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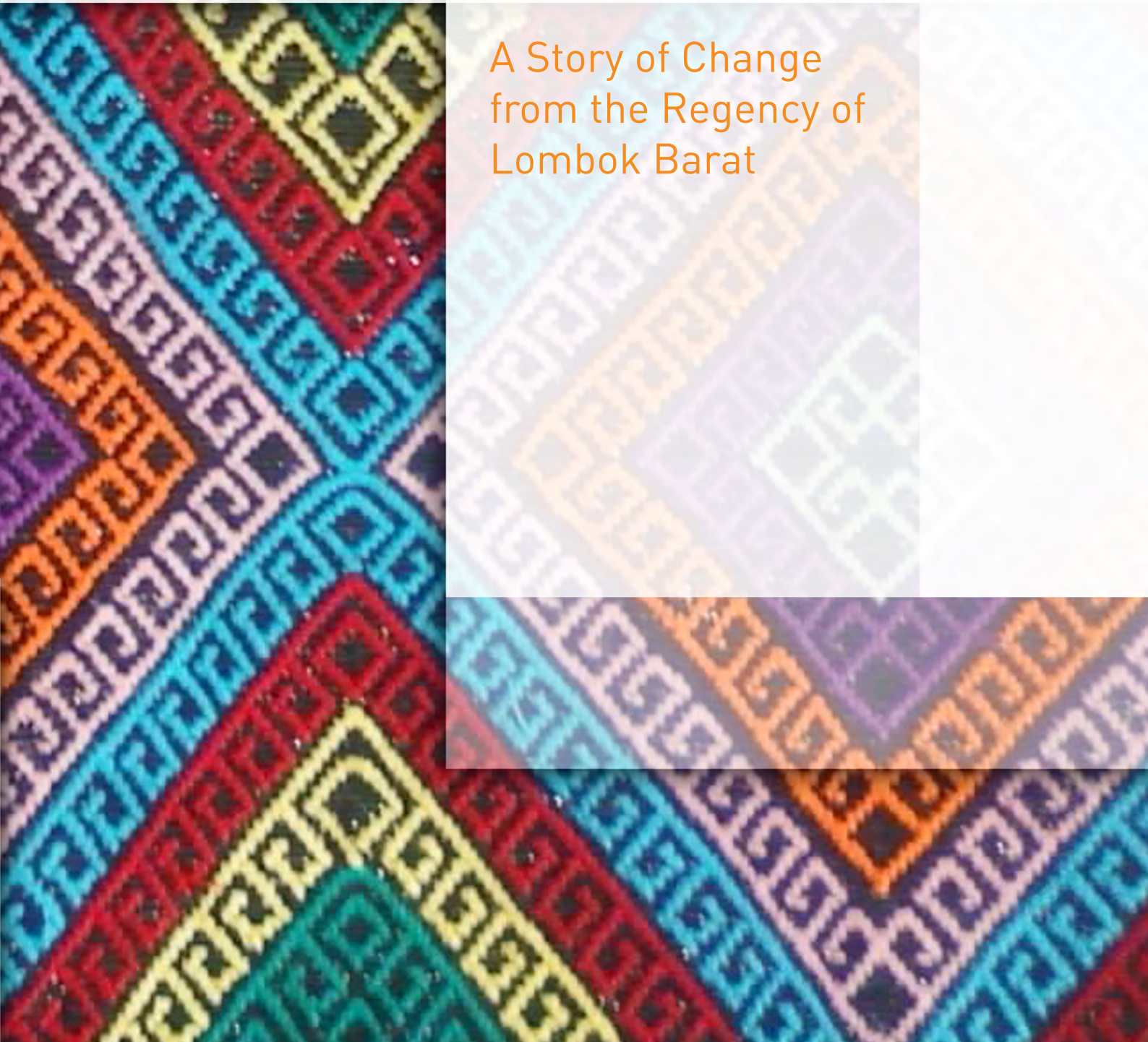
IMPROVING HEALTH SERVICES THROUGH KNOWLEDGE SHARING AND COMMUNICATION

A Story of Change from the Regency of Lombok Barat



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Revised Version

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Revised version includes minor corrections as well as an updated reference list.

Abstract

This Story of Change describes how establishing a Memorandum of Understanding (MOU) between communities and health service providers in Lombok Barat in 2006 helped to re-establish trust between citizens and providers. Facilitated by the Regency Health Office of Lombok Barat and a network of local civil society organisations called *Jaringan Masyarakat Sipil* (JMS), the discussion and sharing that occurred contributed to improvements in the quality of services provided by the health centres, raised the level of accountability of health centre staff and informed the decisions taken by both the centres and the district health agencies. The story describes how these improvements came about.

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List of Abbreviations

ACCESS	Australian Community Development and Civil Society Strengthening Scheme
BPS	*Badan Pusat Statistik* (National Statistics Bureau)
CC	community centre
CSO	Civil Society Organisation
DFAT	Department for Foreign Affairs and Trade, Australia
DFID	Department for International Development
GIS	Geographical Information System
JMS	*Jaringan Masyarakat Sipil* (Civil Society Networks)
KSI	Knowledge Sector Initiative
LSBH	*Lembaga Studi dan Bantuan Hukum* (Legal Aid and Study Institute)
MOU	Memorandum of Understanding
NGO	Nongovernmental Organisation
NTB	*Nusa Tenggara Barat* (West Nusa Tenggara)
NTT	*Nusa Tenggara Timur* (East Nusa Tenggara)
ODI	Overseas Development Institute
PATTIRO	*Pusat Telaah dan Informasi Regional* (Regional Research and Information Centre)
PNPM	*Program Nasional Pemberdayaan Masyarakat Mandiri* (National Programme for Community Empowerment)
SAID	*Sistem Administrasi dan Informasi Desa* (Village Information Management System; online portal)
UK	United Kingdom
Yappika	*Yayasan Penguatan Partisipasi, Inisiatif dan Kemitraan Masyarakat Indonesia* (Participation Strengthening Foundation and Community Partnership Initiative, Indonesia)

List of Terms in Bahasa Indonesia

Bahasa Indonesia	English
desa	village
Dinas Kependudukan dan Catatan Sipil Kabupaten Lombok Barat	Population and Administration Bureau of the Regency of West Lombok
Dinas Kesehatan Kabupaten Lombok Barat	Regency Health Office of Lombok Barat
Kabupaten Lombok Barat	Regency of West Lombok
Posyandu	Integrated Service Post
Pusat Kesehatan Masyarakat, or *Puskesmas*	Community Health Centre
Pustu	*Puskesmas* supporting unit

1 Introduction

This Story of Change is about the importance of sharing information and data to improve the quality of health services and to strengthen the accountability of service providers towards citizens as their clients.

The focus is on the changes that followed the policy decision taken in 2006 to establish a Memorandum of Understanding (MOU) on health service provision in the regency of Lombok Barat (*Kabupaten Lombok Barat*). To prepare the story, the authors both reviewed written documentation and carried out field interviews and focus group discussions with a number of stakeholders, implementers and beneficiaries.

The regency is located in the province of West Nusa Tenggara (*Nusa Tenggara Barat*—NTB). In Lombok Barat, for a population of 613,161 (in 2012), there is one public hospital, which is in the regency capital, Gerung; 16 Community Health Centres (*Pusat Kesehatan Masyarakat,* or *Puskesmas*) at the sub-district level; 18 *Pusling* (mobile *Puskesmas*) and 59 *Pustu* (*Puskesmas*-supporting units) (*Bappeda Kabupaten Lombok Barat* and *BPS Kabupaten Lombok Barat,* 2012, p. 143). Moreover, the number of health workers, including doctors, dentists, nurses and paramedics, is limited for the level of need in the regency (*Bappeda Kabupaten Lombok Barat* and *BPS Kabupaten Lombok Barat,* 2012, p. 150).[1]

1 Only 134 medical workers were recorded in 2011.

The MOU was agreed initially between *Puskesmas* and groups of community representatives—called Community Centres (CCs)—in four sub-districts in Lombok Barat: Gunung Sari, Batu Layar, Narmada and Gerung. A second, higher-level MOU was subsequently signed between the Regency Health Office of Lombok Barat *(Dinas Kesehatan Lombok Barat)* and a network of local civil society organisations (CSOs) called JMS *(Jaringan Masyarakat Sipil)*[2] that acts as an intermediary linking CCs and *Puskesmas,* as well as the Regency Health Office and the CCs in Lombok Barat.

Three main triggers ultimately led to the MOUs:

1. **Distribution of insurance cards.** In 2005, the Government of Indonesia introduced health insurance cards for the poor. The holders of these cards were to be allowed to receive free health services in the *Puskesmas*. The process of distributing these cards, however, proved to be challenging in terms of who was entitled to the cards and who received them. One respondent interviewed for this story noted that while 20% of the population in Lombok is considered officially poor (according

2 JMS was established on 19 March 2008. The network comprises 10 Community Centres (CCs), 13 civil society organisations (CSOs) and 25 individuals.

to 2011 data; *Badan Pusat Statistik*—BPS, 2012), 64% of households had received health insurance cards.[3]

2. **Perception by community members of the poor quality of services** provided by the *Puskesmas* in the four aforementioned sub-districts in Lombok Barat. Complaints reported by interviewees included staff absenteeism during working hours, and patients not receiving a clear explanation of what their health problems were and what medicines they were required to take. There was a strong perception that the *Puskesmas* staff treated community members, particularly the poor, rudely.

3. **Absence of spaces and channels for communication.** People who complained about the services they received in the four *Puskesmas* did so individually: There was not a common voice. At the same time, the head of the *Puskesmas* felt that no avenues were available to explain to communities the challenges *Puskesmas* faced in terms of budget, plans, and human resources.

It was the ideal context for misinformation, miscommunication and misunderstandings. Consequently, some people preferred not to go to the *Puskesmas* when they were sick; instead, they decided to go directly to the regency hospital in Gerung without being referred to the hospital by the *Puskesmas,* as the guidelines required. This resulted in patients, especially for non-emergency cases, being rejected by the public hospital for not following the referral procedure. Some complained directly to the *Puskesmas*' head while others went directly to the Regency Health Office or to the hospital administrators. In 2007, the frustration erupted into protests that resulted in attacks on and damage to some of the *Puskesmas.*

Who are the actors in this story? They are the CCs that signed MOUs with the *Puskesmas,*[4] the Regency Health Office, the Population and Administration Bureau of the Regency of West Lombok (*Dinas Kependudukan dan Catatan Sipil Kabupaten Lombok Barat*), JMS, and the team of the Australian Community Development and Civil Society Strengthening Scheme (ACCESS), a programme of the Australian Department for Foreign Affairs and Trade (DFAT), which has worked in Lombok Barat since 2003 and is in its second phase until mid-2014.[5] ACCESS works with citizens' networks, alliances of citizen groups and nongovernmental organisations (NGOs) to show that active and inclusive participation, linked to responsive governance, contributes to improving public service delivery. ACCESS uses innovative strategic planning and implementation approaches such as Outcome Mapping and Appreciative Inquiry[6] to enable key actors to learn about what works and what is in place in terms of traditional norms and values that can help to achieve behavioural change.[7]

The next section describes the activities that were undertaken and that led to the MOUs.

3 The health insurance cards included both *Jamkesmas* (the national health insurance scheme) and *Jamkesda* (health insurance provided by the provincial or district government to cover poor and near-poor citizens who were missed by *Jamkesmas*).

4 Four CCs signed MOUs with the *Puskemas*. Two were visited during the authors' field visit.

5 ACCESS works in a total of 20 regencies *(kabupaten)* in four provinces: East Nusa Tenggara (NTT), NTB, South Sulawesi and Southeast Sulawesi.

6 *Outcome Mapping* is a monitoring and evaluation technique that measures programme effects in terms of changes that take place in beneficiaries' knowledge, attitudes, and behaviours. *Appreciative Inquiry* is an analysis method that begins by assuming that some things in a community, group, etc., are working well and can be built upon.

7 More information and material about ACCESS can be found at the project's website, www.access-indo.or.id.

Action 2

This Story of Change begins in 2006, when four CCs were established by an ACCESS-supported local CSO, *Solidaritas Perempuan*, which in turn received technical support from the Regional Research and Information Centre (*Pusat Telaah dan Informasi Regional*—PATTIRO), a national CSO contracted by ACCESS. CCs were formed at the village level and consisted of community representatives. The approach was designed to be adaptive, which means there is no blueprint for the structure of a CC. It depends on which groups, networks and leaders are present in a village. CCs can be formal or informal groups of people organised as a complaint handling group, as a co-operative or as other pre-existing groups that take on a few additional responsibilities.

In 2007, each of the four CCs signed an MOU with the *Puskesmas* in their area. These MOUs were straightforward documents with seven agreed points.[8] The CCs and *Puskesmas* also agreed through the MOUs to hold monthly meetings and quarterly workshops for sharing information.

JMS emerged from the CSO work supported by ACCESS and was officially registered in 2008. It was initially involved in capacity-development activities on Outcome Mapping, Networking, Appreciative Inquiry, etc. In 2009, JMS conducted a survey on the effectiveness of the four MOUs. The study compared citizens' satisfaction with the quality of health services in the four villages with a CC and an MOU, and in two villages without a CC and MOU. The results showed that respondents in villages with MOUs were more satisfied with the availability of and access to information from the *Puskesmas* than those in the other villages (over 80% satisfaction rate with *Puskesmas* Meninting and Penimbung compared to an average of 50% for *Puskesmas* Kediri and Sedayu, where there were no MOUs).

These positive results provided the impetus to experiment with other ideas—for example, the revitalisation of traditional forums between communities and local government institutions such as the *gawe rapah* (Box 1; see also Igit, 2011).

8 For example, from an unofficial translation of the MOU between the CC Mandiri and *Puskesmas* Penimbung in the village of Desa Kekeri: 'Both parties agree on the opening hours of the *Puskesmas*; both parties agree that within the service hours, no other unrelated services are allowed and services must be provided upon people's need; services for the poor are assured; complaints can be made in written or oral form through existing mechanisms; complaints should be addressed right away; issues that have not been regulated in this agreement will be regulated in detail in the attachment; this agreement shall come into force on the date it is promulgated'.

Box 1 – *Gawe Rapah*

Gawe rapah is a centuries-old tradition of the Sasak ethnic group in Lombok. It refers to formal meetings between citizens and public officials to discuss issues and find solutions to public services. The word *gawe* means 'a large meeting', while *rapah* comes from the Arabic *arafah*, which means 'peace'.

Sasak communities do not measure the relationship between people and their leaders along a hierarchy of who governs whom. They base the relationship between people and officials on norms such as *sebumbung* (to guard), *sewirang* (to defend) and *sejukung* (together). The underlying *gawe rapah* is that if the people feel that the government has committed an ill-advised policy, there is a forum for them to express and convey their aspirations and criticisms. The officials feel an obligation to respond to people's aspirations. Usually, criticising of officials outside the *gawe rapah* forum is avoided. It is in this spirit that the synergy between people and their leaders becomes crucial for the assurance of the fulfillment of good public service.

(Rais & Suhaimi, 2012)

In February 2010, JMS and its network members organised a *gawe rapah* which resulted, among other things, in a commitment by the *Bupati* (Head of District) to improve the quality of health services. This decision was followed in 2011 by an MOU between the Regency Health Office and JMS covering all *Puskesmas* in the district. The rationale was that in order to speed up the process of improving health services, a regency-wide MOU could be more beneficial and faster than the establishment of CCs in all villages and subsequent MOUs with all the *Puskesmas.*

In 2012, the Legal Aid and Study Institute (*Lembaga Studi dan Bantuan Hukum—LSBH*)—a member of the JMS network—conducted a public satisfaction survey on health services, by request of the *Bupati* of Lombok Barat. The results showed that six out of ten districts in Lombok Barat had a level of satisfaction above 50% (Narmada 78%, Kuripan 78%, Batu Layar 76%, Lingsar and Labuapi 72%, and Gunung Sari 56%) (LSBH, October 2012, pp. 124–136). The results were used as an input to a second *gawe rapah* in 2012, as well as for the annual planning by the Regency Health Office of Lombok Barat.

Importantly, the MOU between JMS and a government line agency (the Regency Health Office of Lombok Barat) also helped to reduce the mistrust and scepticism that for historical reasons exists in Indonesia between government and non-government actors. With the initial MOU, JMS strengthened the legitimacy it needed to assist the Regency Health Office. As a partner, JMS has since provided additional funding, capacity development, and input to

health plans and their implementation. As one public official put it, '*the more people can provide assistance in thinking about how to have healthy communities, the better.'* In addition, the MOU between the Regency Health Office and JMS helped to expand data collection about health services, which is the responsibility of the Health Office.

The next section describes the changes that the MOU introduced and how it changed attitudes and behaviours amongst the actors of the story.

3 Results

The MOUs are helping to re-establish trust between citizens and health service providers. The information and sharing that occurred during the MOU process and in the traditional forums, such as the *gawe rapah*, contributes to the decisions taken by the *Puskesmas* and the Regency Health Office. Importantly, they provide an opportunity for health officials to communicate their concerns, plans and achievements, thus strengthening the accountability of health service providers towards citizens. As of this writing, 45 CCs have been established. There are 132 villages in Lombok Barat regency, and the expansion in the number of CCs from the original four to 45 was facilitated not only by JMS but also through the effort of the CCs themselves. The CC mechanism gained popularity after the 2010 *gawe rapah*, when the success stories were shared that had emerged from the MOUs between the *Puskesmas* and the first four CCs.

While villages with a CC have shown greater citizen participation in the monitoring of health services, the plan is only to establish a CC where it makes sense to have one. Other existing groups—e.g., village cadres, *Posyandu* (Integrated Service Post) cadres,[9] and groups established by other programmes, such as the National Programme for Community Empowerment (*Program Nasional Pemberdayaan Masyarakat Mandiri*—PNPM)—can play the role of a CC.

What key changes have emerged from the MOUs?

The *Puskesmas* staff are more accountable and are observing the agreed-upon working hours. They are more polite and less discriminatory towards the poor, or towards citizens without the appropriate paperwork. This qualitative change is shown by the decrease in discrimination complaints towards *Puskesmas* staff. Every visit to the *Puskesmas* is recorded. Information about the health services that are available to customers is illustrated via a flowchart displayed at the health centre.

Before the MOU existed, neither citizens nor community representatives participated in meetings with the *Puskesmas*. Now there are regular monthly workshops and quarterly meetings involving CCs and *Puskesmas*. This means that community members are involved in taking decisions and planning

9 *Posyandu* are not clinics, but serve as villages' frontline service-delivery units for medical needs such as ante-natal care, first aid, and vaccinations.

alongside the *Puskesmas,* which has increased the transparency in decision making: '*CCs know their communities and the problems they have*,' mentioned a member of the CC representatives, '*and the decision-taking process of the* Puskesmas *benefits from the knowledge and interaction with the CCs*.'

The MOUs allow a two-way sharing of information and data. While the CCs handle most of the complaints, the *Puskesmas* provide technical knowledge about health regulations as well as diseases to CC members and through socialisation activities at the village level. Some *Puskesmas* now provide additional services—for example, to elderly people—based on issues identified through monthly meetings with CC representatives. Moreover, *Puskesmas* are aware that the CC really does know what is going on in the community and that it needs that knowledge to make better decisions. This is, in turn, helping the *Puskesmas*' maintain a reputation for delivering services as well as reporting on health outcomes to the Regency Health Office. One CC member mentioned that the existing cooperation can contribute to the development of proposals which are supported by relevant data and information and which are more likely to be accepted by local government for funding. However, there is at present no evidence that additional budgetary funding has been allocated.

The collaboration between JMS and the Regency Health Office is also two-way, as noted by a Health Office staff member: '*JMS has provided us with information from the findings from the analysis about the impact of the MOUs, which has been used also for the annual work plan and budget, while we [the Health Office] have provided JMS and CCs with technical information and knowledge related to health services.*'

The interaction and sharing linked to the MOU also creates space for new issues to be identified, as highlighted in the *gawe rapah* forum in 2012. Children without birth certificates (often the result of parents not registering their marriage and not having a marriage certificate) cannot be enrolled in school. Similarly, migrant workers who return to their home villages but do not officially register there cannot receive (if entitled) free services in *Puskesmas* and hospitals because they do not qualify for health insurance cards.[10]

The approach implemented by ACCESS and facilitated by JMS helps to revitalise traditional forums and social capital. It is built on the knowledge of what is *there* and it has also contributed to re-energise national programmes and approaches which aim at the decentralisation of health services such as the *Posyandu* and the *Desa Siaga* (Alert Village). *Desa Siaga* is one of the strategies introduced by the Ministry of Health to bring health services as close as possible to the people by building community-based networks to assist pregnant women, providing financial support to offset the costs of giving birth, providing transport to take women to the health post, etc. Villages' *Posyandu* usually operate once a month to provide check-ups for pregnant women, monitor the health and weight gain of infants, and establish a community-based surveillance system for communicable diseases. The discussion facilitated by JMS has helped to link up government programmes such as *Desa Siaga* with frontline and participatory health initiatives such as *Posyandu*.

10 For example, the Population and Administration Bureau has estimated that in Lombok Barat there are 180,000 people without an electronic health card.

A missing element in this story

One element still missing from the story is some form of analysis of the feedback about health services. JMS has conducted analyses and surveys about the impact of the MOUs, and CCs keep records about the complaints they receive from community members. In one case (in the village of Kekeri), the records go back to 2003. In this particular case, keeping records has become the way of working and has prepared the ground for more comprehensive collection of data into a regency database that can verify population and poverty data from the villages, produce graphs and other visualisation tools using Quantum GIS, and disseminate information via an online portal (*Sistem Administrasi dan Informasi Desa—SAID*). Using the example of the village of Kekeri, the data are collected, but there is limited or no analysis of trends in the complaints or the percentage changes from one year to the next. Why is that? It is because the sharing between CCs and *Puskesmas* is oral and not based on reports or research. So far, no *Puskesmas* or Health Office has demanded an analysis of the data held by the CC. This is partly cultural, but it is also determined by the urgency of decisions that community representatives and health service providers need to make as problems occur, which may leave limited or no time for analysis.

The role of ACCESS

The funding vehicle, ACCESS, was not mentioned as a central actor of this story during interviews and focus group discussions by CCs, community members, and local government officials. This is a positive sign. Instead, at the centre of the story, those working "on the ground"—JMS, CCs and *Puskesmas*—are sharing knowledge, exchanging experiences, and building trust in ways that have resulted in improved health services. One respondent noted that '*if ACCESS would be at the forefront and at the centre of the action, that would not be good; it would mean that the project has failed*.' ACCESS's role has been to suggest innovative ways of working—such as Appreciative Inquiry, Outcome Mapping, and other tools—as well as inputs—such as building capacity for developing a monitoring framework that JMS could use to assess the changes produced by the MOU. The capacity building was provided by strategic partners such as the Jakarta-based NGOs PATTIRO and *Yayasan Penguatan Partisipasi, Inisiatif dan Kemitraan Masyarakat Indonesia* (Participation Strengthening Foundation and Community Partnership Initiative, Indonesia—Yappika). This has allowed an adaptive and opportunistic approach in line with the idea that projects are social experiments where learning and adaptation are key elements for achieving positive outcomes (Rondinelli, 1992).

Conclusions 4

As noted earlier, 45 villages now have CCs, and the district MOU with the Regency Health Office covers all 15 *Puskesmas* in Lombok Barat. These numbers were captured by the monitoring and evaluation framework developed by ACCESS and JMS. This Story of Change complements those numbers with its description of changes in health services delivery systems, including more empowered citizens; better organisation of community representation; increased accountability by health services providers; increased satisfaction with the way health services are provided; the (re)discovery of traditional forums and spaces for sharing (non-research-based) knowledge; and, last but not least, the recognition that sharing knowledge (as well as different types of knowledge) helps in making more informed decisions.

What does this Story of Change say in terms of programming and scaling up? One of the informants mentioned that national policies are important but that they take place at the local level: '*This is where they are defined*.' Local decisions have a direct impact on people's lives. National policies have to be translated into better practice through decisions taken locally. This story shows that when decisions are taken together by government agencies and community representatives and are informed by local knowledge, real improvements can emerge.

Can it be replicated? It is believed so. How? By replicating the principles of engaging with existing actors, using traditional knowledge-sharing spaces, building a knowledge base that allows interventions to adapt to local circumstances, and embracing ambiguity and uncertainty rather than designing blueprints. This helps to find solutions that *best fit* local circumstances and traditional norms and values (Booth, 2011a; Booth, 2011b; Woolcock, 2013). Ultimately, interventions such as the one described in this Story of Change, as noted by Albert O. Hirschman (see Gladwell, 2013), are like journeys: they require adaptation, imagination, creativity and a willingness to learn. Having these traits can help 'to predict what we can predict and to react when we can't' (Green, 2013).

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