Strengthening Top-down and Bottom-up Accountability: The View from Aceh

1. Abstract submitted by Lindsay Morgan, Senior Health Analyst, Broad Branch Associates, Washington, D.C., lindsaymorgan@broadbranch.org

2. Context: AusAID's LOGICA2 program in Aceh

On December 26, 2004, the semi-autonomous province of Aceh, on the northernmost tip of the Indonesian archipelago, was hit by a massive tsunami. Already devastated by 30 years of secessionist war, the tsunami ravaged the social and economic fabric of Aceh and killed at least 170,000 people. The Australian Agency for International Development (AusAID) entered the scene. AusAID's support evolved from reconstruction and restoration of government services immediately after the tsunami to facilitating lasting improvements in governance, the provision of basic services, and community participation through the so-called LOGICA2 program (Local Governance for Innovations for Communities in Aceh—phase 2). Launched in January 2010, LOGICA2 is implemented in six districts[1] and has an ambitious theory of change: "In response to community-wide advocacy, governments deliver services to improve living standards," says the project document, all "in order to create an enabling environment for economic growth, peace and stability in Aceh."

3. Description of the Intervention

LOGICA2 is a robust, multifaceted community engagement program that folded a modest results-based financing (RBF) element into the larger project—i.e., it conditioned a portion of pay to civil society organizations (CSOs) on performance.

The community activities in the Indonesia program can best be described as a "menu" approach to community engagement that aims to provide a range of activities for a range of community members—from community leaders to people on the margins; from individuals to various groupings with various levels of formalization and capacity—from new and mostly informal health committees to local CSOs. At the heart of the community engagement effort is a process facilitated by the project and CSOs of collective learning, needs prioritization, and stakeholder dialogue that results in two action plans—one for the community and one for the health centers. The community thus actively participates with health facilities in determining priorities, which ultimately become the indicators and targets the health facility agrees to meet.

The plans of action are then funded with small grants from the project. Following creation of the actions plans, the CSOs work with health facilities to achieve service

[1] The districts are: Pidie Jaya, Bireuen, Aceh Timur, Aceh Tamiang, Aceh Barat Daya, and Aceh Tengah. Within these districts are thirty-six sub-districts (*kecamatan*) and 432 village communities across all six districts.

delivery targets and receive incentives if certain conditions were met by the health centers they support:

- Health centers develop and implement a mission, job descriptions, complaint handling, standard operational procedures, written service standards and service charter; and
- Health centers meet 1-2 minimum service standards[2] target indicators specified in an action plan (such as increasing the number of women who complete four antenatal visits and increasing the number of children who are fully vaccinated).[3]

4. Reflection on the challenges encountered

In LOGICA2, CSOs were rewarded for what health centers achieved, the thinking being that this would give the CSOs a strong incentive to help the facility perform, and strengthen ties between the health system and civil society. However, it may have been demotivating, since health center achievement was ultimately outside CSO control. Moreover, this arrangement appears to have created an environment of secrecy (i.e., the CSOs typically did not tell the health facility about the incentive), in a program intended to increase transparency.

Verification of results was also weak: it was essentially a check—by the CSO—to verify that what was in the registers at the village health post level was consistent with what was in the registers at health centers. If what was recorded in health post registers was incorrect, all this did was to verify that the health centers carried through incorrect figures consistently.

Another challenges for LOGICA2, and for any community engagement program, is measuring the impact of activities. Some program goals, such as increased empowerment, are almost impossible to accurately measure, while others, such as improved health indicators, are difficult to attribute to community engagement.

Finally, there is the challenge of sustainability. Most community engagement efforts are meant, through a limited number of formal engagements—for example, participation in village meetings—to spark an ongoing process of continued engagement and informal monitoring of health service provision. It is unclear, however, how or whether the larger ecosystem of participation, facilitated by LOGICA2, will be sustained, and underlines the need for modesty about what programs that aim to "impose empowerment" can achieve.

[2] The minimum service standards is a nationally decreed performance tool specifying eighteen composite indicators that aim to capture the content of the priority health services, which heath centers are required to provide.
[3] The MSS is nationally decreed performance tool specifying eighteen composite indicators that aim to capture the content of the priority health services heath centers are required to provide.

5. Reflection on the (possible) contribution to conflict transformation

LOGICA2 is an innovative model for combining a top-down approach to accountability (RBF) with bottom-up accountability—i.e., the program's "menu" of activities for empowering citizens to hold service providers accountable. RBF for CSOs is particularly important and innovative—they are empowered and held accountable for funds, in a post-tsunami conflict where there has been significant sums of money but little accountability, a common feature of the CSO/NGO landscape in post-conflict, post-emergency settings. Furthermore, CSOs in some cases may have access, influence, and lasting presence in communities, which may have important implications for sustainability.

The program's community engagement model is also particularly strong. The L2 program, through its robust "menu" approach to community engagement, succeeded in engaging a wide range of community members—both traditional and emerging leaders, as well as marginalized groups—equipping them with resources, and facilitating a process that may, over time, form the basis for stronger accountability links between citizens and government.

6. Evidence of impact of intervention on health, health system, and/or conflict transformation

The program succeeded in engaging a wide swath of communities through its menu approach, including women who had no previous involvement in village or other structured planning forums; people 25 years of age or younger; and ex-combatants. Engagement was persistent: on average, 47% of participants who attended the inaugural village meeting were still in attendance at meetings one year later. Community volunteers, CBOs and CSOs, and village committee members acquired new skills, and health facilities, on average, met targets related to the 1 or 2 MSS indicators specified in the action plans.

7. Other relevant information: Research Methods

Research for this case study was carried out under the aegis of USAID's Healthy Systems 20/20 project, and was part of a cross-country assessment looking at results-based financing programs that engage local communities. Other countries selected for detailed research were Burundi and Mexico. The Indonesia case relied on qualitative research methods, including a review of published and grey literature (i.e., external, internal and non-reviewed reports), in English, and key informant interviews conducted in Indonesia in four districts (Aceh Besar, Pidie, Bireuen, Aceh Tengah), between September 19 – October 9, 2011 and April 29 – May 13, 2012. Respondents consisted of donor and implementing NGO representatives; health facility staff (namely in-charges, head nurses and/or midwives); community health workers; village health committees; and focus group discussions with community members.