changing dynamics of citizen-state relations to better understand the potential impact of SA on public service delivery outcomes. Program design and evaluation indicators should focus more on second order shifts in SA to determine long-term impacts on public service delivery rather than attempting to measure causality of particular interventions.

Recommendation 6: Seek out contexts where SA tools are novel and address pressing needs to promote sustainability

For commitments to SA to be sustained, either from a citizen- or client-centered perspective, it is critical that providers and officials do not treat SA tools as yet another top-down program to be mechanistically implemented. At research locations that reported site-specific and broader changes, Kinerja's interventions were seen as novel and consistently generated positive or negative attention from providers. In terms of positive attention, providers at three sites where providers saw a large role for MSFs (BM3, SAM1, and SIN2) explicitly referred to Kinerja as a program that was different from others:

> *Before [Kinerja], we socialized our programs/services, but were not focused on what people's problems were and how these compared to what was available at the puskesmas. Until now, Dinas provides programs, we implement, and we think they are meeting people's needs (Interview, Puskesmas SIN2).*

At the other end of the spectrum, the negative reactions from many providers in Sambas (Table 6) forced district officials to be involved in implementation and sometimes intervene. Although challenging,

these experiences framed the SA interventions as novel—and, to puskesmas staff, programs that the district cared about—rather than as a normal part of health center and district operations.

In contrast, puskesmas staff and district officials in Banda Aceh generally did not see the Kinerja interventions as anything out of the ordinary.[24] At some sites, respondents had trouble remembering anything about implementing the tools and providers likened them to prior ISO reforms. Dinas Kesehatan staff noted that CSOs had previously introduced SCs at many of the same puskesmas at which Kinerja was working. Further, the prior passing of policy reforms conducive to SA (Figure 1) may have contributed to the perception that the SA tools Kinerja introduced were not addressing new and pressing issues.

Notably, Banda Aceh already had a very high level of medically assisted deliveries, which as Table 4 indicates, were at 100% in 2011. As Kinerja interventions were oriented towards improving these rates, officials are unlikely to have seen these reforms as urgent. For comparison, recall that Sambas, while a relatively wealthy district, had struggled to improve their rates of medically assisted delivery. In this district, officials paid even more attention to Kinerja's reforms after it became clear that they could contribute to improving service delivery. This type of contextual variable is available *a priori*, and could be used to steer SA interventions towards more conducive contexts.

CONCLUSIONS

Our study is a snapshot of a particular moment in the timeline of the adoption of facility-level SA tools and processes in Indonesia. Where data collection and analysis take place along the temporal dimension influences the elements considered and what conclusions can be drawn. Donor time is projectized, usually in four- to six-year segments, beginning when project interventions start, and ending when the project terminates. Country political-bureaucratic timeframes, in contrast, are defined by rules, policies, electoral calendars, mandates, and budget cycles (see Howlett & Goetz, 2014). At the broadest level, the timeline of SA in Indonesia could be viewed as beginning with the fall of the Soeharto regime and continuing through the history of decentralization and contention between central and local governments and of the evolving pattern of state-society relations.

The temporal dimension is important because it affects the extent to which our discussion of study findings suggest optimism or pessimism about SA in Indonesia. Much research on institutional and governance change indicates that it is a long-term process. In this sense, we conducted our study too soon, although it fits with donor time. We recognize the inherent limitations in our timing and methodology. However, we see the study as an effort to search for signs that the seeds for changes related to SA may have been sown and for factors that may influence whether those seeds will grow into a healthy, sustainable, and productive exchange between citizens and service providers, or wither away.

Changes in state-society relations occur over extended time periods. Our study substantiates what other research on Indonesia's lagging service quality concludes: "…the most important initiative that could be undertaken to reform decentralization would be to convince Indonesia's citizens that they

[24] A similar reaction was seen at Puskesmas SIN3, which already carried out regular satisfaction surveys and demonstrated no broader changes in interactions with citizens (Table 9).

deserve better [quality services] and to encourage them to vigorously express their demands to their local leaders" (Lewis 2013, p. 21). This kind of long-term attitudinal shift will be required to institutionalize SA by building pro-accountability coalitions.

It is not only citizens whose attitudes will need to change. Public officials and service providers in Indonesia have a long history of authoritarian and paternalistic attitudes and behaviors that have diminished in the post-Soeharto era, but have far from disappeared (Brinkerhoff & Wetterberg, 2013). SA and impacts on frontline service provision are unlikely to be sustainable without overcoming such attitudes, which will require real incentives for responsiveness from higher levels of government as well as increased demand-making capacity and motivation on the part of citizens.

Recent policy changes in Indonesia should facilitate continuing commitment to SA. In particular, reforms introduced in the Civil Service Law are likely to make client-centered approaches less idiosyncratic, as the policy shifts emphasize provider performance incentives, rewards, and sanctions. At the same time, however, there are signs of reduced support for SA tools and of new limitations on democratic processes. There has been discussion of eliminating complaints surveys from the Public Service Delivery Law. The reversal of subnational direct elections also signals a reduced commitment to citizen voice in the macro-context. Finally, although the Village Law offers strong support for principles of participation, transparency, and accountability, the Law's implementation regulations substantially weaken the commitment to these principles (Wetterberg, 2014).

In combination with a reformist administration that is focused on efficient and effective public services, this policy context puts Indonesia at a pivotal juncture. By capitalizing on opportunities and enforcing existing SA mechanisms, national and regional governments could encourage service providers to recognize and respond to feedback from users and to channel continued citizen demand for improved public service delivery. Efforts like Kinerja's demonstrate that SA mechanisms can build citizen capacity to work with providers for better services, lead to changed provider attitudes and behaviors, and increase the quality and responsiveness of service delivery. If citizen engagement and provider responsiveness are neglected, however, there is a risk of falling back into old patterns and losing the hard-won momentum for service improvements.

REFERENCES

Agarwal, S., & Van Wicklin, W. A. I. (2012). How, when, and why to use demand-side governance approaches in projects. *GAC in Projects*. Washington, DC: Social Development Department, World Bank.

BPS. (2011). Trends of the Selected Socio-Economic Indicators of Indonesia. Jakarta: Badan Pusat Statistik.

Brewer, B. (2007). Citizen or customer? Complaints handling in the public sector. *International Review of Administrative Sciences, 73*(4), 549-556.

Brinkerhoff, D. W. with Azfar, O. (2010) Decentralization and community empowerment. In E. Connerley, K. Eaton & P. Smoke (Eds.), *Making decentralization work: democracy, development and security*. Boulder, CO: Lynne Rienner, 81-114.

Brinkerhoff, D. W., & Wetterberg, A. (2013). Performance-based Public Management Reforms: Experience and Emerging Lessons from Service Delivery Improvement in Indonesia *International Review of Administrative Sciences, 79*(3).

Bukenya, B., Hickey, S., & King, S. 2012. Understanding the role of context in shaping social accountability interventions: towards an evidence-based approach. Manchester: Institute for Development Policy and Management.

Cornwall, A., & Coelho, V. S. (2007). *Spaces for change?: the politics of citizen participation in new democratic arenas*. London: Zed Books.

Fox, J. (2007). The uncertain relationship between transparency and accountability. *Development in Practice, 17*(4-5), 663-671.

Freedman, L. P., & Schaaf, M. (2013). Act global, but think local: accountability at the frontlines. *Reproductive health matters, 21*(42), 103-112.

Fritz, V., Kaiser, K., & Levy, B. (2009). Problem-driven governance and political economy analysis: good practice framework. Washington, DC: World Bank.

Gaduh, A. (2010). Village capacity in maintaining infrastructure: evidence from rural Indonesia. Jakarta: World Bank.

Gaventa, J., & Barrett, G. (2010). So what difference does it make? Mapping the outcomes of citizen engagement. *IDS Working Papers, 2010*(347), 01-72.

Gaventa, J., & Barrett, G. (2012). Mapping the outcomes of citizen engagement. *World Development, 40*(12), 2399-2410.

Gerring, J. 2004. "What is a Case Study and What is it Good for?" *American Political Science Review* 98(02): 341-354.

Holland, J., Ruedin, L., Scott-Villiers, P., & Sheppard, H. (2012). Tackling the Governance of Socially Inclusive Service Delivery. *Public Management Review, 14*(2), 181-196.

Howlett, M., & Goetz, K.H. (2014). Introduction: time, temporality and timescapes in administration and policy. *International Review of Administrative Sciences*, 80(3), 477-493.

Joshi, A. (2014). Reading the Local Context: A Causal Chain Approach to Social Accountability. *IDS Bulletin, 45*(5), 23-35.

Joshi, A., & Houtzager, P. P. (2012). Widgets or watchdogs? Conceptual explorations in social accountability. *Public Management Review, 14*(2), 145-162.

Kinerja. (2011). Kinerja Annual Work Plan Year 2: October 2011 to September 2012. Cooperative Agreement No. AID-497-A-10-00003. Research Triangle Park, NC: RTI International.

Kinerja. (2012). *Tool Profile: Increasing Citizens' Participation in Public Services Delivery through Complaint Survey*. RTI International. Research Triangle Park, NC.

Leonard, D. K. (2010). 'Pockets' of effective agencies in weak governance states: Where are they likely and why does it matter? *Public Administration and Development, 30*(2), 91-101.

Lewis, B. D. (2013, Oct.-Dec.). Public services: the legacy of decentralisation. *East Asia Forum Quarterly, 5*, 20-22.

McGee, R. and Gaventa, J. 2011. "Shifting power? Assessing the impact of transparency and accountability initiatives." *IDS Working Papers* 2011(383): 1-39.

McLaughlin, K., Satu, A., & Hoppe, M. (2007). Kecamatan Development Program Qualitative Impact Evaluation. Jakarta: World Bank.

Meyer, J., & Rowan, B. (1977). Institutionalized Organizations: Formal Structure as Myth and Ceremony. *American Journal of Sociology, 83*(2), 340-363.

Molyneux, S., Atela, M., Angwenyi, V., & Goodman, C. (2012). Community accountability at peripheral health facilities: a review of the empirical literature and development of a conceptual framework. *Health Policy and Planning, 27*(7), 541-554.

O'Meally, S. C. (2013). Mapping Context for Social Accountability: A Resource Paper. Washington, DC: Social Development Department, World Bank.

Olken, B. A. (2007). Monitoring corruption: Evidence from a field experiment in Indonesia. *Journal of Political Economy, 115*(2), 200-249.

Pokja Pengendali PNPM. (2012). PNPM Mandiri Information Kit 2012-2013. Jakarta: Sekretariat Pokja Pengendali PNPM Mandiri.

Rocha Menocal, A., & Sharma, B. (2008). Joint evaluation of citizens' voice and accountability: Synthesis report. *London: DFID*.

SekNas Fitra & The Asia Foundation. (2012). Laporan Analisis Anggaran Daerah 2008-2011: Temuan-temuan Hasil Studi Pengeloloaan Anggaran di 20 Kabuptan/Kota Partisipan Program Kinerja [Local Budget Analysis 2008-2011: Findings from Budget Management in 20 Kinerja Districts]. Jakarta: SekNas Fitra & The Asia Foundation.

Tembo, F. 2013. "Rethinking social accountability in Africa: Lessons from the Mwananchi Programme." *London, UK: Overseas Development Institute, September*.

Wetterberg, A. (2014). Transitioning Community-Driven Development Projects into Policy: From PNPM Mandiri to the Village Law (draft report for TNP2K). Unpublished manuscript. Research Triangle Park, NC: RTI International.

Wetterberg, A., & Brinkerhoff, D. W. (2013). The political economy of adopting public management reforms: patterns in twenty Indonesian districts *International Development Group Working Paper 2013-02*. Research Triangle Park, NC: RTI International.

Wetterberg, A., Dharmawan, L., & Jellema, J. (2013). The Local Level Institutions Study 3: Overview Report. Jakarta: PNPM Support Facility.

Wild, L., King, M., Chambers, V., & Harris, D. (2012, August). *Common constraints and incentive problems in service delivery*. Overseas Development Institute, London, UK.

World Bank. (2014). INDO-DAPOER (Indonesia Database for Policy and Economic Research). Retrieved Dec. 10, 2014, from http://databank.worldbank.org/data/views/variableselection/selectvariables.aspx?source=indo~dapoer-%28indonesia-database-for-policy-and-economic-research%29