

COMMUNITY ENGAGEMENT AND PERFORMANCE-BASED INCENTIVES

THE VIEW FROM INDONESIA

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This report analyzes a performance-based incentive (PBI) pilot that was folded into an AusAID-funded project in the Indonesian province of Aceh. It is based on semi-structured interviews with stakeholders involved in various capacities with the program – including district health office staff, staff of health centers and local civil society organizations, and local communities – conducted during a field visit to Aceh between September 19 and October 9, 2011. After an introduction, the report analyzes the contextual factors that provided the rationale for the project and that also affected implementation. The report then describes the design of the PBI scheme, analyzing strengths and weaknesses of the approach. It concludes with a brief discussion of the strengths to build on for the next iteration of PBI in Aceh.

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ABOUT THIS SERIES

This case study is one in a series examining performance-based incentive (PBI) programs that engage local communities in implementation. The series looks at Burundi’s classic supply-side PBI program, which contracts community-based organizations to conduct verification; Mexico’s conditional cash transfer program, Oportunidades, a classic demand-side PBI program, in which local beneficiaries are elected to oversee program administration at the local level; and a program in Indonesia that contracts civil society organizations (CSOs) to lead communities and health providers through a process of collective learning, needs prioritization, and action planning. Unlike Burundi and Mexico, the Indonesia program is a classic community engagement scheme that also happens to condition a portion of CSO remuneration on performance.

PBI, defined as “any program that rewards the delivery of one or more outputs with one or more incentives, upon verification that the agreed-upon result has actually been delivered” (Musgrove 2010), aims to strengthen accountability between payers and providers by giving higher-level actors (such as ministries of health) tools to incentivize greater performance among front-line service providers. PBI also enhances accountability within health facilities – because the efforts of each individual impact the team’s performance payment, the team members hold each other accountable. And PBI can strengthen accountability between providers and patients, since rewards for increases in the quantity of health services encourage providers to attract patients by doing things like improving quality and being more responsive to patients.

Another way to strengthen accountability is through mechanisms that give average citizens channels through which to hold their providers accountable. Experiments with such community engagement mechanisms are growing in the health sector, from community scorecards to community-based monitoring.

The purpose of this series is to learn what happens when PBI and community engagement are combined. Our hypotheses were that engaging communities in the implementation of PBI programs might be a cost-effective approach to program administration, and that such engagement might also have broader benefits, enhancing social accountability and citizen empowerment.

We thought PBI could strengthen the impact of community engagement in two ways: first, because no amount of bottom-up pressure is likely to change health provider behavior if the environment in which the providers operate is dysfunctional. PBI explicitly addresses those dysfunctions. Second, most community engagement mechanisms presume that information about health services is being gathered and used by the community, and routine collection and verification of health data is part and parcel of PBI programs, and thus a potentially powerful asset for community engagement.

What we learned from the fieldwork challenged our assumptions, and highlighted the risks and tensions inherent in engaging communities. Engaging communities in the implementation of PBI may still be advantageous functionally, even if it does not foster community-wide empowerment and participation, but robust checks and balances are needed to mitigate risk. Our analysis also suggests that there is still scope to strengthen broader empowerment by using PBI as a platform: most community engagement mechanisms are meant, through limited formal commitments initiated by a project, to spark ongoing informal monitoring of providers. Sustainability is always an issue, but where PBI has been scaled up and institutionalized, there is an opportunity to use PBI’s currency –information– to strengthen ongoing engagement between citizens and their health providers.

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ACRONYMS

AusAID	Australian Agency for International Development
BKPG	Financial Assistance for Village Welfare
CBO	Community-Based Organization
CE	Community Engagement
CSO	Civil Society Organization
DAK	Special Allocation Fund
DAU	General Allocation Fund
DPRD	Local Parliaments
GAM	Free Aceh Movement
IDR	Indonesian Rupiah
LoGA	Law on Government in Aceh
LOGICA2	Local Governance for Innovations for Communities in Aceh-Phase 2
MOH	Ministry of Health
MSS	Minimum Service Standards
NGO	Nongovernmental Organization
PAD	Provincial and District Own-Source Revenue
PBI	Performance-Based Incentive
PNPM	National Community Empowerment Program



TOUCH DOWN

Everyone remembers when the wave hit. It was December 2004, a morning like any other. Runners out for a marathon. Parents with their children, soaking in the Sunday morning sun. Then a violent tremor. People, dazed, shaken, gathered in streets littered with broken glass and debris. The sea receded – stretching back, almost to the horizon. They say some people darted through the shallows to collect the fish flapping around in the sand. They didn't know the water was about to come back. First, it was just a fuzzy white line on the horizon. Then, a sound that became a violent roar. In seconds, the people who had been standing on the shore were gone.

When the tsunami hit on December 26, 2004, the semi-autonomous province of Aceh, on the northernmost tip of the massive Indonesian archipelago, was still reeling from 30 years of secessionist war. Eventually, a peace accord was signed,² ending the conflict, but the social and economic fabric of the province would take longer to heal.

²The 2005 Helsinki Memorandum of Understanding, available at <http://www.aceh-mm.org/download/english/Helsinki%20MoU.pdf>.



Donors entered the scene. One of them was the government of neighboring Australia, which, through the Australian Agency for International Development (AusAID), launched the Local Governance and Infrastructure for Communities in Aceh program (LOGICA) to facilitate reconstruction and restoration of government services in subdistricts and villages affected by the tsunami and the still-smoldering conflict.

In January 2010, LOGICA evolved into the Local Governance for Innovations for Communities in Aceh-Phase 2 (LOGICA2), the aim of which was to move beyond providing emergency relief and reconstruction to facilitating lasting improvements in governance, the provision of basic services, and community participation. “In response to community-wide advocacy, governments deliver services to improve living standards,” says a project document, all “in order to create an enabling environment for economic growth, peace and stability in Aceh” (LOGICA2 2011a: 1).

It is an ambitious mandate: to create, by engaging with local community groups and committees, schools, health centers, civil society and local government, an “ecosystem” of accountability, a virtuous cycle whereby communities understand their entitlements and civic responsibilities, and are equipped to advocate for better service provision, both as individuals and through civil society. This in turn spurs governments and health service providers to be more responsive to citizens, strengthens the social contract, improves the supply of health services, and—over the long run—improves health.





THE CONTEXT: AN ERA OF EXTRAORDINARY (AND ONGOING) REFORM

Indonesia is in many ways fertile ground for mechanisms to increase social accountability and improve governance. The country has embarked on a radical political, fiscal, and administrative decentralization; it has a legal mechanism for measuring performance in the health and education sectors; and there is a rich culture of citizen participation. This section elaborates on all three factors, discussing their strengths and limitations, and showing how they can both strengthen interventions such as performance-based incentives (PBI), and be strengthened by such interventions.

The LOGICA2 PBI scheme unfolded in an economic, political, and social context shaped by the Asian financial crisis of 1997 and the resignation of General Suharto in 1998 after 32 years of rule. These events triggered what in Indonesia is known as the era of *reformasi*. During this period, the government initiated significant democratic governance reforms, including measures to increase press freedoms; an overhaul of the electoral system (with free and open general elections in 1999 and 2004, in addition to direct provincial and local elections to newly created subnational assemblies beginning in 2005); a reduction of the role of the military in politics and the economy; the launch of an ambitious program of decentralization; and the creation of new administrative mechanisms for citizen participation.



Many of the democratic and decentralized governance reforms in the reformasi period were initiated with little advance preparation or coordination, resulting in confused (and at times contradictory) policy directives, as well as a host of procedural and legal gaps. Bureaucratic inertia and resistance from entrenched interests also impeded implementation. Beginning in 2004, reformers entered a period that the Indonesian government termed “consolidation,” which was characterized by revised legislation; elaboration of supporting guidelines and regulations; increased coordination across different levels of government and among ministries; an assessment of implementation experience to date; and expanded stakeholder consultation. Today, the Indonesian government and its international partners continue to move forward with decentralization, review experience, and refine and adjust the legal and regulatory framework.³

DECENTRALIZATION – AND ITS DISCONTENTS

As part of reformasi, Indonesia undertook one of the most ambitious decentralization programs attempted anywhere. It began with the passage in 1999 of Law 22 on Regional Government, drafted by the Ministry of Home Affairs, and Law 25 on Fiscal Balance between the Center and the Regions, formulated by the Ministry of Finance. These laws reframed political and administrative relationships among different levels of government, expanded the number and authority of subnational entities, and specified formulas for intergovernmental transfers.⁴ Most basic public services became the responsibility of municipalities and districts. Large numbers of civil servants were transferred to subnational governments.

As part of the first stage of decentralization, in 2001, two provinces – Papua⁵ and Aceh – were granted enhanced special autonomy status. Law 18/2001 on Special Autonomy for Nanggroe Aceh Darussalam gives

³The Ministry of Finance hosted the International Conference on Fiscal Decentralization in Indonesia a Decade after Big Bang: Indonesian and International Perspective on Best Practice for Fiscal Decentralization and its Impact on Economic Development and Social Welfare, held in Jakarta on September 13–14, 2011.

⁴Indonesia is administratively divided into 33 provinces. Each province is subdivided into municipalities, which were originally distinguished as urban areas, and districts (*kabupaten*), originally rural areas. There are 96 municipalities in Indonesia, and 370 districts. Municipalities are headed by a mayor (*walikota*), districts by a head (*bupati*); these officials are selected by and report to elected local parliaments (*dewan perwakilan rakyat daerah*, or DPRD). The next lower administrative units are subdistricts (headed by a *camat*) and villages. See Asian Development Bank (2010), Annex 4, for a summary of this and other decentralization legislation.

⁵This has since been divided into two provinces, Papua and West Papua.



Aceh a greater share of income from its natural resources (chiefly gas), and allows it more freedom to run its internal affairs, to re-design local government in line with local traditions, and to base the legal system of the province on Shar'ia.⁶ In Aceh, the implementation of special autonomy was marred by large-scale corruption, the emergence of national political opposition to autonomy as a threat to the unitary state, renewed insurgency on the part of the Free Aceh Movement (GAM), and a repressive military response to insurgent resistance and attacks.

After three years implementing decentralization reforms, problems with clarity, consistency, coordination, oversight, and efficiency and effectiveness led to additional work on the legal and operational framework for decentralization. In 2004, Law 32 on Regional Government and Law 33 on Fiscal Balance replaced Laws 22 and 25/1999. Among the changes these new laws instituted was increased political accountability to citizens through direct election of mayors and bupati, replacing the practice of their selection by the local parliaments. This created a new cadre of accountable local officials with their own constituencies, who exercise their functions related to service delivery, public welfare, and financial management within a complex web of centrally determined legal and regulatory rules and processes, operating variously through appointed agency and subdistrict administrators and/or in cooperation with elected local parliament officials.^{7,8}

Decentralization has had a significant impact on sectoral public expenditure. The World Bank (2006a) estimates that 40 percent of public spending is currently the responsibility of subnational governments. This pattern increases the potential for spending to match local needs and preferences. However, in many cases, local governments are not aware of what the amount of the central and provincial transfers in a given fiscal year will be, both because they do not know the allocation amount, and because, even if they do, transfers are often delayed (World Bank 2006a).

⁶ The central government retains authority over Aceh's foreign political relations, external defense, and monetary affairs. All other responsibilities are assigned to the provincial government, including the right to form a police force. The law also provides for local electoral reform; the governor, district heads, and mayors are elected directly by the people, rather than by their local legislators.

⁷ Law 32/2004 specifies these in a list of obligatory and discretionary functions (Articles 13 and 14). Rapp et al. (2006: 21–22) note that this specification is confusing and inconsistent, and leaves elaboration of details in the hands of The Ministry of Home Affairs and the central-level sectoral ministries.

⁸ Decentralization remains a work in progress. The Ministry of Home Affairs revisited the 2004 decentralization laws in 2009 to assess progress and remaining gaps, and continues to assess the laws each year. The Ministry of Finance has moved ahead with a long-term plan for fiscal decentralization.



A PERFORMANCE TOOL – BUT WITHOUT TEETH

A similar pattern – i.e., of high-level policy failing to translate into improved practice outside Jakarta – can be seen in relation to another key policy area, this one related to a nationally decreed performance tool known as the minimum service standards (MSS).

The foundation for the assessment of government performance under decentralization are the regional/district/subdistrict plans that operationalize the fulfillment of their functions, and the reporting requirements on implementation to citizens, the DPRD, and Ministry of Home Affairs (Rapp et al. 2006). Law 32/2004 contributes to this foundation by specifying that basic services provided by subnational governments conform to the MSS for quality and access.⁹

In health, the MSS consists of 18 composite indicators, which aim to capture the content of care. For example, the indicator that each pregnant woman receive a minimum of four antenatal visits also stipulates that during such visits height and weight be measured, blood pressure taken, tetanus toxoid vaccine administered, and urine tested, among other things. The indicators are mainly related to maternal and child health, including family planning and nutrition.

The MSS has the potential to be a powerful tool to orient service delivery towards results, but the policy has not been well communicated to subnational levels of government and health facilities, and it is unclear how progress on MSS is monitored and what incentives subnational governments have to implement them (Lewis and Smoke 2011). In the words of Jeff Herbert, Team Leader for LOGICA2, “Indonesia is ahead on innovation and reform at the legal level. People are eager to get things done, so many laws/policies are passed. But they are weak when it comes to operationalizing it. There is no strong enforcement.” Indeed, field research revealed that many health center (*puskesmas*) staff were unaware of the MSS policy before the LOGICA2 program. Indeed, one of the main impetuses behind LOGICA2 is to orient thinking, at the *puskesmas*, district, and subdistrict government levels, towards the MSS.

⁹ The MSS were a component of Law 22/1999, and sectoral ministries had begun compiling lists of standards in 2000 (see Ferrazzi 2005). By 2005, however, it was apparent that the quality and utility of the lists left much to be desired, leading to the issuance of Government Regulation 65/2005 on MSS, which sought to give clarity and guidance to sectoral ministries and subnational governments on the standard identification and setting process. The MSS for health was enacted in 2008 by the Ministry of Health.



The problems of unreliability of central transfers to the provinces/ districts, as well as the lack of actual discretion wielded by lower levels of government over spending on health, also create obvious disconnects between the pursuit of MSS and the resources necessary to achieve them (Asian Development Bank 2010). Respondents confirmed this disconnect, and in several cases health officials indicated that they were unaware of the requirements of Government Regulation 65/2005.

CITIZEN PARTICIPATION

From a policy perspective, successful decentralization rests on the assumption that citizens, through their participation in civil society organizations (CSOs), will undertake many planning and service delivery functions previously the responsibility of various levels of government (Beard 2005). Indeed, Law 23/1992 on Health stated that health systems should be implemented by the community with the government as facilitator. The LOGICA2 program seeks to build on and strengthen a culture of village participation in civil affairs, while also raising the expectations of citizens about what such engagement should result in.

Prior to reformasi, village-level governance was essentially an extension of deconcentrated national government. Under the Suharto regime, village heads functioned under the authority of districts and subdistricts; though nominally chiefs were elected by their villages, elections were heavily influenced by patronage and the intervention of district/ subdistrict authorities and/or the military. Law 22/1999 introduced democratic self-government for villages, establishing elected village councils to which chiefs were accountable; it also allowed traditional authority structures, which had been previously repressed. But a newer law, Law 32/2004, which enlists the village councils and chiefs to improve basic service delivery, transforms the elected village councils into consultative and advisory bodies, which has effectively reduced their supervisory and accountability functions. (Decentralization always involves a contestation for power and resources; this was a case where the 2004 law reduced the role of the elected body in favor of focusing on service delivery “efficiency.”¹⁰)

¹⁰ For more detail on village governance, see Rapp et al. (2006: 110–122).



In Aceh, due to the insurgency, village-level elections remained largely under the control of subdistrict authorities, who chose village heads in consultation with the village council of elders (*tuhapeut*), which represents traditional elites. Following the 2005 peace accords, electoral reforms for village leadership were introduced, including democratizing the *tuhapeut*, though in practice traditional elites maintain significant influence (Thorburn 2008; Freire et al. 2011).¹¹

Law 32/2004 on Regional Government stresses citizen participation, specifying in Article 139 the people's right to provide input to the development of local regulations (*peraturan daerah*, or *perda* for short). Law 25/2004 on the National Planning System creates decentralized administrative mechanisms that enable citizen and community engagement, through the *Musyawarah Perencanaan Pembangunan*, or *Musrenbang*, a government-organized multi-stakeholder consultation forum intended to gather input from citizens for the preparation of local development plans (see Box 1). In practice, the *Musrenbang* process has proven to be more top-down than bottom-up. Community-level meetings have tended to serve as information transmission sessions, where local officials inform citizens of government planning decisions, rather than a two-way consultative dialogue. In our interviews, several informants referred to the *Musrenbang* as moribund or nonfunctional.

Another initiative designed to enhance citizen participation is the National Community Empowerment Program (*Program Nasional*

Box 1. Musrenbang in Aceh

From February to April all villages engage in a bottom-up, deliberative planning process called *Musrenbang*, which is facilitated by the district planning agency (BAPPEDA). It is intended to be a forum in which citizens express their aspirations and priorities, which are then presented by the village head to a subdistrict meeting usually held the following month. This larger meeting is attended by officials from district government line departments and members of parliament, and proposals are compiled from these meetings to be presented to a much larger district meeting (SKPK), alongside competing proposals from technical departments. Usually this district meeting is attended by a large number of people, and includes members of the public, CSOs, academics, and members of parliament. While all levels of *Musrenbang* are based on the principle of broad public participation, this often does not occur and meetings are highly structured to exclude debate, or are attended by community leaders rather than the general public. Respondents in LOGICA2 villages said they did not feel confident or have sufficient knowledge or understanding to actively participate in *Musrenbang*, even though they may have been encouraged to attend by village leaders.

Source: LOGICA2 (2011a: 39)

¹¹ One interesting effect of more democratic village-level elections in Aceh has been that newly elected leaders tend to be younger, better educated (more likely to have completed high school), less likely to share the occupations of traditional elites, and less likely to have previously held village governance positions than pre-tsunami leadership (Freire et al. 2011).



Pemberdayaan Masyarakat-Mandiri, known as PNPM).¹³ The program provides block grants to subdistricts, and through a participatory process, villages decide upon funds allocation for the self-defined needs of their poorest members, and monitor implementation. PNPM's focus is poverty reduction along with community empowerment.

In addition to PNPM, in 2009, the Aceh government initiated its own province-level grant program for villages. Called the Financial Assistance for Village Welfare (*Bantuan Keuangan Peumakmue Gampong*, or BKPG), the program establishes a village allocation fund to provide a yearly grant of IDR100 million to each village from the provincial government, supplemented by IDR50 million per village from district-level budgets.¹³

Indonesia also has large numbers of community-based organizations, such as religious associations, farmer federations, and citizen forums. CSOs have expanded their activities greatly in the post-Suharto era, often with international donor funding. This pattern has been especially strong in Aceh, where the massive influx of assistance following the tsunami created a funding bonanza for local CSOs as the international community sought conduits to deliver aid. However, despite their initial successes and their growing importance as political and development actors, CSOs in Indonesia are under-organized and lack capacity (Antlöv et al. 2010). Lacking indigenous sources of funding, they tend to follow donor money, continuously reinventing themselves to fit current donor priorities, regardless of their initial missions and goals. Our interviews revealed, for example, that few of the NGO partners working with LOGICA2 and the puskesmas had missions related to, or previous experience in, health.

Finally, in addition to village-level governance structures, village empowerment programs, and the presence of civil society, Indonesian village life is marked by a strong social fabric. At the center of community life is the *meunasah*, a community hall used for village prayer meetings, the monthly community childcare clinic, and Qu'ran classes, among other things. Though village chiefs represent communities in local government affairs, the *mukim* (traditional, religious leaders) hold sway over family and religious matters. All these individuals interact frequently (and in small communities are very often related), and decisions that affect communities are subject to social sanctions.

¹² PNPM's origins lie in the World Bank's Kecamatan Development Program, which began in 1998 (see Guggenheim et al. 2004).

¹³ The BKPG is based on the provincial Qanun (law) 1/2009. As specified in the 2005 peace accords, among the provisions of Aceh's special autonomy is the right to apply Shar'ia law; provincial legislation is therefore referred to using Islamic terminology. One US\$ equals approximately IDR 8,800.



THE ORIGINS OF THE LOGICA2 PBI PILOT

The last section described a social and political context in Indonesia that is increasingly focused on results and social accountability, but with a long way to go towards fully realizing these goals. This context laid the groundwork for LOGICA2's activities in Aceh, but what consolidated the decision to fold a PBI program into the larger project was a situation peculiar to Aceh: that is, in addition to decentralization and efforts to enhance citizen engagement in civic life, Aceh has benefitted from large amounts of revenue – although increases in spending on health had failed to lead to better health results.





ACEH'S SIGNIFICANT FISCAL RESOURCES

Aceh has the third-highest per capita revenue in Indonesia after Papua and East Kalimantan, and double the national average. Aceh's regular revenues increased from IDR2.4 trillion (US\$240 million) in 1999 to almost IDR16 trillion (US\$1.6 billion) in 2008. Much of this increase stemmed from the devolution of responsibilities and budgets as set out in the decentralization laws, but there were also new “special autonomy” arrangements for Aceh beginning in 2002, and major increases in General Allocation Fund (*dana alokasi umum*, or DAU) disbursements since 2006 (World Bank. 2006b). Moreover, the Law on Government in Aceh (LoGA) mandates that Aceh receive the equivalent of an additional 2 percent share of national DAU funds for 15 years, then 1 percent for five more years (until 2028). The first allocation of in 2008 provided an additional IDR3.6 trillion (US\$360 million) to Aceh's revenues.¹⁴

In addition to regular DAU and *dana otsus* funds, Aceh receives the third-largest resource-sharing allocation in Indonesia, after East Kalimantan and Riau. The LoGA guarantees Aceh a 70 percent share of hydrocarbon revenues (far greater than for other hydrocarbon-producing regions, where 15 and 30 percent for oil and gas, respectively, are the norm).¹⁵ And Special Allocation Fund (*dana alokasi khusus*; or DAK) allocations in Aceh have increased significantly. DAK allocations to district governments have increased fivefold since 2003. In 2007, DAK funds were earmarked for three main sectors: education (28 percent), health (20 percent), and infrastructure (30 percent). The Aceh provincial government also received DAK funds in 2008, to support road and irrigation projects.

Finally, provincial and district own-source revenue (*pendapatan asli daerah*, or PAD) has increased as well. Driven by an increase in provincial taxes (vehicle and fuel taxes), provincial PAD has increased more than fourfold since 2005, contributing about 6 percent of the provincial government's budget in 2008. District and municipal governments' PAD more than doubled during the same period, largely from taxes and retributions.

¹⁴This allocation, now called the Special Autonomy Fund (*dana otsus*) used to refer to the resource revenue-sharing scheme wherein Aceh received a higher share of revenues from gas and oil. In a rather bewildering word swap in the 2006 LoGA, this term now refers to Aceh's additional 2 percent share of DAU funds, while the hydrocarbon revenue-sharing allocations are called Additional Revenue-Sharing Oil and Gas (*dana bagi hasil sumberdaya alam*, or DBH SDA). The allocation is disbursed quarterly and is intended to finance the development and maintenance of infrastructure, as well as economic empowerment, education, social, and health programs.

¹⁵Oil and gas production in Aceh has declined steadily since 2001, a trend that is expected to continue as reserves are depleted.



BUT WITHOUT THE COMMENSURATE RESULTS

But high revenue levels in Aceh have not translated into greater prosperity for the majority of Acehnese. Based on per capita spending, the people of Aceh are among the poorest in Indonesia. Aceh's poverty rate is high compared to most other provinces, at around 22 percent in 2009 compared to 14 percent nationally. In the last five years, Aceh has lagged in the UNDP Human Development Index, falling well behind progress made by other provinces in Indonesia.¹⁶

Matching the overall trend in Indonesia, the policy of fiscal decentralization has not been fully practiced in Aceh. For example, under Indonesia's decentralization and revenue-sharing framework, 90 percent of DAU dana otsus funding, the largest source of funding for both Aceh and other provinces, is distributed to districts and municipalities, with 10 percent going to the provincial government. However, the LoGA significantly alters this distribution for Aceh, giving the provincial government almost 40 percent of fiscal resources from the fund.

In health, "districts have discretion over less than a third of the public funds for health spent in the district [and] the proportion over which discretion can be exercised is much higher in hospitals and much less in the district health office/health center" (Heywood and Choi 2010: 10). Moreover, in interviews, district health officials confirmed the problem of unreliable fiscal transfers from the center, which make strategic planning difficult.

As with decentralization in many countries, where local discretion on spending has increased, it has not always resulted in optimal resource allocation. For example, in health, local parliamentarians have in some cases favored investments in visible infrastructure that supports increased curative care rather than in prevention. In Aceh, several interviewees indicated that such spending patterns are reinforced by the power of well-off former GAM members who head construction firms to influence local parliament budgeting votes, as well as by the desire of local politicians to be associated with visible results of their budgeting decisions.¹⁷

¹⁶ The Human Development Index in Aceh has improved more slowly than in other provinces in recent years. Aceh ranked 29th among 33 provinces in 2008 (UNDP 2010).

¹⁷ LOGICA2 has documented this problem in its reports: "Increases in fiscal revenues have primarily been absorbed by governments in expenditure on administration, staffing and asset acquisition" (LOGICA2 2011b: 12). Heywood and Choi (2010: 2) echo the problem: "district level health spending per capita is not related to critical health outcomes..."



Though the government of Aceh has committed¹⁸ to improving primary health care, this has yet to be realized in actual budget allocations. While there was a shared commitment by all district heads for a budgetary allocation of 10–15 percent, real allocations for primary health care remain at 4–8 percent of district budgets (LOGICA2 2011b: 16).

Therefore, despite average per capita threefold increases in spending on health in Aceh between 2004 and 2007, Aceh ranks in the bottom third of all provinces against all health indicators, particularly in Southern and Western Aceh, where one in six people lack access to health facilities within a reasonable distance.

ENTER: PERFORMANCE-BASED INCENTIVES

In an environment like the province of Aceh – where the ground is fertile with resources, policies, and structures for citizen engagement to enable social accountability and improved health service delivery – PBI is a natural approach to tackle the web of disincentives that often prevent individuals (families, health workers, and district and provincial managers) from making the decisions that would lead to better health.

PBI approaches are not entirely new in Indonesia. The Dutch nongovernmental organization (NGO) Cordaid also piloted a supply-side PBI scheme that paid fees for services delivered above a baseline on the island of Flores, which showed mixed results.¹⁹ One of the most notable examples of PBI in Indonesia is PNPM Generasi, an innovative pilot program launched by the government of Indonesia in July 2007, designed to accelerate achievement of universal basic education, reduction in child mortality, and improvements in maternal health.²⁰

Villages participating in PNPM Generasi commit to improving 12 basic health and education indicators through the use of annual block grants averaging US\$8,400 per village, which the village can spend on anything

¹⁸The government of Aceh committed to improving reproductive health outcomes for women in its charter on the rights of Acehese women in Aceh, especially in Article 12, which proposed wider dissemination of information on sexual health, including HIV/AIDS, and improved access to facilities and qualified health services (including for victims or drug users with HIV/AIDS). This commitment was strengthened at the end of 2009 by new legislation (Qanan 6/2009) which again explicitly stated these measures and made provision of resource allocations under provincial and district budgets.

¹⁹For example, though immunization rates increased, the number of women attending four ANC visits decreased, while attended deliveries was unchanged. For more see Horstman et al. (2011). Cordaid has implemented PBI pilots in many countries. For more see: Toonen et al n.d.

²⁰PNPM Generasi is short for PNPM Generasi Sehat dan Cerdas, which means “A Healthy and Bright Generation,” and is part of the government’s flagship PNPM poverty alleviation program. For more see World Bank (<http://web.worldbank.org/WBSITE/EXTERNAL/NEWS/0,,contentMDK:21732806~menuPK:141310~pagePK:34370~piPK:34424~theSitePK:4607,00.html>); and Olken et al. (2011).



they can claim will help to address one of the indicators.²¹ Trained facilitators help each village elect an 11-member village management team, and together, through social mapping and in-depth discussion groups, they identify problems and finds local solutions. Twenty percent of the subsequent year's block grant is allocated among villages in a subdistrict based on their relative performance on each of the 12 targeted health and education indicators. A rigorous impact evaluation of the Generasi program found that the incentives led to improved performance on health indicators: over the two years of the program, prenatal visits and immunization rates were higher in areas where the incentive scheme was operating than in other areas.²²

AusAID has a history of engagement and interest in PBI approaches. In 2009, it sent staff to an Asia regional workshop on PBI that was led by Health Systems 20/20 and funded by USAID, the government of Norway, and the World Bank. At the workshop, participants from Southeast Asia (including three groups from Indonesia) developed proposals for PBI pilots, some of which went on to receive seed funding and be piloted.²³ The Center for Global Development, a Washington, DC-based think tank, also provided PBI training to hundreds of AusAID staff.

In attendance at the workshop was the man who would become the governance advisor for LOGICA2 in Banda Aceh. Years later, on a field visit to one of the LOGICA2 districts to check on program progress, Mohammah Najib, Senior Governance Advisor to LOGICA2, got an idea: "I saw puskesmas that were not performing, and broken links between them and their communities, as well as between the puskesmas and the district. I thought PBI was a way to strengthen accountability and focus attention on MSS results."²⁴

²¹ The overall size of the Generasi allocation for the entire subdistrict is based on the subdistrict's population and poverty level. In year one of the program, funds are divided among villages in proportion to the number of target beneficiaries in each village, i.e., the number of children and the number of pregnant women.

²² On average, midwives spent 1.7 additional hours working over the three-day period prior to the survey in incentive areas. It is not clear from the report if communities agreed to share incentive payments with midwives to spur this change or not. There was no impact on education indicators, teacher attendance, or provider attendance at the puskesmas. They also found no evidence of increased effort on the part of communities as measured by holding more *posyandus* (the monthly village health meetings attended by puskesmas staff where many maternal and child health services are delivered), doing community outreach such as door-to-door visits to pregnant women, or monitoring service providers.

²³ Funded pilots included Bangladesh and the Philippines. Proposals from Pakistan and Cambodia were not funded, but both countries have robust PBI experience, particularly with demand-side approaches.

²⁴ Conversation between authors Lindsay Morgan and Mohammad Najib.



THE LOGICA2 PBI DESIGN

LOGICA2 aims to facilitate change by supporting communities, “particularly the marginalized, [to] effectively advocate priority needs to government resulting in services that improve living standards.” LOGICA2 also works with governments to strengthen their capacity to respond to community needs through transparent planning and budget allocations, streamlined regulations and administrative procedures, competent staffing, and improved service delivery based on the MSS. The aim is that “governments respond to citizen priorities, including those of the marginalized, by effectively allocating resources and delivering services to improve living standards” (LOGICA2 2011b: 24).

Halfway through the LOGICA2 program, local CSOs were contracted by LOGICA2 in order to:

- Facilitate stronger ties between service providers and community;
- Build capacity of service providers to deliver results; and
- Build a cadre of CSOs who use their access and influence to advocate on health sector issues with local and provincial governments.



CSOs received the bulk of their grant from LOGICA2 in regular, reliable monthly installments,²⁵ but they also had the opportunity to earn a bonus at the end of the contract period if certain conditions were met:

- Puskesmas developed and implemented a mission, job descriptions, complaint handling procedure, standard operational procedures, written service standards, and service charter; and
- Puskesmas met 1–2 MSS target indicators specified in the action plan.

Thus, a mini-PBI pilot was folded into the larger project, and implemented for a period of seven months (between March and December 2011) in the districts in Aceh where LOGICA2 activities were ongoing, which were generally rural (with some peri-urban areas) and poor.²⁶ The idea was to test an initial approach in order to learn what might work for a longer-term pilot in cooperation with the district government.

Along with the primary goal of supporting the puskesmas was the secondary goal of holding CSOs accountable for results. Following the tsunami, many local CSOs sprang up, both to respond to the emergency and to act as conduits for the vast sums of aid flowing into the province. Aceh received an unprecedented amount of assistance. In 2006, total funds flowing into Aceh were estimated at IDR28.5 trillion (US\$3.1 billion) (World Bank 2006b). This is part of the reason LOGICA2 decided to target the incentive payment to CSOs – in order to introduce accountability for the vast sums of money they had become responsible for managing.

Engaging local CSOs was also seen as a key to sustaining the social changes the program was meant to spark: the CSOs would continue to engage in their communities after the LOGICA2 program came to an end. Moreover, in some cases CSOs had access and channels to government officials, channels which could be leveraged by the LOGICA2 program.

²⁵ This paid for the innovation facilitator and coordinator salaries. Each innovation facilitator receives IDR2 million per month and each coordinator receives IDR3 million per month. In addition, each NGO receives 15 percent for a management fee.

²⁶ The districts are: Pidie Jaya, Bireuen, Aceh Timur, Aceh Tamiang, Aceh Barat Daya, and Aceh Tengah. Within these districts are 36 subdistricts (*kecamatan*) and 432 village communities.



Box 2: Levels of Health Care in Aceh at a Glance

The puskesmas, or community health center, is the unit within the Indonesian public health system intended to provide affordable access to basic health care for the majority of the population. Usually, a subdistrict is served by one puskesmas, which is headed by a physician, the puskesmas serves an average of 30,000 residents (MOH 2008). The main services offered at puskesmas are pre- and postnatal care, immunization, dental care, family planning, nutrition, and environmental sanitation. Operating under the direction of puskesmas are *pustus*, auxiliary centers usually headed by a nurse; *polindes*, community-based clinics staffed by the village midwife that provide maternal and child health services; and *posyandus*, health service posts that are operational an average of two days per month for pre-announced maternal and child health services. Community members are expected to make financial contributions and take turns administering the posyandu: setting up the tables, maintaining the equipment, and recording height and weight information.

Health Structures by Level

Level	Structure
Center	<ul style="list-style-type: none"> ● Ministry of Health (<i>kementerian kesehatan</i>)
Province (<i>provinsi</i>)	<ul style="list-style-type: none"> ● Provincial Health Office (<i>kanwil departemen kesehatan</i>)
District (<i>kabupaten</i>)	<ul style="list-style-type: none"> ● District Health Office (<i>dina kesehatan</i>) ● Hospital (<i>rumah sakit</i>)
Subdistrict (<i>kecamatan</i>)	<ul style="list-style-type: none"> ● Community health clinic (<i>pusat kesehatan masyarakat, or puskesmas</i>) ● Auxiliary health center (<i>puskesmas pembantu, or pustu</i>)
Village (<i>desa</i>)	<ul style="list-style-type: none"> ● Village birthing center (<i>pondok bersalin desa, or polindes</i>) ● Health service post (<i>pos pelayanan terpadu, or posyandu</i>)

In order to liaise with communities, puskesmas establish health councils, which cover 15–20 villages each and consist of 5–10 members elected by the village committees. The health councils are supposed to assist government in improving communities' health outcomes and to monitor the attainment of the MSS, although in practice, there are few councils.

The CSOs were chosen by LOGICA2 with help from the Aceh NGO Forum, an umbrella organization. LOGICA2 contracted the CSOs to appoint, train, and manage six “innovation facilitators” (one in each district). These were individuals who were either existing CSO staff or contracted by the CSO for the LOGICA2 program. The innovation facilitators were charged with strengthening the links to and between the puskesmas and communities and building the capacity of puskesmas to achieve health service delivery targets, such as increasing the number of women who complete four prenatal visits and increasing the number of children who are fully vaccinated. These indicators and targets were determined through a consultative process, facilitated by the innovation facilitator, with local community members and puskesmas staff, and were based on the nationally decreed MSS.



The role of the innovation facilitator was key. Facilitators organized the meetings that resulted in the puskesmas action plan, which delineated the indicators and targets the puskesmas had to meet, and interacted with the puskesmas after signing the contract with LOGICA2, encouraging them and supporting them to meet the targets. Sometimes, the innovation facilitators also interacted with the local community, although LOGICA2 community mobilizers were primarily responsible for this component.

Once puskesmas' achievements were verified, the CSOs received a bonus of IDR30 million (for achievement of MSS indicators) and IDR20 million (for achievement of service standards), for a total of IDR50 million per subdistrict. (The contract between the CSO and LOGICA2 stipulated that the innovation facilitator receive at least 25 percent of the bonus payment.) Since each CSO had responsibility for six subdistricts, this meant a grand total of IDR300 million per CSO, a sum that represented a significant portion of some CSOs budgets.

The CSO reported to LOGICA2 every two weeks, and puskesmas reported through the national health information management system. This whole process was managed by LOGICA2 field coordinators (Program Manager-Government Management), who worked closely with innovation facilitators, their managers at the CSOs, and community mobilizers on the community side.

THE PERFORMANCE CONTRACT

The mechanism that connected community engagement to measurable, incentivized results was the creation of the “action plan,” which formed the basis for the performance contract between the puskesmas and LOGICA2 and specified the targets they agreed to reach by the end of the contract period, on which the CSO bonuses in turn depended.

Information was collected and disseminated to communities and their puskesmas together during a series of meetings, which culminated in a meeting to draft the action plan contract. CSO innovation facilitators worked with the puskesmas and communities to jointly assess facility performance on the MSS and produce action plans, which specify one or two performance indicators and targets to be reached. The community members who participated in the meetings were identified by the innovation facilitators, in coordination with LOGICA2 field staff, according to standards to ensure that marginalized groups were represented.



Communities were presented with both subjective and objective data, which were used to develop the community action plan. The objective data came from a survey conducted by the district health offices, with technical assistance from LOGICA2; it provided a baseline of MSS coverage in their villages. The subjective data came from focus group discussions and a survey conducted by LOGICA2 community mobilizers, which identified community priorities in health and education. For its action plan, the community determined which issues they believed they could address themselves, and which required action by village health clinics, schools, and subdistrict offices. This process highlighted issues such as: the absence of a midwife service for pregnant women; child nutrition and immunization; pockets of high incidence of preventable diseases (e.g., tuberculosis); village sanitation; provision of free clean water; the poor quality and accessibility of local health services through the puskesmas; and the poor availability of pharmaceuticals.²⁷

LOGICA2 analyzed the MSS surveys and the community action plans in advance of the action plan meetings and identified the two worst-performing MSS indicators. It then encouraged facilities to choose those indicators for the action plan.

Participants in each meeting selected individuals to be members of a technical team to establish MSS targets, develop activities, and budget to achieve the MSS targets. Team members included representatives from the puskesmas and community, such as health cadres, village leaders, and/or members of the village health council. With assistance from innovation facilitators, they set achievable MSS targets and produced a proposal to be submitted to LOGICA2. Their MSS targets could be above or under the district government MSS targets, as long as they were thought achievable and were supported by valid data.

Once approved, the action plan triggered payment of an “innovation grant” of IDR80 million to the puskesmas to help them attain the MSS targets. The health centers also had the opportunity to receive so-called “service improvement management grants” if they could demonstrate they had made certain improvements (mostly related to processes – for example, instituted a standard operating procedure); that improvements were made in a participatory way (involving village committees); that improvements in service delivery have been institutionalized; and that service improvements were disseminated through the community. Neither grant was conditional on performance.

²⁷ World Bank (2006a) notes that absenteeism from health facilities is a widely observed problem in Indonesia.



STRENGTHS OF THE PROGRAM

The LOGICA2 PBI pilot had several strengths. It had a robust community engagement component and a strong “ecosystem” approach that brought together a range of stakeholders, including district and subdistrict government, health facilities, communities, and civil society (Morgan 2012 forthcoming). The program also succeeded in mainstreaming the language of accountability and the idea of linking incentives to health results among communities and service providers. This is critical, as one of the goals of introducing a small, time-limited PBI program was to set the stage for a more robust iteration of PBI.

Furthermore, while there is no fixed set of best practices for community engagement, as it is recognized to be highly context-specific, the literature does suggest that having a mix of information sources is important (or at a minimum, ensuring that information provided for decision-making is not only subjective; see Croke [2012]). The LOGICA2 program provided both subjective and objective data to communities and puskesmas in the process of formulating the action plan.

But provision of information alone is rarely enough to spur action. Communities must also be given a channel to voice their views and concerns in such a way that it makes an impact. Having such a way to actually do something with the information you receive – what Björkman and Svensson (2009) call “relaxing the collective action constraint” – is critical.



Here, LOGICA2 program was strong: community views were incorporated into a binding contract between LOGICA2 and the puskesmas, and a portion of CSO payment depended on achievement of indicators and targets that the community helped to determine. Though there are many mechanisms for communities to engage in service delivery (as described earlier), this is a strong approach and a novelty in Indonesia.

Like most community engagement programs, the LOGICA2 pilot focused on processes that serve as proxies for complex behavior changes, which are very difficult to precisely measure. The idea, of course, is that empowerment and accountability, along with other support, will result in increased utilization of health services. But because empowerment is difficult to measure, LOGICA2 interestingly choose to reward health output indicators. Community members may attend a meeting, but this is not itself a goal. Better service provision – indeed, better health itself – is, along with empowerment and accountability. This is potentially powerful and certainly ambitious. It is both a novelty and a key strength of the program.

Bringing CSOs into this process is also a strength of the LOGICA2 program – the CSOs are empowered and held accountable for funds, in a post-tsunami context where there has been significant sums of money but little accountability (a common feature of the CSO landscape in post-conflict, post-emergency settings). Furthermore, CSOs in some cases may have access, influence, and lasting presence in communities, which may have important implications for sustainability.

Another strength of the program is that it builds on and in many cases reinvigorates existing structures, such as the MSS. It aims not to create a parallel system for measuring performance, but to strengthen the national policy of the MSS, which has so far been little-implemented and understood, let alone enforced.



AREAS THAT COULD BE IMPROVED

There are many lessons to learn from the first phase of the LOGICA2 pilot program that can inform the next iteration of PBI in Aceh. Two key areas emerged as ripe for strengthening.

THE INCENTIVE RECIPIENT

In LOGICA2, CSOs were offered the opportunity to earn incentives for something (MSS targets) that the puskesmas were responsible for achieving, yet the puskesmas faced no reward or sanction for achievement – that is, they received a grant from LOGICA2 irrespective of their performance. This arrangement has several potentially negative implications, the first of which is that it can be demotivating for CSOs. Indeed, interviews confirmed that many innovation facilitators and their managers were concerned about meeting targets, with some threatening to quit during the first visit.

Providing an incentive to the CSO for what puskesmas achieved also resulted in a lack of clarity about the role of the CSOs and innovation facilitators relative to LOGICA2 field staff, and made the program unnecessarily complicated. Field visits revealed that although the idea behind engaging CSOs was to empower them to lead the action plan process with puskesmas, LOGICA2 field managers maintained a dominant role, and in some cases, the CSOs seemed redundant.



Moreover, this arrangement appears to have driven a sense of secrecy among innovation facilitators, who, at the time of the first field visit, had kept the incentive payment a secret from the puskesmas, since they wagered (probably correctly) that this would demotivate them. In other words, this arrangement created an environment of secrecy, in a program intended to increase transparency.

Should CSOs be held accountable for results? Certainly – and conditioning a portion of their funding on performance is probably a good thing. But they should be incentivized only for actions and outcomes within their control, and which can be measured and verified.

Furthermore, incentivizing CSOs does nothing to address the dysfunctions in the health system that are barriers to achieving targets. No amount of community engagement can make providers more responsive when they work in an environment where information management systems are weak, where there is little systematic monitoring and validation of what is reported, and where they have little discretion over funding and are not empowered to come up with creative solutions. The current health financing strategy in Aceh of reimbursing individual health workers for each service delivered (as part of a complex insurance repayment scheme) has led to a prioritization of curative rather than preventive care, and probably leads to simply increasing the numbers of patients served rather than focusing on the quality of care.

THE VERIFICATION SYSTEM

According to data collected by LOGICA2, nearly all the puskesmas met or exceeded their performance targets, so how can we say that the incentive recipient was misplaced? Part of the answer is that, clearly, increased supervision by the CSOs, LOGICA2, and district officials, along with pressure from communities, probably pushed puskesmas to perform better than they were performing before – there were simply more people watching them and they had more resources and support.

But the other part of the answer is that it is almost impossible to know whether the reported results were accurate, because the verification system was weak. Any program that pays for results must ensure that those results actually happened – the program is likely to stimulate false reporting unless there are robust checks and balances and actors know there are penalties for fraud.



The LOGICA2 verification process was essentially a check, by the CSO, to verify that what was in the registers at the polindes was consistent with what was in the registers at the puskesmas. This is an important first step toward ensuring the integrity of the health information system – ensuring that what is reported in lower-level facilities is consistent with what is recorded at higher levels. However, if what is recorded in the polindes register is incorrect, all this does is verify that the puskesmas has carried through this incorrect figure consistently. To strengthen the reliability of these data, it would be ideal to verify with a sample of households that some of the people listed on the register as having received services actually did receive them. Moreover, verification should be conducted by an external entity – the CSOs had a conflict of interest, as they stood to receive the incentives.



CONCLUDING THOUGHTS

The pilot described above was a first and ambitious attempt, and as with any innovation, there were bumps and many lessons learned. But there is much to build on from this model. More than any other PBI program we are aware of, this one has community engagement at its heart. Says Mohammad Najib: “the program is fundamentally about cultivating a culture that is not passive – that doesn’t just sit around when things go wrong but that feels empowered to make changes in their own lives and in the lives of their communities, and who understand their rights and responsibilities as citizens.”

Combining a robust community engagement program with PBI can improve this accountability chain by making providers more responsive and empowered, creating a virtuous cycle. LOGICA2’s “ecosystem” approach, which touches district officials, health staff, local civil society, and communities, is exciting. Other programs can learn from this strong community information and channeling component.



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