TRANSPARENCY FOR DEVELOPMENT

Transparency for Development Project Intervention Design

This draft working paper provides an overview of the design of the Transparency for Development (T4D) project intervention. Over the next several months, we will be publishing further materials focusing on our guidelines and experiences for developing the intervention.

Introduction

Guided by a set of design principles (detailed in the full intervention design report, which will be released shortly), the T4D intervention was co-designed to achieve two related but distinct goals: (1) to improve maternal and newborn health outcomes in the communities in which it is implemented and (2) to increase citizens' sense of empowerment and efficacy in treatment villages. This brief details the resulting design.

Because the intervention seeks to improve both health and empowerment, it relies heavily on the participation and decisions of community members themselves, with the implementing civil society organization partner playing a facilitation role that is more limited than what is often seen in T/A interventions. The description below highlights the role CSO facilitators play in the intervention; the remainder—any part of the intervention that is not described as being led by the facilitator—is designed, led, and implemented by the community itself as a result of the intervention.

The intervention was designed to help community members learn about and discuss underlying problems with maternal and newborn health and to design social actions that the communities themselves could take to overcome these problems. The bulk of the intervention takes place over six weeks, followed by three follow-up meetings at 30, 60, and 90 days. In all the intervention has seven major components:

1. Entering the village
2. Conducting the survey on maternal and newborn health
3. Identify community activists (CA) or community representatives (CR)
4. Survey results/scorecard and social action meetings
5. Open meeting
6. Social action[1]
7. Follow up meetings

The process of the intervention is displayed in Figure 1 for Indonesia and Figure 2 for Tanzania. As noted above, one important goal of the co-design process was an intervention that would be effective in two very different countries. Thus while the interventions in the two countries were designed to be as similar as possible, in keeping with the principle that the intervention should adaptable across contexts, they could not be exactly the same: important differences between our two CSO partners and in the health

[1] The social action is included here as a component of the intervention; however, it is worth noting that this is actually a goal of the intervention. The intervention seeks to use the other components to encourage community members to undertake social action, but these actions are entirely up to the community and no social actions are guaranteed to result.

problems and cultures of Tanzania and Indonesia required subtle differences in the two interventions. The figures reflect these subtle differences, which are noted explicitly in the description below.

Figure 1. T4D Intervention (Indonesia)

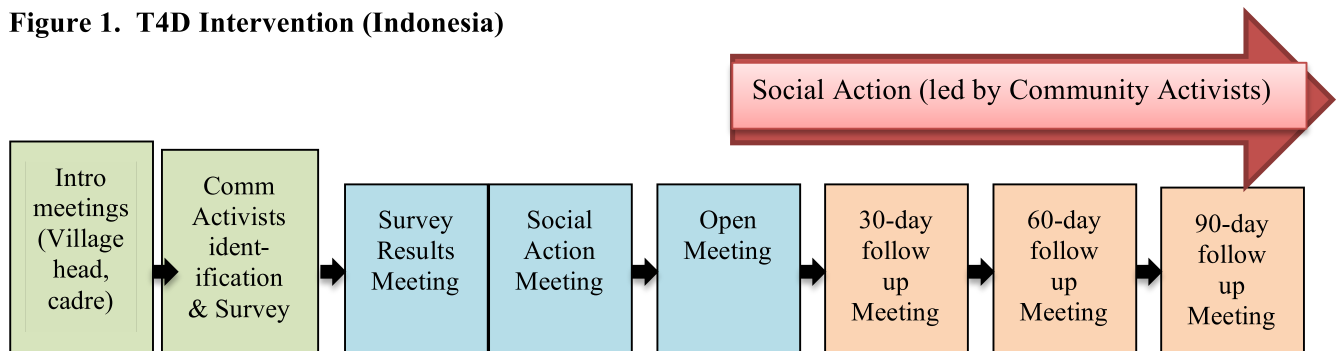
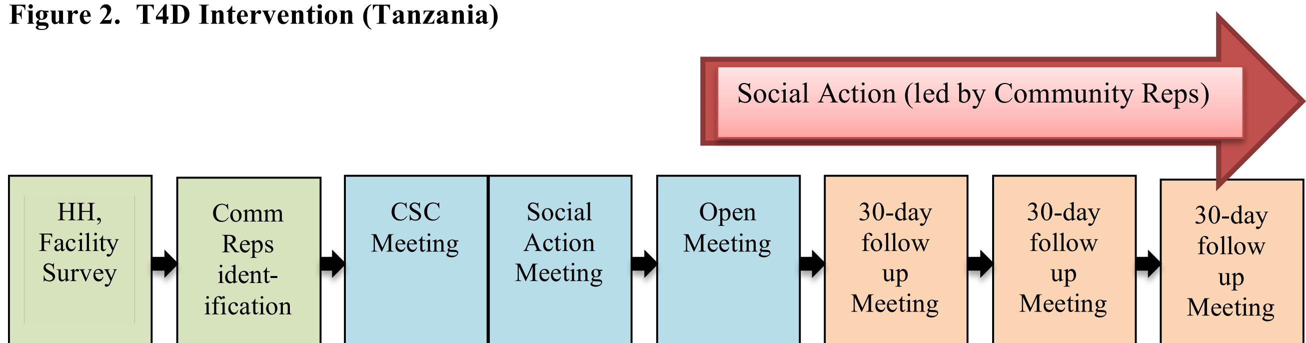


Figure 2. T4D Intervention (Tanzania)



1. Entering the Village

The first component of the intervention involves the CSO facilitators entering the village. The main objectives at this stage are (1) to obtain necessary permissions and buy-in from village government officials and (2) to inform health officials about the intervention and the importance of building empowerment of people in the village to improve service delivery in maternal and newborn health. In addition, the facilitators use these initial meetings to begin identifying people to be engaged in the next two intervention steps, including women who have recently given birth for the scorecard survey and potential community representatives (Indonesia) or community activists (Tanzania) to participate in the intervention. In the remainder of the intervention, facilitators work in pairs; however, village entry is largely undertaken by the primary facilitator in each village.

First, the facilitator meets with the village head (Indonesia) or village executive officer (Tanzania). The facilitator introduces the intervention and asks about the state of maternal and newborn health in the village. In addition, the facilitator asks for the village leadership's help in developing a list of women who have recently given birth (for the scorecard survey) and people who could be good potential community representatives/activists.

While the village head meeting is the only required introduction meeting with village leaders, facilitators may decide to undertake additional introduction meetings. In pilots that we undertook as part of the co-design process, we found that in some villages there were additional formal and informal leaders with whom it was important for facilitators to meet and secure buy-in. When these meetings occur, they largely follow the same agenda and have the same objectives as the village leadership meeting.

In *Indonesia only*, our partner CSO identified two additional sets of stakeholders with whom introductory meetings are necessary: the village midwives and the volunteer health workers (called "health cadres"). Although these stakeholders are not a part of the primary intervention, they are an important part of maternal and newborn healthcare system in the village. (Community representatives may choose to involve the midwife or cadres in the social actions, but this is not prescribed.) These meetings have the same goals as the meetings with village leadership: to provide background information about the intervention and to begin to collect information on women who have recently given birth.

2. Conducting surveys on maternal and newborn health

The second component of the intervention is the collection of data on the condition of maternal and newborn health for use in the "survey results" (Indonesia) or "community scorecard" (Tanzania) portions of the intervention. This component is similar to many community scorecard (CSC) interventions, with one key difference: the data are collected on any underlying problem with maternal and newborn health, rather than being limited to problems that occur at the facility level.

The scorecard or surveys are built on aspects of maternal and newborn care that medical research and practice has clearly shown to be critical for improving maternal and newborn health. The particular outcomes differ between Tanzania and Indonesia based on the conditions in the two countries. For example, while relatively few pregnant women receive four antenatal care appointments in Tanzania, this is common in Indonesia. The resulting aspects are:

1. Four antenatal care appointments including one in the first trimester (Tanzania only)
2. Comprehensive birth preparedness planning (Indonesia only)
3. Giving birth in a health facility with a trained birth attendant
4. Proper postnatal care for the mother and baby

In accordance with the T4D logic model, which identifies potential ways by which community action might improve the aspects listed above, data are collected on these aspects of care as well as potential barriers pregnant women might face in receiving care.

The data are from two surveys. The first is a facility survey. This survey focuses on barriers such as supply of medicines and equipment, privacy and availability of infrastructure, facility staffing and open hours, and other potential obstacles to maternal and newborn health outcomes that could occur at the

facility level. This survey includes both direct observations by the facilitators (to review cleanliness, privacy, availability of equipment, and other items) and interviews with health workers including the head of the facility and workers involved directly in maternal and newborn health.

The second survey is administered to between 20 and 30 women who have given birth in the last two years. It asks about women's experiences with, decisions about, and perceptions of antenatal and postnatal care. These women are identified through a number of techniques and discussions led by the facilitators. Facilitators speak with trained health workers as well as informal leaders and traditional birth attendants to ensure that it includes both women who have sought care in the formal MNH health system as well as women who did not use the formal system. The objective is to develop a list as complete and unbiased as possible of women who have recently given birth. Facilitators then administer the survey to random sample of women from the list of all women who have given birth in the village over the past two years. For women who sought care in the formal system, the questions focus on their experiences with the system, while women who did not are asked about the reasons that they did not use the formal system.

The data from these surveys are then analyzed to provide village-level statistics on maternal and newborn health outcomes as well as the major barriers to achieving higher outcomes in the village. In total, the surveys provide data on the 3-4 aspects of care, as well as approximately 20 potential barriers. The specific surveys and barriers from the two countries differ based on the different outcomes and major barriers in Indonesia and Tanzania. (Surveys for both countries are available at on the T4D website.)

3. Identification of Community Activists (CAs) or Community Representatives (CRs).

While administering the surveys, facilitators in the villages are also working to identify potential community activists (Indonesia) or community representatives (Tanzania), the preferred labels for these individuals in Indonesia and Tanzania respectively. But CAs and CRs share the same characteristics; thus for the remainder of this report we will refer to them as CRs. In each village, facilitators seek to identify 15-16 CRs, who will be the primary participants in the intervention.

In seeking candidates for community representatives, facilitators look for community members with several important characteristics, including individuals who have a personal interest in maternal and newborn health, who have time and are willing to volunteer to be involved in the meetings and social actions, and who are enthusiastic about improving the village. Formal leaders and health workers are excluded, so as to ensure that CRs are typical community members from outside the formal health system. From among the individuals with these characteristics, facilitators work to bring together a group of CRs that is a balanced cross-section of the community: a mix of regular village members and informal village leaders of different ages, genders, and from different parts of the village. (The recruitment process differs some between Indonesia and Tanzania; these differences will be discussed in future briefs about the intervention.)

After facilitators identify potential candidate CRs, they approach them to share more about the roles and responsibilities of being a CR and to assess both interest and potential fit. Based on these interactions, the facilitators select a final set of 15-16 CRs. In Indonesia, the names of the CRs are then publicly announced; piloting revealed that this was important for building their legitimacy in the village.

4. Survey results/scorecard and social action meetings

After selecting the CRs, the facilitators lead them through an intensive two-day set of meetings. These meetings are designed to allow CRs to hear and discuss information about the major maternal and newborn health problems in their community, to learn about how other communities have undertaken social actions to address service delivery problems, and to design their own detailed social action plans to improve maternal and newborn health in their village. Facilitators conduct these and subsequent meetings in pairs, allowing them to trade off and support each other. Throughout the meetings, the facilitators employ a number of tactics to engage the CRs and to help participants feel comfortable sharing their experiences and ideas. These tactics are detailed in the facilitator manuals (available on the T4D website) and include icebreakers and small group work to encourage greater participation.

Survey results/scorecard meeting

The first meeting is the survey results (Indonesia) or community scorecard (Tanzania) meeting. This is the “transparency” part of the intervention: the meeting focuses largely on sharing and discussing the village-specific data and information collected from the facility and household surveys. The pair of facilitators begins by introducing problems with maternal and newborn health care, presenting some key national-level statistics on maternal and newborn mortality and asking CRs to share their personal experiences with problems with maternal and newborn health care.

After establishing the importance of addressing maternal and newborn health in the country and the village, the facilitators shift to a discussion of the aspects of care (listed above) for improved maternal and newborn health and the specific barriers in the village to improvements in maternal and newborn health. For each aspect of care (such as percentage of women who give birth in a facility with a trained birth attendant), the facilitators present village statistics from the surveys to anchor the situation in the village and share some information about why these aspects of care are important for healthy mothers and babies. The facilitators then ask the CRs for their opinions about the reasons why these aspects of care (such as proper antenatal and postnatal care, birth preparedness planning, and facility births) are not being achieved in the village. They then use statistics from the surveys to bolster the discussion: when a CR shares a barrier for which the facilitator has a village statistic from the survey, this statistic is presented. The discussion continues until CRs have identified all the barriers they think may be responsible for lack of progress on maternal and newborn health. When the CRs can no longer think of any more barriers, the facilitators present any barriers that came up in the surveys but had not been mentioned by CRs.

This discussion inevitably leads to a long list of barriers, far more than the CRs could realistically address in the scope of the intervention. Thus the facilitators next lead the CRs through an exercise to winnow the list of barriers to those they think are most important in the village and that they would like to focus on improving. The goal is to decide on between five and six. (The process to select these barriers is somewhat different in Indonesia and Tanzania; each is detailed in the facilitator guidebooks, which are available on the T4D website.)

The meeting concludes with a brief discussion of stories of other villages taking actions to improve health and other public services in their community. These stories, which also play a prominent role in the next meeting, serve both as encouragement—underlining the ability of community members like the CRs to make improvements on their own, without outside assistance—and as a source of ideas for how to make

progress on the 5-6 barriers the CRs have chosen to try to improve. They are real examples of social actions of nine types:

1. Choice (individuals making better choices regarding service providers—for example, choosing a provider that is further away but provides better service);
2. Individual complaint, petition, or supplication (individuals complaining to providers or to government officials about services);
3. Collaborative problem solving (working with providers or officials to develop a collaborative solution to the barrier);
4. Examining better performing services (learning from other places where services are working better);
5. Social demonstration, protest, or group assembly to express a demand;
6. Developing and advocating for reforms to improve services;
7. Talking to journalists or local media to publicize problems;
8. Working through a "broker" who links community demands with allies in the government; and,
9. Highlighting well-performing providers or naming and shaming underperforming providers.

To improve understanding, all the stories are presented in the form of a cartoon. The stories and associated cartoons are available on the T4D website and have been included as an annex to this document (Annex A).

The first meeting concludes with the facilitators offering the CRs copies of the social action stories to take home and consider, as they deliberate on how to make progress on the barriers to improved maternal and newborn health that they have chosen.

Social action meeting

The intervention resumes the following day. The goal of the second meeting is for the CRs to develop a detailed plan for social actions that they will carry out to overcome the major barriers that they identified to maternal and newborn health. The process of selecting and detailing a plan to undertake social actions is complex and takes many hours to complete.

During the social action planning, the facilitator generally divides the CRs into small groups, each of which works on actions to address a set of the barriers they selected the previous day. The small groups brainstorm social actions that they think, based on their knowledge and experience of their community, are most likely to be feasible and successful in addressing the barriers. They then work through a detailed plan for each action, with the support of facilitators as needed. Each social action plan includes[2]:

- Specific steps that the CRs will take to complete the action;
- A CR who will take charge of each step;
- A list of tools and/or resources needed to complete the step, and how these resources will be mobilized;
- A deadline for completing the step; and
- A way of evaluating whether the action was successful.

[2] An example of a social action plan for one action has been included in Annex B.

In the course of developing these plans, the facilitators help the CRs work through the steps they need to take and the advantages and disadvantages of different approaches. But all decisions regarding the social actions are left completely up to the CRs. Facilitators are never the people to lead or undertake any step in any social action, nor do facilitators provide any resources or connections to enable or assist the CRs in undertaking any action.

At the end of the social action meeting, the pair of facilitators wraps up by facilitating the selection of several CR leaders, who will help to ensure the overall implementation and success of the set of social actions they have planned. Selecting the leaders helps the CRs to begin building a plan for sustainability after the facilitator is no longer involved—a process that continues during the follow-up meetings described below.

5. Open Meeting

Shortly after the survey results and social action meetings, the CRs and facilitators lead an "open meeting," in which the CRs present their social action plan to the larger community, often including village leaders. This is an important step to take before the CRs begin conducting the social actions; it allows the CRs to gain broader community buy-in for their social action plan, and begins to build their legitimacy as social action leaders. At the meeting, the CRs present the maternal and newborn health barriers that they have decided to address and the social action plans that they intend to undertake. They also seek input from the broader community into the social action plans, and ask for any volunteers from the community who are interested in working on or supporting the actions.

6. Social Action

Following the open meeting, the facilitator leaves the community. If all goes well, the CRs then begin to undertake the actions they have planned—though, as noted, no CR is under any obligation to do anything. No additional resources or support are provided to the CRs, with the exception of three follow-up meetings; it is completely up to the CRs to organize themselves to conduct the social actions, to assess their effectiveness, and to adapt or update their plans based on the actions they try to undertake.

7. Follow-Up Meetings

The final prescribed component of the intervention is a set of three follow-up meetings, led by the primary facilitator for the village and held approximately 30, 60, and 90 days after the open meeting.

These meetings have two goals. First, they provide a structured forum for the CRs and facilitators to discuss progress on the social action plan and improve or adapt. Second, over the course of the three meetings, the facilitators work with the CRs to build a sustainability plan to ensure that the actions continue after the facilitator is no longer interacting with the CRs.

In each meeting, the CRs walk through each of the social actions from their original plan and discuss which steps were completed, why or why not, and whether the action was successful. For actions the

CRs have completed, the facilitator guides the CRs through a discussion of whether they want to add new social actions to address the 5-6 maternal and newborn health barriers they originally selected at the start of the intervention. The facilitators also prompt the CRs to consider any new barriers that may have become clear as they undertook the actions. In cases in which social actions have not been successful, facilitators lead a discussion about whether and how the CRs would like to adapt their approach in response to the challenges they faced.

Throughout these meetings, the facilitators also focus the CRs on the sustainability of their approach, encouraging them and helping them plan to stay active. At the final, 90-day follow-up meeting, they work with the CRs on a final sustainability plan for continuing to work on remaining social actions without the facilitators' guidance and participation. By the conclusion of the 90-day follow-up, the facilitators' goal is for the CRs to be committed to undertaking social actions and adapting their approach, so that they continue working on improving maternal and newborn health in their community long after the intervention ends.

Annexes

Annex A. Social Action Stories

The stories below are those from Indonesia. Both the Indonesia and Tanzania stories – as well as the cartoons that accompany the Indonesia stories – can be accessed on the T4D website.

STORY 1: INDIVIDUAL CHOICE

In some communities, people who are unhappy with the health care they are receiving choose to go to a different provider:

Dogiyai: Bad service has led the community to shift to a different provider

DOGIYAI, 20 Oct. 2013 – The Head of Dedemani Puskesmas in Dogiyai District, Papua, told the media that 15,000 community members in Dogiyai District chose to seek medical attention in the District's Health Hospital (RSUD) Dogiyai, despite the longer distance, instead of their local Puskesmas. They made this decision due to the lack of doctor availability at the local Puskesmas—the assigned doctor was often absent from the Puskesmas.

"I really regret what happened, due to doctor's absenteeism people no longer seek healthcare in my area," the Head of Dedemani Puskesmas said. "I will do my best to improve the services here so people will come back and seek the healthcare in the Puskesmas."

The head of the sub-village (dusun) in Dogimani, Piter Tagi, shared his own bad experiences in going to the local Puskesmas: "The doctor came very late, so it's too bad that I have to seek medical treatment in another place. I actually want to appreciate and love the health facility in our own area, but this is necessary to make the Puskesmas improve their service. (PAPUA POS NABIRE)

Summarized from http://www.papuaposnabire.com/index.php/kabar-dari-papua-tengah/21-dogiyai/509-dokter-tak-ditempat-warga-dogiyai-memilih-berobat-ke-rsud-dogiyai)

STORY 2:
INDIVIDUAL COMPLAINT, PETITION OR SUPPLICATION

In some communities, people who are unhappy with the health care they are receiving complain to the providers or to officials and ask them to make improvements.

Cipayung: Voice Complaints by Writing to 'Reader's Letter' Poskota

CIPAYUNG, November 2013 – Community members complained about the quality of the service of Puskesmas staff in Cipayung Village. After receiving these complaints, the Health Department Officials for East Jakarta, Yudhita, went to investigate the Puskesmas directly. "We have assembled a team to check the reports from the community members," she stated. One of the complaints regarding the Puskesmas was in the format of a Reader's Letter in the newspaper *Poskota*, which detailed the case. "The Puskesmas in Cipayung Village was closed at 11:30, even though it should be open from 08:00-12:00 and 13:00-16:00. I came back at 13:00 and it was still closed. When I asked why it was closed, one Puskesmas staff said 'the doctors are in a meeting.'" The investigation report said that the doctors at the Puskesmas had to complete another task (to check the health of those who will go to Mecca – Haji). Yudhita promised that the quality of the Puskesmas will be improved and encouraged the community members to report any problems with the Puskesmas. When Pos Kota (local media) returned to the Cipayung Puskesmas approximately one month later, the Puskesmas was open during operational hours, and they found that it was well organized. (POS KOTA)

Summarized from
http://poskotanews.com/2013/11/07/pelayanan-puskesmas-cipayung-dikeluhkan-warga/

STORY 3:
COLLABORATIVE PROBLEM SOLVING AND MUTUAL COMMITMENT TO IMPLEMENTING SOLUTIONS

In some communities, people who are unhappy with the health care they are receiving arrange for meetings with doctors and nurses or health officials. During these meetings, they work together to develop solutions to problems with health service delivery, and then they agree to implement those solutions.

Garassikang Community's Cooperation Results in Access to Clean Water

People of Garassikang in Jeneponto Regency have had a problem with access to clean water for a long time. Many women and children had to walk and carry the water for miles every single day. They have been trying to write a proposal for digging a well through the National Program for Community Empowerment (PNPM) and Village Development Planning (Musrenbang). Unfortunately, this plan was never approved nor implemented.

Finally in 2011, several community members decided to take the matter into their own hands. They gathered and discussed what they can do to improve the situation. The discussion began with distributing task of finding funding and labor to accomplish build the well. They fundraised and were able to collect around Rp 500.000 for initial capital. This was used to hire people to start the digging process for the well. When the digging process started to show some results, they informed the rest of the community so that the larger community could also contribute to this effort. They received positive responses and more residents joined the effort. The men contributed their labor and money, while the women helped prepare meals for all of the workers and donated rice, vegetables, and food. A community member also donated the land used to build the well because he realized that it was for the common good.

Now, the people of Garassikang are able to access clean water easily through a collaborative effort of the community. They also formed a committee for water management and agreed on well management regulation so that the water will be enjoyed for a long time. (DIDIK / STAFF PATTIRO JAKARTA)

STORY 4: EXAMINING BETTER-PERFORMING SERVICES

In some communities, people who are unhappy with the health care services they receive visit places where health care is working better, so they can learn what they can do to improve their own health services.

African Community Studied Health Facility in Neighboring Village and Lobbied for Funding

In one district in Africa, community members noticed that the clinic in their village was very poor quality, while the clinic in the neighboring district was much better. Their clinic was unhygienic and only had two staff members serving around 4,000 patients, while the clinic in the neighboring district had 5 staff members and better equipment.

They asked to meet with the medical officer in charge of their clinic to discuss why the clinic's quality in the neighboring district was better than their own clinic.

During the meeting the health care workers learned about the community's concerns and the community members came to better understand the problems facing their clinic. Together, they wanted to improve the services in the clinic by learning what the neighboring district had done. The health care workers and the representatives of the community gathered data on the condition of the neighboring clinic through personal visits and meetings with health officials there.

They learned that the clinic in the neighboring districts were able to access the District's fund, which allowed them to have more staff and better equipment. Upon learning this, the clinic and community members tried to voice their concerns to the District.

After this effort, the community successfully convinced the district to provide funds to construct a new health clinic. Once the clinic was built, four new staff members, including two midwives, were recruited, and the district purchased new equipment. The clinic now serves 11,000 people out of a catchment area of 7,000-10,000, meaning many people from outside the district come to the clinic due to its good quality. Of the women who have received antenatal services, 70 percent have returned to the clinic to give birth and receive more services, far surpassing the government target of 50 percent. (WORLD VISION)

Source:
http://www.worldvision.com.au/Libraries/3_3_1_Children_PDF_reports/Citizen_Voice_and_Action_Civic_demand_for_better_health_and_education_services.pdf

STORY 5:
SOCIAL DEMONSTRATION OR PROTEST

Citizens could demonstrate to target underperforming providers or civil servants, like the district medical officer, who are not doing enough to improve health care.

Yanomami and Yekuana Indians:
Demonstration to Reelect Health Coordinator

Yanomami and Yekuana Indians are the indigenous community in the Amazon rainforest in Brazil. For years, they have enjoyed good quality healthcare through a health coordinator who had been living there for years and was familiar with their health concerns. The Indians are particularly vulnerable as they have little resistance to outside diseases. With thousands of gold miners coming in and operating illegally on their land, polluting their rivers and transmitting diseases, it is very important that they have a health coordinator who understand their specific needs.

However, a new health coordinator was appointed in 2011. The new person had little experience with the indigenous community, was unable to speak their language, and thus was unable to provide good quality service. It seemed clear to the community that the new health coordinator had been nominated solely for political reasons.

The Indians were outraged by this nomination. They led protests for weeks so that they could continue to receive good healthcare. Their protests included sending letters to the Brazilian authorities and the UN, urging them to take action on this serious issue. They even seized an airplane used by health workers in the Yanomami territory as part of their protests against the corruption in the health system. Their protests led to the appointment of their preferred candidate for health coordinator: the same person who had worked closely with the Yanomami for years, and who has been providing good quality healthcare. A Yanomami spokesman said, “Now we Yanomami are very happy with our fight for our right to receive good healthcare services.”

Source: summarized from http://www.survivalinternational.org/news/7394

STORY 6: DEVELOPING AND ADVOCATING FOR REFORMS TO IMPROVE HEALTH CARE

People who are unhappy with the health care they are receiving could brainstorm solutions and then take those proposals to their fellow community members to be implemented. Sometimes they need to do this repeatedly, but eventually they get what they are asking for.

Grobogan Village: Community Members Work in a Team to Reduce Open Defecation

In 2010, the community members of Grobogan Village worked with a local organization to improve the village's sanitation. Indonesia has long tried to battle the issue of sanitation through providing public toilets. However, the simple availability of toilets did not always change the mindset of people, who were used to open defecation. There was no sense of ownership of government-constructed public toilets, and nobody bothered to maintain them. Often, the toilets were used as chicken coops or storage spaces, while villagers continued to defecate in the fields and by water sources.

Members of the Sanitation Entrepreneurs Association of Grobogan (Papsigro) try to reduce open defecation by ensuring that every household has a toilet. Papsigro was established in 2011 wand consisted of a watermelon seller, a rice farmer, a mason, a retired government health official, and a *kyai* or Islamic scholar from different villages within the district. They came individually to a training offered by a local organization to set up sanitation-related businesses, and then the 30 members divided themselves into groups specializing in different areas.

Fifty-year-old Pak Pardiyanto focuses on manufacturing the actual closets, which he sells for as little as IDR 40,000 ($4). Forty-four-year-old Pak Suminto, the "latrine package" specialist, sources toilets and installs them. Sixty-seven-year-old Pak Iwan, a retired health department specialist, keeps up with the latest toilet research. There are technicians, fiberglass mould makers, and even a local Islamic scholar, 39-year-old Pak Umar.

Ibu Siticoma, mother of five grown children, cannot stop giggling with embarrassment when talking about the latrine. "We used to just go outside, under the trees," she says before covering her mouth in a fit of laughter. "But my son thought it was dangerous. We could slip and fall, or get bitten by snakes. So he asked Pak Suminto to build us one [toilet] inside." She breaks out into another round of laughter. "It's very good now. Safe and comfortable, even if it's raining." Within two years, 150 of the 153 target villages in Grobogan, were open defecation-free. (THE HINDU TIMES)

Summarized fom
http://www.thehindu.com/todays-paper/tp-opinion/indonesias-toilet-trojans/article5412345.ece

STORY 7: TALKING TO JOURNALISTS / LOCAL MEDIA TO PUBLICIZE PROBLEMS

Often local journalists and media can be powerful allies in helping citizens publicize problems with health services, which can put pressure on underperforming service providers to improve.

Media Reports Raised Awareness on Vaccine Unavailability in Ngada Regency

In Ngada District, NTT, people successfully proposed an anti-rabies vaccine budget allocation of Rp 40 million in the 2013 local government budget amendment. Previously, Ngada Regency relied on the vaccine stocks from the Special Allocation Fund of Health from the central government. Unfortunately this was never adequate due to the high number of dog bite cases in the area. The fund from the Central Government was apparently only enough for 175 patients, which not close to enough for a year. By May of 2013, the vaccines were already out of stock. Realizing that this was a huge problem, the community members sought the local mass media to publicize it. The bad news on vaccines was then prominently featured and published in the local media Ngada Mandiri and was reported by other local journalists organized in Bajawa Media Club (BMC). Finally, the District Government listened to their complaints and approved the budget changes in early November of 2013. Now, Ngada District has enough vaccines to cure the community members who have been bitten by dogs. (DIDIK / STAF PATTIRO JAKARTA)

STORY 8: WORKING THROUGH A 'BROKER' WHO COULD LINK COMMUNITY DEMANDS WITH ALLIES IN THE GOVERNMENT

A community that is unhappy with the quality of healthcare they are receiving can ask for help from a member of their community who is good at getting government officials to be responsive to community needs.

Cikulur: Pak Oni, a Community Activist

Pak Oni is a regular community member in Lebak District, Banten. He learned about his rights as a citizen to petition the government for better services and gained significant advocacy skills from an NGO. He knows a lot about different persuasive methods: asking persistently, invoking religious duty, and shaming. He also knows about a lot government programs that should be accessible to citizens, such as annual grants to establish and run ECCD (Early Childhood Care and Development) centers in the village, health insurance, and programs to get equipment for the Rice Farmers' association (Gapoktan). Moreover, he spent a lot of time writing letters to government agencies to ask for information regarding their programs and their budget plans. Once, he managed to initiate road construction after a series of advocacy efforts with the Public Works office. Although Pak Oni does not formally hold any position in the village, the villagers have come to know him as the go-to-guy to talk to about community problems because he can connect them to specific government employees. His village did not have a health facility and community members had to travel to the Puskesmas to access even the most basic healthcare. **Community members sought help from Pak Oni to address this issue.** Pak Oni organized meetings between the community members who felt strongly about having a Poskesdes in the village, the District's Health Department, and several other donors to provide funding. Pak Oni also organized open donations for community members who wanted to provide support (such as cement, woods, and rocks) for the construction. The Poskesdes was completed in 2012, and is now used by community members in the village. (PANDJI & ANYEP / STAF PATTIRO BANTEN)

STORY 9: HIGHLIGHTING HIGH PERFORMING PROVIDERS OR NAMING AND SHAMING UNDERPERFORMING PROVIDERS

Citizens could reward high performing providers with praise or other social recognition and/or sanction poorly performing providers by failing to include them in village events or by ignoring/ shunning them.

Banyuasin Residents Reported Outstanding and Underperforming Government Service Providers

Community members in Banyuasin District recognized that not all of the government officers in their area were working diligently. In some cases, the community members went to meet officials but couldn't find them in their offices. Community members then met with a local organization (Pengabdi Putra Banyuasin/PBB) regarding this issue. Based on the discussion, it was agreed that it is important to name the high performing officials to encourage them to keep up the good work, and also to name the underperforming officials in order to shame them into performing better.

The head of PBB then held a press conference to publicize this finding. He criticized several Department Heads in Banyuasin District for absenteeism. Community members provided him with information on the department's performance throughout the year. With this information, he named the underperforming Department Heads and praised several of the Departments that were performing well. According to community members' report, the Department Head of PU (Public Works) received the most complaints for absenteeism and for being unavailable for meetings. (PALEMBANG POS)

Summarized from
http://palembang-pos.com/index.php?option=com_content&view=article&id=6350:kadis-puck-dituding-jarang-ngantor&catid=49:sumsel-raya&Itemid=62

Annex B. Example of a Social Action Plan

List Steps	Responsible Person	What tools, community resources are needed? How will they be mobilized?	Timeline/ Deadline	How is success measured?
Traditional birth attendants (TBAs) are the target group Identify all TBAs and other women who carry out deliveries here in the village	All CRs	Notebooks and pens - CRs already have these and will bring them	20/10/2014	All TBAs and other women carrying out deliveries identified
Inform the leaders of the village	CR leaders	None	23/10/2014	Leaders of the village informed
Hold a meeting of all CRs to put together a message to motivate TBAs to escort pregnant women to deliver at the dispensary or hospital	All CRs	None	23/10/2014	Meeting happens
Meet with TBAs and all women who are carrying out deliveries in each sub-village to explain the norms/by-law about escorting women to deliver at the dispensary or hospital	• Mariam Kasidi • Zaina Mbuji • Iddi Abdallah • Samwel Moto • CR leaders	None	5/11/2014 to 15/11/2014	Meeting happens
Extend invitation to TBAs and other women who are carrying out deliveries to join the regular CR meetings	All CRs	None	18/11/2014	TBAs and other women who carry out deliveries invited