Fostering Genuine Participation: Lesson Learnt from Citizen Engagement in Transparency for Development (T4D) Pilot Project

by: Yunie Nurhayati & Heidi Cho | Researchers: Didik Purwandanu & Novita Anggraini

Location: Banten, Indonesia | Category: Local Governance - Participation

Goal Area: Public Health Service Improvement | Scope of Work: Community Organizing, Capacity Building, Model Development
Executive Summary

One of the biggest health challenges in Indonesia is maternal and newborn health. Child mortality rates in poor peri-urban areas are much higher than the urban average. A 2012 study by UNICEF found that child mortality rates are five times higher in Jabodetabek’s poor peri-urban sub-districts. As the nearest peri-urban area to Jakarta, Banten province was found to suffer from the fourth highest provincial maternal and neonatal mortality rates, whilst also suffering from a lack of health resources (Ministry of Health, 2011). Furthermore, many of the problems that led to poor maternal and neonatal health can be found at the community or infrastructural level (AIPMNH, 2011). For such issues, the application of social accountability is a potential solution for identifying problems and advocating for solutions through the citizen engagement (CDC, 1997). It is for that reason that the first Transparency for Development (T4D) pilot conducted by the Harvard Kennedy School and the Results for Development Institute, in collaboration with PATTIRO, focused on fostering community participation to develop and implement collective action to respond to MNH problems within their neighborhood.

During 6 (six) months of project implementation, there was a significant improvement in community participation in and awareness of MNH issues. Major improvements included an increase in awareness of MNH problems within the communities, which further brought out a sense of urgency to take necessary action and a shift towards considering MNH as a collective responsibility. By the conclusion of the pilot program, several villages were successful in sustaining and increasing participation. Others were not as successful, largely as a result of community activists’ (CA) lack of interest in the issue or conflict among them. Inevitably, CAs sense of volunteerism, leadership, and responsibility were characteristics that magnified project success.

Accordingly, there were four main lessons throughout the process of the T4D pilot project: 1) the need to leverage citizen engagement as a process of building community capacity, 2) need to strengthen community capacity to be able to access resources, 3) need to strengthen the social capital to enhance effective participation, 4) need to combine the ‘inward’ and ‘outward’ approach to build social accountability.

There were, however, several significant challenges beyond the T4D control, including: 1) lack of government resources and support, 2) the politics related to the heads of villages, 3) mistrust of CSOs and NGOs and 4) individual family interests brought conflicts to the program. Moreover, in terms of sustainability, the program needs to undertake more careful consideration in selecting new community activists. Consequently, additional informal meetings and supplementary training for CAs is needed. In addition, a better recording system to monitor villages and the establishment of a new instrument to track wider territorial network is recommended, as the program will be scaled-up territorially.

Background and Context

Indonesia is an emerging leader in South East Asia, yet million of Indonesians still suffer from poor health condition and accessing quality care continue to impede further progress. Health indicators throughout the country remains poor and national level data disguise the magnitude of sub-national inequity in health indicator. Furthermore, the lack of source to health infra and access to health education and nation’s inconsiderate distribution of capital is another rational for health deficiency, largely on the urban peripheries. In Indonesia, one of the biggest health challenges is related to maternal and newborn health.

National level data from 2007 to 2012 shows that the maternal mortality rate (MMR) increased from 228 per 100,000 births, to 359 (Basic Health Survey 2007 – 2012, Health Ministry). This is very far from the target of the 2015 Millennium Development Goals (MDGs): 102 per 100,000 births. Also, child mortality rates in poor peri-urban areas are much higher than the urban average. A study of “mega-urban” Jabotaken, Bandung and Surabaya in 2000 found child mortality rates are five times higher in Jabotabek’s poor peri-urban sub-districts, such as West Java Province and Banten Province, than Jakarta city centre. (UNICEF, 2012)
Many of the problems that led to poor maternal and neonatal health can be found at the community or facility level (AIPMNH, 2011). For these types of problems, social accountability is a potential solution for identifying problems and advocating for solutions. However, social accountability for basic health service providers is not sufficiently developed or used in communities in Indonesia. In 2004, the Health Ministry issued a decree on health committees (HC) that would provide the opportunity for the public to collaborate with puskesmas (governmental community health centre) and health offices. Unfortunately, only 10 of 542 regency and city governments (1.85%) had acted on this decree by 2013. Even with support from the national government, public engagement around improving health services has been incredibly low.

Nevertheless, social action, or advocacy, is needed since development practices often use top-down approaches (led by government or international organizations), which have the potential to ignore or marginalize vulnerable groups, preventing them from reaching adequate health and education services. A social accountability framework builds on the belief that high-quality health care requires public engagement. (CDC 1997) Practices associated with this framework include public oversight, public consultation, hearing, and social monitoring. A cross-time comparison conducted by Craig Mitton (2009) showed that deliberative engagement processes on healthcare have increased, particularly in recent years.

Consequently, the first Transparency for Development (T4D) pilot focuses on the peri-urban area specifically in Banten province to improve maternal and neonatal health through social accountability. Banten has the fourth highest province with maternal and neonatal mortality rate and suffer from lack of health resources. (Ministry of Health, 2011) The facilitators are allocated to run the pilot in four villages with different urban conditions; Potang the urban, Serang the suburb and Jurak and Chibarak the rural. Similar to many other peri-urban areas, Banten lacks service at the community and facility level. Neither, the social accountability for basic health service provider is not sufficiently developed or used in communities. Most of the maternal women depend on dukun (traditional midwives) or midwives, for their delivery and posyandu (integrated health service centre), monthly health service meeting for their maternal check-up. T4D pilot is intent to provide more awareness towards maternal and neonatal health and transparent access to facilities and health resources through magnifying their social action and accountability.

Program Overview

Transparency for Development (T4D) project is process over the next three years, conducted by the Harvard Kennedy School and the Results for Development Institute working with Pattiro and other partners. Starting from April to September 2014, the first pilot was organized by Pattiro in four villages in Banten. Following six months (October 2014 to March 2015) the second pilot program will expand its boundary to hundred other peri-urban province villages. The overall objective of the project is to use social accountability to improve basic health care, particularly maternal and neonatal health indicators (figure. 3). T4D intervention is divided into three main sections: preparation, implementation and reflection (figure 1).
In the preparation step a facilitator identifies community activists and equips these community activists with basic knowledge and skills, particularly in stakeholder mapping, social or situation analysis, and the decision making process. The community activists are composed of different gender, education and occupation (figure 2). Though, the large percentages of the community activist were teachers or housewives who were already engaged in public service.

![figure 2 Profile of Community Activists](image)

The implementation phase includes gathering information about health problems in conjunction with the community activists, sharing this information with the larger community, and supporting the community when they decide on social actions. Particularly, the program aim to strengthen selected four health levers. The four levers are; at least four antenatal care visits during pregnancy, iron supplements for 90 days during pregnancy, birth in a health facility with a skilled provider and breastfeeding. Then the community decides on individual social actions relating to four health levers.

Finally, the reflection section focuses on the final part of the intervention, which concludes the facilitator conducting monitoring and evaluation activities to review the community’s achievement in its social actions. Hence, the social accountability process to overcome barriers includes two pillars – first sharing relevant information about health problems in the community and second improving the ability of community to conduct social action on that topic.

The overriding goal of T4D is to generate actionable evidence for practitioners, researchers, and other stakeholders working to improve health, accountability and citizen participation. The T4D project is test-bed in investigating the well-designed transparency and accountability interventions to improve health outcome and under what conditions.

![figure 3 T4D Overview](image)
Results

The overall objective of this program was to use social accountability as a means with which to improve basic health care, particularly maternal and neonatal health (MNH). In terms of MNH, there has yet to be any significant outcome due to the limited time provided (six months) and a lack of proper instrumentation for data measurement at the moment. Therefore, the program goal focused on an increase of community participation and engagement, in order to establish social action in favour of MNH improvement.

Although the level of participation varies among villages, in general, there was a significant improvement in participation and awareness of MNH issues through the community activist (CA) forums. More than 50% of CAs actively engage in the community meetings to assess the community needs, develop social action, and implement the action. According to Arnstein’s ladder of participation, CAs has reached the degree of citizen power where community has power and further utilizes it to make decisions and take actions toward their well-being. In terms of Burns’ ladder of citizen empowerment, it also belongs to citizen control as active citizens can be seen in the whole process of T4D program.

One of the critical issues for understanding participation and empowerment beyond the ladder of participation is determining which issues the community is allowed to be involved in. Unlike many other efforts, which tend to put only the operational issues on the agenda whilst the strategic issues are decided elsewhere (Stewart and Taylor, 1995), T4D started with determining strategic issues broadly and specifically within communities, based on community experiences, and let the community prioritize them and develop action as response.

In terms of MNH outcomes, major improvements included an increase in awareness of MNH problems within the communities and further bring out the sense of urgency to take necessary action. Previously, the communities—particularly the male population—had seen MNH issues as being beyond their responsibilities, however, with the T4D program there has been a shift towards considering MNH as a collective responsibility, with both males and females becoming active participants (59% of CAs are men).

By the conclusion of the pilot program, some villages were successful in sustaining and increasing participation. Others were not as successful, largely as a result of CAs’ lack of interest in the issue or conflict among them. Volunteerism in CAs filters out the conflict of interest among CAs and remains those who truly interested in taking actions towards MNH problems. Consequently, drop out and turn over of CAs occurred throughout the process.

![Community Activist Meeting Process](image)
Throughout the process also, we found that information and knowledge was not the only factor in boosting community participation, but rather the CAs’ sense of urgency towards the MNH issue determined their level of participation, which manifested in voluntary actions. In other words, information and knowledge are not enough to maintain participation levels, without a sense of urgency. Education levels, however, did not significantly correlate with participation levels, neither did involvement in politics. In fact, these factors could have the potential to negatively influence, hindering their acceptance of the program as a result of preconceived notions of the issue.

Lesson Learnt

The lessons are divided into four sections, namely program insight, external challenges, recommendation, and improvement for future.

Program Insight

We identified at least four main insights of the program, namely citizen engagement and capacity building process, access to resources, social capital, and strengthen the social accountability.

Citizen Participation to Active Engagement: Community Capacity Building Process

In T4D, three important players are in the community capacity building; role of the community activists, the social action and partnership among stakeholders. First, the community activists are critical in controlling the community participation. Interestingly, the community activists’ education level or their formal political involvement in the village had no significant relation to the success of the program. In fact, high education level and strong political view hinder their acceptance to the programs with their own view toward the MNH issue or the program. Thus, the CAs sense of urgency towards the MNH plays large part to the program sustainability. Furthermore, the CAs’ sense of volunteerism, leadership, and responsibility were characters that magnified the project level. Some of community activist did not participate till the end. Some due to loss of interest, others have biased view from their previous experience in similar projects. Nonetheless, community activist with good interest and personal experience towards MNH understood the significance of topic and led other community activists to be more active as well.

Secondly, the social action is a critical stage in transferring a citizen’s participation into social engagement level. Since, a community meeting does not offer full engagement as participation level depends on individual characteristic or behavior. One is less likely to speak up or act on than the others. Though, the community action planning pushes citizen to actively think and directly engage into the program taking a role in the social action. Some of these social actions include establishing health facility, facility maintenance, socialization of breastfeeding and iron pill.

Third, the partnership between diverse stakeholders can provide access to more fixed resources, which will sustain in the long-run. In Pontang, the community and government co-produced health facility to more accessible location. In socialization of iron pill, community worked with midwives to mandatorily educate the pregnant mothers to take iron pills. Also community activist and community collaborated to collect soft loans for the pregnant women. These co-production partnership in social action provide more preserved and attainable resources to women in pregnancy.

In conclusion, three actors; community activist, social action and partnership among the stakeholders, are catalyst to improve the levels of community capacity building. Robert Chaskin describes the level of community capacity building in four stages; 1) sense of community, 2) level of commitment, 3) mechanism of problem solving and 4) access to resources (Chaskin, 2001)

The community activist is a core mechanism to develop sense of community through organized meetings and their personal interaction with community member. The social action then brings level of commitment and become mechanism of problem solving.

From the consecutive meetings, the community comes up with action plan for implementation. This is the phase when individual advance from participation to an engaged process. Then the partnership, with the government or private institution, can solidify the social action to be more sustainable and accessible giving valid framework for the citizens. In the first pilot, community belonging, commitment to social issue, and social action to solve MNH problems were well conducted thus it lacked providing fixed access and sustainable framework to resources.
Access to Resources as One of The Critical Issues to be Addressed

One of the findings of this study was that the T4D program tended to be inward-looking. The issue of MNH is constituted by a wider health system, which involves broad governance structures, such as government institutions, as well as professional and non-government/private institutions. The program’s inward-looking perspective often deemed that the problems within community could only be solved by and in the community. The program seemed to ignore that resources were mostly outside the community (targeted communities are often poor and marginalized groups). According to Chaskin (2000), access to resources is one critical issue that needs to be intervened in, because it reflects the community’s capacity. For example, citizens of Pontang Village failure to seek additional midwives by themselves – the existing midwives and Puskesmas are far away and inaccessible – showed their lack of access to resources. Despite them eventually addressing their problems by organizing cooperatives and providing soft loans for mothers and pregnant women, it did not eliminate the need for professional medical personnel (midwives, doctors, etc.). Solutions generated by and with the resources of community cannot solve the problems in their entirety, because MNH problems are not merely local problems. MNH problem are wide and complex problems.

The community initiatives are indeed important but they are not, of themselves, enough. As such, these initiatives must be complemented by support to access the resources they need.

Building and Awakening The Social Capital to Foster Effective Participation

T4D program was successful in building and ‘awakening’ the social capital within communities – what Putnam (1993) and other scholars have referred to as ‘closed social capital’ – but this needs to be complemented by the building of network and strengthening of access to those ‘resources holders’ outside the community, in a process known as ‘bridging social capital’ (Coleman, 1988; Schneider, 2004).

Communities with MNH problems—such as high maternal and infant mortality rate—tend to be more aware and more easily organized than those who do not. Accordingly, they have more initiative in developing social actions and maintaining participation at all phases, despite the CAs not being the subject of the MNH problems individually.

These conditions reflect the high social capital within their communities, which manifested in willingness for collective action. Social capital can occur within or between communities, but bringing it out in a certain context needs an understanding of the cultural ‘cues’ and local power dynamics (Bourdieu and Wacquant, 1992). The cultural cues for communities in the T4D program were characterized by the sense of urgency around MNH problems. As a result of research undertaken in Philadelphia, the Washington DC metropolitan area, Milwaukee and Kenosha, Wisconsin, Schneider (2004) found that communities that successfully improve their health simultaneously foster the social capital within and across the community. Further, fostering healthy communities involves expanding two types of social capital: closed social capital within the community and bridging social capital among local communities and citywide institutions.

Consequently, drop out and turn over of CAs occurred throughout the process.

Combination of Inward and Outward Approach to Enhance the Social Accountability

Social capital, which mostly seen as a network, trust, and bonding within and across communities (Coleman, 1988; Putnam, 1990; Fukuyama, 1995; and Schneider, 2004), is strongly related to the accountability. Research in Italy using data on the Italian members of parliament in the postwar period (1948–2001) showed that the electoral punishment for political misbehavior was considerably larger in electoral districts with high social capital (Nannicini et al, 2010). Accordingly, episodes of political misbehavior were less frequent in electoral districts with high social capital (Nannicini et al, 2010). Therefore, improving MNH outcomes by fostering community participation, as part of building social accountability, should be approached with recognition of both inward and outward social capital.
Inward social capital refers to the community capacity to develop and maintain the collective action, while an outward perspective refers to strengthening their networks with other stakeholders or institutions outside the community, in order to access the resources that they need. The inward approach can be performed by fostering the effective participation by CAs to develop social action in favor of MNH improvement, as well as educating them related to MNH issues. On the other side, the outward approach can be carried out by facilitating CAs to build networks, dialogue, and partnerships with other stakeholders outside the community, particularly those who hold the resources that they need. Furthermore, building community capacity for accessing resources and enhancing their relationship with other institutions can foster the social accountability. As they possess more information, knowledge, and networks, they will be more aware about government duties and they can better hold government to account.

**Fostering healthy communities involves expanding two types of social capital: closed social capital within the community and bridging social capital among local communities and statewide institutions.**

**External Challenges**

In T4D program, the villages cope with external challenges, the barriers that are uncontrolled. Some of these challenges are; 1) lack of government resources and support, 2) the politics with head village, 3) mistrust in CSOs and NGO organization and 4) individual family value brought conflicts in the program.

Overall at the national and state level, the government lack sources and no proper data are presented to public. In the preparation phase the facilitators have struggled due to lack of information on the MNH mortality rate. The government data are not reliable, in cases; the data differ from one to the other. Though, the national statically agency provides data on MNH mortality, the sources are collected at the national and district level yet lack detailed data at the sub-district and village level.

The politics keep away some of the social actions planned. For instance, in Pontang, a location has been chosen and grants are gathered for the new health center. The social action has been well established through the meetings, though the new head village wants the location for own home. In Serang, the head village is just not interested in the maternal neonatal health issue, simply indiscreet of any community action.

Also some of the villagers have biased view towards T4D program from previous experiences with other CSOs and NGO organization. In view of the fact, these supporting organizations come in to the village to test studies and the villagers realize that these programs do not benefit them in any way. Just leaving the community with feeling left out.

There were other personal barriers such as their family values. In the community participation and engagement process many of the participants were not committed throughout due to their family concerns, such as jealousy from their spouse or women’s domestic role in the family.

**The external challenges hinder the progress and quality of T4D. More engagement and support from the government, instructing village head and villagers on misconception on program, minutely informing about program and securing for sustainable development can improve these external challenges in the further development.**

**Recommendations**

This part will briefly suggest the recommendations on more technical agendas, namely stakeholder mapping, informal community meeting, and supplementary training for CAs. First, since the stakeholder mapping stage is the most significant to recruit suitable CAs to sustain the project, it should be performed more comprehensively, not only political leaders or knowledgeable citizens, but also seeking them out one by one through the cultural ‘cues’. As for that, facilitators must also understand the local wisdom within community. Second, engagement process in the first formal meeting is very crucial but it is difficult to build the engagement only by series of formal meetings. Therefore, informal meetings and intense discussion is important, not only to keep them participated but also to educate them about the MNH issues and build their capacity to organize communities more broadly. Third, discussion and meetings is not enough, supplementary training for the CAs is needed for the capacity building purpose.
Improvement for Future

Accordingly, the second pilot program for T4D is in progress. For the future development, our concerns lie on two factors; first **how to sustain the project in longer-run** and secondly, **how to scale-up and support program with additional hundred villages**.

In regards to sustainability, the Cibadak village’s sustainability was doubtful even so other three villages had fifty percent possibility to continue the program. As mentioned, the first pilot concluded the importance of the community activist’s commitment and composition, more so since they affect sustainability of the project. For the second pilot, the program needs more careful consideration in selecting new community activists. Here are few significant CA’s characters; good leadership, strong interest in MNHI, easily adoptable to the program and ability to understand and translate into local context. Also these selected community activists should be better prepared in additional informal meeting with the facilitators. Further training on their leadership, public speaking, and management can help enhance the quality of program tolerance.

T4D to expand its territorial boundary, the facilitator will be responsible for two or more villages. Reasonably in expansion, the facilitator needs to understand the different local context and precise stakeholder mapping is necessary. Additionally, better recording system to monitor the villages is suggested and establishing new instrument to track wider territorial network in need.
References

Adamson, Dave and Richard Bromiley, (2008), Community empowerment in practice: Lessons from Communities First, North Yorkshire: York Publishing Services Ltd


Center for Disease Control and Prevention, Principles of community engagement, Atlanta: CDC/ATSDR Committee on Community Engagement; 1997


Nannicini, Tommaso, et al. (2010), Social Capital and Political Accountability, Bocconi University, IGIER & IZA


Schneider, Anne. (2004), The Role of Social Capital in Building Healthy Communities, Policy Paper Produced for the Annie E. Casey Foundation


UNICEF Issue Brief 2012