

Insights from Transparency and Accountability Action Plans in Indonesia and Tanzania

Jessica Creighton, Jean Arkedis, Archon Fung, Stephen Kosack,
Dan Levy & Courtney Tolmie

January 2020



Insights from Transparency and Accountability Action Plans in Indonesia and Tanzania

Jessica Creighton, Jean Arkedis, Archon Fung, Stephen Kosack,
Dan Levy & Courtney Tolmie

January 2020



Firstly, thank you to J. Preston Whitt for the meticulous coding of more than one thousand action plans. Additional thanks to our research and data analysts, Akshay Dixit, Dan Levy, Cara Myers, James Rasaiah, and Niriksha Shetty, and field staff Sarah Alphs, Jenna Juwono, Lindsey Roots, R. Reksa Samudra, and Astri Waluyo. For generous funding for this project, we thank the William and Flora Hewlett Foundation, the UK Department for International Development, and the Bill and Melinda Gates Foundation, as well as the Transparency and Accountability Initiative, which conceptualized and brokered the project. We would also like to thank our design and implementation partners, the teams at the Clinton Health Access Initiative in Tanzania and PATTIRO in Indonesia. We are grateful to SurveyMETER in Indonesia and Ideas in Action in Tanzania for collecting key informant interview data. We thank ethnographic researchers Iqra Anugrah, Megan Cogburn, Mohmed Yunus Rafiq, and Kankan Xie. We would also like to thank our partner J-PAL Southeast Asia. Finally, our most important debt is to the thousands of community members in Indonesia and Tanzania who volunteered their time and energy to participate in the Transparency for Development activities.

ABSTRACT

This paper provides insight into community designed and led actions in Indonesia and Tanzania that were prompted by Transparency for Development (T4D), a six-year research project that explores whether, how, and in what conditions “transparency and accountability” or “social accountability” programs improve maternal and newborn health care.

We find that all communities participating in the T4D program planned social actions, with the vast majority completing at least one action. We also find that the focus of the actions was diverse in nature, though participants in nearly every community planned at least one action aimed at educating members of the community.

We compare actions designed in Indonesia to those in Tanzania and find a number of similarities and differences in the types of actions designed and whether the actions were completed.

When analyzed from a social accountability lens, we find three trends. Firstly, the actions were overwhelmingly collaborative in nature. Secondly, the majority of the actions were short route, meaning they targeted the health facility or provider directly, rather than government officials higher up the accountability chain. Finally, when classified by accountability “type” we find that more than half of communities took a self-help approach, with only about a quarter pursuing solutions through social accountability channels.

CONTENTS

Introduction	1
The Problem	1
A Potential Solution	1
Purpose and Outline	3
Community Choice in Social Action	3
Paper Outline	4
T4D Intervention	5
Description of the T4D Intervention	5
Open Social Actions	9
Methods	10
Primary Data Source	10
Supplementary Data Sources	15
Additional Considerations	16
Findings	17
1. Description of Actions	17
Distribution of Actions	17
Completion Status	19
2. Social Action Goals	21
2.1 Theory of Change	21
2.2 Action Goals	23
2.3 Discussion	29
2.3.1 A Deeper Look at Prominent Intermediate Outcome Pathways	29
2.3.2 Similarities and Notable Differences between Actions in Indonesia and Tanzania	42
2.3.3 Action Completeness	54
3. Social Accountability Analysis	57
“Five Worlds” of Service Delivery	58
Accountability Targets	60
Confrontational and Collaborative Strategies	63
Beyond Social Accountability: Broader Approaches for Fixing Problems	65
Conclusion	68
Appendices	71
Works Cited	79

TABLES

Table 1. Distribution of Villages by Number of Actions	18
Table 2. Number of New Actions by Meeting	19
Table 3. Completion Status of Actions	19
Table 4. Distribution of Villages by Completed Actions	20
Table 5. Distribution of Actions by Number of Goals	24
Table 6. Proportion of Villages Designing Actions by Goal, Pathway, and Intermediate Outcome Category (Full Sample)	27
Table 7. Education Activities by Topic	31
Table 8. Improved Facility Access by Goal	33
Table 9. Increased Ability to Pay by Goal	35
Table 10. Actions Aimed at Health Service Uptake by Goal	36
Table 11. Improved Information and Communication by Goal	37
Table 12. Improved Attitude, Effort, or Trust of Provider by Goal	39
Table 13. Improved Facility Infrastructure by Goal	40
Table 14. Infrastructure Goals by Topic	41
Table 15. Increased Availability of Drugs, Supplies, Other Inputs by Goal	41
Table 16. Proportion of Villages Designing Actions by Pathway, by Country	42
Table 17. Bylaws, Partnerships, or Other Interventions Aimed at Health Service Uptake by Goal & Country	44
Table 18. Tanzania Bylaws by Topic	46
Table 19. Improved Facility Access by Goal & Country	49
Table 20. Increased Ability to Pay by Goal & Country	51
Table 21. Improved Information and Communication by Goal & Country	52
Table 22. Improved Facility Infrastructure by Goal & Country	53
Table 23. Proportion of Villages Designing Actions by Pathway, by Country (All, Completed & % Completed)	55
Table 24. Actions by Ultimate Target	61
Table 25. Actions by Strategy (Collaborative or Confrontational)	63
Table 26. Actions by Strategy (Collaborative or Confrontational) – Excluding Education Actions	64
Table 27. Actions by Social Accountability Type	67

BOXES

Box 1. Example Social Actions	9
Box 2. Community-Organized Transportation in Indonesia	34
Box 3. Suggestion Box in Tanzania	38
Box 4. Action Evolution in Indonesia	62

PHOTOS

Photo 1. CRs in Tanzania Creating a Social Action Plan	7
Photo 2. Public Poster for an Education Activity in Indonesia	30
Photo 3. Foundation of a Health Facility Being Built in a T4D Village in Tanzania	32
Photo 4. Comment Box at a Health Facility in Tanzania	38
Photo 5. Garbage Pile from a Village Cleaning Campaign in Indonesia	48

FIGURES

Figure 1. Intervention Components	8
Figure 2. Example Social Action Plan (Tanzania)	12
Figure 3. Theory of Change of the Intervention	23
Figure 4. Intermediate Outcome Pathway Heatmap	26
Figure 5. The Five Worlds of Service Delivery	60
Figure 6. Four Ways to Solve Public Problems	66
Figure 7. Coordinated Co-Production	67

APPENDICES

Appendix A. Social Action Plan Templates for Indonesia and Tanzania	71
Appendix B. Description of Social Action Goal Types	73
Appendix C. Key Informant Interview Verification of Actions	78

INTRODUCTION

This paper provides insight into community designed and led actions related to Transparency for Development (T4D), a six-year research project led by researchers and practitioners based at Harvard Kennedy School and Results for Development. The T4D project explores whether, how, and in what conditions “transparency and accountability” or “social accountability” programs improve maternal and newborn health care.

The Problem

Following a decades-long worldwide commitment to expanding public services,¹ globally an increasing number of communities have access to modern medical care, education, roads, and other public services. Though the expansion has been sizable, a large population still lacks access to services, and for many who have access, the quality is subpar. For example, many of the world’s clinics and schools are understaffed or without electricity, water, or basic supplies; and many health facilities are difficult to get to in an emergency.² Partly in response, improvements in basic education, health care, and other public services are the focus of intensive international resources and attention, and are at the core of the next generation of international development goals (UN General Assembly, 2015).³

A Potential Solution

One increasingly common approach to improving access to and quality of services is to facilitate transparency and accountability (T/A) around public services: hundreds of nongovernmental organizations across the world now regularly offer programs designed to encourage and enable citizens to work with government officials, service providers, and other citizens to overcome problems with the way their public services work, generally by offering information about those problems (or about how public

.....
1 Sen, A. (1999); UNDP (1990); UN General Assembly (2000).

2 Kruk et al. (2016); Farmer et al. (2013); World Economic Forum (2015); Hsia et al. (2012).

3 Recognizing that many of the problems and solutions are local and idiosyncratic, and seeking to improve on past international efforts, much of this international effort is committed to seeking these improvements in participation and partnership with the communities whom the public services are designed to serve (OECD, 2008).

services are performing), and providing deliberative space in which to discuss how to alleviate the problems.

The T4D project undertook two large-scale randomized controlled trials (RCTs) of a T/A program in Indonesia and Tanzania (hereafter referred to as the “intervention”) designed specifically to improve outcomes associated with one particular public service—maternal and newborn health (MNH) care. MNH is currently the focus of particularly intensive international resources and attention⁴. The statistics reinforce the importance of this focus: an estimated 830 women die each day from pregnancy or childbirth, and another 7,000 newborns die each day, many from causes that are easily preventable with better medical care.⁵ The specific intervention we tested was designed with local partners in Indonesia and Tanzania over two years of discussion and piloting, and then implemented in 200 randomly selected villages across four regions (two per country).⁶

As part of the T4D intervention, participants from these 200 villages were encouraged to plan and undertake “social actions” to improve the quality of care at local health facilities or use of the health-care system during critical periods in pregnancy and birth. The intervention was designed to provide information to participants about breakdowns in their MNH care and then leave it up to the participants to decide what problems to focus on and what approaches to take to solve them. This paper explores the 1,139 social actions that participants designed.⁷ In particular, we look at the types of problems participants chose to focus on, the approach they used to solve those problems, and the progress they described in meetings over the course of the intervention program.

.....
4 Storeng, K. T. Béhague, D. P. (2016); UN General Assembly (2015).

5 Radin, J. M. Topol, E. J. Steinhubl, S. R. (2018).

6 For a discussion of the design of the program and other similarities to and differences from other commonly used designs, see Kosack, S. Fung, A. (2013).

7 Tables 1 and 2 are based on analysis of the full set of 1,139 social actions. In all subsequent analysis (beginning with Table 3), one action in Tanzania is excluded due to an error in data coding.

PURPOSE AND OUTLINE

Community Choice in Social Action

Many T/A programs seek to steer participants towards certain types of activities, such as direct collaborative engagement with local health providers to mutually solve a particular challenge or organized forums in which citizens confront elected officials regarding problems with services. The T4D intervention takes a less prescriptive approach in two ways. First, the intervention was designed to encourage citizens to solve MNH problems broadly, rather than mobilizing them around a particular governance or service delivery problem (such as focusing exclusively on health facility infrastructure, staff absenteeism, or expenditure tracking). In doing so, the T4D intervention left open the possibility that communities might seek to address a broad scope of problems in their health system: for example, health facility infrastructure or staff absenteeism; other types of breakdowns in the facility, such as drug stock outs; or a lack of demand for or utilization of existing services.

Secondly, the T4D intervention was designed to create space for participants to determine who their actions should engage—frontline service providers, local or regional politicians, health officials, or other community members—and how to approach them: e.g., educate them, confront them, or collaborate with them.

Because T4D was designed to facilitate more choice for program participants than the typical T/A intervention, studying it offers the opportunity to see what participants in communities on two continents chose to do to attempt to alleviate problems with their MNH care. The goals of this paper are to explore the social actions that the T4D community participants designed and to provide a glimpse into how these actions might ultimately affect the health outcomes that the T4D project aimed to improve.

In particular, this paper has four main aims. The first is to answer the question “in a program designed to maximize the choice community participants are given to solve a problem, what will participants decide to do?” We answer this by describing the actions T4D participants designed.

The second purpose is to describe and explore country differences between the actions designed by participants in Indonesia and Tanzania.

The third purpose of the paper is to explore how the social actions match the theoretical underpinnings of the project, linking a T/A program to improvements in a public service. We rely on two frameworks, the T4D theory of change and the “five worlds” of service delivery, each described in more detail in the *Social Accountability Analysis* section of the paper.⁸ To explore the T4D theory of change, we look at the particular problems participants attempted to solve and how these problems match up with health development outcomes. To explore the five worlds framework, we look at the targets of the social actions, whether the approach was confrontational or collaborative, and the use (or non-use) of social accountability to solve problems.

The final aim is to provide initial insights from field observation and observations by our partners into why certain choices were made with regard to the actions designed and undertaken by communities. Unlike many social accountability approaches that prescribe specific problems, actions, and/or targets, the open nature of action planning in the design of the T4D approach allows us to examine patterns in the choices that communities made in trying to improve health services, which may provide insights and suggest further hypotheses regarding where citizens are best placed to take actions to improve health—or alternatively where additional support may be required in future programs.

Paper Outline

The remainder of the paper comprises four sections: intervention, methods, findings, and conclusion.

Intervention

This section describes the T4D program, or “intervention,” that the T4D team is evaluating. The intervention was a series of community meetings that took place in 200 villages across Indonesia and Tanzania. During these meetings, participants designed “social actions” to improve the quality of care at local health facilities or increase use of the healthcare system. This section includes insight into the social action planning process and provides examples of actions designed by T4D communities.

.....
8 Outlined in Kosack, S. and Fung, A. (2014).

Methods

The methods section gives an overview of the primary and supplementary data sources used in the paper. The primary data are the social action plans designed and discussed at the T4D intervention meetings. Supplementary data sources include interviews with key informants, reports written by ethnographers who lived in a subset of the T4D communities, and “community scorecard” data that was presented at the initial community meetings.

Findings

The findings section comprises the bulk of the paper and is divided into three subsections. In subsection one, we describe the actions, including the number of actions planned, their distribution across villages, and self-reported completion status. In subsection two, we examine the action goals. First, we lay out the T4D theory of change and map the action goals to it. Then, we categorize the goals to identify patterns and examine similarities and differences between the actions in Indonesia and Tanzania. In subsection three, we describe the five worlds of social accountability and classify the actions within this framework.

Conclusion

The paper concludes with key takeaways from the analysis.

T4D INTERVENTION

Description of the T4D Intervention

The ultimate goal of the T4D intervention was to improve maternal and newborn health in rural villages in select areas of Indonesia and Tanzania. It took place in a total of 200 villages between October 2015 and July 2016.

We worked with local civil society organization (CSO) partners in each country—PATTIRO in Indonesia and the Clinton Health Access Initiative (CHAI) in Tanzania—to co-design and pilot the intervention over a two-year period. These partners were then responsible for implementing the intervention.

Since the intervention was co-designed with different partners in each country, there is a slight variation between the two models, but at a high level, the T4D intervention was a series of six meetings between a facilitator from the local CSO and a group of citizens from a single village. These meetings were designed to encourage participants to use information and facilitated discussion to address local MNH problems affecting them and their neighbors.

In each village, the meetings took place over a period of approximately three months. At the conclusion of the first two meetings, those attending developed a plan of social actions to target health problems that they discussed, that they intended to carry out and whose progress they would reflect on over the remainder of the program meetings. These actions were designed to address MNH-related issues, whether within the community itself, at the local health facility, or further up the accountability chain (such as at the district or regional level).

The first two meetings—the Scorecard and Social Action Planning meetings—were the core of the intervention. These meetings included the facilitator and fifteen to sixteen citizens known as “community representatives” (CRs) in Tanzania and “community activists,” (CAs) in Indonesia, who were recruited by the facilitator to take part in the intervention (henceforth, CRs/CAs will simply be referred to as “CRs”). At the Scorecard meeting, information on the uptake of three key MNH health “levers”—aspects of care widely thought to improve the survival and health of mothers and babies—was presented to the CRs: antenatal care (ANC),⁹ delivery, and post-natal care (PNC) services. The facilitators used the information from the levers to start a discussion about barriers to improved MNH in the village.¹⁰ Once participants discussed and identified the perceived barriers to better care, the facilitator presented CRs with short vignettes of actions that similar communities had taken to improve delivery and/or use of their public services (“social action stories”). Then, during the Social Action

.....
9 ANC uptake in Indonesia is already high, so the lever in Indonesia focused on one particular aspect of ANC: birth preparedness planning.

10 Examples of barriers include: transportation to the health facility, knowledge of proper health seeking behavior, and treatment by facility staff. The discussion was structured to encourage CRs to bring up barriers organically, though the facilitators had survey information on most barriers, which they presented during the discussion. Examples of this information include: proportion of women who reported cost as a reason for not seeking services, availability of key drugs and supplies, and measures of facility cleanliness.

Planning meeting, facilitators helped CRs formulate social action plans to address the specific MNH problems they faced in their communities. CRs were encouraged to formulate a mix of actions, including actions that might lead to improvements within ninety days (roughly when the final meeting of the intervention would be held) and those that were longer term. Otherwise the facilitator left it up to the CRs to design the actions they thought were most appropriate and likely to fix the barriers on which they decided to focus.

.....

Photo 1. CRs in Tanzania creating a social action plan.



Immediately following these two core meetings was an Open Public meeting where the CRs presented the social actions they designed to the broader community to gain input and offer a chance for others in the community to become involved.

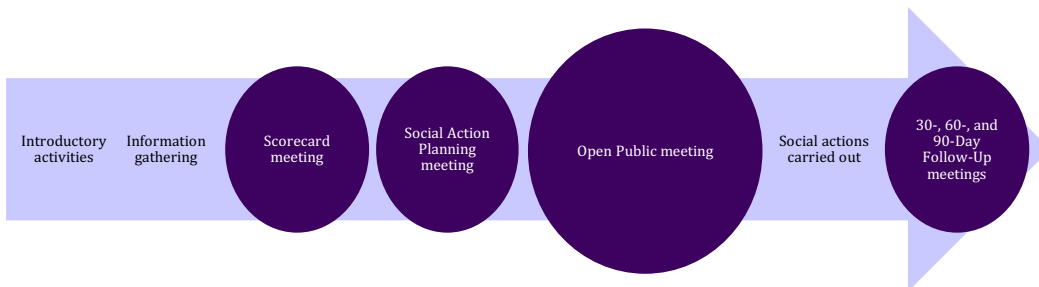
The final three Follow-Up meetings occurred at 30-day intervals after the Open Public meeting. At each Follow-Up meeting, the facilitator checked in with the CR

group to learn about the progress of the social actions. The purpose of these meetings was to celebrate successes, to brainstorm how to address obstacles, and generally to encourage the CRs’ continued work on the actions. The intervention officially “ended” after the 90-Day Follow-Up meeting, although the CR group was encouraged to continue to meet and work on further improvements.

Throughout the intervention, it was entirely up to the CRs to decide what to do—to design and undertake the actions they believed, based on their knowledge, experience, and what they learned during the course of the T4D intervention, would work in their particular context—or whether they should do anything at all. CRs did not receive financial resources from the project to carry out actions, even those that would require funding (such as building new infrastructure). CRs in Indonesia received no payment for their participation in the program, and those in Tanzania received a small sum (on average, less than other similar programs) to compensate for their time participating in the Scorecard and Social Action Planning meetings, but nothing for their participation in the Open Public meeting or any subsequent meeting.

The intervention components are illustrated in *Figure 1*. For a comprehensive description of the T4D intervention, including a description of the co-design process and the core design principles, see “[Citizen Voices, Community Solutions](#).”¹¹

Figure 1. Intervention Components



¹¹ Transparency for Development Team (2017).

Open Social Actions

One of the core design principles of the T4D intervention was to be “non-prescriptive.”¹² Just as problems differ between communities, so do ways of making improvements. For example, one community might attend a health facility where the provider is frequently absent. If this community has access to multiple facilities, the CRs could encourage fellow community members to bypass the facility with the absent provider in favor of one where this is not a problem. The CRs could also take an approach where they provide a house nearby the facility to help reduce the provider’s commute time. Or they could complain to the provider’s supervisor. Another community might have an issue where people simply are not going to the health facility. In this case, the CRs might solve the issue by educating fellow community members about the importance of visiting the facility, fixing a bridge that makes the distance to the facility shorter, or advocating for an ambulance to bring patients to the facility. The choice of action is dependent on both the particular problem and the particular circumstances of the village.

As a result, the T4D intervention meetings were designed to enable the CRs to develop actions that they thought would suit the unique contexts of their villages. This meant it was impossible to know in advance what they would choose to do.

In theory, CRs in diverse communities may still have converged on a common approach, particularly if they faced common problems. In reality, we saw a wide range in the types of actions CRs designed. *Box 1* illustrates a small subset of example actions.

Box 1. Example Social Actions

- Visit pregnant women in the village to talk to them about the importance of giving birth at a health facility
- Meet with head of the local health facility to discuss the availability of medicine, supplies, and the high cost of delivery
- List the community members whose cars can be used to transport patients to health facilities (both for treatment of illness/injury and for delivery)
- Repair roads in the village to allow easier access to the health facility

.....
¹² We define non-prescriptive as providing information to communities about problems and potential ways they might think of fixing them, but without suggesting or urging any particular course of action. See Transparency for Development Team (2017).

METHODS

This paper aims to provide insights into the CR-designed social actions by examining the social action plans collected over the course of the T4D intervention. It describes some of the interesting patterns as well as similarities and differences between actions in Tanzania and Indonesia. This analysis was also used to finalize the design of the survey tools and [analysis plan](#)¹³ for the RCT impact evaluation component of the T4D project.

Primary Data Source

The *social action plans* are the primary data source used in this paper. Each community’s facilitator, who was recruited, trained, and overseen by the CSO partner, was responsible for recording a copy of the social action plans developed during the Social Action Planning meeting. The facilitators also recorded a copy of the social action plans that were discussed during each of the three Follow-Up meetings. The facilitator gave a copy of these plans to the project team at CHAI or PATTIRO, who compiled the plans and shared them with the T4D research team. Members of the T4D research team then coded the plans into a dataset. An example is plan is presented in *Figure 2*.

Communities used a social action plan template to aid in creating the plans (see *Appendix A*). The template varied slightly between the two countries, resulting in data that are similar, although not identical, across Tanzania and Indonesia. The raw plans contain the following information:

Tanzania:

1. Name of action
2. Each planned “step” of the action, including:
 - a. Brief description of the step
 - b. Person (CR) in charge
 - c. Materials or tools needed
 - d. Target date for implementation
 - e. Measure of success

.....
¹³ Bombyk, M. Creighton, J. Dixit, A. Levy, D. Roots, L. (2018).

3. Progress on each step (filled out by the facilitator during or after Follow-Up meetings only), including:
 - a. Successes
 - b. Challenges
 - c. Whether an additional action was designed as a follow up to the step
 - d. Whether the step was completed
 - e. Additional notes

Indonesia:

1. Name of action
2. Barrier(s) the action is designed to address
3. Person (CA) in charge of the action
4. Each planned “step” of the action, including:
 - a. Brief description of the step
 - b. Person in charge
 - c. Materials or tools needed
 - d. Target date for implementation
 - e. Measure of success
5. Progress on each step (filled out during Follow-Up meetings only), including:
 - a. Whether an action has been taken on the step
 - b. Whether the step was completed

Figure 2. Example Social Action Plan (Tanzania)

Action Name: Fundraising to support MNH				
List Steps	Responsible Person	What tools, community resources are needed?	Timeline/ Deadline	How is success measured?
1: Inform the village government	CRs: Salim, Jessie, Peter, Asha	People, time	16/01/2016	Village government is informed
2: CR meeting for feedback from the village government	All CRs	People, time and area	22/01/2016	Feedback received from the village government
3: Meeting with the village government	All CRs, village government	People, time and area	29/01/2016	Meeting is done and the idea is accepted
4: Open meeting with the community	Entire community	People, time and area	15/02/2016	Open meeting is done and agreement on the contribution
5: Educate the community on the importance of the fund	All CRs	People and time	17/02/2016	Community sees the importance of the fund
6: Propose sub-village accountant	Sub-village communities	People, time and area	23/02/2016	Sub-village accountant proposed
7: Contributions begin	Sub-village Communities	Money	25/02/2016	Raise enough funds for MNH
8: Fund serves the community	Entire community	People and money	02/03/2016	Mothers and children benefit from the MNH fund

Each CR group designed multiple actions (and thus multiple plans). In the remainder of the paper, we will consider each action separately (as a single observation). For example, if the CR participants in a village: 1) designed an education campaign, 2) decided to raise funds for a village ambulance, and 3) planned to advocate for more drugs at the local health facility, these would be coded as three separate observations.

To further understand the choices participants made in planning these actions, we classified actions into categories along several dimensions:

Action Goal: what improvements the CRs hoped to achieve with the action. Actions were classified into forty-three goals.¹⁴ Examples include: fixing the road to the facility, longer facility hours, savings pool for delivery or other maternity costs, and facility cleanliness. An action can have more than one goal. A full list of action goals and their descriptions is included in *Appendix B*.

Topic: three of the most common action goals—education, bylaws, and infrastructure—are classified further into topics in order to provide more detail. In the case of education and bylaws, these further classifications capture the specific topic of the education or bylaw, such as the MNH levers, cost, male participation, or health insurance. In the case of infrastructure, further classification provides detail on the specific type of infrastructure (toilets, electricity, water, etc.).

Completion Status: whether the action was reported as “complete” by the 90-Day Follow-Up meeting. Complete means that the CRs described all steps in the action as completed, though this does not necessarily indicate that the action was successful. Incomplete actions were classified as either “ongoing” (not all steps had been completed but the action was continuing), “stopped” (action was abandoned before completion), “canceled” (CRs never worked on the action and had no plans to do so), or “incomplete but unclear.”

Ultimate Target: the person or group of people the CRs sought to ultimately change with the action. This also includes those whose top-down authority was sought in influencing the behavior of the ultimate target. Examples of ultimate targets include the “community” in the case of an education activity aimed at increasing MNH service uptake and “health provider” in the case of attempts to improve the attitude of the village midwife. An action could have multiple ultimate targets if that action sought to *ultimately* change the behavior of more than

.....
¹⁴ These goals are a detailed classification of the “intermediate outcomes” column in the T4D theory of change, explained later in this paper.

one person or group of people, or if a long route actor was engaged to influence the behavior of the ultimate target.

Step Target: a person or group of people targeted during one or more steps in the process of implementing a social action. An example of a step target would be “government (village level)” in the case of CRs requesting the village chief to help them contact regional officials to discuss the drug supply chain. A step target is *not* the ultimate target of the action, but instead a target along the way to reaching the ultimate target. Each action could have multiple step targets.

Collaborative or Confrontational: each action step was classified as collaborative, confrontational, or unclear. Collaborative actions involved activities such as joint problem-solving, education, collaboration with allies, requests through normal or official channels, or rewarding good performance. Confrontation included activities such as complaints, protests or demonstrations, or highlighting or seeking to punish poor performance. Because collaboration or confrontation may be difficult to tell from the written plans, we assigned each a confidence level: clear or unclear.

Social Accountability Approach: is a classification of whose responsibility it is to fix the problem combined with whomever the CRs sought to fix the problem. We classified each action into one of four categories: 1) social accountability, an action where service providers or other officials were asked to do something because it is their responsibility; 2) innovation, where the service providers or officials were asked to take on a new responsibility; 3) substitution, actions involving citizens or non-government actors undertaking activities that are the responsibility of service providers or other officials and 4) community self-help, in which citizens took on responsibilities that were previously neither theirs nor service providers’ or officials’. More explanation of the four categories, along with a figure describing the categories, can be found in “Beyond Social Accountability: Broader Approaches for Fixing Problems” in part 3 of the findings section of this paper.

Most social action plans were sufficiently detailed to classify actions on these seven dimensions. Where there was a lack of clarity, we made a judgment call. We had to make a judgment call on at least one dimension for less than 3% of actions.

Action plans were available at four time points: the Social Action Planning meeting, and 30-, 60-, and 90-Day Follow-Up meetings. Thus, we were able to determine which actions were added during later meetings and, in certain circumstances, how actions evolved over time.

Supplementary Data Sources

In limited circumstances, we refer to data from three additional sources: 1) key informant interviews, 2) reports by ethnographers who lived in eight communities before, during, and after the program, and 3) the T4D scorecard presented at the Scorecard meeting.

Key informant interviews were conducted with approximately ten key informants in a sub-sample of forty-one treatment villages in Indonesia and twenty-four in Tanzania (out of 100 total treatment villages in each country). These interviews took place just after the 90-Day Follow-Up meeting. In ten villages in Tanzania only, an additional round of key informant interviews was conducted after another sixty to ninety days. Key informant interviews were used in part to verify that actions took place, and we found that interviewers were able to verify 87% of the actions they inquired about. In this paper, we use the interviews to create the vignettes presented in *Boxes 2, 3 and 4*. We also use them to provide insight into some of the trends we observe. Many of the photos in this paper were taken by the interviewers.

The *ethnographic reports* were generated by four ethnographers who each lived in Tanzania or Indonesia for six to eight months during the course of the T4D intervention. Each ethnographer observed two intervention and one control village (villages where the intervention did not take place but where data was collected for the evaluation). These ethnographic reports provided insight into some of the country-specific phenomena we observed.

The *T4D scorecard* comprises information that was presented to each community during the Scorecard meeting. The scorecard included information for each village on

the three health levers,¹⁵ plus data on the barriers to uptake (such as lack of transportation options, insufficient drug supplies, and poor staff attitude). Scorecard data are village-specific and were collected by the facilitator from two sources: the local health facility and 20–30 randomly selected women who gave birth in the previous two years. CSO facilitators and staff compiled the data, generated the scorecards, and shared the raw data with the T4D research team. Like the ethnographic reports, data from the T4D scorecard were used to provide insights into observed differences between actions in the two countries.

In addition to the three supplementary data sources, the paper incorporates insights, anecdotes, and observations by the T4D research team and partners, gleaned from more than a dozen field visits and conversations with numerous in-country experts, researchers, CSO staff, and citizens.

Additional Considerations

The remainder of this paper describes the social actions designed by the CRs during the course of the T4D intervention. Actions could have been designed during the initial Social Action Planning meeting or at any time between then and the final official intervention meeting, the 90-Day Follow-Up meeting. It is possible (and, in fact, it was encouraged) that additional actions were planned after the final meeting, but any such actions are not included in this analysis.

Most of the analysis describes planned actions. Although we have self-reported information about whether actions were completed by the 90-Day Follow-Up meeting and certain analysis is restricted to completed actions, it is possible that some of the actions that remained outstanding at ninety days were completed later. For this reason, the majority of the analysis is on the full set of designed actions, rather than a restricted sample of completed actions.

The social action plans range in quality and detail, as do the actions themselves. It is difficult to judge the quality of an action based on what was written in a plan (both because details could be missing, and because, in the case of Follow-Up meetings, the information on what was done was self-reported) and, as such, the T4D research

.....
¹⁵ ANC/birth preparedness planning, delivery, and PNC services.

team has not attempted to systematically “judge” the quality of the actions. Therefore, this analysis remains agnostic on the quality of actions, meaning we include all of the actions in the analysis, whether they are of high quality or not.

FINDINGS

The remainder of this paper focuses on analysis of the CR-designed social actions. *Section 1: Description of Actions* describes the social actions, including the distribution of actions across villages and their completion status. *Section 2: Analysis of Action Goals Along the T4D Theory of Change* describes the T4D theory of change and how the actions map to the theory of change. This section also includes discussion of the most commonly targeted theory of change pathways and explores notable differences in actions between the two countries. *Section 3: Social Accountability Analysis* examines the actions against the “five worlds” framework and includes analysis by intervention target (including classification according to the traditional “accountability triangle’s” short and long route from the 2004 World Development Report¹⁶), whether the action was collaborative or confrontational, and social accountability approach.

1. Description of Actions

Distribution of actions

The CR participants in the 200 T4D intervention communities designed a total of 1,139 actions, an average of five and a half per community. Intervention villages in Indonesia designed 715 of these actions, and intervention villages in Tanzania designed 424.

CRs designed an average of five and a half actions per community, but there was wide variation in the number of actions designed. *Table 1* shows the distribution of villages by number of actions for Indonesia, Tanzania, and the total across the two countries. In Indonesia, each community designed between three and seventeen actions, with a median of seven actions per village. In Tanzania, each community designed between two and eight actions, with a median of four actions per village.

.....
16 World Bank (2003).

.....
Table 1. Distribution of Villages by Number of Actions

Number of Actions	Overall	Indonesia	Tanzania
1	0.0%	0.0%	0.0%
2	2.0%	0.0%	4.0%
3	11.0%	4.0%	18.0%
4	26.0%	7.0%	45.0%
5	19.0%	15.0%	23.0%
6	11.0%	18.0%	4.0%
7	10.0%	15.0%	5.0%
8	7.5%	14.0%	1.0%
9	6.0%	12.0%	0.0%
10+	7.5%	15.0%	0.0%
Mean	5.70	7.15	4.24
Median	5	7	4

We suspect two reasons for the difference in number of actions between the two countries. First, communities in Indonesia were far more likely than those in Tanzania to add new social actions over the course of the intervention, driving up the total number of actions in Indonesia. In fact, the Indonesian villages designed *fewer* actions in total than Tanzanian villages during the initial Social Action Planning meeting (348 vs. 408—see *Table 2*). Secondly, and perhaps relatedly, the intervention was implemented by a different CSO partner in each country. It is possible that the facilitators were trained to work with the CRs in subtly different ways: e.g., that facilitators from PATTIRO in Indonesia encouraged communities to design actions throughout the course of the intervention, whereas facilitators from CHAI in Tanzania encouraged the communities to focus on a limited number of actions and see them through to completion before adding new actions.

Table 2. Number of New Actions by Meeting

Meeting	Indonesia¹⁷	Tanzania
Social Action Planning	348	408
30-Day Follow-Up	110	8
60-Day Follow-Up	120	7
90-Day Follow-Up	133	1
All	715	424

Completion status

Completion status is self-reported information on whether the action was reported as “complete” by the 90-Day Follow-Up meeting. Complete means that all steps in the action plan were completed. As of the 90-Day Follow-Up meeting, approximately three months after the start of the program, participants described most of the social actions as either complete (57.5%) or ongoing (28.8%). *Table 3* shows the completion status of actions by country and the full sample.

Table 3. Completion Status of Actions¹⁸

Completion Status	Overall	Indonesia	Tanzania
Complete	57.6%	53.0%	65.2%
Ongoing	28.7%	31.3%	24.3%
Stopped or Not Started	9.0%	9.8%	7.6%
Unclear	4.7%	5.9%	2.8%

In total, 655 actions were reported completed at the end of ninety days—57.6% of the total actions. Villages in Indonesia completed a total of 379 actions (53.0% of those designed) and villages in Tanzania completed a total of 276 actions (65.2% of those designed).

¹⁷ Four actions in Indonesia were designed outside of the Social Action Planning and Follow-Up meetings, which is why these numbers total to 711.

¹⁸ Based on a sample of 1,138 actions.

Completion status should be interpreted with caution for several reasons. First, completion status was self-reported (and based on the judgment of the CRs, which may be different than our own). This indicates that completion could have been lower than reported. In fact, external verification using the KII data indicate that 91.9% of that subsample of the actions were completed as described. It is also possible that completion was higher than reported. One reason is that longer-term actions could have been completed after the final official meeting, the 90-Day Follow-Up. Additionally, CRs in some communities added new social actions during the 90-Day Follow-Up meeting. These new actions are included in the analysis even though the CRs did not have the chance to start the actions before the 90-Day Follow-Up meeting.

On average, intervention villages in Indonesia completed more actions than intervention villages in Tanzania. *Table 4* shows the distribution of villages by completed action for Indonesia, Tanzania, and the total completed across the two countries. In Indonesia, each community completed between zero and eight actions, with a median of four actions completed per village. In Tanzania, each community completed between zero and six actions, with a median of three actions completed per village.

In Indonesia, 9.0% of villages did not report completing a single action by the 90-Day Follow-Up meeting. In Tanzania, 2.0% of villages reported not completing any actions by the final meeting.

.....
Table 4. Distribution of Villages by Completed Actions¹⁹

Number of Actions	Overall	Indonesia	Tanzania
0	5.5%	9.0%	2.0%
1	7.5%	6.0%	9.0%
2	19.5%	14.0%	25.0%
3	27.5%	11.0%	44.0%
4	19.0%	22.0%	16.0%
5	10.5%	18.0%	3.0%
6	5.0%	9.0%	1.0%
7	4.0%	8.0%	0.0%
8	1.5%	3.0%	0.0%

.....
¹⁹ Based on a sample of 1,138 actions.

Comparing the designed actions to completed actions, we find a higher percentage of the designed actions were completed in Tanzania than Indonesia, but overall, communities in Indonesia completed more actions. This is not surprising considering Indonesian communities designed more total actions than those in Tanzania. The lower percentage of action completion in Indonesia can be partially attributed to Indonesian communities adding new actions throughout the intervention, including 133 actions added during the 90-Day Follow-Up meeting (at which point they would not have had time to complete these actions). If we restrict completion status to only those designed in the original Social Action Planning meeting, we find similar completion rates between the two countries: Indonesian communities completed 67.8% of their initial actions and Tanzanian communities completed 66.3%.

2. Social Action Goals

Since the T4D program was deliberately non-prescriptive about what MNH problems participants should focus on or what approaches they should take to try to alleviate those problems, it was difficult to predict in advance the mechanisms through which the T4D intervention might improve MNH. Would the actions be homogenous, with nearly every community choosing to interface with health facility providers about poor services? Or would each village choose actions so unique to their particular circumstances that we would see a wide range of actions and very little coalescing around one particular approach? Analyzing action goals gives us insight into what the CRs decided to try to do to alleviate MNH challenges in their communities.

We start this section by describing the T4D theory of change, which illustrates the range of potential mechanisms through which the T4D-inspired community actions could improve MNH. Next we classify the actions by goal, and map these goals to the pathways within the theory of change. We walk through each pathway to identify interesting patterns. We conclude by examining similarities in and differences between action goals in Indonesia and Tanzania.

2.1 Theory of change

Figure 3 illustrates the wide range of mechanisms by which the intervention might affect health outcomes. To have an impact, the community must understand and be

motivated by the information and/or discussion, develop a plausible social action plan, and successfully carry it out. This process may have an impact and improve health outcomes in three main ways:

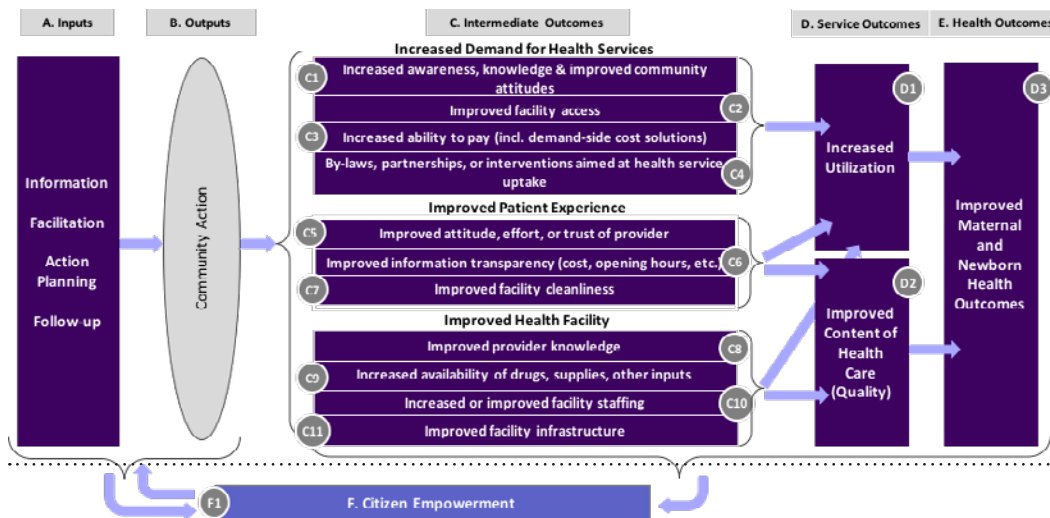
1. The proportion of people receiving services increases (increased utilization);
2. The quality of services delivered through existing channels improves (improved content of clinical care); and
3. People who were receiving lower quality care at one outlet choose to seek care at a higher quality outlet.

This intervention was designed to primarily trigger (1) and (2): collective action targeted at improving service utilization (D1 in *Figure 3*), the content of clinical health care (D2 in *Figure 3*), or both. These pathways form the basis of two of the T4D project's primary research questions. Since the information component of the intervention did not inform communities of the relative quality of health facilities, the T4D team did not expect the intervention to explicitly trigger (3): communities seeking care at different outlets.

Participants may choose to carry out a range of social actions (B in *Figure 3*) that were designed to trigger one or more intermediate outcomes (C in *Figure 3*), such as awareness of activities mothers should undertake during pregnancy, or a change in midwife behavior. We group these intermediate outcomes into three categories (increased demand for health services, improved patient experience, and improved health facility), which should lead to an impact on utilization of healthcare services, content of healthcare services, or both (D in *Figure 3*). Improvements in these service outcomes should ultimately improve health outcomes (E in *Figure 3*). Examples of health outcomes that are linked to the service outcomes (D in *Figure 3*) are increased infant height-for-age and weight-for-age and decreased neonatal and infant mortality.²⁰

.....
20 Appropriate medical attention during delivery is linked to reduction in complications that can cause serious illness or death to the mother and newborn (Statistics Indonesia et al. 2013). Research has also found the risk of death for infants to be six times higher if a birth occurs at home with a TBA instead of at a health facility (Abdullah, A. et al. 2016). Weight-for-age is a measure of chronic and acute malnutrition (Gertler, P. J. Vermeersch, C. 2012); Height-for-age is a measure of chronic malnutrition. Stunting is affected by both chronic and recurrent illness and, unlike weight indicators, is not sensitive to recent, short-term changes to diet. In principle, better antenatal care, including the provision of micronutrient supplements, nutritional advice, and the treatment of

Figure 3. Theory of Change of the Intervention



2.2 Action goals

We classified each action as having one or more action “goals,” such as fixing roads, educating community members, improving facility infrastructure, and complaining about poor service. Actions were categorized into a total of forty-three goals. In addition, there was a small percentage of actions (less than 1%, and only in Indonesia) aimed at sustaining the T4D program rather than improving health (such as officially registering the CR group). An even smaller percentage of actions was too vague to be classified. These are not included in the analysis. See *Appendix B* for a description of each goal type.

maternal illness could increase infant height and weight, as could vaccinations and growth monitoring (Gertler, P. J. Vermeersch, C. 2012). A study in Tanzania find place of delivery a significant predictor of neonatal mortality; mothers who delivered outside a health facility experienced 1.85 times higher odds of experiencing neonatal deaths than those who delivered in a health facility (Ajaari, J. et al. 2012). In a systematic review, Bhutta, Z. A. et al. (2014) find certain ANC measures (namely malaria prevention) are associated with reductions in low birth-weight (by 29%) and neonatal mortality (31%), while delivery with a skilled birth attendant has a significant effect in reducing neonatal mortality. The packages of care with greatest impact on ending preventable neonatal deaths and stillbirths include: care during labor, childbirth and the first week of life, and care for small and sick newborns (WHO, 2014).

While we classified most actions as having a single goal, about one-quarter focused on multiple goals. *Table 5* shows the distribution of actions by number of goals.

Table 5. Distribution of Actions by Number of Goals

Number of Goals	Frequency
1	74.3%
2	16.7%
3	6.1%
4	3.0%

We then classified each of the forty-three goals into one of the eleven intermediate outcome pathways within the theory of change (C1-C11 in *Figure 3*) or a twelfth pathway outside of the theory of change: those not directed explicitly at improving uptake or quality at a health facility or of the health system (but that are related to improving health more generally).²¹

In the analysis that follows, we focus on the village or community level, and explore the proportion of villages in which participants designed an action with a particular goal, or with a goal that fell into a certain pathway or category. *Figure 4* summarizes the proportion of communities undertaking each of the eleven intermediate outcome pathways into a “heat map.” *Figure 4* is organized by intermediate outcome category (increased demand for health services, improved patient experience, and improved health facility). Within each category, the pathways are ordered by most to least prominent based on the percentage of communities designing an action (or actions) aimed at activating that particular pathway.

Participants in an overwhelming majority of communities (99.5%—that is, all but one) designed an action with the overall goal of *increasing demand for health services*. Within this category, increased awareness, knowledge, and improved community attitudes is the most common pathway, with 93.5% of the intervention villages

²¹ For ease of analysis, we mapped each goal into a single pathway, though we recognize that certain goals could have fit into more than one. Which pathway was chosen was a judgement call on the part of the T4D research team.

designing at least one action that fits this description. The second most common pathway, at 71.0%, is improved facility access. In addition to being the two most prominent pathways within the increased demand for health services category, these were the two most prominent pathways overall. Nearly half of the communities (45.0%) designed an action aimed at increasing the ability to pay for services, and just over a third (35.0%) designed an action using bylaws, partnerships, or other interventions aimed at increasing health service uptake.

Participants in three-fifths (60.0%) of communities designed one or more actions aimed at *improving the patient experience*. Within this pathway, improving information and communication (39.0%) and provider attitude, effort, or trust (36.0%) were the most common. Only 6.0% of villages designed an action aimed at improving facility cleanliness.

Finally, participants in just over half (54.5%) of the villages designed an action geared towards *improving the health facility itself*. About a quarter (28.0%) of villages targeted improving facility infrastructure. The same amount (28.0%) targeted drug, supply or equipment stocks. Less than one-fifth (17.5%) of villages targeted changes in facility staffing. Finally, only 1.0% (two villages total) designed an action aimed at improving health provider knowledge. This is unsurprising in that improving provider knowledge is perhaps the most unlikely pathway for program participants to attempt: not only is it difficult for average citizens to know that health providers lack necessary knowledge, even if they did, the chain of steps required to improve that knowledge is particularly complex, involving decision-makers at multiple levels of government and outside actors such as universities or health-care curriculum-focused NGOs.

Figure 4. Intermediate Outcome Pathway Heatmap

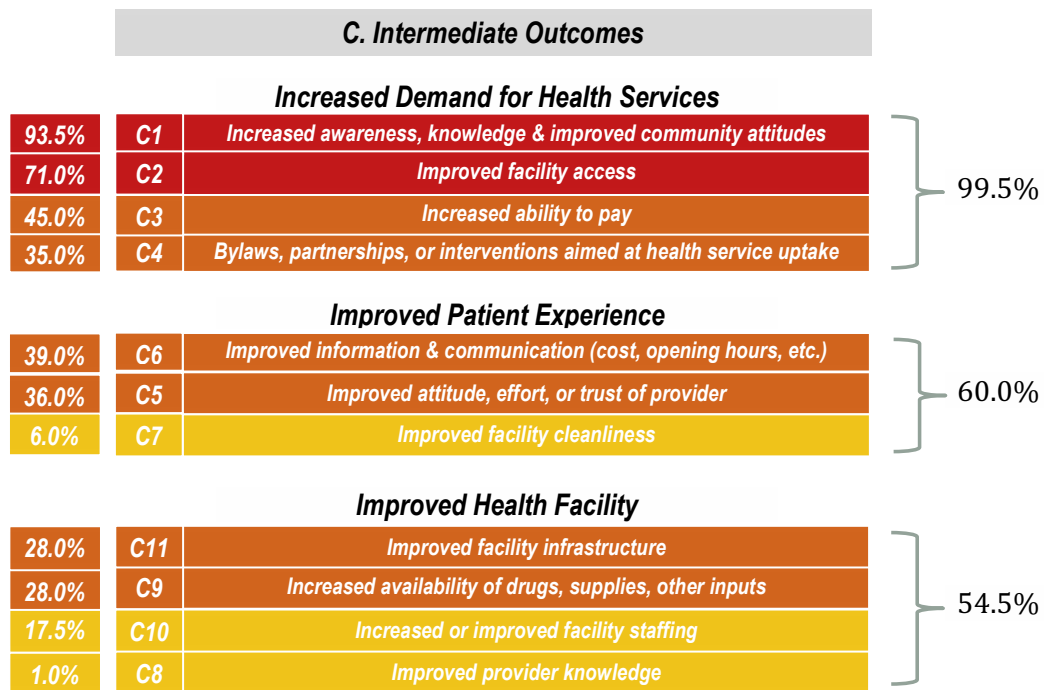


Table 6 provides additional detail: it shows the percentage of communities undertaking actions aimed at each: 1) goal, 2) theory of change intermediate outcome pathway (“pathway”), and 3) theory of change intermediate outcome category (“category”). Each goal maps to a pathway in column C of the T4D theory of change, and these pathways are grouped into the three categories: increased demand for health services, improved patient experience, and improved health facility.

Table 6. Proportion of Villages Designing Actions by Goal, Pathway, and Intermediate Outcome Category (Full Sample)

Goal	Frequency	Pathway	Frequency	Category	Frequency
Education or socialization	93.5%	C1: Increased awareness, knowledge & improved community attitudes	93.5%	Increased Demand for Health Services	99.5%
Blood type identification	1.5%				
Build or request a new facility	34.5%	C2: Improved facility access	71.0%		
Request ambulance	25.5%				
Fix road	18.0%				
Mobile clinic or outreach services	15.5%	C3: Increased ability to pay (including demand-side cost solutions)	45.0%		
Community organized transportation	8.5%				
Ambulance info	5.0%				
Longer facility hours	2.5%				
Address distance or transportation – general	0.5%				
Raise community funds for delivery or other maternity costs	18.5%				
Savings pool for delivery or other maternity costs	9.0%				
Help people access health insurance	7.5%	C4: Bylaws, partnerships, or interventions aimed at health service uptake	35.0%		
Advocate for reduced cost of service	6.5%				
Group entrepreneurship to raise income	6.0%				
Complain about illegal fees	3.0%				
Bylaws	22.0%				
Educate TBAs	6.5%				
Midwife-TBA partnerships	5.5%				
Registry of men	4.0%				
Pregnancy test	2.0%				
Create incentives for expecting mothers to go to check-ups	2.0%				

Table 6. continued

Goal	Frequency	Pathway	Frequency	Category	Frequency
Feedback on facility staff performance	32.5%	C5: Improved attitude, effort, or trust of provider	36.0%	Improved Patient Experience	60.0%
Midwife residence in village	4.5%				
Customer service	1.5%				
Complaint mechanism	21.5%	C6: Improved information & communication (cost, opening hours, etc.)	39.0%		
Cost information	16.0%				
Hours information	6.0%				
Facility cleanliness	6.0%	C7: Improved facility cleanliness	6.0%	Improved Health Facility	54.5%
Improve midwife capacity	1.0%	C8: Improved provider knowledge	1.0%		
Stock of drugs, equipment and supplies	27.0%	C9: Increased availability of drugs, supplies, other inputs	28.0%		
Blood bank	1.0%				
Additional staff (midwife, doctor, etc.)	17.5%	C10: Increased or improved facility staffing	17.5%	Non-health System Directed Community Solutions	9.0%
Fix or improve health facility infrastructure	22.5%	C11: Improved facility infrastructure	28.0%		
Maternity home	4.0%				
Construct placenta pit	3.0%	G: Non-health system directed community solutions	9.0%		
Hygiene/cleaning campaign	4.5%				
Plant garden	2.0%				
Funds for baby food	1.0%				
Healthy mother or child competition	1.0%				
Sports day for women	1.0%	Community well	0.5%		
Community mosquito spraying	0.5%				

2.3 Discussion

Once we mapped the actions to the theory of change, we were able to explore the actions to look for interesting patterns, which we did in three ways: by 1) exploring the intermediate outcomes we would have expected to be triggered by the planned actions, 2) examining differences between countries, and 3) looking at variation in completion by action pathway. Where possible, we also attempted to explain our findings using insights from our partners, ethnographers, and other observers.

In subsection 2.3.1, we examine in detail each of the most prominent intermediate outcome pathways within the theory of change. Prominent pathways were defined as those attempted by CRs in 25% or more of the communities. Of note is that only two pathways were attempted by more than half of the communities—increased awareness, knowledge & improved community attitudes, and improved facility access

In subsection 2.3.2, we examine differences and similarities in the actions designed in the two countries. Specifically, we explore differences in: 1) pathways and 2) the goals within the pathways.

In subsection 2.3.3, we look at variation in completion by action pathway and find that it was largely driven by the mix of long-term vs. short-term actions and by between-country differences.

2.3.1 A deeper look at prominent intermediate outcome pathways

Examining the prominent pathways (those attempted by participants in 25% or more of communities and shown as red or orange in the heat map) enabled us to trace the process of the T4D intervention, giving insight into the mechanisms through which the intervention might have influenced the quality or use of MNH services.

This subsection is organized in the same way as the heat map; the pathways are discussed from most to least prominent within each of the three intermediate outcome categories: 1) increased demand for health services, 2) improved patient experience, and 3) improved health facility.

Increased Demand for Health Services Pathway

Increased awareness, knowledge & improved community attitudes (C1)

Photo 2. Public poster for an education activity in a T4D village in Indonesia. It includes: the name and contact information of all of the community representatives, the duty schedule of the midwife, and information about the three health levers (birth preparedness planning, birth in a health facility with a skilled attendant, and postnatal care).



Nearly all communities (93.5%) designed an action to increase awareness, knowledge, or improve community attitudes. The major activity within this pathway was educating communities, representing 99.0% of the action “goals” within these categories. Community education varied in intensity and took a variety of forms. In some communities, CRs conducted door-to-door education campaigns (encouraging pregnant women to attend antenatal services, for example), and in others they distributed leaflets throughout the community. The remaining activities in this category comprised blood type identification drives to help with birth preparedness planning.

There was variation in the topic of the education activities. *Table 7* shows the distribution of education activities by topic.

Table 7. Education Activities by Topic²²

Topic	Frequency
MNH/Health Levers	87.7%
Family Participation	14.8%
Address Harmful Customs	7.1%
Cost	3.0%
Parent Child Conversations	1.6%
Other	2.7%
Unclear	3.8%

The vast majority (87.7%) of the education activities were aimed at maternal and neonatal health services, mainly focusing on the uptake of the MNH health levers that were emphasized by the T4D intervention: antenatal care, birth preparedness planning, facility birth, and postnatal care. Fifteen percent (14.8%) of the education activities focused on family participation, mainly encouraging fathers to support their partners throughout pregnancy and birth. Approximately seven percent (7.1%) addressed customs or cultural issues that may prevent expectant and recent mothers from seeking services. The remaining topics, all representing 3% or less of the actions, included educating on the cost of services, encouraging parents to talk to their children about sex and family planning, family planning more generally, cleanliness, and health insurance.

²² Because education activities could focus on more than one topic, the total adds up to greater than 100%.

Improved facility access (C2)

.....
Photo 3. Foundation of a health facility being built in a T4D village in Tanzania.



Nearly three-quarters of the communities (71.0%) designed an action aimed at improving facility access. This was the second-most prominent pathway targeted.

Table 8. Improved Facility Access by Goal²³

Goal	Frequency within Pathway (% of Villages Overall)
New Health Facility	29.9% (34.5%)
Request an Ambulance	25.6% (25.5%)
Fix Roads	17.3% (18.0%)
Mobile Clinic or Outreach Services ²⁴	16.5% (15.5%)
Community Organized Transportation	8.3% (8.5%)
Information on Ambulance Services	5.5% (5.0%)
Longer Facility Hours	2.8% (2.5%)
Unclear	0.4% (0.5%)

Table 8 shows improved facility access by goal. The table displays the *percentage of actions* with a certain goal within the pathway. For reference, in parentheses below is the information contained in Table 6: the percentage of communities overall that designed an action with this goal.

The goals within the improved facility access pathway were many. The most prominent were building or advocating for a new, closer health facility (representing 29.9% of the facility access actions), requesting ambulance services (25.6%), repairing the road between the village and the health facility (17.3%), and advocating for a mobile clinic or outreach services (16.5%). The remaining goals, each of which represented 10% or less of the actions included: community organized transportation,

²³ Because actions could have more than one goal, the total adds up to greater than 100%.

²⁴ This includes *Posyandu* services in Indonesia. *Posyandu* are promotive and preventive services focused on antenatal and postnatal care for women and children under 5. These services are provided monthly by the village midwife and community volunteers at the village or sub-village level (Tumbelaka, P. et al. 2018.).

disseminating information on the availability of ambulance services, and advocating for longer facility operating hours.

CRs also took varying approaches within this pathway to address the issues they were trying to improve. For example, to address transportation challenges, some communities decided to ask for an ambulance, whereas others attempted to solve the problem by identifying community members with vehicles who were willing to provide emergency transportation (see *Box 2*). Still others decided the solution was to bring services to communities directly, in the form of a mobile clinic or other outreach services.

Box 2. Community-Organized Transportation in Indonesia

In one Indonesian village, the CRs decided to help pregnant women access transportation to the health facility. They began by listing the ten people in their community that they knew owned a car. They then approached each individually to see if they would voluntarily drive women in need. A total of four people volunteered, and their names were shared with the community. At the same time, the CRs began tracking women they knew who were approaching their due dates and checking in with them to discuss their birth preparedness plans. By the end of the intervention, one driver had already transported three women to the clinic while another had helped two. A midwife stated that the service “really helps mothers who are going to give birth,” while the village secretary stated that the action had been “the most important thing that [the group] has given the facility.”

Increased ability to pay (C3)

Increased ability to pay was the third most prominent pathway, with just fewer than half (45.0%) of communities designing an action of this type. *Table 9* shows increased ability to pay by goal.

Table 9. Increased Ability to Pay by Goal

Goal	Frequency within Pathway (% of Villages Overall)
Fundraise	37.7% (18.5%)
Maternity Savings Pool	15.8% (9.0%)
Health Insurance Access	15.8% (7.5%)
Ask to Reduce Cost	14.0% (6.5%)
Entrepreneurship Activities	11.4% (6.0%)
Complain About Illegal Fees	5.3% (3.0%)

The goals within this pathway fell within three categories. One was cost on the demand-side, which participants tried to reduce by providing supplemental funds to those seeking health services, such as through fundraising (37.7%), creating savings pools (15.8%), or creating mission-driven businesses whose funds were donated to those who needed services (11.4%). Combined, these demand-side cost solutions represented 64.9% of the actions within this goal. Another category included actions to address the cost of health services at the facility itself, through complaining about cost or asking for it to be reduced (14.0 %) or attempting to address illegal fees (5.3%). The final category aimed to increase access to health insurance (15.8%). Combined, the latter two categories represent 35.1%. This means that about two-thirds of the actions were aimed at finding ways to cover current costs vs. about one-third that were aimed at making the services more affordable.

Bylaws, partnerships, or interventions aimed at health service uptake (C4)

Approximately one-third of communities (35.0%) designed interventions aimed at health service uptake, such as through bylaws or partnerships. These actions are described in *Table 10*.

.....
Table 10. Actions Aimed at Health Service Uptake by Goal

Goal	Frequency within Pathway (% of Villages Overall)
Bylaws	51.1% (22.0%)
Midwife TBA Partnerships	15.6% (5.5%)
Educate TBAs	14.4% (6.5%)
Register Husbands/Partners	10.0% (4.0%)
Create Incentives for Expecting Mothers	4.4% (2.0%)
Pregnancy Tests in Schools	4.4% (2.0%)

The most common goal in this pathway, utilized in about half of the actions (51.1%), was establishing bylaws. These were local laws (usually at the village level) that typically involved fines for minor infractions. The specific aims of the bylaws varied; examples include: fining men who did not attend antenatal care appointments with their pregnant partners and laws prohibiting home delivery (punishing either the TBAs who delivered the baby outside of a health facility setting or the expectant mothers themselves).

At 15.6%, the next most prominent goal was creating partnerships between the midwife (or other health facility staff) and traditional birth attendants (TBAs). These partnerships aimed at encouraging midwives and TBAs to work together to ensure women delivered their babies in a health facility with skilled personnel. Fourteen percent (14.4%) of the goals in this pathway aimed at educating TBAs, mainly on the

dangers of delivering babies in homes without the supervision of a midwife. Ten percent (10.0%) of the actions focused on registering the names of husbands/partners of pregnant women who did not attend ANC visits or who were otherwise unsupportive. A lesser number of communities designed actions to create incentives for expectant mothers to seek MNH care, or to administer pregnancy tests in schools.

Improved Patient Experience Pathway

Improved information and communication (C6)

Nearly four out of ten communities (39.0%) designed at least one action having to do with improving the availability of information or the ability to provide feedback to the health facility. All of the actions in this pathway focused on the health facility specifically.

.....
Table 11. Improved Information and Communication by Goal

Goal	Frequency within Pathway (% of Villages Overall)
Cost Information	46.3% (16.0%)
Complaint Mechanism	41.7% (21.5%)
Hours Information	12.0% (6.0%)

As shown in *Table 11*, nearly half of these actions (46.3%) focused on increasing the availability of information about the cost of services. Another two-fifths (41.7%) dealt with instituting a feedback mechanism—most often a “complaint box” at the health facility (see *Box 3* for an example). A lesser percentage of the actions (12.0%) focused on posting information on operating hours.

Box 3. Suggestion Box in Tanzania

In a village in Tanzania, the CRs decided that an anonymous suggestion box would be useful in tackling the rude behavior of staff at the local dispensary. After securing support from the village authorities and clinic staff, each CR donated TZS 1,000 (approximately 0.40 USD) to pay for the construction of a wooden box that was installed in the facility. After explaining to the community how it should be used, the group made plans to open the box and check for suggestions at least once a month. However, the first time the box was opened, the CRs were surprised to find it empty. One CR stated that the group “didn’t understand” why this was the case, while a dispensary staff person provided her own explanation: “the people are afraid to put [in] comments.” Nevertheless, the same staff member stated that the presence of the box had challenged them to work harder and improve their performance.

.....
Photo 4. Comment box at a health facility in Tanzania.



Improved attitude, effort, or trust of provider (C5)

Thirty-six percent (36.0%) of communities designed an action aimed at improving the attitude, effort, or trust of the health provider, such as the nurse or midwife. *Table 12* shows the improved attitude pathway by goal.

.....
Table 12. Improved Attitude, Effort, or Trust of Provider by Goal

Goal	Frequency within Pathway (% of Villages Overall)
Feedback on Staff Performance	86.3% (32.5%)
Ensure the Midwife Lives in the Village	9.8% (4.5%)
Customer Service	3.9% (1.5%)

The majority of the actions in this pathway (86.3%) focused on giving feedback on staff performance in some way, such as complaining to the health provider, his or her boss, or a government official about the health provider’s negative attitude or poor services, or organizing an interface meeting between the community and health facility staff. Ten percent (9.8%) of the actions focused on ensuring the midwife lived in the village. This was specific to Indonesia, where each village is assigned its own village-based midwife, regardless of whether there is a health facility in the village or not. These midwives run monthly outreach services known as “*Posyandu*”²⁵ and serve the community more generally as the first point of contact for primary health care, but it is not uncommon for assigned midwives to work in one village but live in another. A small percentage of actions (3.9%) focused on improving customer service more generally.

.....
 25 Focused on services such as ANC, child health, family planning, immunization, and nutrition.

Improved Health Facility Pathway

Improved facility infrastructure (C11)

Participants in just greater than one-quarter (28.0%) of communities designed actions to improve health facility infrastructure. The vast majority of these actions aimed to fix or add facility infrastructure (82.7%). One-tenth (9.9%) of the actions focused on building a maternity home or waiting area near the health facility for women close to their due dates to wait to give birth, so they would not have to travel a long distance while in labor. Another 7% of the actions were to construct a placenta burial pit.

.....
Table 13. Improved Facility Infrastructure by Goal

Goal	Frequency within Pathway (% of Villages Overall)
Fix or Add Facility Infrastructure	82.7% (22.5%)
Construct Maternity Home	9.9% (4.0%)
Construct Placenta Pit	7.4% (3.0%)

Since most of the actions in *Table 13* were aimed at fixing or adding facility infrastructure, we looked at the goals of these infrastructure projects in additional detail. *Table 14* shows the grouping of infrastructure goals by topic.

Most of the infrastructure projects were aimed at electricity or water supply (34.3% and 31.3%, respectively), but other aims included privacy walls, toilets, beds, telecommunications, general renovations, or additional services such as upgrading the facility to provide inpatient care.

Table 14. Infrastructure Goals by Topic²⁶

Topic	Frequency
Electricity	34.3%
Water	31.3%
Privacy	14.9%
General renovations	14.9%
Toilets	7.5%
Additional services	6.0%
Beds	6.0%
Telecommunications	3.0%
Incinerator	1.5%

Increased availability of drugs, supplies, other inputs (C9)

Approximately one-quarter (28.0%) of communities designed an action geared towards increasing the availability of health facility inputs. As shown in *Table 15*, almost all of these actions (97.5%) focused on increasing the availability of drugs, supplies, and equipment. Two actions (representing 2.5% of this category) were to organize a blood drive to increase the availability of blood supply at the facility.

Table 15. Increased Availability of Drugs, Supplies, Other Inputs by Goal

Goal	Frequency within Pathway (% of Villages Overall)
Supply of Drugs, Supplies, and Equipment	97.5% (27.0%)
Blood Supply (Blood Bank)	2.5% (1.0%)

²⁶ Because infrastructure improvement activities could focus on more than one topic, the total adds up to greater than 100%.

2.3.2 Similarities and notable differences between actions in Indonesia and Tanzania

This subsection compares action pathways and goals in the Indonesian and Tanzanian communities. Where possible, we attempt to explain the differences we observed. These explanations fall into two broad categories: design or implementation differences in the intervention itself, and contextual differences. Though we do not have the information necessary to explore on a granular level, it is important to note that contextual differences are not only at the level of country; they can be at the regional, the district, or even down to the village level. This was one of the main findings of the ethnography—that history and memory, such as of prior development programs, shaped how the CRs perceived the intervention and ultimately carried out the activities.²⁷

Action pathways

Table 16 compares action pathways between the two countries. Overall, the proportion of actions focused on each pathway is very similar across the two countries. There are three notable exceptions, which are elaborated below.

.....
Table 16. Proportion of Villages Designing Actions by Pathway, by Country

Pathway	Overall	Indonesia	Tanzania	Difference
C1: Increased awareness, knowledge & improved community attitudes	93.5%	92.0%	95.0%	3.0
C2: Improved facility access	71.0%	79.0%	63.0%	16.0
C3: Increased ability to pay (including demand-side cost solutions)	45.0%	44.0%	46.0%	2.0
C4: Bylaws, partnerships, or interventions aimed at health service uptake	35.0%	16.0%	54.0%	38.0
C5: Improved attitude, effort, or trust of provider	36.0%	41.0%	31.0%	10.0
C6: Improved information & communication (cost, opening hours, etc.)	39.0%	42.0%	36.0%	6.0
C7: Improved facility cleanliness	6.0%	10.0%	2.0%	8.0
C8: Improved provider knowledge	1.0%	2.0%	0.0%	2.0
C9: Increased availability of drugs, supplies, other inputs	28.0%	45.0%	11.0%	34.0
C10: Increased or improved facility staffing	17.5%	16.0%	19.0%	3.0
C11: Improved facility infrastructure	28.0%	32.0%	24.0%	8.0
G: Non-health system directed community solutions	9.0%	18.0%	0.0%	18.0

.....
²⁷ See forthcoming volume of ethnographic studies of a subsample of T4D villages.

Villages in both countries overwhelmingly chose to design education activities or campaigns aimed at increasing awareness, knowledge and attitudes (92.0% Indonesia, 95.0% Tanzania). Improving facility access, such as through building a new health facility or fixing roads, was the second most prominent pathway chosen by participants in both countries (79.0% Indonesia, 63.0% Tanzania), though in Tanzania, participants in 16.0% fewer communities designed an action within this pathway.

Participants in a moderate number of villages in both countries targeted increasing the ability to pay, with participants in almost an identical proportion of communities in each country engaging this pathway (44.0% in Indonesia and 46.0% in Tanzania). Other pathways targeted by participants in a moderate number of communities in both countries (though slightly less in Tanzania) included improving the attitude, effort or trust of the provider (41.0% Indonesia, 31.0% Tanzania), improving information and communication (42.0% Indonesia, 36.0% Tanzania), and improving facility infrastructure (32.0% Indonesia, 24.0% Tanzania).

In both countries, participants in relatively few villages targeted improving provider knowledge (2.0% Indonesia, 0.0% Tanzania), facility cleanliness (10.0% Indonesia, 2.0% Tanzania), and facility staffing (16.0% Indonesia, 19.0% Tanzania).

The major differences between actions in Indonesia and Tanzania lay in three pathways: bylaws, partnerships, or other interventions aimed at increasing health uptake; increased availability of drugs, supplies, and other inputs; and non-health system directed community actions. The health uptake pathway was far more likely to be activated in Tanzania, where over half of the communities designed an action within this category. Conversely, increased availability of drugs was far more prevalent in the Indonesia action plans. The non-health system directed actions were not pre-hypothesized by the T4D team and are therefore not explicitly part of the logic model. These actions were seen exclusively in Indonesia.

To explore these differences, we looked at the specific action goals within each pathway that participants in Indonesia and Tanzania chose to focus on. Looking at the breakdown within pathways gave us insight into the country-level differences in how communities decided to approach similar problems.

Bylaws, partnerships, or other interventions aimed at increasing health uptake

Actions aimed at bylaws, partnerships, or other interventions aimed at increasing health uptake were far more popular in Tanzania than in Indonesia. Over half (54.0%) the communities in Tanzania (where it was the third most prominent pathway overall) designed an action along these lines. In Indonesia, only 16.0% of communities took this approach.

To explore the difference more closely, *Table 17* shows the breakdown of goals within the bylaw’s pathway by country. As in the previous section, the table displays the *percentage of actions with a certain goal within the pathway*. For reference, the numbers in parentheses below are the percentage of communities in which participants designed an action with this goal.

The most frequent goal of this type in Tanzania was bylaws (62.3% of the actions), followed by educating TBAs (17.4%) and creating a registry of husbands/men who did not support their partners through pregnancy (13.0%). In Indonesia, the most frequent goal was creating partnerships between midwives and TBAs (61.9%), followed by creating incentives for expecting women to take up services (19.0%) and bylaws (14.3%).

.....
Table 17. Bylaws, Partnerships, or Other Interventions Aimed at Health Service Uptake by Goal & Country

Goal	Frequency within Pathway (% of Villages Overall)			
	Overall	Indonesia	Tanzania	Difference
Bylaws	51.1% (22.0%)	14.3% (3.0%)	62.3% (41.0%)	48.0
Midwife-TBA Partnerships	15.6% (5.5%)	61.9% (10.0%)	1.4% (1.0%)	60.5
Educate TBAs	14.4% (6.5%)	4.8% (1.0%)	17.4% (12.0%)	12.6
Register Husbands/Partners	10.0% (4.0%)	0.0% (0.0%)	13.0% (8.0%)	13.0
Create Incentives for Expecting Mothers	4.4% (2.0%)	19.0% (4.0%)	0.0% (0.0%)	19.0
Pregnancy Tests in Schools	4.4% (2.0%)	0.0% (0.0%)	5.8% (4.0%)	5.8

It is notable that the majority of the health service uptake actions in Tanzania were punitive: bylaws generally focused on punishing men who did not support their pregnant partners, pregnant women who did not deliver in a health facility, and TBAs who delivered babies outside of a health facility (see *Table 18*). The registry of men/husbands was also a punitive measure; the consequences of being recorded in such a book were fines or other forms of punishment.

The focus on bylaws and other punitive measures likely comes from familiarity with these types of approaches. For example, Tanzanian communities have a history of using bylaws to promote behavior change, such as around funeral practices.²⁸ And health policies that used disciplinary approaches, like homebirth fines or denial of care, were prominent within the communities in which we worked.²⁹

In Indonesia, by contrast, the actions in this category tended to be positive: the “carrot” approach, versus the “stick” approach in Tanzania. Midwife-TBA partnerships were meant to encourage midwives and TBAs to work in tandem during the delivery of a child, rather than simply punishing the TBA. Same with creating incentives for expecting mothers: these actions included providing snacks at check-ups and rewards for facility delivery, and were exclusively positive.

Anecdotal evidence suggests one reason for the proliferation of midwife-TBA partnerships in Indonesia is a strong pre-existing emphasis on these partnerships within certain district health directorates and NGO programs.³⁰ While these partnerships do not exist everywhere, according to the Indonesia Health Profile 2014, “for difficult [to] access areas, the policy of the Ministry of Health is to develop a partnership program among Midwives and Traditional Birth Attendant[s]. . . .”³¹ It’s possible that CRs were aware of these types of partnerships in other communities and attempted to emulate them within their own.

.....
28 See Whitt, P. (2017).

29 See forthcoming volume of ethnographic studies of a subsample of T4D villages.

30 Sofyan, D. A. S. Khoiri, A. Witcahyo, E. (2015); Walton, K. (2015).

31 Ministry of Health Republic of Indonesia (2014).

.....
Table 18. Tanzania Bylaws by Topic³²

Topic	Frequency
Husband/Partner Participation	76.0%
Punishment for Non-Uptake of MNH Services (Including Home Deliveries)	28.0%
TBAs	24.0%
General MNH	4.0%
Unclear	2.0%

Increased availability of drugs, supplies, and other inputs

The second major difference between pathways in the two countries is in increased availability of drugs, supplies, and other inputs. In Indonesia, participants in nearly half the villages (45.0%) designed an action targeting this pathway, whereas in Tanzania only 11.0% did so. This difference is not explained by a difference in facility conditions between the two countries; in fact, according to the scorecard data, 70.0% of the Tanzanian villages were in the catchment area of a facility with a current drug stock out, versus only 45.0% of the villages in Indonesia.

What accounts for the difference if it is not explained by facility conditions? Answering this question will require further research. One possible reason—intervention design and/or implementation—does not appear to play a role. Neither facilitation nor intervention design differences seem like they would impact this particular pathway; the availability of drugs and supplies was included in the scorecard in both countries and to the best of our knowledge there was no reason for facilitators in either country to place a particular emphasis on this issue. The most plausible answer is some element of context. For instance, we have an example from Tanzania where community members blamed the shortage of medicine on the health workers (suspecting them of selling the drugs for profit), rather than faulting systemic problems with the supply chain.³³ This perception would beget a confrontational solution, which we see from our analysis in *Table 25* was not one CRs were likely to pursue.

.....
³² Because bylaws could focus on more than one topic, the total adds up to greater than 100%.

³³ See forthcoming volume of ethnographic studies of a subsample of T4D villages.

Non-health system directed community actions

The final notable difference between pathways chosen in Indonesia and Tanzania was in non-health system directed community actions. As mentioned earlier in this paper, this is a pathway that we on the T4D research team had not predicted in advance. It represents actions that were outside of the T4D theory of change (which emphasizes the health system, and in particular the facility—either through improvements in the uptake or quality of health services), but that still indirectly sought improvements in MNH outcomes. Actions in this pathway only showed up in Indonesia: participants in 18.0% of communities designed this type of action; none did in Tanzania. The particular actions within the pathway varied widely, from advocating for a mosquito spraying campaign to ward off Malaria and other mosquito-borne diseases (which are particularly dangerous during pregnancy and infancy), to village water, sanitation and hygiene (WASH) campaigns aimed at reducing illness related to unsafe water and sanitation. A comprehensive list of the goals within this pathway is in *Table 6*, earlier in the paper.

Why the difference? While it is not possible to answer this question definitively, it is plausible that intervention implementation plays a role; facilitators in Tanzania may have encouraged CRs to focus on a narrower definition of MNH improvement (restricted to the health system) than facilitators in Indonesia. Evidence from the ethnography³⁴ suggests that some of the facilitators in Tanzania acted more like teachers than facilitators: applauding “correct” answers and using symbols of authority throughout the meetings. This climate may have led the CRs to stick more closely to the guidance of the facilitator.

.....
34 Cogburn, M. (2016).

.....
Photo 5. Garbage pile from a village cleaning campaign in Indonesia.



Action goals

Even within pathways that appear similar between the two countries, there was sometimes a notable difference in the mix of goals. For example, CRs in 44–46% of villages in Indonesia and Tanzania designed actions aimed at increased ability to pay. But in Indonesia the majority of the actions aimed to address the cost of services, whereas in Tanzania the goals primarily focused on providing more money for health service seekers to cover their own costs. Another difference, already discussed, was in actions aimed at increasing uptake of health services, such as bylaws and partnerships. Noticeable differences were also found in the improved facility access, improved information and communication, and improved facility infrastructure pathways. We attribute between-country differences to context and small but important differences in design and implementation of the intervention in the two countries.

Improved facility access

The most notable difference between Indonesia and Tanzania in the improved facility access pathway was that participants in communities in Tanzania focused mainly on building or requesting new health facilities (52.4% of the action goals within this pathway), whereas communities in Indonesia focused more on transportation, either through requesting an ambulance (37.2%), arranging community transportation (9.9%), or publicizing information on ambulance services (8.1%). See *Table 19* for a full rundown of the differences.

Table 19. Improved Facility Access by Goal & Country

Goal	Frequency within Pathway (% of Villages Overall)			
	Overall	Indonesia	Tanzania	Difference
Build or request a new facility	29.9% (34.5%)	19.2% (26.0%)	52.4% (43.0%)	33.3
Request ambulance	25.6% (25.5%)	37.2% (48.0%)	1.2% (3.0%)	36.0
Fix road	17.3% (18.0%)	18.0% (23.0%)	15.9% (13.0%)	2.2
Mobile clinic or outreach services ³⁵	16.5% (15.5%)	12.8% (12.0%)	24.4% (19.0%)	11.6
Community organized transportation	8.3% (8.5%)	9.9% (15.0%)	4.9% (2.0%)	5.0
Ambulance info	5.5% (5.0%)	8.1% (10.0%)	0.0% (0.0%)	8.1
Longer facility hours	2.8% (2.5%)	4.1% (5.0%)	0.0% (0.0%)	4.1
Address distance or transportation – general	0.4% (0.5%)	0.0% (0.0%)	1.2% (1.0%)	1.2

Although we do not know for sure what accounted for the differences, there are a few plausible possibilities. First, we heard anecdotally from CRs in several Tanzanian villages about a government program in which communities who constructed a physical health facility structure would have the necessary staff and equipment provided by

³⁵ Includes *Posyandu* in Indonesia.

the district health ministry. Whether true or not, this belief seemed to be widespread throughout the T4D communities in Tanzania, and could explain why so many chose to focus on building a new dispensary. Social action plans indicated that a number of the villages where CRs designed a dispensary construction project had successfully procured dispensary blueprints from their respective districts, lending credibility to the belief that such a program existed. We also have a photo of dispensary blueprints taken by a KII interviewer.

In Indonesia, the Ministry of Health has a program called “Desa Siaga” or “alert village.” This program began as a pilot in the early 2000s and has slowly scaled up since, though it is still not in every village. Desa Siaga is a community based MNH program with five key pillars, one of which is a transportation system. In these villages, vehicle owners volunteer to drive pregnant women in emergency situations.³⁶ It is possible that citizens in non-Desa Siaga villages were aware of the program and its elements or had heard campaign messages about the importance of timely transportation during labor and for emergencies.

Increased ability to pay

The differences between Indonesia and Tanzania in the increased ability to pay pathway are illustrated in *Table 20*. Of note is that the majority of the actions in Indonesia focused on addressing the cost of service on the supply-side, such as through advocating for a reduced cost of service (25.0% in Indonesia, none in Tanzania) and helping people access health insurance (28.1% in Indonesia, none in Tanzania), whereas the Tanzanian actions focused on addressing cost on the demand-side by providing resources for people to seek health services, such as through fundraising (46.0% in Tanzania, 31.3% in Indonesia), savings pools (18.0% in Tanzania, 14.1% in Indonesia), or group entrepreneurship activities (26.0% in Tanzania, none in Indonesia).

.....
³⁶ John Hopkins Bloomberg School of Public Health (2004); GIZ (2011).

Table 20. Increased Ability to Pay by Goal & Country

Goal	Frequency within Pathway (% of Villages Overall)			
	Overall	Indonesia	Tanzania	Difference
Raise community funds for delivery or other maternity costs	37.7% (18.5%)	31.3% (16.0%)	46.0% (21.0%)	14.8
Savings pool for delivery or other maternity costs	15.8% (9.0%)	14.1% (9.0%)	18.0% (9.0%)	3.9
Help people access health insurance	15.8% (7.5%)	28.1% (15.0%)	0.0% (0.0%)	28.1
Advocate for reduced cost of service	14.0% (6.5%)	25.0% (13.0%)	0.0% (0.0%)	25.0
Group entrepreneurship to raise income	11.4% (6.0%)	0.0% (0.0%)	26.0% (12.0%)	26.0
Complain about illegal fees	5.3% (3.0%)	1.6% (1.0%)	10.0% (5.0%)	8.4

Actions to address the cost of service focused on complaining about high fees or requesting free or reduced fees for health services, or helping people gain access to health insurance. In Tanzania, the majority of maternal and neonatal health services were provided free of cost at public facilities, so it is logical that communities did not focus on this. Another way to address the cost of service is to complain about illegal fees—something we saw in both countries, but that was more prevalent in Tanzania, where it represented 10.0% of the actions in this pathway. In Indonesia, the health system is decentralized and the cost of service varied by district. Although there were some districts where MNH services were free, the majority of the communities in the T4D program were in districts where payment for MNH services was not only required, but relatively expensive: the average cost for delivery (of those who paid) in our baseline sample was 100 USD.³⁷ Therefore it makes sense that participants in a greater percentage of communities in Indonesia than Tanzania focused on cost reduction at the health facility.

The other approaches in this pathway were aimed at providing more money for health service seekers—which could be used for expenses not covered by the health

37 Arkedis, J. et al. (2016).

facility (such as transportation, time away from home, or personal supplies for delivery). Within this grouping, one particular goal—group entrepreneurship actions—was exclusive to Tanzania. We learned from the ethnographic work of a widespread belief that “Magufuli money” (loans from a government program initiated by current Tanzanian President John Magufuli) would be available to citizen-organized entrepreneurship groups. This could explain the proliferation of actions with this goal in Tanzania specifically, as opposed to general fundraising and savings pools, which we saw in both countries.

Improved information and communication

There were notable differences between the Indonesian and Tanzanian villages in the improved information and communication category. In Indonesia, the actions in this category were split between three different goals: cost information (71.4% of the actions), complaint mechanisms (10.0%) and hours information (18.6%). In Tanzania, information and communication actions exclusively focused on complaint mechanisms (see *Table 21*).

.....
Table 21. Improved Information and Communication by Goal & Country

Goal	Frequency within Pathway (% of Villages Overall)			
	Overall	Indonesia	Tanzania	Difference
Cost transparency	46.3% (16.0%)	71.4% (32.0%)	0.0% (0.0%)	71.4
Complaint mechanism	41.7% (21.5%)	10.0% (7.0%)	100.0% (36.0%)	90.0
Hours transparency	12.0% (6.0%)	18.6% (12.0%)	0.0% (0.0%)	18.6

The reasons for these differences might have stemmed from intervention differences in the two countries. First, the scorecard in Indonesia included information on whether or not cost of services was displayed clearly at the health facility, whereas the scorecard in Tanzania did not (this was because in Tanzania, MNH services are

provided free at public health facilities).³⁸ Second, unlike the program in Indonesia, the program in Tanzania included a social action story that featured a facility suggestion box.

Improved facility infrastructure

As illustrated in *Table 22*, there were also notable differences between the Indonesian and Tanzanian villages in the improved facility infrastructure category. In Indonesia, 100% of the actions were aimed at fixing or improving facility infrastructure such as electricity and water. In Tanzania, half (50.0%) of the actions focused on similar infrastructure issues, whereas the other half were aimed at building a maternity resting home so women close to their due dates could wait near the dispensary (28.6%) or constructing a placenta pit for culturally appropriate placenta disposal (21.4%).

.....
Table 22. Improved Facility Infrastructure by Goal & Country

Goal	Frequency within Pathway (% of Villages Overall)			
	Overall	Indonesia	Tanzania	Difference
Fix or improve health facility infrastructure	82.7% (22.5%)	100.0% (32.0%)	50.0% (13.0%)	50.0
Maternity home	9.9% (4.0%)	0.0% (0.0%)	28.6% (8.0%)	28.6
Construct placenta pit	7.4% (3.0%)	0.0% (0.0%)	21.4% (6.0%)	21.4

Like variation seen in the improved information and communication pathway, at least some of these differences can likely be attributed to the intervention design. In Tanzania, during the Scorecard meeting, the facilitator cited an example of a community digging a placenta pit at a health facility. A placenta pit is a disposal site one might find at or near a health facility in Tanzania. Placenta pits are not common in Indonesia, and this example was not used in the Indonesian Scorecard meeting.

.....
³⁸ Information on whether or not operating hours were displayed was presented in both countries.

2.3.3 Action completeness

There were differences across action pathways and between the two countries in the frequency with which actions designed were completed. As described earlier in this paper, overall, communities self-reported completing 57.6% of designed actions by the 90-Day Follow-Up meeting. Indonesian communities reported completing 53.0% of actions and Tanzanian communities 65.2% of actions. See the section “Completion status” and *Tables 3 and 4* for more insight into these overall differences.

Table 23 shows completion status by pathway, both overall and by country. Looking at completion status by theory of change pathway reveals variation in completion status between the pathways. Excluding those pathways with limited observations (improved facility cleanliness, improved provider knowledge, increased or improved facility staffing, non-health system directed community solutions) completion ranged from 57.1% to 82.9% by pathway.

There are several plausible explanations for why there was such a wide range in completeness across the different pathways. First, there were certain action pathways geared more toward longer-term actions, such as major infrastructure projects or supply chains, and it was unlikely that longer-term actions would be completed within the ninety-day window of the project. Improved facility infrastructure; increased availability of drugs, supplies, or other inputs; and improved facility access (when solved by building a closer health facility) were all pathways for which we would expect actions to take longer to complete, and these are indeed the three pathways with the lowest proportion of actions completed (57.1%, 57.1%, and 59.2%, respectively). Conversely, other types of actions—most notably education actions—represented “quick wins:” low effort actions that could be completed quickly. The action pathway with the highest completion status—increased awareness, knowledge & improved community attitudes (82.9%)—comprised mainly community education actions.³⁹

.....
 39 Education actions were considered “complete” if they occurred. This does not necessarily mean the education led to a change in knowledge or behavior.

Table 23. Proportion of Villages Designing Actions by Pathway, by Country (All, Completed & % Completed)⁴⁰

Pathway	Indonesia			Tanzania			Total		
	All	Completed	% Completed	All	Completed	% Completed	All	Completed	% Completed
	C1: Increased awareness, knowledge & improved community attitudes	92.0%	69.0%	75.0%	95.0%	86.0%	90.5%	93.5%	77.5%
C2: Improved facility access	79.0%	58.0%	73.4%	63.0%	26.0%	41.3%	71.0%	42.0%	59.2%
C3: Increased ability to pay (including demand-side cost solutions)	44.0%	26.0%	59.1%	46.0%	31.0%	67.4%	45.0%	28.5%	63.3%
C4: Bylaws, partnerships, or interventions aimed at health service uptake	16.0%	9.0%	56.3%	54.0%	43.0%	79.6%	35.0%	26.0%	74.3%
C5: Improved attitude, effort, or trust of provider	41.0%	30.0%	73.2%	31.0%	23.0%	74.2%	36.0%	26.5%	73.6%
C6: Improved information & communication (cost, opening hours, etc.)	42.0%	36.0%	85.7%	36.0%	26.0%	72.2%	39.0%	31.0%	79.5%
C7: Improved facility cleanliness	10.0%	8.0%	80.0%	2.0%	1.0%	50.0%	6.0%	4.5%	75.0%
C8: Improved provider knowledge	2.0%	1.0%	50.0%	0.0%	0.0%	N/A	1.0%	0.5%	50.0%
C9: Increased availability of drugs, supplies, other inputs	45.0%	27.0%	60.0%	11.0%	5.0%	45.5%	28.0%	16.0%	57.1%
C10: Increased or improved facility staffing	16.0%	12.0%	75.0%	19.0%	12.0%	63.2%	17.5%	12.0%	68.6%
C11: Improved facility infrastructure	32.0%	24.0%	75.0%	24.0%	8.0%	33.3%	28.0%	16.0%	57.1%
G: Non-health system directed community solutions	18.0%	10.0%	55.6%	0.0%	0.0%	N/A	9.0%	5.0%	55.6%

⁴⁰ *Italics denote limited observations.*

Country differences

It is also possible that the difference in completion status was driven by between-country variation. There are three pathways for which the difference in completeness in Indonesia and Tanzania was greater than 20%.⁴¹ We explore the three pathways in turn.

Improved facility access

Nearly three quarters (73.4%) of actions that focused on improving facility access were completed in Indonesia, compared with only 41.3% in Tanzania. What accounts for this difference? The most likely factor was the longer-term nature of actions in Tanzania compared to those in Indonesia. *Table 19* reveals that over half (52.4%) of the Tanzania actions within this pathway were requests for or efforts to build a new health facility. This action goal represented only 19.2% of the pathway in Indonesia. It would be nearly impossible to have secured a new health facility within the three-month period of the program itself, meaning that we would anticipate the majority of the Tanzanian actions in this category to be unfinished.

Bylaws, partnerships, or interventions aimed at health service uptake

In contrast to improved facility access, communities in Tanzania were far more likely to complete actions in the bylaws, partnerships, or interventions aimed at health service uptake pathway than communities in Indonesia (79.6% vs. 56.3%). One potential explanatory factor is that there were limited observations in this category for Indonesia. While participants in more than half (54.0%) the villages in Tanzania designed an action within this pathway, only 16.0% in Indonesia did. Also, there was a lot of variation between the two countries in the specific action goals. The majority (62.3%) of these actions in Tanzania (as shown in *Table 17*) were bylaws, local laws that could be quickly passed at the village level.

Improved facility infrastructure

The final pathway with large variation in completeness between countries was improved facility infrastructure. Three quarters (75.0%) of these actions were reported as completed in Indonesia, versus just a third (33.3%) in Tanzania.

.....
⁴¹ Excluding those pathways with limited variation.

As shown in *Table 22*, in Indonesia, the exclusive goal (100%) within this pathway was to fix or improve health facility infrastructure. This mainly consisted of communities asking for certain reforms at the health facility, and many reported these actions as completed if the request was simply made, not if the reforms were achieved. By contrast, in Tanzania, only half the actions (50.0%) had this goal, whereas the other half were to construct a maternity home (28.6%) or a placenta pit (21.4%), actions that typically involved mobilizing the community to complete construction projects, rather than asking the government or others to do so. Like building a new health facility, these were potentially longer-term actions (or at least actions that involve more sustained energy) making them less likely to be completed within three months.

3. Social Accountability Analysis

So far the analysis has focused on trends in social actions as they relate to the MNH outcomes that communities sought to address. However, these actions can be categorized in other important ways that provide insight into how the T4D intervention, and other similar interventions, have the potential to influence health. This intervention was designed as a transparency and accountability, or social accountability, intervention; however, we made a deliberate decision to leave the design of the social actions open to the communities that participated in the intervention.⁴² As such, the actions designed by communities were open to include a mix of traditional social accountability activities and activities that used other approaches to improving MNH. One useful way to assess trends in social actions is whether and how they were focused on achieving improvement through the mechanism of accountability or through a different mechanism.

For this analysis, we define social accountability actions as actions implemented by citizen, civil society, or service provider beneficiaries that seek to improve the responsiveness of government officials and/or service providers to make improvements in the services, policies, and programs for which they are responsible. In other words, there are three important criteria that define social accountability actions: (1)

.....
⁴² A detailed description of this design principle can be found in “[Citizen Voices, Community Solutions](#).” Transparency for Development Team (2017).

they are implemented by citizens or civil society, (2) they seek to address a problem that is the responsibility of government or service providers, and (3) they seek to address this problem by influencing the actions of the government or service provider responsible.⁴³

While all of the analyzed actions meet the first criteria, actions took many different approaches to who was targeted as well as how they were targeted. Further, many actions that communities designed and completed took a different approach than social accountability to address a specific health problem. This section frames and presents the analysis of how actions differed by target and strategy as well as the types of actions by approach (including non-social accountability actions). We present this analysis to provide information regarding whether and how communities decide to use accountability or other approaches to improve health.

“Five Worlds” of Service Delivery

The theoretical underpinning of the T4D project is a framework known as the “five worlds” of service delivery, outlined in detail in Kosack and Fung’s paper *Does Transparency Improve Governance?*⁴⁴ This framework helps us understand contextual factors that influence the pathways by which T/A programs, like the T4D intervention, might translate into improved services, by examining three schemata:

1. the action cycle;
2. the short and long routes of accountability; and
3. the willingness of providers, policy makers and politicians to make improvements.

First, the action cycle, developed by Fung et al. in *Full Disclosure: the Perils and Promise of Transparency*,⁴⁵ describes how information becomes useful by outlining a succession of four steps by which successful transparency policies induce public authorities to improve practice. The steps are: 1) salient and accessible information is

.....
43 Because all T4D intervention communities were provided with information in the Scorecard Meeting, we do not explicitly include “information” as a criterion for our analysis.

44 Kosack, S. Fung, A. (2014).

45 Fung, A. et al. (2007).

provided, which 2) causes users to change decisions and actions; 3) the new actions are salient or consequent to providers, who 4) respond constructively.

The second framework is the short and long routes of accountability, which were first put forward in the World Bank's 2004 *World Development Report*.⁴⁶ In the "short route," citizens (as consumers of public services) request or induce improvements directly with front-line service providers, whereas in the "long route" they do so by asking government actors, such as policy makers or politicians, who in turn exercise their supervisory responsibilities to improve supply chains or press front-line service providers to improve their performance.

Finally, the willingness of short and long route actors to make improvements varies. In some circumstances, provider and/or government actors may be enthusiastic partners in improving the quality of public services, whereas in others they may be resistant to reform. Such willingness or resistance may influence the effectiveness of approaches citizens take that are collaborative (e.g., joint problem solving between communities and providers) versus those that are more confrontational (e.g., naming and shaming, as encouraged by social audits).⁴⁷

When combined, these three frameworks translate into five "worlds" of service delivery: varied contexts in which transparency could lead to service improvement through different hypothesized mechanisms. The five worlds are summarized in *Figure 5*.

.....
46 World Bank (2004).

47 Bately, R. (1999); Fung, A. (2006); Fung, A. Wright, E. O. (2003); Joshi, A. (2008); Joshi, A. Houtzager, P. P. (2012).

Figure 5. The Five Worlds of Service Delivery⁴⁸

World	Service Context	Contribution of Information	Accountability Path	Collaboration or Confrontation
1	Competition between providers	Inform individual choices	Short route	N/A (exit options)
2	Providers willing (or have incentives) to engage in reform	Feed collaborative problem solving	Short route	Collaboration (e.g., joint problem solving)
3	Providers unwilling to reform; community tries to pressure them	Increase pressure and accountability on service providers	Short route	Confrontation (e.g., social audits)
4	Providers unwilling; policy makers willing to reform	Enable policy makers to enact top-down reform	Long route	Collaboration
5	Providers unwilling and policy makers unwilling	Build countervailing power to increase accountability	Long route	Confrontation

The social action plans allow insight into two of the three schemata: accountability path and the choices of participants to pursue confrontational or collaborative approaches. Both are explored below.

Accountability Targets

As described above, there are broadly two targets through which citizens may use accountability to press for improvement of a public service. The first, known as the “short route,” targets front-line service providers, which in the case of T4D, are the health providers or managers at the local health facilities. The second, known as the “long route,” targets the government (typically policy makers or politicians) or anyone who has formal or informal power or authority over their performance. Examples of long route approaches include advocating for reform and voting.⁴⁹

Table 24 shows action by ultimate target. Ultimate targets are those whose behavior the CRs were ultimately trying to change and/or those whose help or authority was sought in influencing the behavior of the ultimate target. We divided long route actors into two categories: those in village level governments and those above the village

⁴⁸ Modified from Table 2 in Kosack, S. Fung, A. (2014).

⁴⁹ Kosack, S. Fung, A. (2014).

level. The reason for the distinction is that, while they are formally long route actors, those in the village government may not have the same degree of authority over the health system or service provider as government actors above the village level. The table contrasts these targets with members of the broader community—a frequent target of the social actions who are outside of the social accountability framework.

.....
Table 24. Actions by Ultimate Target⁵⁰

Target	Overall	Indonesia	Tanzania
Community	59.5%	50.2%	76.4%
Health Provider – Short Route	35.1%	39.6%	27.4%
Government (village level) – Long Route	22.1%	17.5%	30.0%
Government (above village level) – Long Route	7.9%	5.6%	11.8%
Other (including TBA)	4.4%	4.5%	4.3%
Unclear	0.1%	0.0%	0.2%

At 59.5% overall (and 50.2% and 76.4% in Indonesia and Tanzania, respectively) the community was the most common target of social actions. This can be explained largely by the prevalence of community education actions (designed by participants in 93.5% of communities). In addition, CRs designed a number of actions in which the community was asked to “substitute” for government responsibilities. Substitution is described in more detail below, but an example was rallying the community to build a toilet at the health facility.

The health provider was the second most prominent target (35.1%), suggesting that participants in most communities chose short route approaches. The prevalence of short-route targets, paired with the prevalence of collaborative actions (discussed above), suggest a high number of communities contextualizing themselves within “world 2” of the five worlds framework: those with providers willing to engage in reforms and other improvements.

By contrast, above-village government actors (e.g., policymakers) represent long route accountability in circumstances where short route methods fail (citizens find themselves in a “world 4” scenario where providers are unable or unwilling, but policymakers

.....
⁵⁰ Some actions had more than one ultimate target, hence columns adding up to greater than 100%.

are). Only 7.9% of the actions targeted these types of actors.⁵¹ The five worlds framework predicts that communities would not take this approach when short route approaches were available, as the short route is quicker and easier. But as others have noted,⁵² there may also be other reasons. For example, citizens may have been uncomfortable approaching higher-level government officials, or may have been unaware of or unable to navigate the formal chains of accountability above their village government or front-line service providers. Indeed the third most common target was the village government (22.1%), which does not generally exercise formal power over the health provider, but could have played an important role as broker or ally for community members who wished to approach either the health provider or higher levels of government.

It is also important to note that actions were not static; many of them evolved over time. Though our data does not enable us to analyze the evolution of actions in a systematic way, we did see examples of CRs taking one approach and then changing course when the original approach did not work. This sometimes meant changing targets of the action from short route to long route actors. See *Box 4* for an example.

Box 4. Action Evolution in Indonesia

In an Indonesian village, the CRs believed that a lack of clarity on cost was impacting community members’ decisions on whether to seek care. “The community is afraid to check their health in the health facility,” explained one representative, “because they don’t know the estimated cost.” The CRs’ first step was to meet with the village headman. In this meeting, the CRs asked him to set up a consultation with a local midwife, so that the CRs could advocate for a cost information board to be erected in the facility. The meeting took place a few days later, but while sympathetic, the midwife said she could not provide the representatives with what they wanted. “Cost information can be shared,” she explained, “but [according to the district health office] it cannot be [posted] on the bulletin board. . . .” While disappointed, the CRs were not deterred. In their final Follow-Up meeting, they designed a new action to reach out to the district health office directly for permission to post the cost information in the health center.

.....
 51 T4D Phase 2 aims to stimulate more long-route actions. See Kosack, S. Creighton, J. Tolmie, C. (2017).

52 Fox, J. (2007); Fox, J. (2015); Fung, A. (2001); Fung, A. Graham, M. Weil, D. (2007); Joshi, A. Houtzager, P. P. (2012).

The very few “other” targets included brokers, the media, and TBAs. This was despite social action stories presented as part of the intervention that explicitly mentioned two of these targets: brokers and the media.

Confrontational and Collaborative Strategies

Front-line service providers, such as health workers, may be willing to help improve the quality of health services or health facilities, or they may resist reforms. The same applies to the government officials who supervise them. Reasons for resistance include the potential of extra work or the loss of independence.⁵³ Potential collaborators outside of service providers or government officials include brokers or reform-minded individuals who simply do not have the resources or official authorization to make changes.

Many T/A interventions are designed to encourage or incentivize a particular type of approach. For example, community scorecards are often paired with collaborative interface meetings with frontline providers that may lead citizens towards a collaborative approach to problem solving with providers, an example being citizens working with their local health provider on a grant proposal to fund a new toilet at the health facility. By contrast, social audits, another common approach, include a component in which citizens explicitly confront government officials with problems.

The T4D program is unusual in that it neither urged participants to take particular types of actions nor encouraged these actions to be confrontational or collaborative—both were left entirely up to participants. *Table 25* shows the strategies participants in the two diverse country contexts chose.

.....
Table 25. Actions by Strategy (Collaborative or Confrontational)

Strategy	Overall	Indonesia	Tanzania
Collaborative	90.9%	88.0%	95.7%
Confrontational ⁵⁴	5.5%	7.0%	3.1%
Unclear	3.6%	5.0%	1.2%

.....
 53 Kosack, S. Fung, A. (2014).

54 For the purposes of this analysis, an action was considered confrontational if it included at least one confrontational element.

The strategies participants in T4D communities chose were overwhelmingly collaborative: for example, collaborating with allies or making requests through official channels. In Indonesia, 88.0% of actions were collaborative; only 7.0% were confrontational. Tanzanian participants were nearly universally collaborative: 95.7% of actions were collaborative, versus 3.1% that were confrontational. In addition, confrontational actions were typically only mildly confrontational: mainly complaining or, in limited circumstances, naming and shaming.

This pattern was not driven by the volume of education actions (which, by their nature, were collaborative). As shown in *Table 26*, even if we exclude education actions, the actions were overwhelmingly collaborative.

.....
Table 26. Actions by Strategy (Collaborative or Confrontational) – Excluding Education Actions

Strategy	Overall	Indonesia	Tanzania
Collaborative	88.1%	84.3%	94.0%
Confrontational ⁵⁵	7.6%	9.8%	4.3%
Unclear	4.3%	5.9%	1.7%

This finding suggests that when a T/A program does not prescribe a particular strategy, those who participate will generally choose to be collaborative. It is also possible that most communities in our sample diagnosed their providers and as “willing,” placing them within worlds 2 or 4 of the five worlds framework. There are also a number of additional factors that could explain what we saw: for example, both CHAI and the ethnographers in Tanzania predicted collaborative approaches, citing the non-confrontational culture in Tanzania. Another is simple self-interest—the CRs live in these communities, so they needed to be very careful to avoid approaches that could alienate them from their communities or from those in positions of power. Though we do not have enough data to accurately quantify, it is also worth noting that we have information that at least some actions started out collaborative and turned confrontational and vice versa.

.....
⁵⁵ For the purposes of this analysis, an action was considered confrontational if it included at least one confrontational element.

Beyond Social Accountability: Broader Approaches for Fixing Problems

While we observed diversity in the targets and strategies used by participants in designing and carrying out actions, we also observed that participants went well beyond social accountability when making plans to improve MNH. Rather than using voice, many tried to fix the problems themselves; they intended to take on new responsibility, including, in several communities, responsibilities that are often the government's. In other cases, participants urged their village governments to take on new responsibilities.

As described above, there are three critical components of social accountability actions: (1) they are implemented by citizens or civil society, (2) they seek to address a problem that is the responsibility of government or service providers, and (3) they seek to address this problem by influencing the actions of the government or service provider responsible. The actions designed and implemented in this program all meet the first criteria, but the second and third are not always met.

Transportation pools, community education, efforts to improve the facility's infrastructure, and most of the other approaches that participants planned are all attempts to fix problems that might be the responsibility of the "supply side" (government or public service providers), of the community ("demand side"), or both, depending on the political context. Further, participants may seek to fix a given problem themselves, or they may seek solutions that are developed, organized, coordinated, supported, funded, and implemented by the government and/or service providers. Theoretically we can distinguish four ideal types (shown in *Figure 4*) according to 1) where responsibility for each problem lies and 2) who ends up actually fixing the problem:

1. **Social accountability.** These include actions for which participants were seeking to influence government officials or service providers to fix a problem that was the responsibility of these supply side actors. Among the approaches participants designed, examples included: citizens requesting that health officials reprimand a midwife who was frequently absent from work, petitioning the facility-in-charge to stop requesting informal payments from patients, and requesting the repair of the health facility's generator.
2. **Innovation.** We use this term to describe actions in which participants were seeking to influence government officials or service providers to do something to fix a

problem that was not their formal responsibility (creating policy/responsibility in real time). Examples of this included: creating bylaws, and advocating for lower service fees, ambulances, or closer facilities (to the extent that these were not responsibilities of the state).

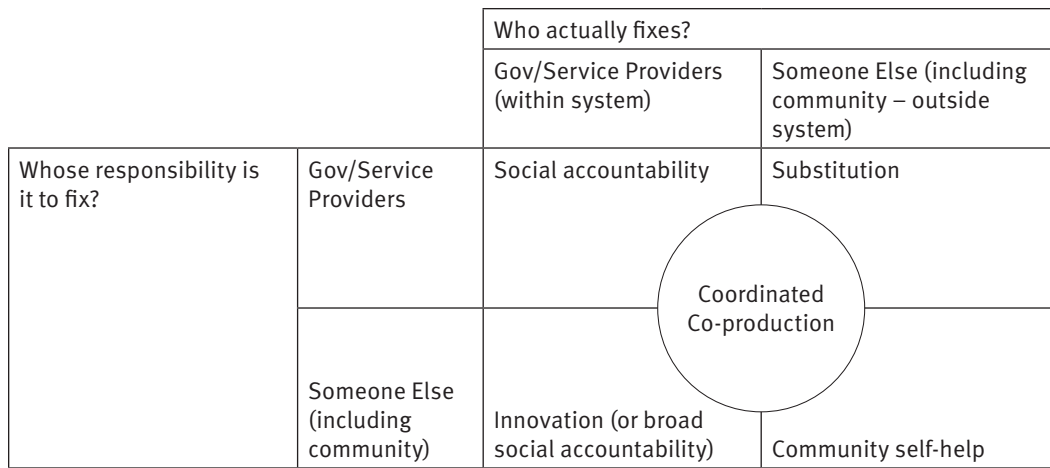
3. **Substitution.** This term refers to actions undertaken by participants in which they or other non-state actors acted to fix a problem that was officially a responsibility of the government or service providers. An examples of this included: citizens fixing broken or damaged equipment at the facility when it was in fact the state’s responsibility to ensure functioning supplies and equipment.
4. **Community self-help.** The final category of action refers to those in which participants sought to fix a problem that they identified that was not the formal responsibility of the government or service providers. The most widespread example in the action plans were education activities encouraging the uptake of MNH services. Another example was finding housing for the midwife in the village (assuming that there was not a law or policy stating that the government must provide housing for health workers).

.....
Figure 6. Four Ways to Solve Public Problems

		Who actually fixes?	
		Gov. or service providers (supply side)	Someone else (including community – demand side)
Whose responsibility is it to fix?	Gov. or service providers	Social accountability	Substitution
	Someone else (including community)	Innovation (or broad social accountability)	Community self-help

Each of these are ideal points; in the middle of these we might distinguish a fifth type, shown in *Figure 7*, in which solutions that are neither the government’s responsibility nor the community’s are coordinated and co-produced.

Figure 7. Coordinated Co-Production



To better understand where the T4D-inspired actions fit in this framework, in *Table 27* we grouped the plans into the four categories noted in *Figure 6*: social accountability, substitution, innovation, and community self-help. The majority of the actions (51.4%) were classified as community self-help, driven by the large proportion of education activities. What was surprising, given the intervention, is how few were classified as social accountability—only about a quarter (25.7%). Another quarter (27.0%) were innovation, and fewer than 5% (4.5%) were substitution.

Table 27. Actions by Social Accountability Type⁵⁶

Social Accountability Type	Overall	Indonesia	Tanzania
Social Accountability	25.7%	28.8%	20.3%
Innovation	27.0%	23.6%	32.6%
Substitution	4.5%	3.6%	5.9%
Community Self-Help	51.4%	54.7%	45.9%

⁵⁶ Because actions could be classified into more than one social accountability type, the total adds up to greater than 100%.

The categorization by country exhibited a similar pattern, though social accountability and community self-help approaches were slightly more common in Indonesia, and innovation slightly more common in Tanzania. The similar pattern could mean that citizens in both countries faced similar problems (that called for similar responses). It also suggests a similar tendency to rely first on self-help.

CONCLUSION

What did we learn from analyzing the plans designed by participants in the T4D communities?

Firstly, in all T4D communities, participants planned social actions. The minimum number was two, and most planned several. Most also at least attempted these actions; in fact, all but eleven communities—representing close to 95% of the intervention villages—reported completing at least one action. This was certainly not guaranteed considering the T4D intervention was voluntary and participants were not paid to undertake actions.

Secondly, the social actions were diverse in nature. One question we had when designing the T4D intervention was whether participant groups would each design actions unique to their community’s circumstances, or whether they would all converge around a small number of action types. We saw a wide range of actions—forty-three types—which we were able to classify into eleven distinct pathways along the T4D theory of change, and an additional pathway outside of the theory of change.

Despite the wide-range in actions, there was one striking similarity across nearly all T4D communities: 93.5% designed at least one community education-focused action. Other common actions included attempts to build or request a new health facility (34.5% of communities), providing feedback on facility staff performance (32.5%), and advocating for ambulance services (25.5%).

Because we examined a similar intervention in two countries, we were able to explore differences between what communities designed in two very different places. We found a lot of consistency in the action pathways targeted by communities in the two countries; a high number in each designed actions aimed at increasing or

improving awareness, knowledge, and attitudes (93.5% overall); improving facility access (71.0%); and easing the ability to pay (45.0%). Very few in each country designed actions aimed at facility cleanliness (6.0% overall) or improving health provider knowledge (1.0%).

The main between-country differences were in three pathways: bylaws, partnerships, or other interventions aimed at increasing health uptake (16.0% in Indonesia, 54.0% in Tanzania); increased availability of drugs, supplies, and other inputs (45.0% in Indonesia, 11.0% in Tanzania); and non-health system directed community actions (18.0% in Indonesia, none in Tanzania). We also found notable country differences within certain pathways. For example, even though a majority of T4D communities in both countries aimed to improve facility access, they went about it in different ways. Over half (52.4%) of the villages in Tanzania that aimed to improve facility access planned to build or request a new health facility, whereas only 19.2% in Indonesia did the same, though in Indonesia the T4D communities were much more likely to attempt actions aimed at improving transportation, such as requesting an ambulance or self-organizing community-based transportation.

We attribute between-country differences in the T4D communities to three main factors: 1) differences in context that have to do with different health barriers in the two countries, 2) differences in context that have to do with path dependency, such as previous exposure to similar programs and replicating what was done in the past, and 3) intervention design and implementation differences.

We also observed differences in how frequently participants completed their actions across the different action categories. Unsurprisingly, increased awareness, knowledge & improved community attitudes was the pathway most likely to be completed. This pathway comprised mainly education actions, which were often implemented by the CRs themselves, avoiding the need to navigate complex social accountability chains. We attribute differences in completion status to two factors: 1) between-country differences, and 2) short- vs. long-term actions.

When we analyzed the actions from a social accountability lens, we found three striking trends. Firstly, the actions were overwhelmingly collaborative in nature. This was not driven by the volume of education actions, and suggests that when a T/A program does not prescribe a particular strategy, communities will choose to be

collaborative. Secondly, the majority of the actions were short route, that is they targeted the health facility or provider directly, rather than government officials higher up the accountability chain. This was especially true in the case of government actors above the village level. Our assessment is citizens may have been uncomfortable approaching higher-level government officials, or may have been unaware of or unable to navigate the formal chains of accountability above their village government or front-line service providers.⁵⁷ Finally, when classified by accountability “type” we found a similar breakdown by country, with more than half of communities in both Indonesia and Tanzania taking a self-help approach, about a quarter pursuing solutions through social accountability, and another quarter pursuing solutions that entailed additional responsibility by their governments (what we label “innovation”).

In sum, one key aspect of the T4D intervention is it was non-prescriptive, creating space for T4D communities to design actions fitting the unique circumstances of their respective villages. This meant it was impossible to know in advance what they would choose to do. Our analysis of these plans gives insight into what activities citizens choose to undertake if given the liberty to decide.

.....
57 We attempt to explore this issue further with an adapted intervention design in Phase 2 of the T4D project. See Kosack, S. Creighton, J. Tolmie, C. (2017).

APPENDICES

Appendix A. Social Action Plan Templates for Indonesia and Tanzania

Indonesia

Action Title:						
Action's Measure of Success:						
Obstacle(s) to be overcome:						
Action's Person in Charge:						
Steps	Person in charge	Materials, tools, equipment needed	Duration	How is success measured?	Progress	
					1. Has anything been done on this step? Explain 2. Is this step finished? (Y/N)	
					1. Has anything been done on this step? Explain 2. Is this step finished? (Y/N)	
					1. Has anything been done on this step? Explain 2. Is this step finished? (Y/N)	
Additional volunteers for this action (from open meeting):						

Tanzania

Action Title:							
List Steps	Responsible Person	What tools or community resources are needed?	Timeline/ Deadline	How is success measured?	Successes	Challenges	

Appendix B. Description of Social Action Goal Types

Goal	Description	Logic Model Pathway	ToC Classification
Additional staff (midwife, doctor, etc.)	Refers to requests for a doctor, midwife, or other health facility staff, including requests for more experienced staff (higher credentials) or female staff specifically.	Increased or improved facility staffing	C10
Address distance or transportation - general	Improved facility access, dealing with the distance barrier, but too vague to categorize further.	Improved facility access (transportation, new facility, longer facility hours, outreach services)	C2
Advocate for reduced cost of service	Refers to requesting free or reduced cost services or complaining about high cost of service.	Increased ability to pay	C3
Ambulance info	Publishing information so people know about ambulance availability and/or cost (includes education campaigns around ambulances).	Improved facility access (transportation, new facility, longer facility hours, outreach services)	C2
Blood bank	Refers to establishing a blood bank,	Increased availability of drugs, supplies and other inputs	C9
Blood type identification	Refers to community members getting their blood type identified.	Increased awareness, knowledge and improved community attitudes	C1

Goal	Description	Logic Model Pathway	ToC Classification
Build or request a new facility	Refers to building or requesting a new health facility (excluding Posityandu).	Improved facility access (transportation, new facility, longer facility hours, outreach services)	C2
Bylaws	Refers to establishing a bylaw or other legal measure requiring/encouraging the uptake of MNH services. Also categorized by “bylaw goal” for greater granularity.	Bylaws, partnerships, or other interventions aimed at health system uptake	C4
Community mosquito spraying	Refers to spraying the community to reduce mosquitos.	Community self-help - not facility directed (healthier behaviors, nutrition, etc.)	G
Community organized transportation	Refers to identifying community members with cars or motorcycles to serve as an ambulance, fundraising to purchase an ambulance, purchasing a motorcycle to be used as an ambulance, etc.	Improved facility access (transportation, new facility, longer facility hours, outreach services)	C2
Community well	Building or advocating for a water source for the community.	Community self-help - not facility directed (healthier behaviors, nutrition, etc.)	G
Complain about illegal fees	Refers to complaining about irregular fees for service.	Increased ability to pay	C3
Complaint mechanism	Includes complaint boxes, complaint hotlines, and committees or groups aimed at delivering suggestions to the health facility.	Improved information and communication (cost, opening hours, etc.)	C6
Construct placenta pit	Refers to constructing a placenta pit.	Improved facility infrastructure	C11
Cost information	Includes displaying cost information and education campaigns around cost.	Improved information and communication (cost, opening hours, etc.)	C6
Create incentives for expecting mothers to go to check-ups	Refers to creating additional incentives for mothers to go to the clinic.	Bylaws, partnerships, or other interventions aimed at health system uptake	C4
Customer service	Refers to improving the customer service at the clinic, including examining better performing clinics, highlighting the best performing healthcare workers, and improving comfort.	Improved attitude, effort, trust of the provider (includes increased availability of provider)	C5
Educate TBAs	Refers to mobilizing and educating TBAs against the risks of home deliveries and having them refer mothers to health facilities.	Bylaws, partnerships, or other interventions aimed at health system uptake	C4

Goal	Description	Logic Model Pathway	ToC Classification
Education or socialization	Refers to some sort of socialization/education action, typically concerning the importance of the 3 health levers. This can include direct (door-to-door) visits, formal classes, etc. Also categorized by “socialization topic” for greater granularity.	Increased awareness, knowledge and improved community attitudes	C1
Facility cleanliness	Refers to cleaning the facility or complaints about the cleanliness of the facility.	Improved facility cleanliness	C7
Feedback on facility staff performance	Refers to monitoring the midwife’s performance and service delivery, especially following complaints. Includes interface meetings between the community members and the midwife or other health facility staff. Also includes asking the midwife to improve or offer routine services.	Improved attitude, effort, trust of the provider (includes increased availability of provider)	C5
Fix or improve health facility infrastructure	Refers to fixing electricity, telecommunications, water, and other main infrastructure, including privacy, beds, toilets and adding extra space or services to the facility. Also categorized by “infrastructure goal” for greater granularity.	Improved facility infrastructure	C11
Fix road	Refers to fixing or building new roads, bridges, or procuring inflatable boats.	Improved facility access (transportation, new facility, longer facility hours, outreach services)	C2
Funds for baby food	Refers to raising funds for additional food for babies.	Community self-help - not facility directed (healthier behaviors, nutrition, etc.)	G
Group entrepreneurship to raise income	Refers to starting some type of group entrepreneurship activity to raise incomes so that families can afford maternity costs.	Increased ability to pay (demand side)	C3
Healthy mother or child competition	Refers to holding a competition to motivate communities to be healthy.	Community self-help - not facility directed (healthier behaviors, nutrition, etc.)	G
Help people access health insurance	Refers to helping people gain access to health insurance.	Increased ability to pay	C3
Hours information	Refers to asking for information on facility operating hours and displaying this information publicly.	Improved information and communication (cost, opening hours, etc.)	C6
Hygiene/cleaning campaign	Refers to general community hygiene and cleaning.	Community self-help - not facility directed (healthier behaviors, nutrition, etc.)	G
Improve midwife capacity	Refers to educating or training midwives.	Improved provider knowledge	C8

Goal	Description	Logic Model Pathway	ToC Classification
Longer facility hours	Refers to increasing the hours of the clinic, mainly requesting 24-hour service.	Improved facility access (transportation, new facility, longer facility hours, outreach services)	C2
Maternity home	Refers to building or improving a maternity home for mothers to wait prior to delivery and/or after giving birth.	Improved facility infrastructure	C11
Midwife residence in village	Refers to asking the midwife to live in the village, enforcing that s/he lives in the village, or attempting to procure a midwife residence.	Improved attitude, effort, trust of the provider (includes increased availability of provider)	C5
Midwife-TBA partnerships	Refers to midwife partnerships with baby dukun or TBAs.	Bylaws, partnerships, or other interventions aimed at health system uptake	C4
Mobile clinic or outreach services	Refers to the creation of a mobile maternity clinic or advocating for outreach services from the local health facility, including asking midwives to provide services during home visits. This also includes (in Indonesia only) starting a new Posyandu, building a physical Posyandu structure, or reactivating the Posyandu cadre.	Improved facility access (transportation, new facility, longer facility hours, outreach services)	C2
Plant garden	Refers to planting a medicinal herb garden.	Community self-help - not facility directed (healthier behaviors, nutrition, etc.)	G
Pregnancy test	Refers to schools administering pregnancy tests to girls [to encourage them to attend prenatal care].	Bylaws, partnerships, or other interventions aimed at health system uptake	C4
Raise community funds for delivery or other maternity costs	Refers to raising community funds to help defray health facility costs.	Increased ability to pay (demand side)	C3
Registry of men	Refers to creating a registry of men who do not support their partners or otherwise participate in MNH (punitive measure).	Bylaws, partnerships, or other interventions aimed at health system uptake	C4
Request ambulance	Refers to requesting an ambulance, mainly for the purpose of taking women in labor to the health facility.	Improved facility access (transportation, new facility, longer facility hours, outreach services)	C2
Savings pool for delivery or other maternity costs	Refers to creating savings groups to alleviate the cost of maternity service (such as tabulun in Indonesia).	Increased ability to pay (demand side)	C3
Sports day for women	Refers to creating a sports day for women.	Community self-help – not facility-directed (healthier behaviors, nutrition, etc.)	G

Goal	Description	Logic Model Pathway	ToC Classification
Stock of drugs, equipment and supplies	Refers to complaining about a shortage of medicines or supplies, or otherwise attempting to procure additional medicines, supplies and equipment.	Increased availability of drugs, supplies and other inputs	C9
Not included in analysis			
Vague requests	Refers to vague requests for meetings, fundraising, or unclear activities that could not be categorized.	Other – too vague to characterize	Other – too vague to characterize
Official establishment of CR group	Refers to activities related to long-term sustainability of the CR group, typically coming from sustainability discussions during the follow up meetings.	N/A—this does not have to do with the logic model; instead, sustainability of the program.	N/A

Appendix C. Key Informant Interview Verification of Actions

INDONESIA		
Level of Completion	Social Action Plans	Key Informant Interviews
CRs did not start	23	N/A
Preparation Only	6	2
Limited	31	23
Substantial	36	30
Activity but insufficiently described*	24	17
Complete	71	66
Unclear	4	N/A
Total	196	138

* These were actions where the description of the respondent confirmed that some activity occurred but were insufficient to code.

TANZANIA		
Level of Completion	Social Action Plans	Key Informant Interviews
CRs did not start	5	N/A
Preparation Only	0	N/A
Limited	17	12
Substantial	25	22
Complete	52	47
Unclear	0	N/A
Total	99	81

WORKS CITED

- Abdullah, A. et al. 2016. "Maternal Health & Risk Factors Associated with Neonatal Death in AIPMNH-Assisted Districts in NTT: A Matched Case-Control Study." *Indonesia: Australia Indonesia Partnership for Maternal and Neonatal Health*.
- Ajaari, J., Masanja, H., Weiner, R., Shalom, A. A., Owusu-Agyei, S. 2012. "Impact of Place of Delivery on Neonatal Mortality in Rural Tanzania." *International Journal of MCH and AIDS* 1, 1: 49–59
- Arkedis, J., Creighton, J., Fung, A., Kosack, S., Levy, D., Naimpally, R., Roots, L., Tolmie, C. 2016. "Baseline Report." Available at: https://ash.harvard.edu/files/ash/files/baseline_report.pdf. Accessed 08/16/19.
- Bately, R. 1999. "The New Public Management in Developing Countries: Implications for Policy and Organizational Reform." *Journal of International Development* 11 (5): 761–65.
- Bhutta, Z. A. et al. 2014. "Can available interventions end preventable deaths in mothers, newborn babies, and stillbirths, and at what cost?" *The Lancet*. 384: 347–370.
- Bombyk, M., Creighton, J., Dixit, A., Levy, D., Roots, L. 2018. "Transparency for Development: Pre-Analysis Plan." Available at: https://ash.harvard.edu/files/ash/files/transparency_for_development_pre-analysis_plan.pdf. Accessed 08/16/19.
- Cogburn, M. 2016. "Teachers or facilitators? How T4D facilitators shape our intervention." *Medium*. Available at: <https://medium.com/challenges-to-democracy/teachers-or-facilitators-how-t4d-facilitators-shape-our-intervention-83280d32c373>. Accessed 08/16/19.
- Farmer, P. Kim, J. Y. Kleinman, A. Basílico, M. Eds. 2013. *Reimagining Global Health*. University of California Press. <https://www.ucpress.edu/book/9780520271999/reimagining-global-health>.
- Fox, J. 2007. "The Uncertain Relationship between Transparency and Accountability." *Development in Practice* 17 (4–5): 663–71.
- Fox, J. 2015. "Social Accountability: What Does the Evidence Really Say?" *World Development* 72 (C): 346–361.
- Fung, A. 2001. "Accountable Autonomy: Toward Empowered Deliberation in Chicago Schools and Policing." *Politics and Society* 29 (1): 73–103
- Fung, A. 2006. *Empowered Participation*. Princeton: Princeton University Press. <https://press.princeton.edu/titles/7762.html>.
- Fung, A. et al. 2007. *Full Disclosure: The Perils and Promise of Transparency*. New York: Cambridge University Press.

- Fung, A. Wright, E. O. Eds. 2001. *Deepening Democracy: Innovations in Empowered Participatory Governance*. Verso.
- Gertler, P. Vermeersch, C. 2012. "Using Performance Incentives to Improve Health Outcomes." *Policy Research Working Paper, World Bank; Human Development Network*. 60.
- GIZ, 2011. "Making childbirth a village affair." Available at: http://health.bmz.de/ghpc/case-studies/Making_childbirth_a_village_affair/Desa_Siaga_short_EN.pdf. Accessed 08/16/19.
- Hsia, R. Y. Naboth A. M. Macfarlane, S. Kruk, M. E. 2012. "Access to Emergency and Surgical Care in Sub-Saharan Africa: The Infrastructure Gap." *Health Policy and Planning* 27 (3): 234–44. <https://doi.org/10.1093/heapol/czr023>.
- John Hopkins Bloomberg School of Public Health, 2004. "Mobilizing for Impact." Available at: <http://ccp.jhu.edu/documents/Mobilizing%20for%20Impact-Indonesia%20SIAGA%20campaign%20promotes%20Shared%20Responsibility.pdf>. Accessed 08/16/19.
- Joshi, Anuradha. 2008. "Producing Social Accountability? The Impact of Service Delivery Reforms." *IDS Bulletin* 38 (6): 10–17.
- Joshi, A. Houtzager, P. P. 2012. "Widgets or Watchdogs?" *Public Management Review* 14 (2): 145–62.
- Kosack, S., Fung, A. 2013. "Transparency for Development: Intervention Design and Evaluation Approach." Available at: https://ash.harvard.edu/files/ash/files/intervention_design_evaluation_approach_o.pdf. Accessed 08/16/19.
- Kosack, S., Fung, A. 2013. "Five Worlds for Transparency and Accountability." *Medium*. Available at: <https://medium.com/challenges-to-democracy/five-worlds-for-transparency-and-accountability-46e9e4d257d4>. Accessed 08/16/19.
- Kosack, S., Fung, A. 2014. "Does Transparency Improve Governance?" *Annual Review of Political Science*. 17: 65–87
- Kosack, S. Creighton, J. Tolmie, C. 2017. "An Approach to Small-Scale Mixed-Methods Experimentation: Transparency for Development, Phase 2." Available at: https://ash.harvard.edu/files/ash/files/t4d_phase_2_evaluation_design_working_paper.pdf. Accessed 08/19/19.
- Kruk, M. E. Leslie, H. H. Verguet, S. Mbaruku, G. M. Adanu, R. M. K. Langer, A. 2016. "Quality of Basic Maternal Care Functions in Health Facilities of Five African Countries: An Analysis of National Health System Surveys." *The Lancet Global Health* 4 (11): e845–55. [https://doi.org/10.1016/S2214-109X\(16\)30180-2](https://doi.org/10.1016/S2214-109X(16)30180-2).

- Ministry of Public Health Indonesia. 2015. "Indonesia Health Profile 2014." Available at: <http://www.depkes.go.id/resources/download/pusdatin/profil-kesehatan-indonesia/Indonesia%20Health%20Profile%202014.pdf>. Accessed 08/16/19.
- OECD. 2008. *Paris Declaration on Aid Effectiveness (2005); Accra Agenda for Action (2008)*. Paris: OECD. Available at: <http://www.oecd.org/dac/effectiveness/34428351.pdf>. Accessed 08/23/19.
- Radin, J. M., Topol, E. J., Steinhubl, S. R. 2018. "A digital toolkit for improved maternal health." *The Lancet*. 397: 1107
- Sen, A. 1999. *Development as Freedom*. New York: Alfred A. Knopf.
- Sofyan, D. A. S., Khoiri, A., Witcahyo, E. 2015. "The role of traditional birth attendance in the implementation of partnerships between midwife and traditional birth attendance at Bangsalsari." *E-Journal Pustaka Kesehatan*. 3(2).
- Statistics Indonesia. 2013. "Indonesia Demographic and Health Survey." Available at: <https://dhsprogram.com/pubs/pdf/FR275/FR275.pdf>. Accessed 08/16/19.
- Storeng, K. T. Béhague, D. P. 2016. "'Lives in the Balance': The Politics of Integration in the Partnership for Maternal, Newborn and Child Health." *Health Policy and Planning* 31 (8): 992–1000.
- Transparency for Development Team. 2017. "Citizen Voices, Community Solutions: Designing Better Transparency and Accountability Approaches to Improve Health." *Ash Center Occasional Papers*. Available at: https://ash.harvard.edu/files/ash/files/citizen_voices_community_solutions_o.pdf. Accessed 08/23/19.
- Tumbelaka, P. et al. 2018. "Analysis of Indonesia's community health volunteers (kader) as maternal health promoters in the community integrated health service (Posyandu) following health promotion training." *International Journal of Community Medicine and Public Health*. 5(3): 856–863.
- UNDP. 1990. *Human Development Report*. New York: Oxford University Press for the United Nations Development Program.
- UN General Assembly. 2000. *United Nations Millennium Declaration, Resolution Adopted by the General Assembly*. Vol. A/RES/55/2. <http://www.refworld.org/docid/3boof4ea3.html>.
- UN General Assembly. 2015. *Transforming Our World: The 2030 Agenda for Sustainable Development*. Vol. A/RES/70/1.
- Walton, K. 2015. "Midwife and traditional birth attendant partnerships in Aceh Singkil, Indonesia." *Maternal Health Task Force*.

- Whitt, P. 2017. “Stories and Stats: Can village bylaws and penalties improve maternal and newborn health?” *R4D Insights*. Available at: <https://www.r4d.org/blog/stories-stats-can-village-bylaws-penalties-improve-maternal-newborn-health-care/>. Accessed 10/04/19.
- World Bank. 2003. World Development Report 2004: Making Services Work for Poor People. World Bank. © World Bank. <https://openknowledge.worldbank.org/handle/10986/5986>
License: CC BY 3.0 IGO.
- World Economic Forum. 2015. “Why Health Clinics May Hinder Developing Countries’ Efforts.” World Economic Forum. <https://www.weforum.org/agenda/2017/06/why-health-clinics-may-hinder-developing-countries-efforts>.
- World Health Organization. 2014. “Every Newborn: an action plan to end preventable deaths.” Available at: https://www.who.int/maternal_child_adolescent/documents/every-newborn-action-plan/en/. Accessed 08/16/19.



A publication of the

Ash Center for Democratic Governance and Innovation
Harvard Kennedy School
79 John F. Kennedy Street
Cambridge, MA 02138

617-495-0557