Independent Evaluation Report: *Women's Voices in the Monitoring and Improvement of Indonesia's Universal Health Care Insurance Services Project (Perempuan Kawal JKN)*

Final Report

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June 2025

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Glossary of terms

Collaborative social accountability	This term and approach was coined by the GPSA to differentiate from other forms of social accountability. It encompasses "processes whereby civil society organizations and public sector institutions with decision-making power and public management authority at different levels across the institutional and service delivery chain convene to analyze a problem, identify citizen participation mechanisms to help solve it, and agree on joint actions to co-produce solutions and appropriate responses" (Poli and Guerzovich, 2020). The approach to collaborative social accountability includes four main essential elements: problem-driven; context based; non-confrontational engagement; and multi-stakeholder coalitions and partnerships (GPSA MERL Guide, 2023).
GPSA Theory of Action	A Theory of Action sets out the strategy and tactics to be adopted for an intervention by a given organization, the stakeholders to be involved, and how the exogenous intervention will achieve the outcomes that are expected. The GPSA Theory of Action articulates the GPSA's overall approach to collaborative social accountability (GPSA MERL Guide, 2023).
Multi-stakeholder compact	The GPSA uses the term multi-stakeholder compact to refer to the operational and continuous working arrangements between civil society partners and other stakeholders, such as key public sector authorities and service providers, applying collaborative social accountability to a targeted service delivery problem. These compacts can exist at different levels, both formally and informally (GPSA MERL Guide, 2023).
Process tracing method	A qualitative, within-case analytical approach used to make strong causal inferences by systematically examining evidence for the presence of hypothesised causal mechanisms linking causes (X) to outcomes (Y). Drawing on Bayesian logic, PTM tests whether specific, case-based evidence confirms or disconfirms parts of a proposed mechanism, controlling for alternative explanations. It involves predicting and verifying observable manifestations of the mechanism's components to assess whether and how an intervention contributed to observed effects.
Ripple effect mapping	A participatory evaluation practice that brings to light the intended and unintended consequences of a project, tool/process or collaboration while building trust and connection among participants.
Social accountability	Social accountability seeks to make communities leading agents in their localized development story by: (1) improving the quality of goods and services, (2) primarily through monitoring and oversight of those goods and services, (3) citizens' collective, rather than

	individual, efforts to hold power-holders (primarily service providers and bureaucrats, secondarily politicians) to account, (4) providing a concrete mechanism to rework the social contract and strengthen local systems, in the sense of transforming state-society relationships and the norms and power dynamics associated with them (Guerzovich, 2022, expanding on Aston, 2021) (GPSA MERL Guide, 2023).
Sustainability	When and how a project's net benefits continue or be likely to continue after the end of the project (OECD, 2019). For the GPSA, this is not wholesale uptake or replication of collaborative social accountability processes, but rather certain elements of these processes and/or the use of insights and lessons gained through a GPSA project, in the longer-term by the public sector or other relevant stakeholders (GPSA MERL Guide, 2023).
Theory-based evaluation	An approach to assessing programs that uses a clearly articulated program theory; a predictive logic model explaining how and why an intervention is expected to produce outcomes. It evaluates both the implementation process and longer-term results by examining the underlying assumptions and causal pathways specific to the program being assessed.

Executive summary

This evaluation examines the Global Partnership for Social Accountability (GPSA)-supported social accountability project led by Fatayat and AKATIGA in Indonesia, focusing on its contribution to improving access to quality healthcare for underserved populations. Specifically, it explores how the collaborative social accountability (CSA) model was implemented, the mechanisms that drove change, the outcomes achieved, and the broader strategic implications. The findings offer insights into both the effectiveness and limitations of GPSA's approach and highlight the conditions necessary for CSA to support long-term improvements in service delivery for marginalized groups.

The initiative was implemented in a national context marked by substantial progress toward Universal Health Coverage (UHC) through the National Health Insurance (NHI/JKN) scheme, administered by BPJS Health. However, structural barriers – such as data gaps, bureaucratic hurdles, and limited outreach and capability – continue to impede access for the poorest populations. To address these gaps, the Project sought to strengthen collaboration between civil society actors, service providers, and government agencies through locally driven, relationship-based outreach and multi-stakeholder engagement.

A theory-based evaluation approach was used, combining participatory methods and causal inference. The Project's Theory of Action was articulated through Ripple Effect Mapping (REM), while process tracing was applied to test three causal pathways: (1) how Fatayat's community outreach improved NHI enrollment and service use; (2) how multi-stakeholder forums enhanced service responsiveness; and (3) how project efforts contributed to the institutionalization of CSA practices. Evidence was gathered through consultations and interviews with 62 stakeholders and beneficiaries, including fieldwork across three sites – Muaro Jambi, Tegal, and Kediri – and complemented by a review of documents and monitoring data.

Key Findings

What did the Project achieve?

The evaluation found that the Project made tangible contributions to improving access to NHI services for poor and vulnerable groups. Fatayat cadres used embedded networks and local credibility to identify individuals excluded from formal systems, assist with enrollment, and support access to care. Process tracing confirmed a credible causal link from outreach to service use, demonstrating that the Project filled critical gaps left by national systems. While UHC gains during the period were largely driven by broader government programs, the Project clearly played a targeted and complementary role. However, the lack of outcome-specific tracking tools limited the ability to fully quantify its impact on the most vulnerable.

While access improved, gains in service quality and systemic responsiveness were uneven. Multi-stakeholder compacts led to localized improvements, but these varied by district and lacked mechanisms for broader policy uptake at the national government level. Stakeholders valued the Project's ability to reach excluded populations, yet field-level insights were rarely translated into institutional learning. Beneficiaries frequently cited the easy-to-approach and dedication of Fatayat cadres as key to accessing care, qualities that helped overcome barriers to access.

How did the interventions contribute to results?

The Project was most effective where community outreach, technical support, and coordination converged. Fatayat cadres – trained under the Project – used relational, referral-based strategies to reach vulnerable individuals, often through informal channels like word-of-mouth or hospital staff. These methods extended the reach well beyond initial targets. In emergency cases, registering patients as independent NHI members as a workaround helped secure care but led to debt accumulation and future coverage gaps, highlighting persistent system-level flaws.

What set the initiative apart was not just its design but the dedication of the cadres, many of whom operated well beyond their formal roles, driven by personal conviction and a strong sense of civic duty. These motivations, grounded in ethical and religious values, enabled them to serve as effective and respected liaisons in communities often overlooked by public services. While coordination and civic engagement capacities grew, technical and advocacy skills remained limited, reducing the model's influence at the systemic level. The Project's national policy influence was also modest, constrained by its local focus and limited leverage with central ministries. Nonetheless, its groundwork has laid the foundation for more durable institutional collaboration, particularly through early-stage engagement with BPJS Health.

What are the opportunities and challenges for sustainable collaboration?

The emerging partnership between Fatayat, AKATIGA, and BPJS Health under the PESIAR program presents a concrete opportunity to continue CSA practices, with a national rollout targeting underserved villages. Fatayat's potential role in this initiative, combined with existing coordination tools, offers a promising extension of GPSA's grassroots model. However, the model has yet to be formally adopted by government actors or scaled within the World Bank portfolio.

The Project experience highlighted that genuine cooperation relies not only on shared goals but also on the ability to navigate informal dynamics and institutional complexity. Fatayat's community presence helped bridge access gaps but also raised the risk of network bias, where those outside existing circles may be unintentionally excluded. While cadres aimed to serve all in need, access still often depended on social connections. Future CSA efforts must find ways to broaden these networks and deliberately include those most likely to be left out.

Additionally, the dual role of civil society organizations like Fatayat – as both community representatives and institutional partners – requires careful balance. Their effectiveness depends on maintaining legitimacy across both spheres. As CSA moves forward, civil society must not only deliver services but also shape priorities. Doing so requires shifting from reactive problem-solving toward proactive agenda-setting, where community insights inform policy and where state systems recognize the value of grounded, community-based action. Rather than expanding reach for its own sake, the challenge ahead lies in building more inclusive, responsive, and connected systems that can reach the hardest to serve – and stay with them.

Recommendations

For strengthening CSA in the Indonesian health sector (Fatayat, AKATIGA, the World Bank Country Office, government stakeholders):

1. Expand peer-and community-based identification methods. Formalize and scale Fatayat's snowballing approach into a structured, ethical-aware method – piloted and integrated with formal systems – to identify those missed by national data.
2. Establish a locally validated registry of highly vulnerable individuals to coordinate outreach and support.

3. Embed community-based outreach roles into the NHI system with clear mandates and strong feedback mechanisms.
4. Broaden CSA by engaging diverse grassroots actors, especially in underserved regions, with collaborative works and targeted support.

For global GPSA programming (World Bank, CSA practitioners, development partner organizations and civil society organizations):

1. Expand CSA success indicators to reflect community-based, contextual outcomes, such as community organizing, civic awareness, and local problem-solving alongside policy reform.
2. Strengthen beneficiary participation in shaping CSA approaches. Ground CSA in the voices of poor and vulnerable groups through participatory feedback, reflective monitoring, and ongoing beneficiary tracking.
3. Invest in partner capacity, leadership, community mobilization, and monitoring systems to improve CSA effectiveness and sustainability, while continuing to support a consortium model between organizations with complementary partners.

1. Introduction

1.1 Purpose of this report

This report presents findings from an independent evaluation of the Women's Voices in the Monitoring and Improvement of Indonesia's Universal Health Care Insurance Services project (*Perempuan Kawal JKN*) (henceforth the Project), supported by the World Bank–funded Global Partnership for Social Accountability (GPSA). The evaluation provides evidence on key outcomes, effectiveness, sustainability, and learning generated by the Project. It offers conclusions and recommendations highlighting both areas of strength and opportunities for improvement, with the aim of contributing to a practical discourse on social accountability and enhancing sustainable impact.

Established by the World Bank in 2012, the GPSA is a multi-donor trust fund designed to support civil society and promote collaborative governance aimed at reform and development. It contributes to governance improvements and better service delivery by fostering social accountability processes that engage citizens, communities, civil society organizations, and public sector institutions. For the Indonesian project, the GPSA allocated US$0.73 million to support implementation from April 2021 to June 2025. Activities spanned eight districts and cities, focusing on improving health service delivery for low-income and vulnerable populations. Central to the Project was the development of collaborative capacities among civil society actors, government stakeholders, and service providers.

1.2 Evaluation aims, scope, and audience

The purpose of this evaluation is to determine whether the Project was successful and whether it achieved success in line with the GPSA's vision of effective collaborative social accountability, taking into account the Project's specific context, conditions, and underlying assumptions. As outlined in the evaluation's Terms of Reference, it also aims to contribute to collaborative social accountability strategies that practitioners in the sector can use. This contribution is considered part of the Project's input into the GPSA's global Theory of Action and knowledge platform. Specifically, the evaluation aims to:

1. Assess the Project's key outcomes and evaluate their plausibility for achieving the intended development objectives.
2. Analyze the impact of collaborative social accountability mechanisms across diverse groups, conditions, and contexts.
3. Evaluate the long-term viability of these initiatives and identify the conditions necessary to sustain their impact.
4. Extract key lessons on social accountability and improvement of health services outreach for vulnerable groups.

While the primary audience for this evaluation report is the World Bank GPSA team, its conclusions and recommendations are also relevant to all stakeholders of the Project, as well as researchers and broader public audiences. A follow-on activity is anticipated, making the evaluation findings especially timely. The World Bank will publish the report on the GPSA website.

1.3 Report structure

The remainder of this report is organized as follows:

- **Section 2 Context of the project** describes the background and rationale for the Project. It provides an overview of the Project's governance structure, key activities, geographic focus, target groups and Theory of Action.
- **Section 3 Evaluation questions** presents the key evaluation questions and sub-questions.
- **Section 4 Evaluation approach and methods** outlines the evaluation approach and conceptual framework, the methods used, the stakeholders consulted, ethical considerations and safeguarding measures. It also discusses methodological limitations and how they were addressed.
- **Section 5 Findings** presents the evaluation findings, organized around the key evaluation question (KEQ), its corresponding sub-questions (sub-EQs), and the results of the process tracing analysis.
- **Section 6 Conclusion** summarizes the main conclusions drawn from the synthesis of findings across all KEQs.
- **Section 7 Recommendation** provides a set of actionable recommendations, based on the evaluation's findings and conclusions, to inform relevant practice in social accountability initiatives.

2. Context of the project

The Women's Voices in the Monitoring and Improvement of Indonesia's Universal Health Care Insurance Services project (*Perempuan Kawal JKN*) (henceforth the Project) was initiated to address critical gaps in the service delivery and access to health services for low-income and vulnerable populations. Launched in April 2021 and running through June 2025, the Project was implemented under the World Bank's Global Partnership for Social Accountability (GPSA). Anchored in the GPSA's Theory of Action, the Project viewed improved access and service delivery as the result of collaborative social accountability.

Indonesia's National Health Insurance system (*Jaminan Kesehatan Nasional*, or NHI) is among the most ambitious universal health insurance (UHC) efforts in lower-middle-income countries. However, systemic and structural barriers continue to hinder equitable access. This GPSA project responded to those challenges through a social accountability lens, emphasizing the importance of capacity building for collaboration and adaptive, joint problem-solving with public sector actors and service providers.

The Project was implemented by *Fatayat*, a national grassroots Muslim women's organization affiliated with *Nahdlatul Ulama (NU)*, Indonesia's largest Islamic organization, in collaboration with *AKATIGA*, a national research institute serving as the lead organization and fiduciary responsible partner. NU encompasses multiple organizations working across religious, social, educational and philanthropic sectors. AKATIGA provided technical support, led the monitoring, evaluation, and learning (MEL) components, and coordinated national-level advocacy efforts. The Project was implemented in eight districts and cities across six provinces: Bandung (West Java); Muaro Jambi and Jambi City (Jambi); Tegal and Pati (Central Java); Kediri and Blitar (East Java); and Ternate (North Maluku). Area selection was informed by Fatayat's organizational presence, the World Bank Country Office's guidance, and criteria developed by AKATIGA.

Fatayat has over eight million members and operates through a nationwide structure aligned with government administrative levels. Many members serve as teachers, *Posyandu*[1] cadres, or local volunteers, earning trust and respect within their communities. A growing number of Fatayat members also hold influential roles in political and government institutions, including as regional heads, members of parliament, and leaders of public agencies at both the national and local levels. This extensive network makes Fatayat a regular partner in government outreach initiatives. Fatayat also implements projects focused on issues such as reproductive health and trafficking prevention, primarily through socialization and education activities.

As previously noted, the Project was developed in response to persistent structural inequalities in access to and delivery of services under the NHI system. Many low-income individuals, especially those in the informal sector, are excluded from subsidized NHI coverage due to data gaps, fluctuating incomes, or incomplete documentation. Even among those enrolled, systemic barriers – such as out-of-pocket expenses for non-medical costs, limited accessibility, and the shortage of primary clinics and hospitals – continue to restrict access to healthcare (see Erlangga et al., 2018; Saputri and Murniati, 2023).

The Project's Theory of Action (ToA) envisions its long-term impact as:

[1] In Indonesia, a *Posyandu* (*Pos Pelayanan Terpadu*) is a community-based, small health post or unit run by volunteers with *Puskesmas* support, usually providing basic services in rural and underserved areas.

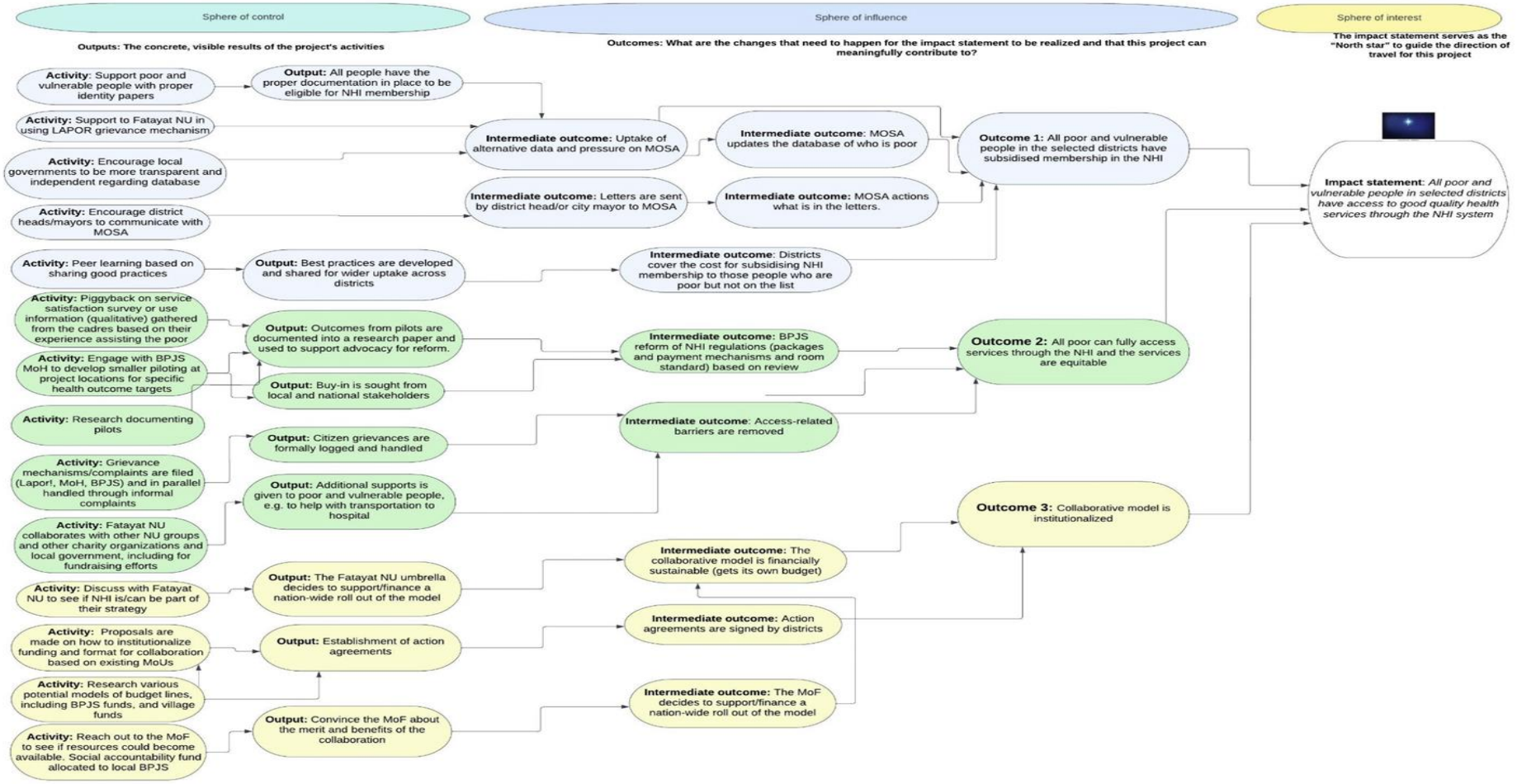
"All poor and vulnerable people in selected districts have access to good quality health services through the NHI system."

To realize this goal, the Project was structured around three outcome streams:

- ⇒ **Outcome 1:** Poor and vulnerable people in selected districts have subsidized NHI membership.
- ⇒ **Outcome 2:** Enrolled individuals access equitable, high-quality services through the NHI.
- ⇒ **Outcome 3:** The collaborative model of social accountability is institutionalized.

Figure 1 illustrates the ToA used in the Mid-Term Review Mission. This evaluation refers to that ToA, in addition to GPSA's global ToA narratives.

Figure 1: The Project's Theory of Action



Source: GPSA Mid-Term Review Mission Aide-Memoire

As illustrated in Figure 1 above, each outcome stream delineates a sequence of activities, outputs, and intermediate outcomes aimed at, e.g. addressing data gaps, enhancing service responsiveness, and fostering budgetary and political commitment to inclusion.

The Project built on several critical assumptions embedded in the GPSA global ToA:

- ⇒ Government and civil society actors are both willing and capable of co-producing solutions.
- ⇒ Civil society actors, particularly those with grassroots legitimacy, such as Fatayat, can serve as credible interlocutors.
- ⇒ Adaptive management and continuous learning are essential to program effectiveness.
- ⇒ Collaborative social accountability reinforces broader health policy and UHC reform efforts.
- ⇒ Institutional buy-in, political will, and operational capacity at both local and national levels are sufficient to act on citizen feedback.

In practice, the Project comprises two main, interconnected components:

- ⇒ Community-level engagement in which Fatayat cadres support low-income populations by providing information and assistance on National Health Insurance (NHI) eligibility, registration, and service access.
- ⇒ Feedback and multi-stakeholder engagement, in which issues emerging from community activities are escalated to district-level forums involving the Office of Health, Social Service Office, BPJS Health, and other service providers. Informal platforms, such as WhatsApp groups, facilitate coordination and follow-up on responses.

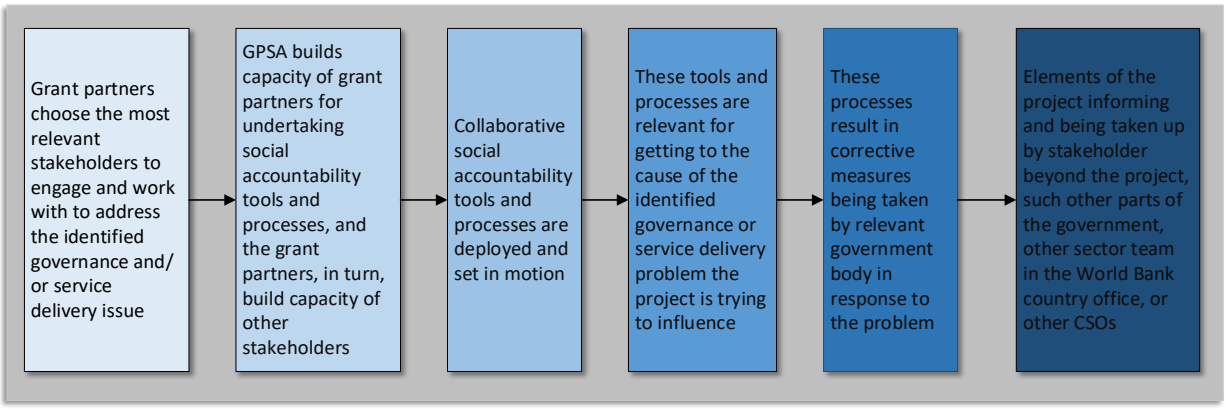
AKATIGA's role was to strengthen Fatayat teams' capacity and lead data collection, MEL activities, and advocacy efforts. The MEL system adopted a feedback loop approach, integrating regular online meetings, monitoring visits, and daily communication channels.

At the local level, implementation was carried out by Fatayat district teams, typically comprising a coordinator, a data officer, and five health cadres. Coordination mechanisms included memorandums of understanding (MoUs), WhatsApp-based communication, and joint monitoring activities.

At the national level, the Project was connected to the Ministry of Health (MoH), BPJS Health, and the Ministry of Social Affairs (MoSA), each responsible for service delivery, insurance administration, and social welfare targeting, respectively. MoSA manages the Integrated Social Welfare Database (DTKS), which determines eligibility for subsidized NHI.

The simplified framing of how change is expected to happen is presented in Figure 2 below.

Figure 2: How change is expected to happen



Source: Independent consultant, GPSA Mid-Term Review Mission Aide-Memoire

3. Evaluation questions

The evaluation addresses key evaluation questions (KEQs) and subsidiary lines of inquiry as outlined in Table 1.

Table 1: Key evaluation questions and sub-questions

Key evaluation questions	Sub-questions
KEQ1: What did the Project achieve in relation to its Project Development Objective?	• How do beneficiaries and key stakeholders perceive the Project's impact on governance and service delivery improvements?
KEQ2: How did the Project's key interventions (capacity building and the Project's use of collaborative social accountability processes/tools) contribute to or drive the observed results?	• What were the specific roles of Fatayat central and local, AKATIGA, and their collaboration in achieving these results? • Were fit-for-purpose multi-stakeholder compacts established, and did they include the most relevant stakeholders? How was stakeholder selection determined? • What additional capacity, if any, was built among implementing organizations (Fatayat NU), and how did this enhance strategic programming? How does Fatayat's position as a faith-based women's organization influence program implementation? • What capacity improvements, if any, were observed among multi-stakeholder compact members, and did these enable more effective joint problem-solving? • What collaborative social accountability (CSA) processes did the multi-stakeholder compacts use? Did these lead to meaningful engagement with public bodies? What factors facilitated or hindered their success? • Did CSA processes lead to public bodies addressing identified problems? What factors contributed to or obstructed these outcomes? • What are the implications of district-driven social accountability given challenges in central ministry engagement? • Did the project demonstrate adaptive learning, making course corrections based on monitoring, evaluation, and shifts in the external context? If so, what are specific examples? If not, what barriers prevented adaptation?
KEQ3: What are the opportunities and challenges for continued	• Have any elements of the CSA processes been replicated or adapted in other locations or policy areas by the government, the World Bank country office, other donors, or civil society

Key evaluation questions	Sub-questions
Fatayat-government collaboration?	organizations? What factors facilitated or hindered this scale-up? • Can civil society-government collaboration be institutionalized within the current context and, if not, what is needed to facilitate this?

4. Evaluation approach and methods

4.1 Evaluation framework

This evaluation uses a theory-based approach with process-tracing method (Chen, 2012; Rogers, 2007; George and Bennet, 2005; Beach and Pedersen, 2013; Bennett and Checkel, 2015; Bamanyaki and Holvoet, 2016) to assess the effects of the GPSA's collaborative social accountability initiative on influencing access to and the quality of Indonesia's NHI services for poor and vulnerable populations. The Project's theories of action serve as the analytical framework for identifying, unpacking and testing causal mechanisms.

Throughout the implementation of the Project, several theories of action evolved and were refined – most notably the version developed during the mid-term review in May 2023, which introduced a revised framing of how change occurs (see Figure 1 and 2 in Section 2). For this evaluation, these frameworks have been unpacked, analyzed, and synthesized into an implicit theory outlining how civil society-led collaborative social accountability initiatives (CSA) are expected to improve access to and delivery of health services within the NHI system.

Process tracing method (PTM) is particularly well-suited for this evaluation because it enables rigorous, within-case causal inference in complex, multi-actor interventions. By focusing on evidence of causal mechanisms and testing hypotheses[2] with structured empirical evidence, it supports robust conclusions about contribution and influence. PTM draws on Bayesian logic, offering a structured framework for evaluating whether specific evidence confirms or disconfirms a hypothesis about the existence of a part within a causal mechanism, relative to the prior probability of encountering such evidence (Beach and Pedersen, 2013: 83).

The approach unfolds in two main stages. First, theory-based evaluation is used to make explicit the implicit project theory underlying civil society-led CSA initiatives and how these are expected to drive improvements in access to and delivery of health services in NHI. **A participatory Ripple Effect Mapping (REM)** technique is applied to identify the most important outcomes and key activities implemented by engaging project implementers and stakeholders during the evaluation design phase.

Second, process tracing method is applied through a three-step procedure: (a) formulation of a plausible causal mechanism grounded in the causal links identified in the project theory; (b) operationalization of this mechanism by generating case-specific predictions of observable manifestations – if the mechanism is functioning – alongside appropriate empirical tests grounded in Bayesian logic; and (c) evaluation of the observed evidence for each part of the mechanism using Bayesian reasoning to assess whether confidence in the presence and functioning of individual components can be updated (Bamanyaki and Holvoet, 2016: 17).

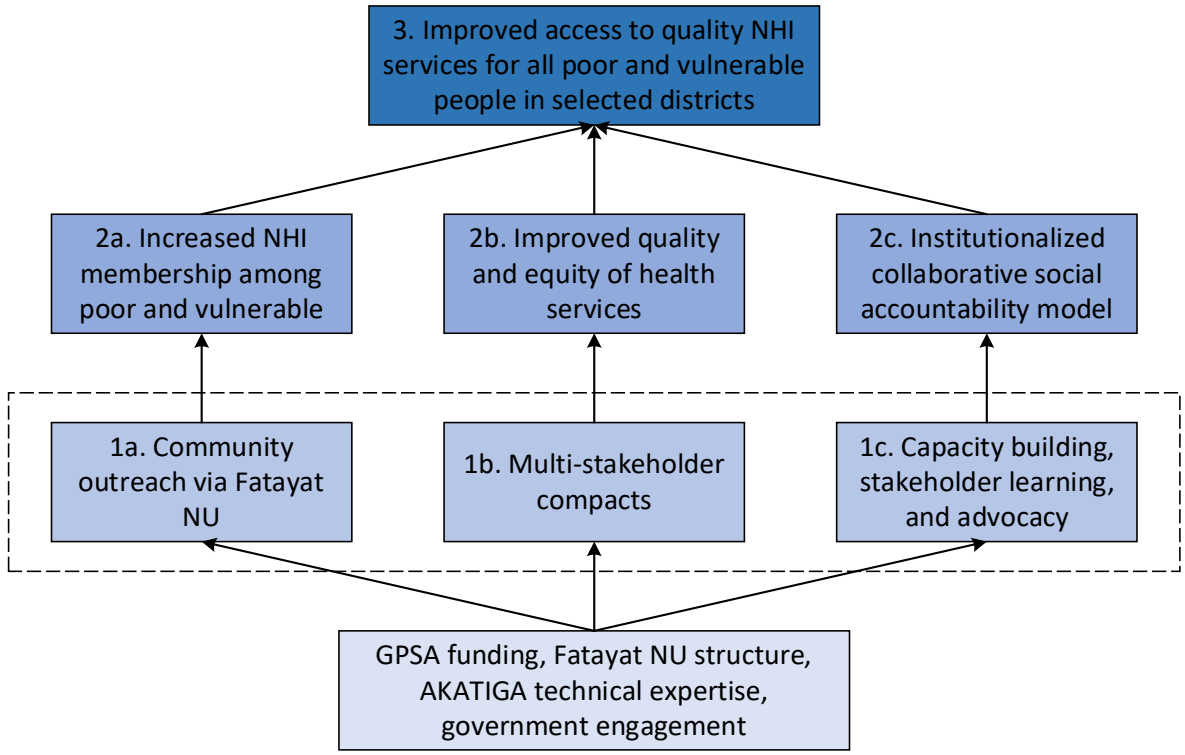
This evaluation has employed a largely qualitative methods approach to gathering evidence for the process tracing, using primary and secondary collected data and several analytical methods to answer the KEQs. All evidence was aggregated at the project level to ensure that the findings support recommendations and facilitate learning at the broadest level.

[2] We use the term hypothesis to denote hypotheses about the existence of each part of a theorized causal mechanism (see Beach and Pedersen, 2013: 83).

4.1.1 Theorizing the causal mechanisms

As previously described, the Project's theories of action were unpacked and synthesized into a working theory that informed both the evaluation design and analysis. This working theory was iteratively refined as new insights emerged through document review, Ripple Effect Mapping (REM), and stakeholder consultations. Two REM sessions were conducted during the evaluation design phase: the first with Fatayat and AKATIGA, and the second with stakeholders from multiple locations. Findings from these sessions informed revisions to the Theory of Action (see Figure 3 below) and guided further data collection.

Figure 3: Updated project theory



Source: Independent consultant

The theory presented in Figure 3 is a programmatic theory (Weiss, 1997), as it elaborates the causal-chain responses between the initiatives of the CSA and the occurrence of the anticipated changes to NHI access and service delivery. It is theorized that the civil society (Fatayat and AKATIGA with support from GPSA) engages with government and implements a three-pronged pathway that targets district-level actors, national policy makers, and grassroots community members.

First, Fatayat cadres inform, assist, and accompany low-income individuals through NHI registration and access processes (box 1a). This is expected to increase NHI membership among poor and vulnerable groups, resulting from effective outreach and registration support (box 2a).

Second, multi-stakeholder compacts serve as structured platforms where Fatayat aggregates and channels issues to relevant government actors and service providers (box 1b). These interventions are expected to improve the quality and equity of health services driven by problem identification, issue escalation, and responsive service delivery (box 2b).

Third, capacity building, learning sessions, and advocacy activities strengthen local actors' ability to generate, interpret, and use data to inform decision-making and policy engagement (box 1c). This is expected to develop a collaborative social accountability model where successful practices become routine in local governance and processes (box 2c).

It is expected that the increased NHI membership, improved quality and equity of health services and the practice of collaborative social accountability model will further improve access to quality services for all poor and vulnerable populations, meaning the GPSA-supported collaborative social accountability model – implemented by Fatayat NU and AKATIGA – contributed to increased access to and improved quality of health services under Indonesia's NHI system for poor and vulnerable populations (box 3).

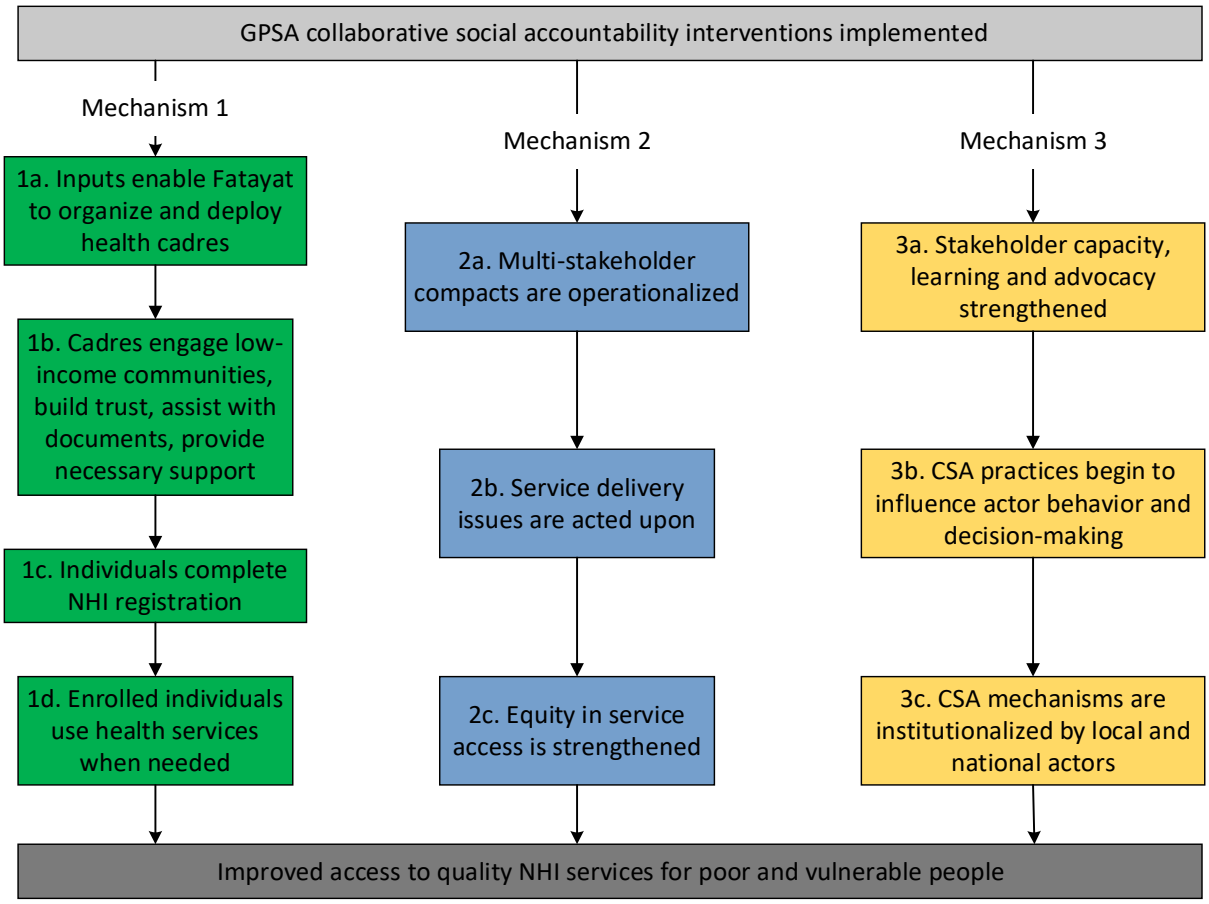
In this evaluation, we adopt the terminology of *uniqueness* and *certainty* to characterize two key types of empirical predictions (Bamanyaki & Holvoet, 2016). *Unique predictions* are those that do not overlap with the expectations of alternative theories, while *certain predictions* are unequivocal; if the expected evidence is not observed, the theory fails the empirical test.

These concepts underpin two primary types of empirical tests. Uniqueness tests, also known as *smoking gun tests*, support confirmation of a hypothesized mechanism by identifying 'signature' evidence that is highly unlikely to be generated by any other mechanism. **Certainty tests**, or *hoop tests*, are designed to disconfirm hypotheses: if the expected evidence is absent, the mechanism can be ruled out. Two additional test types include the *straw-in-the-wind test*, which offers weak evidentiary weight and neither confirms nor disconfirms a hypothesis, and the *doubly-decisive test*, which both confirms the focal hypothesis and eliminates its plausible alternatives.

4.1.2 Operationalizing the causal mechanisms

The three-part causal mechanism tested in this evaluation to assess the strength of our confidence in whether the project's anticipated outcomes and causal pathways hold in practice is presented in Figure 4.

Figure 4: Causal mechanism for Women's Voices in the Monitoring and Improvement of Indonesia's Universal Health Care Insurance Services project



Source: Independent consultant

Table 2 below presents a detailed overview of the causal mechanisms, types of tests, and evidence sources applied in process tracing.

Table 2: Testing causal mechanism

Mechanism	Causal way	Test type	Evidence source
Mechanism 1 – Community outreach led by Fatayat (*green boxes*)	1. Project inputs (funding, technical assistance, stakeholder engagement) enabled Fatayat to organize and deploy cadres	Hoop test	Internal documents, training materials, stakeholder engagement records/cadre reports
	2. Cadres effectively engaged communities and provided NHI-related support	Straw-in-the-wind test	Cadre reports, community meeting notes, interviews
	3. These efforts led to actual NHI registrations	Smoking gun test	BPJS interviews, registration forms, community interviews
	4. Newly registered individuals accessed health services	Hoop test	BPJS interviews, hospital visit records, community interviews
Mechanism 2 – Multi-stakeholder compacts (*blue boxes*)	1. Fatayat and AKATIGA, with GPSA support, established and sustained inclusive platforms for access and service discussions	Hoop test	Forum records, meeting attendance lists, interviews

Mechanism	Causal way	Test type	Evidence source
	2. Issues raised through forums triggered concrete responses by institutional actors	Smoking gun test	Service changes documented, interviews
	3. These changes improved equitable access for underserved populations	Hoop test	Visit or service delivery records, community feedback, stakeholder interviews
Mechanism 3 – Institutionalization of collaborative social accountability (*orange boxes*)	1. Project-supported activities improved stakeholder understanding and engagement with CSA principles	Hoop test	Stakeholder interviews, meeting records
	2. Increased capacity led to behavioral shifts, such as adoption of CSA practices	Straw-in-the-wind test	Observation, interviews
	3. CSA mechanisms formally integrated into policy or operational frameworks	Smoking gun test	Policy document or official memo, interviews

The causal mechanism is situated within an initial condition in which government processes lack meaningful citizen engagement, and both state and civil society actors have limited experience or capacity for collaborative problem-solving.[3] Alternative plausible explanations for observed improvements in access to NHI services for poor and vulnerable populations include: (1) the influence of other civil society initiatives operating in the same districts; and (2) the downstream effects of national programs targeting expanded NHI access and service quality, which may have independently contributed to district-level outcomes.

4.2 Data collection and analytical methods

4.2.1 Data collection

This evaluation was designed to gather data and insights from a broad range of stakeholders and beneficiaries. Data collection began on March 2, 2025, with the Ripple Effect Mapping (REM) session with the Project team. Methods included individual and group interviews, Focus Group Discussions (FGD), REM, and a review of existing documents and monitoring, evaluation, results and learning (MERL) data.

The document review covered project documents – prioritizing monitoring reports, high-level meeting notes, policy briefs and papers, and MEL data – and other relevant documents, including research papers. This review was conducted during the evaluation design phase to help identify priority topics for further exploration in REM sessions and stakeholder interviews. In addition, the GPSA team provided documents from past GPSA project evaluations, which were used to further inform the design and planning of this evaluation.

[3] GPSA MERL Guide, p. 30.

In coordination with the World Bank GPSA team and AKATIGA, three sites were selected from eight project locations. The selection was based on purposive considerations such as Fatayat's organizational structure and network, as well as levels of Universal Health Coverage (UHC). This sample is not representative and should not be interpreted as reflecting all project sites, given the considerable variation across local Fatayat branches and regional contexts.

Table 3: Sites visited for primary data collection

District	Province
Muaro Jambi	Jambi
Tegal	Central Java
Kediri	East Java

Internal stakeholders were selected for group interviews, focus discussions, and REM based on their roles within the Project's governance and implementation structures. These included lead staff and cadres from Fatayat, as well as senior staff from AKATIGA. The internal stakeholders who participated in these discussions are listed in Table 4. Representatives from Fatayat and AKATIGA participated in both the REM online session and the on-site group discussions during the evaluation field visit; they were counted as a single participant.

Table 4: Completed internal stakeholder consultations

Organization	Number of participants	Interview details		
		Female	Male	Mode
AKATIGA	4	3	1	Online REM and in-person FGD
Fatayat central	2	2	-	Online REM
Fatayat local	6	6	-	Online REM and in-person group interview
Fatayat local	15	15	-	In-person group interview
Total	**27**	**26**	**1**	

Following consultation with the Project team, external stakeholders familiar with the Project or broader policy and operational contexts were identified for interviews. Individuals were selected based on their diverse roles and relevant knowledge regarding the rationale for the Project and collaboration with Fatayat and AKATIGA. As shown in Table 5, a total of 23 external interviews were conducted, including with government stakeholders and service providers.

Table 5: Completed external stakeholder interviews

Organization	Number of interviews	Interview details		
		Female	Male	Mode
Dinas Kesehatan – Health Office	5	2	3	In-person
Dinas Sosial – Social Affairs Office	5	1	4	In-person
BPJS Health	3	3	-	In-person
Baznas – National Zakat Agency	5	1	4	In-person
Regional Public Hospital	5	2	3	In-person
Total	**23**	**9**	**14**	

We conducted in-person visits with selected beneficiaries across three sites, purposively chosen to reflect the diversity of beneficiary types. Fatayat cadres who had previously supported these beneficiaries made contact and accompanied them during the visits. Some beneficiaries were only reached on the day of the visit and were interviewed based on availability. During these encounters, the independent evaluator posed a limited number of questions, primarily exploring the challenges beneficiaries faced and the support they received from Fatayat. The respondent's answers were documented but not audio-recorded. At the beginning of each visit, it was clarified that the purpose was not related to any current or potential future support, in order to encourage respondents to answer questions based on their actual circumstances. Several respondents were elderly, young children, or persons with disabilities, and were accompanied by family members (see Table 6 for an overview of beneficiaries).

Table 6: Varied backgrounds of beneficiaries reached

Types	Number of beneficiaries
Not yet registered and enrolled as prospective recipients of NIH contribution assistance or regionally funded health insurance.	1 | 1 | 1 Total: 3
Individuals assisted in accessing services, paying premium outstanding or hospital fees, or receiving other forms of support (cost of living).	2 | 2 | 3 Total: 7
Not yet registered and enrolled as NHI self-paying participants.	1 | 1 | Total: 2

Muaro Jambi
Tegal
Kediri

Most beneficiaries were individuals identified as poor, either by community cadres or village/neighborhood leaders. They included those not yet registered with the NHI, those who were registered but unable to access services, those with outstanding premium payments, or those listed as self-paying participants despite being recognized as poor. Some were not recorded in the Integrated

Social Welfare Database (DTKS) or other official government registries concerning low-income populations. A total of 12 beneficiaries were reached. The largest group of respondents consisted of individuals who had received assistance with NHI registration and required support to access health services when ill. Cadres and local officials accompanying the field visits reported that many other residents in their villages or neighborhoods were also unregistered with NHI – often due to pending DTKS inclusion – or had not accessed services due to various constraints, including illness, old age, or disability.

4.2.2 Data triangulation and analysis

Data collected through interviews (stakeholders and Project team), FGDs, and REM were transcribed and organized according to each evaluation question (EQ) and process tracing component. All evidence from the district level was aggregated at the project level to enable comprehensive analysis.

Three different data analysis methods were employed:

- **Process tracing:** The evaluation has used process tracing method to test causal claims underlying the GPSA's Theory of Action.
- **Content analysis:** The evaluation has applied content analysis to understand patterns and divergence across data from interviews, FGDs, meeting reports, and field observations. Wordclouds with Nvivo were generated to identify frequently discussed issues.
- **Deep dives:** We looked into data collected to capture implementation dynamics, variations in practice, and lived experiences of those involved in the Project. These in-depth explorations enriched the evaluation by providing concrete examples, contextual nuance, and bottom-up insights that complemented broader findings and supported triangulation of evidence.

Wherever possible, we triangulated findings for each EQ using multiple sources, including interviews, project documents, and monitoring data. Two consultative meetings with the World Bank GPSA team (including the Evaluation Adviser and the Social Accountability and Stakeholder Engagement Specialist) were held on June 2 and 25, 2025, to discuss and interpret emerging findings, both before and during the report-writing phase. A face-to-face FGD with the full AKATIGA team took place on May 28, 2025, to validate field visit findings and explore key intervention aspects in greater depth.

The independent evaluator also attended the Project's closing event in Jakarta on May 12–13, 2025, which was attended by the full Project team, including representatives from the World Bank, the GPSA Secretariat, Fatayat, and AKATIGA. A dedicated session on this independent evaluation was held to conduct collective sense-making of preliminary findings and to gather stakeholder reflections on the most important results and lessons learned from the Project's key interventions. Discussions were held in small groups and presented in a panel session. The outputs from this event were used to triangulate and enrich the evaluation findings.

4.3 Limitations and mitigations

The following limitations have been encountered and mitigated to the extent possible.

Table 7: Limitations encountered and mitigated

Limitation	Mitigation
Availability and quality of data: The availability and quality of secondary data across the project were inconsistent, with cadres activity reports lacking the detail necessary for rigorous analysis of key intervention outputs. As a result, the range and strength of evidence supporting some evaluation questions were limited, with the analysis relying heavily on interviews.	Where gaps in secondary data were identified, we supplemented the analysis with primary sources, including interviews with stakeholders and the Project team, and triangulated findings across multiple interviews when evidence depended on a single source.
Respondent bias: Respondents may have under-reported socially undesirable information or provided responses they believed the evaluator wanted to hear—often favoring positive outcomes or reflecting a specific perspective. Given that the Project has been operating for four years, some respondents also understandably struggled to recall details of earlier activities.	To mitigate this, we assured confidentiality wherever possible and established strong rapport during data collection. Additionally, we supported respondents in contextualizing their responses and recollections to improve accuracy and reduce recall bias.
Attribution challenges: Causal complexity presents a fundamental limitation; real-world outcomes, such as improved access to health services, often result from a web of interrelated factors beyond those identified in the hypothesized pathway.	To address this, the evaluation triangulated findings across multiple data sources, maintained transparency in its causal logic, and interpreted results with careful attention to contextual influences and alternative explanations.

The evaluation does not independently validate the numerical data reported in annual or other project documents. Instead, it works on the assumption that these historical figures are accurate and uses them illustratively – to reflect patterns of success and challenge – rather than as a primary source for performance verification.

5. Findings

This section presents the key findings of the evaluation, structured around the three key evaluation questions (KEQs) and sub-questions. The theory-based, process tracing approach has been applied to examine the causal pathways linking project interventions to observed changes in access, service delivery, and institutional sustainability. The aim is not only to determine whether the Project was effective but to unpack *how*, *why*, and *under what conditions* results were achieved.

5.1 KEQ1: What did the project achieve in relation to its Project Development Objective?

When we began addressing this question – *what did the project achieve in relation to improving access to and the quality of services for poor and vulnerable people* – we assumed that the answer of "access" and "quality" could be formulated in clear, analytical terms, as is common in evaluation. But we soon realized that the realities of illness and poverty, as experienced by poor and vulnerable individuals, are as real as the scorching sun and as concrete as war. While "illness" and "poverty" are familiar concepts in texts and statistics, their lived experience is far more complex, impossible to fully grasp without 'self-experience' of coming into contact with illness and poverty. Of course, we are not suggesting that understanding is impossible without having personally been sick or poor. Rather, we emphasize the importance of making a deliberate effort to engage with the meanings and realities of illness and poverty from the horizon of those who experience them.

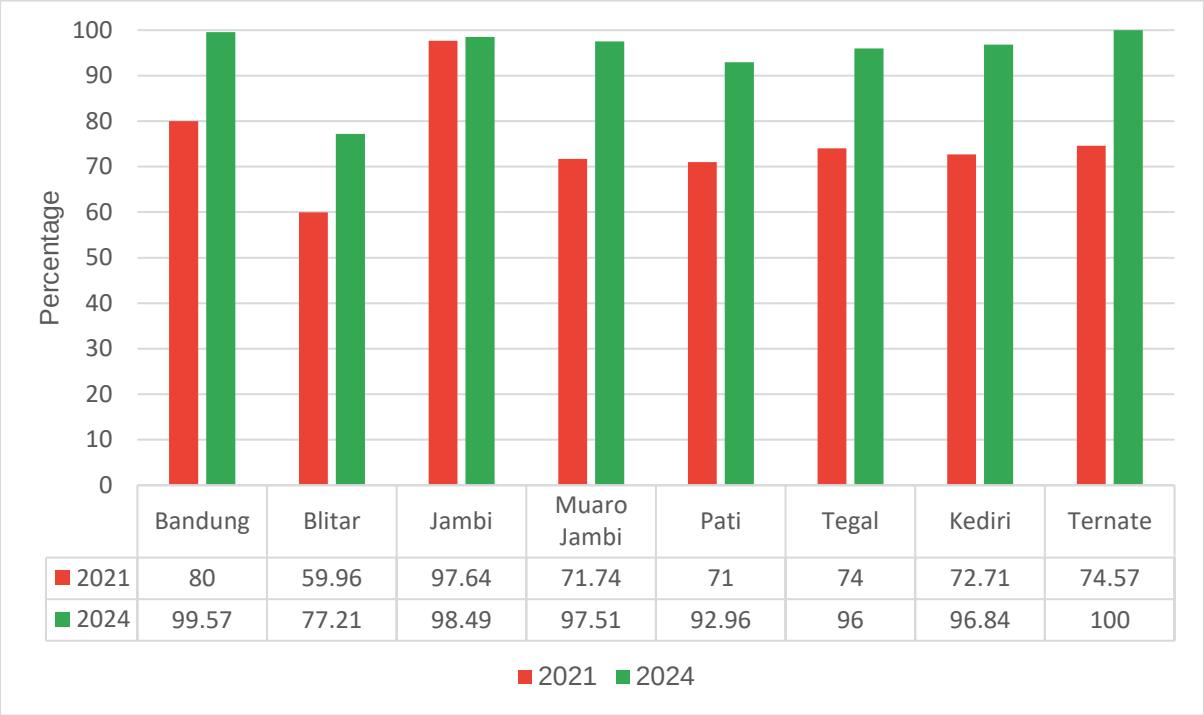
It was from this more grounded perspective that we assessed what the Project has accomplished. This evaluation finds that it made meaningful contributions toward improving access to and the quality of NHI services for targeted poor and vulnerable groups. These contributions were most evident in the Project's community outreach efforts, which identified and assisted individuals who had long been excluded from formal systems of support. Many of those reached by the Project were living in rural or underserved areas, often with chronic illnesses and complex socioeconomic conditions that rendered them invisible to standard government programs. Despite the existence of policies and resources on paper, these individuals had consistently fallen through the cracks; missed by eligibility surveys, left out of enrollment schemes, or unable to navigate a fragmented service environment. The Project's achievements are therefore not only programmatic but also corrective: they helped close persistent gaps in inclusion and demonstrated the value of person-to-person, trust-based outreach as a way of overcoming structural exclusion.

Process tracing supports the plausibility of the outreach–enrollment–access causal chain: cadres deployed by the Project, and enabled through project resources, provided individualized assistance that led directly to successful NHI registration and subsequent service use. Testimonies from beneficiaries and stakeholders, along with project monitoring data from selected districts, offer strong evidence that Project-supported interventions filled critical gaps in information access and bureaucratic navigation, cost of living and transportation costs, etc., removing barriers to care and reaching those previously excluded from the system. The removal of such barriers is particularly significant in terms of accessibility. A 2018 impact evaluation of the NHI using longitudinal data in Indonesia had already demonstrated that enrollment alone is not sufficient to ensure access, especially for the poor who make up the majority of the NHI-subsidized group (*Penerima Bantuan Iuran* or PBI). The same study showed that NHI enrollment led to only a modest increase in access to inpatient

services for this group (Erlangga et al., 2018). Enrollment had no impact on outpatient care access, as persistent barriers persisted. While insurance may reduce financial barriers such as treatment fees (affordability), it is often inadequate to overcome other key obstacles, such as transportation costs or the lack of available clinics and hospitals (Erlangga et al., 2018; Saputri and Murniati, 2023).

It is important to note that the level of Universal Health Coverage (UHC) increased in all Project locations between 2021 and 2024, with activity logs from cadres and stakeholder testimonies indicating a potential contribution from the Project (UHC changes are presented in Figure 5). During the project period, GPSA cadres at least in some of the sites actively participated in data validation efforts with the Social Affairs Office, Health Office, and BPJS Health to identify exclusion and inclusion errors, conducted outreach to targeted populations, and provided socialization about the NHI system. While it is likely that the increase in UHC was largely driven by national programs and resources mobilized to meet UHC targets during the same period, it is also evident that the Project contributed to reaching some of the hard-to-reach populations.

Figure 5: UHC in project sites (2021 & 2024)

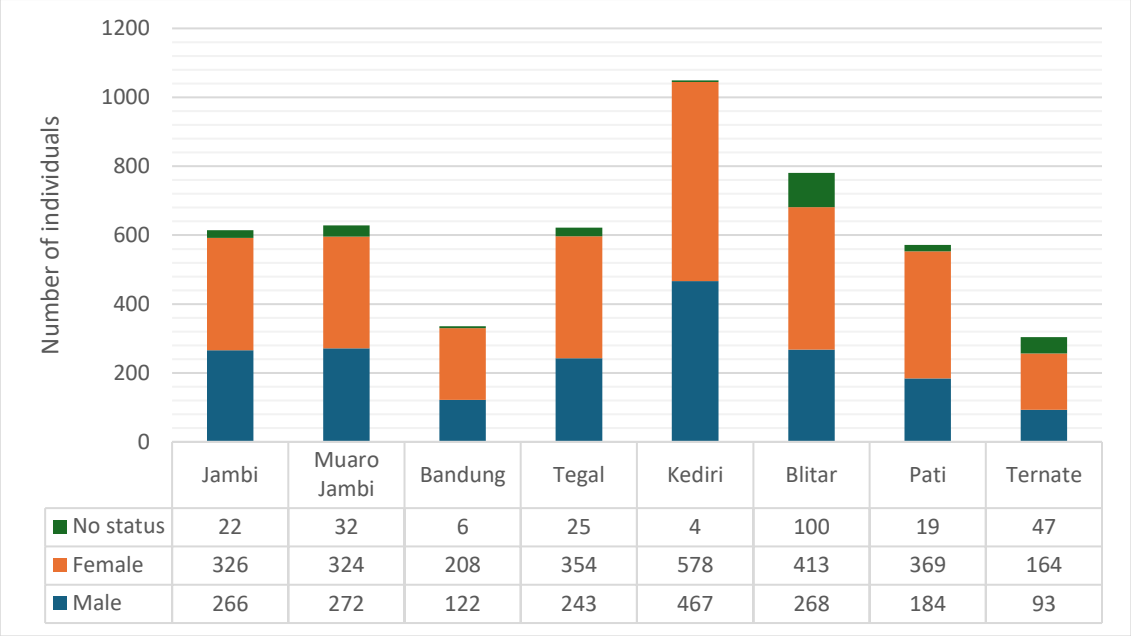


	Bandung	Blitar	Jambi	Muaro Jambi	Pati	Tegal	Kediri	Ternate
2021	80	59.96	97.64	71.74	71	74	72.71	74.57
2024	99.57	77.21	98.49	97.51	92.96	96	96.84	100

Source: The GPSA Project, independent consultant

Over the course of the Project, approximately 4,906 individuals (2,736 female, 1915 male, and 255 individuals with no recorded sex) were supported with enrollment and access to various health services. This figure includes all individuals assisted, not exclusively those who meet the definitions of poor and vulnerable. This evaluation encountered challenges in determining the precise number of poor and vulnerable individuals reached, as cadre reports were not designed to systematically aggregate this data. Rather, they served primarily as donor-facing documentation of activities.

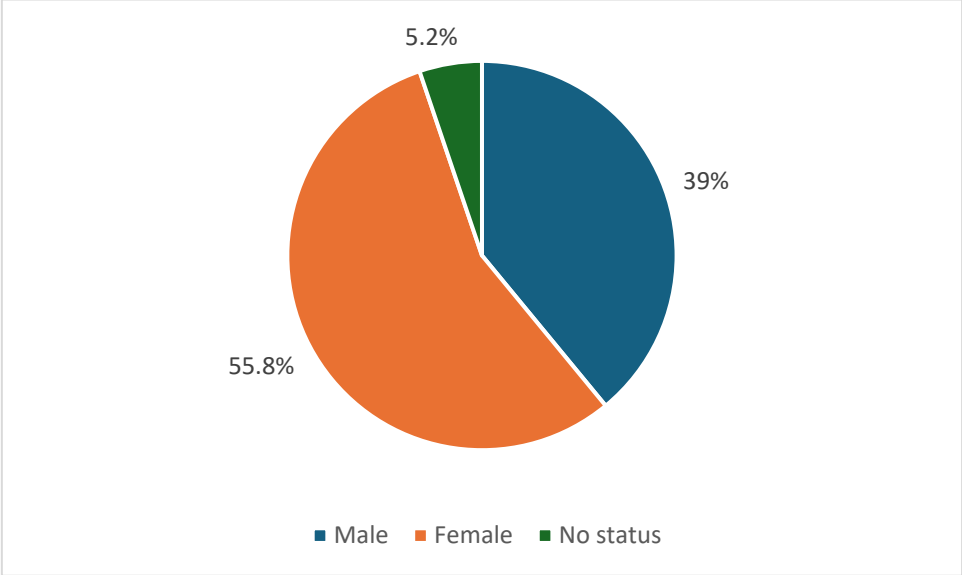
Figure 6a: Project beneficiaries by area and gender



	Jambi	Muaro Jambi	Bandung	Tegal	Kediri	Blitar	Pati	Ternate
No status	22	32	6	25	4	100	19	47
Female	326	324	208	354	578	413	369	164
Male	266	272	122	243	467	268	184	93

Source: The GPSA Project, independent consutant

Figure 7b: Overall distribution of beneficiaries (n=4,906)



Source: The GPSA Project, independent consultant

The evaluation found cases of individuals suffering from chronic illness, disability, or economic hardship who were either excluded from the subsidized criteria or had inactive insurance status. In some instances, these individuals technically did not meet official poverty criteria yet faced clear health and financial vulnerabilities. The study highlights systemic contradictions; for example, people with modest assets, like a television or motorbike, are deemed ineligible for PBI, despite living in precarious conditions. This points to a disconnect between statistical definitions of poverty and the lived experiences of those most in need.

The evaluation also documented complex household situations in which financial capacity was unclear, and long-term neglect of medical conditions had occurred. In these cases, the problems

extended beyond insurance eligibility, revealing deeper socioeconomic distress, such as caregiving limitations, mobility barriers, and resignation among patients who had lost hope. Even when eligible for subsidized insurance, many families remained unable to access care due to structural barriers. The evaluation also revealed limitations in digital systems, inconsistent validation, and constrained local budgets, further complicating access.

In this context, community outreach initiatives like this Project were seen as highly relevant and necessary. Local officials and stakeholders interviewed confirmed the existence of these persistent barriers. Health authorities acknowledged that despite nearing official UHC targets, constant fluctuations in subsidized participant status – due to central government data adjustments – undermined stable access to care. Officials emphasized that poverty is dynamic and that local validation processes must be continuous and community-informed.

While the outcomes related to access to targeted beneficiaries were clear, progress in improving service quality and systemic responsiveness was more uneven. Multi-stakeholder forums raised important service delivery issues and, in some instances, led to concrete action, such as improving conditions at a regional hospital or mobilizing private funds in a district to support NHI enrollment. However, such outcomes varied across locations. In districts with stronger local leadership or established relationships between civil society and government actors, collaborative accountability mechanisms had more traction.

The pathway to systemic change appeared constrained by the fact that government stakeholders did not receive a compelling message about how the Project's model could effectively support priority agendas – such as improving outreach strategies, data systems, or addressing NHI participant inactivity – beyond the immediate resolution of individual cases. Of course, there is never a guarantee that stakeholders will act simply because something is proven effective. The risk of "free-riders" remains: actors who benefit from an initiative but are unwilling to contribute to its continuation or expansion with their own resources.

Nonetheless, as with all human behavior, change is shaped by the interplay of ideas and practice. It is precisely for this reason that the pursuit of systemic change cannot be separated from ongoing contestation and debate over what can be done. In this case, the patterns emerging from the Project offer valuable grounding for proposing, for example, more effective data strategies, contributing to a broader discourse with stakeholders about what is possible. Despite periodic (six-monthly) meetings with key stakeholders, **this evaluation found little evidence, including from stakeholder testimonies, that the Project's model has resulted in systemic change in how governance, access, and services are structured.** However, the evaluation notes that all stakeholders consulted appreciated the role and contributions of the Project, and that a collaboration with BPJS Health has already been initiated to deploy Fatayat cadres, including beyond the original Project sites. This partnership presents a potential opportunity to sustain and expand the community outreach model in the future.

A detailed process tracing of how, why, and under what conditions Project interventions contributed to improvements in access and service delivery is presented in Sections KEQ2 and KEQ3, along with the subsequent evaluation questions. Before turning to those sections, the following part offers an elaboration on how beneficiaries and key stakeholders perceive the Project's impact.

5.1.1 How do beneficiaries and key stakeholders perceive the Project's impact on governance and service delivery improvements?

The perceptions of both beneficiaries and stakeholders reflect a generally positive assessment of the Project's contributions. It is worth noting that beneficiaries were not explicitly asked about the impact

of the Project, as their understanding of it was primarily through their interactions with Fatayat cadres and AKATIGA. Instead, beneficiaries were asked to share their perceptions of the assistance and support they received from these cadres.

1. Perceived contributions to governance

From a governance perspective, the Project was seen as instrumental in improving 'micro-level' accountability and responsiveness. Stakeholders in BPJS Health, Health Office, and Social Service Office appreciated the distinct role the Fatayat cadres played in surfacing "invisible" cases, i.e., those who would otherwise likely remain unregistered or unassisted due to data gaps, mobility barriers, or lack of institutional follow-up. Fatayat and stakeholders' integration into WhatsApp groups, intended as a multi-stakeholder channel for communication, helped enhance real-time problem-solving and facilitate collaboration across sectors.

Stakeholders consistently valued the Project for helping bridge gaps between citizens and still fragmented health governance systems. Fatayat was seen as serving as crucial intermediaries who guided communities through bureaucratic complexity, especially in registering for NHI, correcting data mismatches, and validating eligibility for subsidized NHI. This hands-on involvement in local data validation and reporting mechanisms helped reduce inclusion errors and improved the responsiveness of institutions like BPJS Health and Health Office.

"Fatayat has cadres everywhere. So first, we asked them to help identify and collect data on residents in the villages who are truly poor, so they could be enrolled in the Regional Health Insurance program, which is the JKN *(NHI) scheme funded by the local government."* (Respondent from the District Health Office)

"This assistance was truly impactful, especially for identifying the poor and sick; Fatayat cadres were the ones who really knew and could reach them. So we, as the local government, felt greatly supported." (Respondent from the Social Affairs Office)

While stakeholders acknowledged improvements in coordination and expanded grassroots reach, these contributions were not uniformly seen as translating into broader institutional or policy reforms. For instance, although cadres played a critical role in resolving individual cases and temporarily bridging systemic gaps, there was limited evidence that their insights or recurring patterns of issues consistently informed a broader approach. The absence of sustained mechanisms to integrate cadre-sourced evidence into formal government systems was a noted limitation, despite stakeholder meetings.

Stakeholders consulted in the evaluation stated that the information and learning generated by the Project had been useful, but they also expressed reservations about how, or in what concrete ways, these were taken up into government programs and policies. This does not mean that the Project had no influence on systemic governance reform, but the evaluation found it difficult to trace such influence, especially in the absence of documentation on this aspect. There were anecdotal reports of Project input contributing to service improvements at a regional hospital in Bandung and collaboration with private actors to support local subsidized NHI enrollment through donations.

2. Perceived impact on service delivery improvements

Beneficiaries widely recognized the critical role of Fatayat cadres in bridging the gap to access and health service use. The personalized assistance – ranging from helping with NHI registration and resolving inactive cards to arranging transportation and liaising with local officials – translated directly

into improved enrollment to health services (discussed more in Section 5.2.1). As noted by stakeholders in the Health Office and regional hospital, cadres enabled service access that would have otherwise been missed, especially for vulnerable groups such as people with chronic illnesses, widows, people with disabilities, and the extremely poor.

Moreover, beneficiaries reported that cadres were accessible, responsive, and often the first and only point of assistance available to them. Cadres' interventions were not only logistical but also emotional and motivational, helping individuals navigate complex and intimidating bureaucratic systems. Their presence increased trust and reduced barriers of fear or reluctance that typically prevent poor communities from engaging with health services.

Beneficiaries viewed the Project as directly beneficial in improving access to services. Cadres were frequently described as empathetic and accessible actors who demystified insurance processes, facilitated emergency cases, and even organized donations through Baznas (a public charity institution). The prominence of organized donations varied by location: in Jambi, Muaro Jambi, and Bandung, Baznas played a leading role, while in Tegal and Blitar, Lazisnu, the charity institution under NU, was more accessible for the Project. The initiative filled a critical void left by absent or ineffective formal actors. Fatayat's embeddedness in local life allowed them to identify those "invisible" to government surveys; those who, despite being poor or chronically ill, had fallen outside the radar of public assistance. In districts like Muaro Jambi, Tegal and Kediri, this role was likely crucial in lifting UHC rates and addressing immediate care needs.

One consistent theme across both stakeholder and beneficiary groups was the high level of trust and social legitimacy enjoyed by Fatayat cadres. This trust enabled more accurate identification of needs and more successful referrals to health and social services. Stakeholders noted that Fatayat cadres had a unique positionality – not fully governmental, but not entirely detached – that enabled them to operate with credibility and flexibility. This trust was a vital factor in enabling the most excluded community members to come forward and seek help.

Both stakeholders and beneficiaries repeatedly emphasized the trustworthiness and moral credibility of Fatayat cadres. In contrast to government agents, who might be seen as distant or impersonal, cadres from Fatayat were described as having *"aura kebaikan"* (an aura of goodness), a term that reflects their standing in community dynamics. This enabled them to access the "hard to reach," including isolated elderly, female-headed households, and individuals with disabilities.

The trust extended to informal settings, such as religious gatherings, WhatsApp, and home visits, where cadres collected information, relayed entitlements, and followed up on complaints. This relational capital translated into practical results, such as faster registration, emergency aid, and smoother referrals.

5.2 KEQ2: How did the project's key interventions (capacity building and the Project's use of collaborative social accountability processes/tools) contribute to or drive the observed results?

At the heart of social accountability lies a normative idea: a flexible, non-confrontational approach to engaging in the constrained use of social power. It is intended to open alternative spaces for (political) influence bycitizens, especially when formal channels (such as parliamentary representation)

prove inadequate or ineffective (Guerzovich & Poli, 2020; Kuppens, 2016; Lodenstein et al., 2013). Given that a single idea can generate many variations – given enough time – it is not surprising that a wide range of practices can now be found in the literature on social accountability or political science in general. Every position, whether on a spectrum of pro and contra, or between effective and less effective, can find support. The approach adopted by the Project, and whose effectiveness this evaluation seeks to understand, is simply one more position within that spectrum. As the old proverb says, there is nothing new under the sun.

What this evaluation assesses is whether the particular practice of social accountability promoted by the Project worked, how the Project functioned as a vehicle to contribute to or drive observed results, and the extent to which recurring patterns suggest potential for sustainability. The evaluation of outcomes and impact is presented in Section 5.1 (KEQ1). This section (KEQ2) discusses how the Project contributed to or influenced those results, while Section 5.3 (KEQ3) provides an assessment of sustainability.

The discussion below presents the findings of a process tracing analysis of the Project's three pathways of change (a narrative explanation of the pathways is found in Section 4.1.2, and a visual representation in Figure 4).

5.2.1 Mechanism 1: Community outreach

Table 8 presents the summary of findings along the community outreach pathway of change.

Table 8: Verified contribution of community outreach to improving access

Summary of findings:
The evaluation confirms that Mechanism 1 functioned as predicted, with strong evidence supporting the causal pathway from the Project's support to improved enrollment outcomes. Project inputs – particularly funding, technical assistance, and stakeholder engagement – played a critical enabling role in the deployment and operation of Fatayat cadres, passing the hoop test (Part 1a). Cadres engaged communities effectively using relational, trust-based approaches, supporting the plausibility of their influence on access and passing the straw-in-the-wind test (Part 1b). Most importantly, substantial evidence showed that these outreach efforts directly contributed to successful registration into subsidized insurance schemes, thus passing the smoking gun test (Part 1c) and affirming the central role of community outreach in advancing health coverage.

The evaluation found that Project inputs – particularly funding, technical assistance, and stakeholder engagement – were present and played a crucial enabling role in the organization and deployment of Fatayat cadres. The found evidence indicates the passing of the *hoop test* (Part 1a). While Fatayat and its members were already accustomed to engaging in government or parliamentary advocacy – for example, the Fatayat central had prior experience in advocacy on issues such as domestic violence – the Project marked their first comprehensive and programmatic involvement in social accountability within the health sector. It specifically focused on community outreach and on improving access to and the delivery of services for poor and vulnerable populations. This was also the first such experience for the cadres involved in the Project.

At the start of the Project, Fatayat cadres and staff, along with AKATIGA, participated in an intensive, multi-day, face-to-face workshop that introduced key concepts such as social accountability, advocacy, stakeholder engagement, and community outreach. It was followed by more regular monthly and quarterly coordination sessions between Fatayat and AKATIGA. Over time, cadres became

embedded in a rhythm of structured communication and peer support, where they could regularly discuss case findings and receive up-to-date information on NHI. WhatsApp groups with local stakeholders – established early in the Project – proved particularly useful for real-time problem-solving and rapid dissemination of information. Interviews with cadres consistently underscored how these mechanisms had enhanced their confidence and capacity to serve as trusted informants and advocates for community members navigating the healthcare system.

The Project also leveraged and strengthened Fatayat's relationships with local authorities. Stakeholders were generally responsive and accessible when approached by cadres, reflecting a level of institutional trust that was nurtured through the project's ongoing engagement efforts. Fatayat membership is voluntary. To maintain this spirit, the Project provided a modest monthly stipend – intended primarily to cover transportation, communication, and related out-of-pocket costs – which amounted to less than US$80 per cadre per month. While modest, this financial support was meaningful, enabling cadres to remain consistently active in the field without placing undue financial burden on themselves or their families.

It is to be noted that the success of the cadre model also drew upon a degree of pre-existing organizational capital within Fatayat. Many of the cadres had prior exposure to advocacy and community facilitation through other Fatayat or Nahdlatul Ulama platforms. They came from a variety of professional backgrounds – ranging from teachers and civil society activists to local legislators and entrepreneurs – bringing a valuable mix of local knowledge and social legitimacy. While this prior experience certainly helped, it was the Project's structured inputs that transformed this latent capacity into a coordinated, functional model of grassroots accountability.

The evaluation found consistent evidence that cadres effectively engaged communities, built trust, and provided practical support related to the NHI, interestingly, by using an approach that closely resembles what is widely known as the 'word-of-mouth' or 'snowballing' method. These findings support the plausibility of Part 1b in the causal mechanism, passing the *straw-in-the-wind test*. It is important to note that the term word-of-mouth or snowballing is not used by the Project itself, but rather is our analytical interpretation. This approach likely explains why cadres were able to continuously identify and reach hard-to-reach populations, something even state officials, despite the power of government behind them, have struggled to do consistently and effectively.

The districts selected as Project sites were those with low levels of UHC and NHI registration, originally comprising 40 subdistricts (*kecamatan*) across eight districts/cities. Over the course of implementation, the coverage expanded to beneficiaries in 140 subdistricts (559 villages) across 17 districts, as cadres often received requests for assistance from people in other areas. These requests came through word-of-mouth, referrals from hospitals or clinics, WhatsApp contacts, and other channels. The contribution of the Project could be understood in the context of its strategic focus: working in or with groups that are particularly hard to reach. This targeted approach suggests that the Project's value lies not mainly in scale, but in its ability to engage those who are most often left behind by mainstream systems.

During the evaluation, several complex cases were observed, prompting the question: Why do these vulnerable individuals always seem to find the cadres (often beyond the assigned subdistricts), or conversely, why do the cadres appear to act like magnets, drawing in the chronically ill, persons with disabilities, the elderly, and the poor? In practice, each cadre was assigned to one subdistrict and tasked with community outreach and accompaniment, targeting four individuals per month. However, many cadres reported assisting up to 10 people monthly. In Muaro Jambi, some cadres even supported individuals outside their assigned areas or beyond the district borders. Not all beneficiaries were

economically poor or seriously ill, but among those assisted, there were always cases involving such conditions. Many were complex cases involving a combination of chronic illness and poverty; individuals who had either never sought care or had stopped doing so due to transport costs, the inability to take time off work, or the burden of caregiving.

What stood out, as repeatedly stated by the cadres, was that those in need were often referred to them by others in similarly vulnerable situations who had previously been helped. In other words, poor and vulnerable people were the ones telling others in the same condition that the cadre might be able to help. Individuals who were reluctant or afraid to approach officials or strangers felt more comfortable speaking with a cadre because they were encouraged by someone they knew – a friend or family member – who had once been in the same situation. This highlights a key dynamic: poor individuals tend to be part of larger networks of others who are similarly economically disadvantaged, and they are often best positioned to recognize what poverty looks like in practice.

Another channel through which individuals connected with cadres was through emergency room encounters. In hospitals collaborating with the Project across the three evaluation sites, it was reported that some hospital staff were able to connect unregistered NHI patients, or those facing blocked access due to unpaid premiums, with Fatayat cadres. A respondent in Tegal noted that hospital staff often referred patients to Fatayat, especially when the patient's family was unable to handle the administrative requirements to resolve NHI-related access issues, such as obtaining a poverty certificate or clearing back payments.

The evaluation found considerable evidence that cadre-led community outreach resulted in the registration of individuals into the subsidized insurance schemes. This includes enrollment into both NHI and locally funded subsidized insurance schemes. This represents the passing of *smoking gun test* in the mechanism (Part 1c). Several health office officials explicitly noted that they relied on Fatayat cadres to identify and assist poor households for inclusion in local health financing schemes and NHI. As one local health official stated:

"Fatayat cadres were instrumental in locating and helping extremely poor villagers who were invisible to official systems and referring them to the district-subsidized NHI program." (Respondent from the District Health Office)

Moreover, testimonials from Fatayat cadres themselves confirmed that they not only helped individuals enroll in the NHI but often followed through to ensure activation of their insurance cards and accompaniment to healthcare facilities. In many cases, cadres navigated administrative bottlenecks and bureaucratic obstacles on behalf of beneficiaries, often coordinating directly with local BPJS Health, Health Office, or Baznas to secure documentation and resolve premium arrears.

In several cases reported by the cadres, individuals in critical condition who required emergency care were assisted in registering as independent (non-subsidized) BPJS participants to ensure they could receive immediate treatment. If they had waited for subsidized NHI enrollment, the process could take a minimum of 14 days and approval was not guaranteed, particularly if the quota for subsidized patients had already been filled. This situation presents a difficult dilemma: after receiving care, these low-income patients – now registered as independent members – almost certainly could not continue paying the monthly premiums due to financial constraints.

This workaround, while effective in securing emergency access, creates downstream problems: these individuals typically become delinquent on their premium payments, leading to the accumulation of debt and eventual deactivation of their coverage. In districts where the active

participation rate exceeds 80% (previously 75%), in accordance with BPJS Health regulations, subsidized enrollees can be processed and treated on the same day. However, in many areas where the active participation rate remains below this threshold, registering patients as independent members is often the only available solution.

Cadre reports, project monitoring data, and testimonies from both beneficiaries and health providers consistently indicated that successful NHI registration was often followed by the utilization of health services. For instance, in cases involving emergency care, cadres facilitated either subsidized or independent NHI registration to ensure immediate access to hospital treatment. Multiple respondents across stakeholder groups – including health offices, social affairs departments, hospitals, and beneficiaries – attested that without cadre intervention, many poor or vulnerable individuals would not have gained access to health services. The last *hoop test* passes (Part 1d). This strengthens the plausibility that the full causal chain, from outreach to enrollment to service use, functioned as intended in the context of this mechanism.

"In terms of costs, they were not yet JKN participants and came from low-income households. There was also no one to accompany them to the nearest health facility. It was the Fatayat cadres who facilitated by coordinating with the Health Office and directly communicating with Baznas." (Respondent from the District Health Office)

"Fatayat has shown great concern in helping the community, especially in covering healthcare costs for patients who are struggling financially or are not covered under NHI scheme." (Respondent from the Regional Public Hospital)

The Project community outreach is enabling actual access and engagement with care, particularly for groups for whom insurance on paper does not translate into service use in practice. Importantly, outreach also extended to cases in which structural or social vulnerabilities, including mental illness, disability, or widowhood, would have otherwise prevented access to services. In the absence of sufficient government resources, stakeholders advocated community solidarity and donation-based solutions as interim measures to address emergency health needs.

The evaluation also highlighted promising local solutions. The Government of Kediri have implemented donation-based co-financing schemes and responsive district-level subsidized insurance programs that allow immediate activation when patients are identified as poor and in urgent need. These innovations, however, rely heavily on accurate local data, coordination between stakeholders, and committed frontline actors. Other efforts, such as the BPJS Health "JKN Partner" and "PESIAR" (community outreach) programs, have attempted to expand awareness and outreach, but effectiveness has varied based on local leadership commitment and community engagement. While digital outreach via social media has grown, it has not yet compensated for the structural lack of access, especially in underserved and remote areas.

One notable observation from this evaluation is the strong personal commitment shown by many Fatayat cadres, particularly in their efforts to support poor and sick individuals. In numerous cases, cadres provided assistance without expecting adequate compensation and continued their work despite logistical or bureaucratic obstacles. During interviews and focus group discussions, the evaluation posed a key question: Why were you willing to do more than what the program formally asked of you? In a world marked by scarcity and struggle, perhaps the more compelling question is not why people fail to care, but why they choose to care at all.

While part of this dedication can be explained by organizational affiliation and social expectations, many cadres pointed to deeper motivations rooted in personal values, shaped by their religious faith

and a strong ethical-cultural sense of what is right and good. Helping others was seen not merely as a job, but as an expression of meaning and purpose. Although not a central focus of this evaluation, these value-based drivers warrant greater attention. Future CSA programs may benefit from acknowledging and nurturing such intrinsic motivations, as they appear to play a key role in sustaining engagement and building trust in communities, especially when formal incentives or structures fall short.

5.2.2 Mechanism 2: Multi-stakeholder compacts

The main evaluation findings on the multi-stakeholder compacts pathway of change are depicted in Table 9.

Table 9: Effectiveness and limitations of compact-based collaboration in advancing equitable access

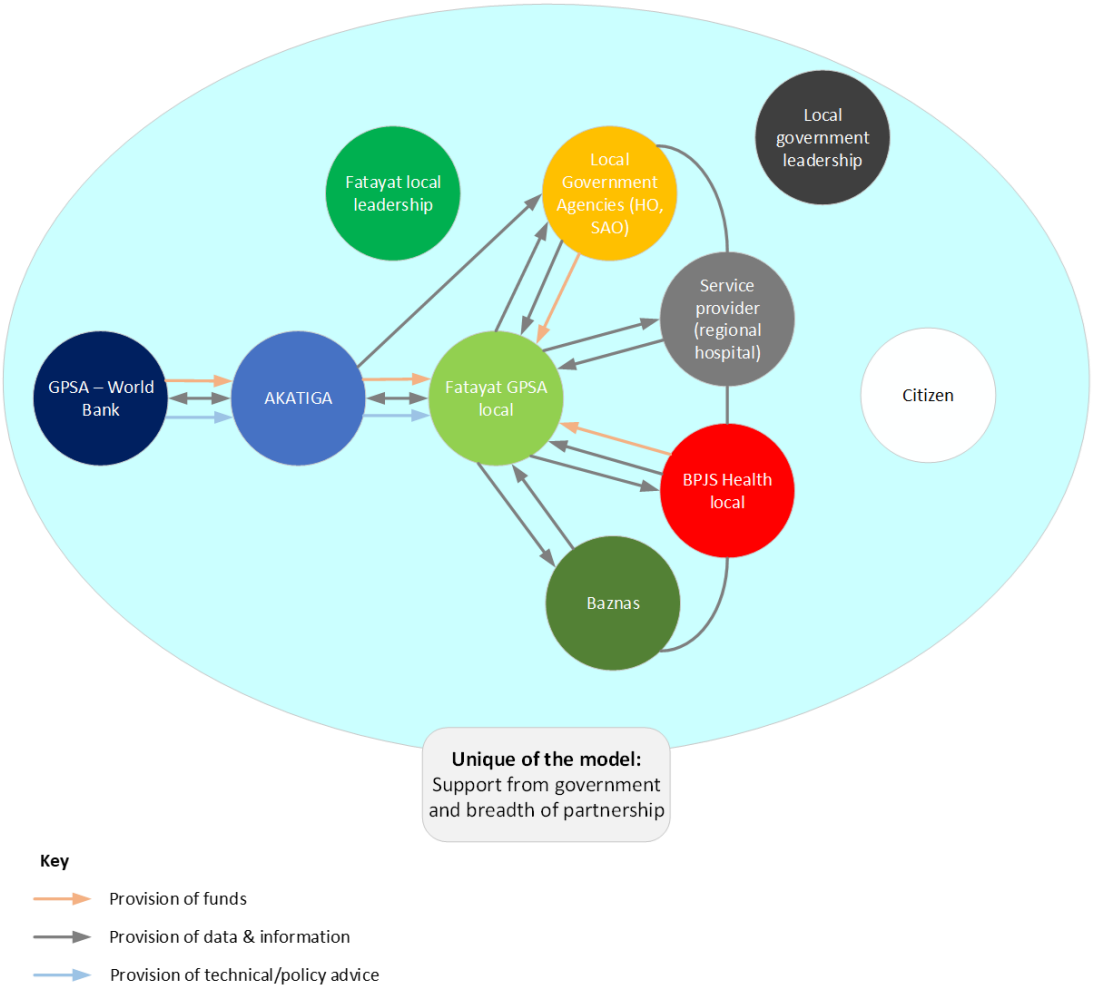
Summary of findings:
The evaluation concludes that Mechanism 2 functioned largely as hypothesized. The Project successfully established multi-stakeholder compacts that not only facilitated collaborative dialogue but also prompted institutional responses to specific issues, passing both the hoop and smoking gun tests for Parts 2a and 2b. However, the extent to which these efforts translated into improved equitable access remains limited, with Part 2c only narrowly passing the hoop test due to modest and uneven evidence of systemic change for underserved populations.

The evaluation found that the Project supported the establishment of quasi-formal multi-stakeholder compacts where issues of access and service delivery were discussed with relevant government agencies and service providers. By 'quasi-formal multi-stakeholder,' this refers to an organized and consistent process of engagement that operates without a formal institutional structure. In assessing this aspect, the evaluation applied GPSA's definition and delineation of a multi-stakeholder compact, which refers to the operational and continuous working arrangements between CSO partners and other stakeholders, such as relevant public sector authorities and service providers (GPSA MERL Guide, 2023). Based on this framing, the Project successfully established and operationalized multi-stakeholder compacts that served their intended function, thus passing the *hoop test* for the first part of this mechanism (Part 2a).

However, the inclusiveness and functional use of these compacts appeared to vary across project sites and were relatively less institutionalized than anticipated at the national level. Figures 7, 8, and 9 below illustrate the models of multi-stakeholder compacts implemented in the three visited project locations. The accompanying descriptions of each model also address several sub-evaluation questions under KEQ2:

- What were the specific roles of Fatayat central and local, AKATIGA, and their collaboration in achieving these results?
- Were fit-for-purpose multi-stakeholder compacts established, and did they include the most relevant stakeholders? How was stakeholder selection determined?
- What collaborative social accountability (CSA) processes did the multi-stakeholder compacts use? Did these lead to meaningful engagement with public bodies? What factors facilitated or hindered their success?

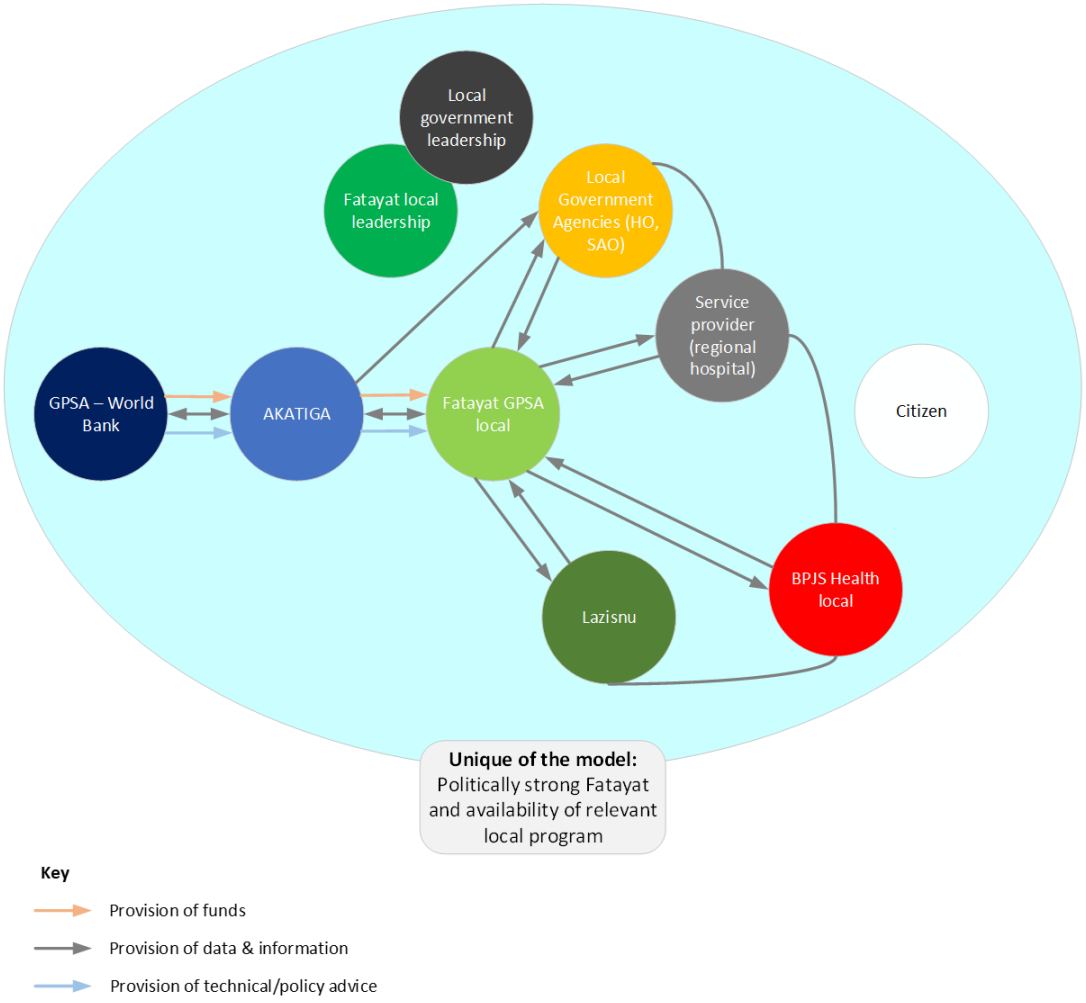
Figure 8: Multi-stakeholder compact model in the District of Muaro Jambi



Source: Independent consultant

The multi-stakeholder compact model in Muaro Jambi demonstrates strong support from key stakeholders and a wide network of partnerships at both organizational and individual levels. Actors involved in this area include key government stakeholders (such as the District Health Office and Social Affairs Office), BPJS Health, public hospital service providers, Baznas, Fatayat, and AKATIGA. Fatayat effectively established communication with these stakeholders and leveraged existing social modalities – both through institutional relationships and personal connections between Fatayat members and individuals in other organizations – to mobilize the necessary support for resolving cases and sustaining cadre activities. At the time of the evaluation visit, BPJS Health and the Social Affairs Office were preparing to allocate funding from their own budgets to support Project-related activities.

Figure 9: Multi-stakeholder compact model in the District of Tegal



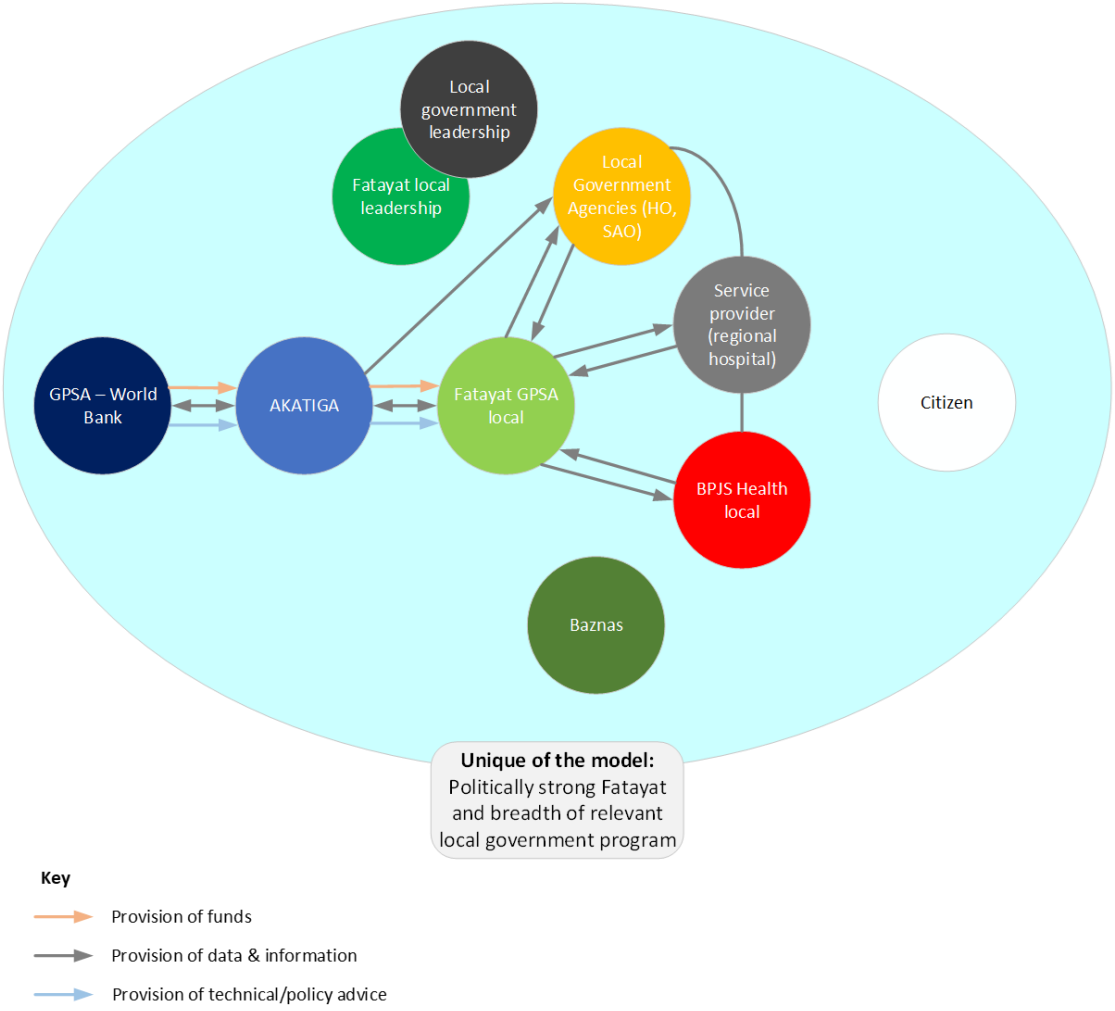
Source: Independent consultant

The multi-stakeholder compact model in Tegal appears to be shaped by close political ties with the political leaderships, and in Fatayat's case, reflects a tension between autonomy and dependency. Normatively, within the enduring dynamic between civil society's autonomy and its reliance on the state (i.e., political authorities), the 'rightness' of any position cannot be judged solely by outcomes; or more plainly, by tangible gains. For CSA, what matters is that collaborative social accountability may need to operate in such contexts, especially when the main actor 'representing' citizens is an organization with close political ties to those in power. It is logical to think that CSA becomes more sustainable when this relational tension is actively maintained, not leaning too far toward either autonomy or dependency. In such a balance, the state also relies on the performance of civil society, which in turn must retain its autonomy. CSA actors are not 'holy angels'; they also benefit from the deliberate and critical practice of asking 'who guards the guardian,' to ensure that the relational tension with political power remains balanced and does not slip into negative dependency.

It is also worth noting that in Tegal, while the composition of stakeholders within the multi-stakeholder compact mirrored that of other districts, the potential for institutional collaboration between Fatayat and BPJS Health at one point became uncertain, due to internal dynamics, which had been solved by the time of this report. Such internal dynamics can influence CSA and are therefore worth monitoring to avoid unintended effects. In Tegal, the Project worked more closely with Lazisnu – NU's charitable

donation organization – instead of Baznas, with Lazisnu playing a similar role in providing financial resource support for poor people.

Figure 10: Multi-stakeholder compact model in the District of Kediri



Source: Independent consultant

The multi-stakeholder compact model in Kediri also appears to reflect political proximity, although what stood out more prominently during this evaluation was the presence of relevant local government programs that had been leveraged to provide NHI access for poor individuals supported by Fatayat cadres. Stakeholders, including the District Health Office, the Social Affairs Office, and BPJS Health, had programs aligned with the Project. Unlike the two previously assessed districts, however, the multi-stakeholder compact in Kediri did not involve Baznas due to internal leadership dynamics within Fatayat and Nahdlatul Ulama (NU). At the time of the evaluation visit, Baznas had already established collaboration with Muslimat, another NU-affiliated women's organization, which in effect limited Fatayat's access.

It is noteworthy that none of the multi-stakeholder compacts referenced above explicitly included direct citizen/public participation. Based on our observations, the GPSA guidelines also do not provide clear direction regarding the specific role of citizens in the social accountability process, despite their inclusion in the GPSA multi-stakeholder compact framework (GPSA MERL Guide, 2023, see p. 65). Of

course, it should be assumed that citizens – or society more broadly – are the intended beneficiaries of social accountability mechanisms. However, even if not involved through direct participation, the role of citizens must still be clearly articulated, as civil society actors function as intermediaries, and should not be conflated with citizens themselves.

Overall, the evaluation found that functional multi-stakeholder compacts were used to support responses to cases identified by cadres, primarily through real-time consultation and question-and-answer exchanges. These interactions took place via a dedicated WhatsApp group and through direct visits by cadres to relevant stakeholders. However, not all organizational leaders, particularly heads of the District Health and Social Affairs Offices, were included in the WhatsApp group. As such, its function was largely limited to facilitating rapid response to individual cases. That said, it is understandable that the fast-paced and concise nature of social media platforms like WhatsApp can limit their suitability for more strategic or in-depth discussions, and senior officials may not view joining such groups as a priority.

Another multi-stakeholder engagement applied was stakeholder meetings, generally held every six months between 2022 and 2024. These gatherings invited organizational heads or their representatives to discuss the Project's progress, results, and lessons learned. Meetings were conducted in hybrid or fully online formats. Most senior stakeholder respondents (heads of Dinas or divisions) at the three evaluation sites reported attending at least one in-person meeting or receiving reports from staff representatives. Respondents could recall 1–2 meeting instances (including the month and year) but often could not remember the specific topics discussed.

A third mechanism involved ad hoc visits by the Project cadre team to stakeholders, which were reported as stakeholder engagements or meetings. Cadres submitted visit data from eight districts. In 2023, 76 visits were reported; in 2024, this increased to 113. However, these figures are likely inaccurate, as cadre reports often lacked important context or detail. The most frequently visited stakeholders were local government agencies (District Health and Social Affairs Offices), Baznas, and BPJS Health. There were also reports of visits to public hospitals (RSUD) and local parliament members. Stakeholders consulted in the three districts confirmed that these visits took place. Unfortunately, many cadre reports lacked detail on what was discussed or achieved during the visits. Most entries simply stated the purpose of the visit and who was met, typically in one to three short sentences. This suggests that the visit reports may have primarily served administrative or accountability purposes, rather than strategic tracking of stakeholder engagement outcomes or advocacy impact.

The evaluation found that issues raised through these various forms of multi-stakeholder compacts did, in many instances, trigger concrete responses from institutional actors, thus passing *the smoking gun test* for this part of the mechanism (Part 2b). Passing the test is sufficient but not necessary for inferring causation. What makes the issues surfaced through these platforms distinctive is that they emerged from real-life cases identified and supported by the Project cadres, cases that likely would not have entered the public or institutional discourse without their intervention. Stakeholders consulted during the evaluation confirmed the role of Fatayat cadres and the Project in bringing these cases to the forefront.

However, the evaluation also noted that the issues discussed and the resulting institutional responses were mostly tied to individual case resolution, with limited evidence of consistent or systemic impact at the strategic programmatic or policy level. Figures 10 and 11 below provide illustrative visuals of the types of topics brought up in stakeholder meetings by the Project team. These visualizations are based on an analysis of the Project team visit reports, as previously discussed. To generate this analysis, the evaluation team conducted a simple wordcloud analysis using NVivo12

software, drawing from the narrative text in stakeholder visit and meeting reports submitted by cadres. The aim was to identify and visualize the main themes discussed in stakeholder meetings. The content analysis focused on the 100 most frequently occurring words, excluding one-time mentions. This analytical process also informs the response to the relevant sub-evaluation questions, as follows:

- Did CSA processes lead to public bodies addressing identified problems? What factors contributed to or obstructed these outcomes?

Figure 11: Overview of topics discussed during stakeholder meetings (2023)

Source: Independent consultant

The 2023 visit and meeting data indicate that the most frequently discussed topics were related to individual patient cases, their conditions, and efforts to provide assistance (see Figure 10). This is evidenced by the prominence of words such as "patient (*pasien*)," "don't" (*tidak*, referring to patients not being registered), "PBI" (subsidized group), "has/have not" (*belum*, again pointing to unregistered patients), "accompany" (*pendampingan*), and "support" or "assistance" (*bantuan*). Other frequently mentioned terms – such as "NHI" (JKN), "program," "quota," "data," "activity" (*kegiatan)*, "poor" (*miskin*), and "case" (*kasus*) – also likely relate to the conditions of patients and the attempts to resolve their issues. Reported cases involved specific groups or challenges, as shown by the recurring appearance of words like "children" (*anak*), "under five" (*balita*), "stunting," "sickness" (*penyakit*), "ill" (*sakit*), and "family" (*keluarga*).

Figure 12: Overview of topics discussed during stakeholder meetings (2024)

Source: Independent consultant

The stakeholder visit and meeting data reported in 2024 similarly indicate that the primary focus remained on addressing the conditions and individual cases supported by the cadres (see Figure 11). In addition, there was increasing attention to the topic of Project sustainability, as reflected in the appearance of terms such as "sustainability" (*keberlanjutan*) and "continuation" (*kelanjutan*). Case-related discussions were represented by frequent mentions of words like "support or assistance" (*bantuan*), "proposal" (*pengajuan*, referring to assistance requests), "patient" (*pasien*), "people" (*warga*), "giving" (*pemberian*), "PBI" (subsidized group), and "cost or payment" (*biaya*). Other terms, such as "active" (*aktif*) likely referred to BPJS membership status, while "accompany" (*pendampingan*) and "treatment" (*perawatan*) indicated continued cadre involvement in healthcare support. The terms "DTKS" (Unified Database for Social Welfare) and "data" appeared in the context of patient or beneficiary data registration and verification. Cadre reporting documentation typically did not include outcomes from visits or meetings. To address this, outcomes were gathered orally during the monthly Zoom meetings between the AKATIGA-Fatayat cadre teams.

However, interviews with both stakeholders and cadres revealed that these reports were acted upon, resulting in the provision of data or information, assistance, registration of participants, and other forms of support. This indicates that the issues raised were indeed responded to by stakeholders, particularly in relation to the conditions of individuals and case resolution. At least five stakeholders expressed their trust in the cadre teams and noted that they usually responded promptly to cadre reports without needing to re-verify the information (e.g., whether the cases reported were accurate). Respondents from Baznas in Muaro Jambi and Tegal clarified that although they still assessed aid recipients based on established criteria, the data provided by the cadres greatly facilitated the verification process and delivery of assistance.

A senior official from one of the consulted district government agencies expressed a view suggesting a more structured engagement with the Project should have been pursued, such as through the establishment of joint output targets between the government and the Project. Existing

communication was seen as largely technical in nature, as previously noted, with stakeholder meetings primarily remembered for focusing on individual cases and their resolution. The respondent believed that a more structured and strategic approach could have enhanced the Project's impact.

"Ideally, the Project and the government could engage more intensively to jointly define the program's intended targets. That way, we as stakeholders could provide stronger and more focused support. Right now, we only have a limited understanding; we're not asking to know everything about how the Project works, but we'd like to know what specific outputs are expected so we can discuss how best to support them. Up until now, most of the communication has been technical. A more structured approach would help the Project be utilized more effectively." (District Government agency official)

The final component (Part 2c) of Mechanism 2 – whether multi-stakeholder compacts improved equitable access – barely passes the hoop test, as the evaluation found limited evidence that actions to address access barriers were implemented or resulted in systematic improvements for underserved groups. The literature highlights that addressing structural access barriers is central to expanding access, with such barriers shaped by multiple, intersecting factors; tackling access costs alone is insufficient to guarantee service utilization (Jacobs et al., 2012). Although these barriers were identified in many of the cases supported by the Project cadres (as described in Mechanism 1) and raised within multi-stakeholder compact platforms, these efforts have yet to prompt deliberate or sustained action by stakeholders beyond the Project. As access for poor and vulnerable populations remains uneven and unpredictable, the plausibility of a strong causal link for this part of the mechanism is weakened.

That said, the evaluation acknowledges the meaningful contributions of multi-stakeholder compacts in surfacing access challenges faced by women, persons with disabilities, informal workers, young children, and the elderly, as confirmed through interviews with both stakeholders and beneficiaries. One beneficiary in Muaro Jambi, two in Tegal, and two in Kediri reported accessing services because of cadre support. Health officials interviewed also confirmed treatment of cases facilitated by cadres. However, two officials noted that the presence or absence of the Project did not influence the quality of care, asserting that equal treatment (non-discrimination) is a core principle already applied; for instance, emergency patients are treated regardless of their NHI status. While determining the availability and equality of service lies outside the scope of this evaluation, what is noteworthy is that some people clearly did not access services for various reasons – reasons that may not be directly related to the 'supply-side' of treatment.

This brings the evaluation to one of the sub-questions under KEQ2:

- What are the implications of district-driven social accountability, given challenges in central ministry engagement?

The limited effective engagement with ministries at the national level has constrained the Project's influence on national programs and policies, making it difficult to demonstrate such impact. This evaluation echoes the Project team's view that the model of social accountability implemented through the project was primarily district-driven. The evaluation found that the Project faced challenges engaging national-level stakeholders – such as the Ministry of Health and the Ministry of Social Affairs – with fewer meetings than anticipated. While several visits and meetings were held to discuss the Project's learning and findings, these have not yet yielded concrete outcomes.

The evaluation concludes that the Project's influence on national policymaking has been relatively limited. This finding is not surprising, as existing literature consistently emphasizes that the success of social accountability initiatives depends on a range of external factors that are often beyond the control of the implementing actors. As noted by Naher et al. (2020), there is no single blueprint for making accountability mechanisms effective. In line with this, the evaluation set a conservatively low prior expectation for the Project's influence at the policy level, an assumption that is reflected in the observed outcomes.

5.2.3 Mechanism 3: Institutionalization of collaborative social accountability

Table 10 summarizes the findings along the social accountability model pathway of change.

Table 10: Incremental progress in embedding CSA practices

Summary of findings:
The evaluation finds that Mechanism 3 – focused on the institutionalization of collaborative social accountability – shows early but credible indications of progress. The hoop test (Part 3a) is passed, with sufficient evidence of improved stakeholder understanding and engagement with CSA principles. The straw-in-the-wind test (Part 3b) is also passed, based on modest, mostly anecdotal evidence suggesting some behavioral shifts consistent with CSA practices, although these remain informal and context-dependent. Finally, the smoking gun test (Part 3c) is considered met through the evolving collaboration between Fatayat and BPJS Health, which offers a tangible sign of CSA practices being carried forward beyond the project lifecycle. Though still in development and not yet codified through formal policy or budget mechanisms, this partnership suggests potential for broader institutional embedding over time.

The third mechanism of the Project centers on the aspiration to institutionalize a collaborative model of social accountability, transforming it from a project-bound innovation into a sustained, system-integrated practice. This evaluation applies the chain of results intended by the Project – outlined in its theory of action (see Figure 1 in Section 2: Context of the Project) – as the defining features of institutionalization pursued by the Project. It is not as an abstract ideal, but as a concrete ambition to embed the model within the government's way of working and to ensure its endurance through formal recognition and dedicated funding streams. As part of this pathway, the Project also envisioned Fatayat serving as a national umbrella organization to coordinate and support a nationwide roll-out of the model in collaboration with key stakeholders, including BPJS Health.

The evaluation found layered and nuanced evidence of increased stakeholder understanding, engagement, and alignment with CSA principles across the Project, thereby passing the hoop test for Part 3a of Mechanism 3. Passing the test is necessary for inferring causation of movement toward formal institutional adoption of CSA practices. While stakeholders did not always explicitly refer to their actions as CSA, this disconnect does not necessarily reflect a lack of understanding. Rather, it may represent a form of 'unconscious motivation,' in which values and practices are internalized through repetition and routine rather than through formal conceptualization. Social reproduction often occurs in this way, through familiar, repeated behaviors that are no longer questioned.[4] As the AKATIGA team

[4] By unconscious motivation, this evaluation refer not to the Freudian notion of the unconscious, but to tacit knowledge formed through repeated practices that become taken-for-granted and reproduce social structures

recalled, the term CSA was rarely mentioned in the Project meetings; instead, phrases such as 'helping the poor to get into NHI' were more commonly used.

The evaluation observed this pattern in how stakeholders interacted with the Project processes: responding to cadre reports, engaging via WhatsApp groups, and coordinating with other actors to resolve cases, demonstrating CSA in practice, even if not in name. In this context, stakeholders' understanding of CSA is evidenced by expressions such as "collaboration with Fatayat/cadres," "responding quickly to reported cases," or "coordinating with other offices to resolve problems." These reflect a nuanced, practice-based engagement with CSA, even if not formally articulated as such. Still, the evaluation stops short of concluding that CSA has emerged as a new, routinized social practice within these public institutions. The evidence does not yet support claims of systemic de-routinization, i.e., the durable integration of CSA into institutional behavior. The evaluation also noted that some stakeholders described coordination across agencies – such as between the Health Office, BPJS Health, and Social Affairs Office – as already consistent with existing standard operating procedures. This suggests that external institutional frameworks and routines also shaped their actions, independent of the Project.

Nevertheless, stakeholder interviews generally acknowledged the roles played by Fatayat cadres in bringing access-related issues to light. Cadres were received positively by institutions such as BPJS Health and local hospitals, and communication channels, such as WhatsApp groups, were used to facilitate quick exchanges and case follow-up, practices broadly consistent with collaborative social accountability principles. While stakeholders were not deeply familiar with the Project's internal design, several expressed an openness to engage further if given more structured opportunities. This may suggest a basic receptiveness to collaborative practices and indicates a modest but observable diffusion of CSA-oriented ways of working.

The following sub-evaluation questions under KEQ2 will now be addressed before turning to the remaining components of Mechanism 3:

- What additional capacity, if any, was built among implementing organizations (Fatayat NU), and how did this enhance strategic programming? How does Fatayat's position as a faith-based women's organization influence program implementation?
- What capacity improvements, if any, were observed among multi-stakeholder compact members, and did these enable more effective joint problem-solving?
- Did the project demonstrate adaptive learning, making course corrections based on monitoring, evaluation, and shifts in the external context? If so, what are specific examples? If not, what barriers prevented adaptation?

The evaluation found that the GPSA initiative contributed to incremental but meaningful capacity strengthening within Fatayat Project team in areas central to collaborative social accountability. These included improved civic capacity – both in terms of internal coordination with AKATIGA and external engagement with public sector stakeholders – as well as anecdotal growth in organizational, analytical, and adaptive capacities. Fatayat's position as a faith-based women's organization affiliated with Nahdlatul Ulama lent the initiative social legitimacy and access to community networks, which helped build trust and facilitate outreach. While some capacity gains remain uneven and evolving, the combination of expanded knowledge, experience, and institutional presence has helped Fatayat engage more strategically in stakeholder collaboration and community support. Related discussion on

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or orders. This idea is discussed in social theory, notably in Pierre Bourdieu's concept of *habitus* and Anthony Giddens's distinction between discursive consciousness, practical consciousness, and unconscious motives (see Giddens, Anthony. 1984. *The Constitution of Society* (Cambridge: Polity Press, 1984: 5-7).

capacity gains and their influence on project implementation is presented in *Section 5.2.1, Mechanism 1: Community Outreach*. Table 11 below summarizes the evidence found for each of the core capacities prioritized under the Project framework.[5]

Table 11: Summary of identified core capacities

No.	Capacity	GPSA-defined criteria	Identified evidence
1a	Intra-civic capacity	The ability to sustain collective action and make shared decisions while navigating organizational differences and power imbalances	• Joint workshops and regular coordination meetings between Fatayat and AKATIGA created space for reflection and learning, allowing for shared decision-making and alignment in program strategies and planning • Evidence of co-designing responses to emerging access challenges, based on cadre reports, indicates that decisions were made collectively, adjusting implementation tactics across districts
1b	Inter-civic capacity	The capacity to foster and maintain collaboration with public sector actors through coordination, joint problem-solving, contextual awareness, and independent facilitation	• WhatsApp groups and biannual stakeholder meetings facilitated joint problem-solving and direct, real-time communication between cadres and district-level public service providers • Institutional actors – such as BPJS Health, Social Affairs offices, and hospitals – responded quickly to cadre case submissions, indicating strong trust and operational alignment • Cadres often collaborated with Baznas and other public bodies, taking intermediary roles in facilitating access to emergency registration or medical support, showing the ability to work across bureaucratic boundaries
2	Organizational & operational capacities	The ability to effectively manage projects, including financial, human, and technical resources, to support collaborative social accountability processes	• Cadres were consistently supported with monthly stipends to cover transportation and activity needs, reflecting attention to the operational foundation for outreach and accompaniment • Fatayat's use of pre-existing organizational and religious infrastructure (as a faith-

[5] For more detailed explorations of the core capacities prioritized under GPSA, readers may refer to the GPSA MERL Guide.

No.	Capacity	GPSA-defined criteria	Identified evidence
			based women's network under NU) helped mobilize cadres and leverage institutional legitimacy • Coordination between local Fatayat chapters and AKATIGA for documentation and stakeholder engagement reflects sound project management and reporting practices
3	Analytical capacity	The ability to identify service delivery issues, apply appropriate CSA tools, and use data-driven methods to design and adapt effective, context-specific solutions	• Cadres were trained to prepare activity reports using Word and Excel documents, which served as tools to collect, organize, and store (MERL) data • The project employed regular reporting and case trend reviews during monthly and quarterly coordination meetings to identify bottlenecks and enhance results
4	Adaptive capacity	The ability to adjust strategies and actions in response to new information, learning, and changing contexts	• Regular review meetings and field feedback allowed timely modifications in messaging, technical support, and target-setting for cadre activities • Later adjustments to data collection improved the comprehensiveness, though not consistency, of profiles on individuals supported and their contextual circumstances

"Thanks to the training we've received, we now have a better understanding of BPJS and health-related programs; for example, how people can repay BPJS arrears in installments or apply for a certificate of financial hardship (SKTM). This helps us share useful information with the community more effectively." (Fatayat cadre)

"When I was working at the neighborhood level (RT), many residents had no income and lacked access to health information or knowledge about the benefits of the SKTM (certificate of financial hardship). It was through the Project that I became aware of these things." (Fatayat cadre)

"Through this program, we were able to identify data, specifically individuals who were truly underserved. For example, some were actually eligible for the PKH (government subsidy program for education) but had been removed from the list. In such cases, we provided support through Baznas." (Fatayat cadre)

The capacity improvements noted above are accompanied by important caveats. While cadres showed strong motivation and commitment, the evaluation found limited evidence that all possessed the technical or analytical skills necessary for evidence-based advocacy or analysis. These

skills are, of course, not easy to develop, but the key point is that their absence may constrain impact beyond case-based accompaniment, underscoring the need for greater support in analytical work. Although AKATIGA provided assistance in formal stakeholder forums, the ability to recognize factual, recurring patterns and communicate them strategically, especially in less structured interactions with stakeholders, could significantly improve the potential for fostering discourse and driving systemic change beyond individual case resolution.

A key limitation noted in the evaluation concerns the adequacy of reporting practices and the strategic use of data by the Project team, both essential for supporting learning, advocacy, and program refinement. While activity reports were submitted regularly, many lacked strategic detail, particularly regarding the outcomes of stakeholder engagement. Additionally, the available data appeared underutilized for analysis and advocacy purposes. That said, the evaluation recognizes the team's commendable efforts, especially in the Project's later stages, to expand the data collected on individuals supported by cadres, including health conditions, types of assistance provided, and contextual details. This reflects a clear, adaptive, people-centered focus. Nonetheless, data quality remained uneven, and its strategic application was limited. Further improvements in guidance, clarity on data use, and strengthened capacity at the district level would enhance the Project's ability to leverage data in advancing CSA.

Assessing improvements in stakeholder capacity resulting from Project-supported multi-stakeholder compacts proves challenging in this evaluation. While there was evidence of more effective joint problem-solving, particularly in relation to case reporting, this should be interpreted with caution. The Project did not include a systematic approach to monitoring capacity development, nor were there formal or targeted capacity-building components designed specifically for stakeholder institutions. As a result, any observed improvements are difficult to attribute directly to the Project, and their depth or long-term sustainability remains uncertain.

Stakeholders showed openness to working with the Project and cadres, often responding positively and expressing appreciation for the initiative, with many expressing hopes that the Project would continue. However, key government stakeholders had not made concrete plans to sustain the Project's efforts through their own budgets. This suggests that while capacity improvements were likely present – reflected in responsiveness and coordination – these were largely situational and uneven. Compared with the clearer, more structured capacity gains within Fatayat, the changes among stakeholder institutions appeared more limited and were mostly observable at the district rather than the national level. One promising development noted by the evaluation is the BPJS PESIAR program between BPJS Health and Fatayat, which will be discussed further in the next section.

We now return to testing Mechanism 3. As discussed earlier, the evaluation identified modest evidence – primarily drawn from stakeholder interviews – that increased capacity within Fatayat, along with improved stakeholder understanding, contributed to behaviors broadly consistent with collaborative social accountability. While these findings are largely anecdotal and do not indicate a full institutional shift beyond Fatayat, they offer cautious support for passing the straw-in-the-wind test for Part 3b of the mechanism. Passing the test is neither sufficient nor necessary for inferring causation.

The presence of cadres in government offices was generally welcomed, and their reports were, in several cases, acknowledged as informing public sector responses, suggesting an emerging pattern of joint problem-solving. These behaviors point to informal acceptance of CSA principles, particularly in addressing access challenges for underserved populations. However, the strength of collaboration observed may also be shaped by pre-existing institutional ties or personal relationships, especially in

areas where Fatayat already had a strong foothold. As such, the evidence should be interpreted as indicative rather than conclusive.

Fatayat's national leadership has demonstrated a strong commitment to sustaining and expanding the collaborative social accountability model. If realized, this could extend Project-informed practices to new regions. Although efforts to secure dedicated government funding – both at the national level (including planned engagement with the Ministry of Finance) and within local governments – faced substantial barriers and did not result in formal adoption through public budgeting or regulation, promising signs of institutionalization have emerged through alternative pathways. The most notable of these is the evolving partnership between Fatayat and BPJS Health, which took shape toward the end of the Project. This collaboration reflects a strategic alignment: Fatayat's intent to carry forward the CSA model beyond the Project's duration and BPJS Health's interest in strengthening its community outreach. Alongside AKATIGA, this alliance serves as a credible indication that CSA principles are maintaining traction and are beginning to embed within existing institutional structures. As such, it constitutes sufficient evidence to pass the smoking gun test (Part 3c of Mechanism 3).

Taken together with earlier findings – namely, the passing of the hoop test and one smoking gun test – this suggests that the hypothesized mechanism functioned as intended: generating movement toward formal institutional adoption of CSA practices. While the partnership with BPJS Health may still be viewed as project-driven, it closely aligns with CSA's fundamental aim of enabling civil society to engage public institutions through strategic, coordinated action. If this collaboration continues to develop and evolves into more formal structures, such as joint programming or shared funding arrangements, it could lay a meaningful foundation for the broader institutionalization of CSA in the health sector.

5.3 KEQ3: What are the opportunities and challenges for continued Fatayat-government collaboration?

To address KEQ3, this evaluation takes two complementary approaches. First, it provides a descriptive analysis of the opportunities and challenges for sustaining collaborative social accountability (CSA) based on findings that emerged during the evaluation. Second, it offers a more reflective and critical perspective, considering how the CSA model itself can be strengthened to support long-term, transformative change.

A key insight underpinning this analysis is the importance of distinguishing between CSA as a model, the Project, and Fatayat as the implementing partner. While many stakeholders expressed positive views about CSA, these were often shaped by their trust in Fatayat. Although CSA and Fatayat are closely intertwined in practice, separating the concept from the institution allows for a clearer assessment of what is working and where gaps remain.

The first, descriptive approach focuses on how CSA might be sustained through Fatayat and AKATIGA and their networks of stakeholders. The second, more critical approach asks what must evolve within the CSA model itself for it to move beyond project-based interventions and become an embedded, durable practice. At its core, CSA is about enabling citizens and communities to work collaboratively with public institutions to improve access to quality healthcare, especially for the poor and underserved. This dual lens helps clarify the conditions under which CSA can become a lasting force for systemic change.

The following discussion also addresses two sub-evaluation questions related to KEQ3:

- Have any elements of the CSA processes been replicated or adapted in other locations or policy areas by the government, the World Bank country office, other donors, or civil society organizations? What factors facilitated or hindered this scale-up?
- Can civil society-government collaboration be institutionalized within the current context and, if not, what is needed to facilitate this?

5.3.1 Emerging opportunities for sustaining CSA

One promising development for sustaining CSA beyond the Project's life is the evolving cooperation among Fatayat, AKATIGA, and BPJS Health, as already mentioned in the previous section. Discussions at the national level have advanced toward formalizing a partnership through the BPJS PESIAR program, which aims to expand health insurance enrollment, particularly in underserved rural areas. The program's national rollout – targeting approximately 8,000 villages in 2025 and scaling to all ~300,000 villages by 2026 – offers a strategic entry point for Fatayat to continue its outreach role. BPJS Health has committed to initiating collaboration in former Project locations and is drafting a memorandum of understanding (MoU) with Fatayat to extend this partnership nationwide.

This proposed collaboration reflects the institutional alignment of CSA principles with ongoing public programs. Fatayat's role in PESIAR would mirror its previous function under the Project: identifying and supporting unregistered individuals in accessing health insurance, especially those eligible for government-subsidized coverage. The planned coordination structure, including WhatsApp-based communication groups involving Fatayat, AKATIGA, and BPJS Health, draws on mechanisms already familiar from the local multistakeholder compacts, suggesting continuity in collaborative problem-solving processes. Fatayat's leadership has expressed a strong willingness to continue using the Project's approach, including its strategies and methods for coordinating with government actors. AKATIGA is expected to remain involved in the project setup.

Based on stakeholder feedback captured during this evaluation, government stakeholders generally view the continued involvement of Fatayat positively and have indicated their intent to maintain collaboration, essentially supporting the continuation of the CSA model as implemented under the Project. If such collaboration continues, and the program simply transitions under a different name or framework, opportunities for deeper government engagement can be reasonably anticipated.

Given the scope of the upcoming BPJS PESIAR program, there is also potential to scale CSA practices more broadly. Fatayat's extensive network, particularly in Java and Sumatra, could support expanded outreach to underserved areas. In regions where Fatayat's presence is weaker, such as parts of Eastern Indonesia, a different implementation modality may be needed, based on the Project's experience in those locations.

At the time of this evaluation, there are no confirmed plans from other donors or from the World Bank country office to adopt or scale the Project model in other projects. While there is a small possibility that the World Bank might integrate CSA elements into one upcoming project, this remains uncertain. The Bank's role during implementation was largely supervisory, and the limited traction the Project gained with key national ministries may explain the uncertainty around future engagement or replication at the Bank level.

The evaluation also noted that throughout the project, both AKATIGA and Fatayat made efforts to engage other mass-based organizations, such as Muhammadiyah (Aisyiyah) and Catholic-affiliated groups, to adopt or adapt similar models. However, these efforts had not led to any concrete outcomes by the end of the project period.

5.3.2 Rethinking collaborative social accountability

In presenting our reflective analysis, we begin by outlining our observations of patterns and dynamics that relate directly to CSA practices, as well as more subtle factors, such as underlying situations, structures, and actions that shape how CSA unfolds. We then turn to the opportunities ahead, particularly those that could help improve access to health services for the most vulnerable and hard-to-reach populations.

What must be stated upfront is the importance of maintaining a degree of caution against assuming that interactions between government actors, service providers, and civil society will naturally be collaborative, simply because the initiative is called *collaborative social accountability,* a *multi-stakeholder compact*, or a similar term. While it is reasonable to hope that stakeholders in a CSA framework will collaborate frequently, it would be overly optimistic – and ultimately naïve – to expect that collaboration will always take place. The causal dynamics behind collaboration are far more complex than they may appear. The Project experience revealed the limits of cooperation, which were shaped by divergent political interests, internal organizational disputes, and even private conflicts spilling into public processes. This reality challenges not only our understanding of CSA but also highlights the need to address the quality of interactions within these frameworks. In this sense, a transformation of the interactional dynamics between actors becomes an essential part of strengthening social accountability. It is not only the frequency or number of engagements that matter, but the *quality* of those interactions that ultimately determines the health and sustainability of CSA efforts.

Another pattern that emerged from the Project experience is that many problems, especially those faced by the poor and vulnerable, can only be resolved quickly and thoroughly when connections are involved. These connections might take the form of family ties, friendships, religious or ethnic affiliations, neighborhood networks, and so on. Some may raise an eyebrow and question how such a dynamic can exist amid calls for non-discrimination and equal access nowadays. But the issue here is not about discrimination *per se*; rather, it is about how the same system often produces different outcomes depending on whether or not someone has connections. In everyday life, this becomes apparent when problems are resolved more swiftly for those who can tap into such networks. In this context, it is important to recognize that, to some extent, Fatayat *is* that connection.

This is also why CSA efforts carried out exclusively through Fatayat may unintentionally introduce network-bias, benefiting those within the Fatayat network while potentially leaving out individuals who are outside of it. This point is not a critique of how things operate, nor of Fatayat itself. In fact, Fatayat cadres consistently help anyone who asks for assistance, regardless of background. Rather, this observation is meant to highlight a common reality faced by people struggling at the margins: access to help often depends on whether one is connected to a network, any network at all. The more relevant and constructive question, then, is: If connections are the mechanism by which the world operates, how can we ensure those connections also extend to the poorest and most marginalized, who often have the fewest? This critical point will be revisited in our discussion of opportunities ahead.

The third key point is worth stating clearly: the strength of a civil society organization like Fatayat, one that holds influence and often has some degree of political engagement, can also become its vulnerability. In particular, maintaining the right distance from both state institutions and community actors is not always easy, yet it is essential for ensuring that efforts truly serve the public interest. In the same vein, the tension between engaging with government and staying grounded in community needs is something that CSA actors must manage thoughtfully. While this reflection could benefit from more empirical evidence, the basic idea remains important: civil society actors are expected to carry

the voices of citizens without undermining their working relationship with the state. This makes the ability to navigate between these spheres a valuable skill, one that helps organizations like Fatayat maintain trust from both sides. That trust plays a critical role in CSA and deserves greater attention in discussions about its implementation and sustainability. And within that space, one may ask: how do we continue working with others to support those most in need?

Looking forward, the CSA model must reflect on the insights outlined above, particularly the need to ensure that poor and sick individuals have more pathways and connections to access support. The limitations of formal systems, even with modernized service delivery, have consistently failed to reach those who are most marginalized. In the post-Project context – such as the emerging collaboration between Fatayat and BPJS Health through the PESIAR program – it is crucial to center the agenda around those who are hardest to help. This means that civil society must not only participate in implementation but also have a voice in agenda-setting. Within the CSA framework, civil society actors must be seen as capable of shaping influence, not just responding to it. A sustainable CSA model requires a healthy tension between autonomy and interdependence, in which the state also relies on civil society's performance and credibility.

Snowballing, an approach that successfully identifies the hardest-to-reach populations, must remain central. History has shown that these groups cannot be captured through surveys or formal bureaucratic processes alone. Real suffering is best understood and identified by those who live it or by others in similar conditions. This is a key lesson from this Project experience. While government capacity is indeed limited, once we can identify those who truly need support and provide credible data, resources can often be mobilized. But if we fail to identify them in the first place, the problem remains unresolved.

In this light, one promising direction is to strengthen the connections between local interventions and scattered government programs so they can support and reinforce one another. It has become clear that collaboration is essential; coordination allows for more comprehensive solutions. And through such synergy, they are far more likely to reach those who are most difficult to serve. When they succeed in doing so, the overall wellbeing of the broader community will also improve.

Ultimately, the sustainability of social accountability also depends on the extent to which the practices and aspirations of multiple stakeholders evolve to demand accountability. This is why mobilizing other civil society groups is so important. Encouraging broader participation not only expands the reach of CSA but also reduces the potential bias of relying solely on Fatayat's network, no matter how extensive it may be.

6. Conclusion

This evaluation confirms that the Project made tangible contributions toward improving access to Indonesia's National Health Insurance for poor and vulnerable populations. Its most significant and verifiable achievements lie in helping individuals previously excluded from the system to register, access, and benefit from healthcare services. This was largely achieved through community outreach and the role of Fatayat cadres and network. These efforts proved particularly effective for individuals classified as hard-to-reach; those invisible in official records, living with chronic illness, or experiencing compounded vulnerabilities. Cadres supported these individuals through intensive accompaniment, often helping them navigate complex bureaucratic processes, transportation issues, and living costs.

Process tracing validates the Project's contribution to outcomes along a causal pathway: outreach led to identification, followed by registration, and ultimately to access to care. This demonstrates that community-based actors, when supported, can bridge gaps in large-scale systems and effectively deliver impact at the grassroots. While UHC coverage increased in all Project sites during the implementation period, this was largely due to broader national programs. However, the Project's role in outreach, local data validation, and targeted engagement was crucial in ensuring that some of the most underserved populations were not left behind. These contributions filled persistent gaps that the national system alone could not address.

Though the Project was effective in expanding access, progress in improving service quality was more uneven. Some local multi-stakeholder compacts led to concrete improvements – such as changes in hospital infrastructure or increased enrollment efforts – but these outcomes varied by district, often depending on the strength of local leadership and the history of collaboration between stakeholders and few translated into lasting policy dialogue or systemic accountability reforms.

One critical insight is that the Project interventions, while impactful at the individual and local level, did not lead to systemic transformation in how government actors structure or manage access to healthcare services. The absence of a strong, coordinated message around how the Project's model aligned with broader health system priorities limited its institutional traction.

One of the Project's most significant but under-discussed roles is as a social connector. In a context where access often depends on who you know, Fatayat became a critical bridge for underserved communities. While effective, this approach raises questions about inclusiveness; what happens to those outside these networks?

This dynamic underscores the importance of designing CSA models that both leverage existing trust networks and expand beyond them. Fatayat cadres, while committed to serving all, inevitably work through relational channels. Ensuring broader outreach will require a more deliberate strategy to avoid reinforcing existing 'exclusions.'

Moreover, Fatayat's dual role as a trusted grassroots organization and a potential political actor creates both opportunity and risk. On the one hand, this positioning gives it access to decision-makers; on the other hand, it may compromise its neutrality. Ensuring independence while maintaining relationships across sectors will be critical for future credibility.

Limitations in government data systems, weak local budgets, and rigid eligibility criteria further underscore the necessity of grassroots validation and outreach. The Project demonstrated that local actors can supplement national data gaps, but also that sustained systemic support is needed to institutionalize this role. The snowballing method used by Fatayat to identify cases – based on informal

networks and community trust – proved especially effective in reaching the most marginalized. Formalizing this method as a complementary government mechanism could enhance identification without sacrificing legitimacy or trust.

The emerging partnership with BPJS Health, which seeks to expand the role of Fatayat cadres beyond the original Project sites, presents a promising opportunity for sustaining and scaling the outreach model. However, for this partnership to be impactful, it must be supported by clear agenda-setting and adequate resource commitments from all parties involved. Despite this potential, sustainability remains a concern. Without broader institutional adoption of the Project's model, whether by government bodies or other donors, there is a risk that its positive impact may diminish over time.

CSA is not simply a mechanism; it is a process shaped by relationships, trust, and political will. The Project experience shows what is possible when communities are supported to speak, act, and engage with systems. Moving forward, organizations like Fatayat must continue bridging gaps, challenging exclusions, and advocating for change, not only through individual assistance but by helping shape the systems that define access for all.

7. Recommendations

Given the Project's results and the ongoing challenges in Indonesia's health governance, particularly during this period of rapid modernization and digitalization, this evaluation offers a set of forward-looking recommendations for future GPSA programming. These recommendations are presented in two parts. The first set is tailored to the Indonesian context and involves Fatayat and AKATIGA. The second set is intended for GPSA's global programming and strategy. All recommendations should be considered alongside the findings presented in section 5.3 (KEQ3) and the conclusions outlined in section 6.

Recommendations for strengthening CSA in the Indonesian health sector (Fatayat, AKATIGA, the World Bank Country Office, government stakeholders):

1. Expand the use of peer- and community-based identification methods

To improve the identification of poor and vulnerable populations, build on trusted informal mechanisms that can complement formal data systems. One promising avenue is to further develop Fatayat's snowballing approach into a more structured methodology, complete with ethical guidelines, standardized documentation procedures, and clear referral pathways. This method can be piloted in select districts with support from local health and social service offices. Over time, explore options to digitize and securely manage data collected through this method to facilitate integration with existing public systems, while maintaining community trust and respecting privacy. This approach will help ensure the visibility of those typically missed by national surveys and administrative data.

2. Develop a locally validated registry of highly vulnerable individuals

To strengthen targeting and coordination across actors, support the development of a locally validated, district-level registry of high-risk individuals. This registry should prioritize populations experiencing overlapping vulnerabilities, including those in extreme poverty, those with chronic health conditions, elderly people living alone or with dependents, and single women heading low-income households. Rather than relying solely on centralized data systems, the registry should be informed by local knowledge and trusted networks. When operationalized, it could serve as a shared resource among health, social protection, and civil society actors to coordinate outreach, monitor unmet needs, and improve resource allocation. By grounding this tool in lived realities and linking it to institutional frameworks, this registry would help close persistent access gaps in both health and social support systems.

An additional point, based on internal reflections from the World Bank GPSA team, is the importance of also exploring outreach and support mechanisms for individuals facing sensitive, stigma-associated issues, such as specific diseases (e.g., HIV/AIDS), early pregnancy, or other health or social conditions that people may be reluctant to disclose publicly due to stigma or shame. While this evaluation did not encounter specific cases of this nature, it recognized the need for tailored approaches should they arise, including measures to protect confidentiality and connect individuals with appropriate services. Although such cases were not explicitly targeted by the Project, the evaluation suggests that future, similar initiatives may consider integrating targeted support for these sensitive issues, as there appears to be limited assistance currently available for individuals in these situations.

3. Institutionalize the role of community-based outreach in the NHI system

Move beyond short-term, project-based outreach by formally recognizing and integrating community-based outreach roles – such as those carried out by Fatayat cadres – into the national health insurance (NHI or JKN) framework. For institutional collaborations like the one between Fatayat and BPJS Health, it is essential to clearly define roles and responsibilities, ensure a strong focus on reaching vulnerable populations, and establish clear agenda-setting and feedback mechanisms.

4. Broaden CSA participation by engaging other community-based and civil society actors

To increase outreach and sustainability, expand participation in CSA by involving other community-based and civil society groups. Facilitate structured engagement with other mass-based organizations to adapt and localize CSA strategies in different contexts, especially in underrepresented regions like Eastern Indonesia. Create collaborative platforms at the local level where these actors can jointly prioritize issues, share case data, and coordinate with government agencies. Consider offering small grants or capacity-building packages to grassroots organizations interested in taking on CSA roles, with the goal of building a more resilient and distributed ecosystem of accountability actors.

Recommendations for global GPSA programming (World Bank, CSA practitioners, development partner organizations and civil society organizations):

1. Broaden the understanding of CSA success to reflect community-based and contextual outcomes

Future CSA programming would benefit from adopting a broader, more flexible understanding of what success can look like. The current Theory of Action underpinning GPSA initiatives focuses primarily on policy reform and improvements in public service delivery, assuming that high-level government action is the key pathway to change. It is important to acknowledge that CSA originated from efforts to strengthen state accountability, but this should not be interpreted as its only pathway or purpose. For any strong and sustained demand for accountability to take root, it must also be matched by strong capacities and support for community mobilization, work that happens within, not outside, the CSA frame. Rather than viewing policy change as the sole indicator of success, CSA could also consider outcomes such as strengthened community organizing, improved civic awareness, or the development of local solutions to service gaps.

2. Strengthen the role of beneficiaries in shaping CSA through grounded engagement

To enhance the relevance and impact of CSA efforts, future programming should place greater emphasis on understanding the perspectives and experiences of poor and vulnerable individuals themselves. CSA approaches should support partners in adopting more people-centered, adaptive programming; rooted in regular engagement and learning from those directly affected. This also includes revisiting how 'citizen/public voice' is defined and exercised in CSA models. Representation and participation should not be assumed; there is a need to ensure that the mechanisms used to channel community input genuinely reflect the people whose lives are most impacted. In practical terms, this could involve using participatory feedback methods, conducting more analytical and reflective monitoring visits with beneficiaries, and systematically documenting learning from those engagements. It may also include efforts to map and analyze the profiles of direct beneficiaries over time, along with their responses to the program.

3. Strengthen partner capacity, leadership, community mobilization, and monitoring

Continue supporting a consortium model involving at least two partners with complementary strengths, such as community outreach and policy engagement, to enhance reach and effectiveness. To improve program quality and sustainability, invest in strengthening partner capacity, internal processes, leadership engagement, and monitoring systems. Experience with organizations like Fatayat

highlights the importance of ensuring leadership support and alignment, especially when programs address politically sensitive or complex issues. Capacity-building efforts should support both government engagement and community mobilization, emphasizing facilitation, adaptive management, and the ability to interpret and use data. Improve monitoring tools and practices so they assess not only activity delivery but also the quality of engagement, responsiveness to local needs, and progress in access or service inclusion.

Annexes

Annex 1: Project final results framework

Indicator	Operationalization	Unit of Measurement	Base line	Targets				Achievement				Notes
				2022	2023	2024	2025	2022	2023	2024	2025	
PDO-level Indicators by Results Areas												
PDO INDICATOR 1												
Percentage of problems experienced by target beneficiaries that are identified and followed up through the project's collaborative social accountability mechanism	Calculated as the number of distinct types of problems that are followed up by cadres <u>divided by the</u> total number of types of problems that come to cadres (including those that are not followed up) "Problem" is defined as cases where of people individuals who need assistance to enroll in National Health Insurance (NHI) or wish to enroll to NHI or to get health services requires assistances to meet the NHI requirement or to have the service that meet the regulation standard. The	Percentage	0%	20%	30%	40%	40%	88%	90%	90%	90%	Achievements exceed the target. The project design set comparatively low target since the project was designed as a pilot to test the model. In implementation, Fatayat cadres followed up most cases that came to cadres. There were very few cases that cadres did not follow up. For example: requests from non-eligible individuals who wanted to register for subsidized NHI; 2) requests for assistance outside their districts. In the first

Indicator	Operationalization	Unit of Measurement	Base line	Targets				Achievement				Notes
				2022	2023	2024	2025	2022	2023	2024	2025	
	problems came from cases found and recorded by cadres Data sources: Cadres monthly reports											example, cadres explained that subsidized NHI were only for the poor. In the second example, cadres provided information government agencies responsible for NHI social assistance
PDO INDICATOR 2												
Percentage of direct beneficiaries assisted by the project that have increased access and utilization of health services	Calculated as the number of people who have registered NHI with cadres help and the number of people helped by cadres in utilizing health services divided by the total number of people who request cadres' assistance Direct beneficiaries refer to the community members, poor & non-poor, who reach out to cadres for assistance in enrolling to NHI or to access health services. They reach out either after the	Percentage	0%	20%	30%	40%	40%	88%	90%	90%	90%	Achievements exceed the target. The project design set comparatively low target since the project was designed as a pilot to test the model. In implementation, Fatayat cadres followed up most cases that came to cadres. There were very few cases that cadres did not follow up. For example: requests from non-eligible individuals who wanted to register for subsidized NHI; 2) requests for

Indicator	Operationalization	Unit of Measurement	Base line	Targets				Achievement				Notes
				2022	2023	2024	2025	2022	2023	2024	2025	
	socialization events or through word of mouth. One person can be assisted for different needs: registering to the NHI while at the same time accessing health services Data sources: Cadres monthly reports											assistance outside their districts. In the first example, cadres explained that subsidized NHI were only for the poor. In the second example, cadres provided information government agencies
INTERMEDIATE RESULTS INDICATOR 1												
Number of CSO partner-led multi-stakeholder compacts meeting regularly with involvement from relevant stakeholder groups	Counts the number of Fatayat NU branch (PC) and national board of Fatayat NU (PP), that are routinely engaged with key NHI government stakeholders to agree on specific problems and co-develop solutions to improve health services Data sources: Cadres monthly report Multistakeholder minute meeting AKATIGA field visit notes	Number	0	9	9	8	9	9	8	8	9	Key NHI government stakeholder at the national level: Ministry of Health (MoH), BPJS Health, Ministry of Social Affairs (MOSA), and Ministry of Finance (MOF) At the local level: Head of districts/mayors, Office of BPJS Kesehatan, Office of Health, Office of Social Affairs In 2025, the closing event was attended by the BPJS Health Central and

Indicator	Operationalization	Unit of Measurement	Base line	Targets				Achievement				Notes
				2022	2023	2024	2025	2022	2023	2024	2025	
												representative from MoSA. BPJS Health followed up with plans to sign up an MoU with PP Fatayat for collaboration in PESIAR Program, a BPJS Health initiative to improve community outreach
INTERMEDIATE RESULTS INDICATOR 2												
Number of people participating in formal training on social accountability approaches used by the project from the following stakeholder groups: civil society, targeted public sector counterparts, citizens	Counts the number of Fatayat cadres received formal training. Each local team has 7 members, so in total there were 7 members x 8 locations = 56 people Data sources: Minute meetings of cadres' training in 2021-2022	Number	0	56	56	56	56	56	56	56	56	Target achieved in the first year (2022). The numbers in subsequent columns reflected the number in the first year. Formal trainings were conducted once at each location at the beginning of the program and the number of participants is set as the end target. Followed-up capacity building mechanism or training to new cadres (who replace the original) were conducted through

Indicator	Operationalization	Unit of Measurement	Base line	Targets				Achievement				Notes
				2022	2023	2024	2025	2022	2023	2024	2025	
												continuous mentoring, discussions, and coaching both by coordinators and by AKATIGA
INTERMEDIATE RESULTS INDICATOR 3												
Grant partners participate in GPSA partner learning events (annual forum and annual grant partners workshop).	Whether AKATIGA participated in GPSA annual forum and GPSA grantee workshop during the reporting year (Yes/No). A "Yes" is recorded if AKATIGA attended at least one event. Data sources: AKATIGA's back to office reports	Yes/No	No	Yes	Yes	Yes	Yes	Yes	Yes	No	No	AKATIGA participated in GPSA Annual Forum & Grantee Workshop (Online) in 2021 and 2022. AKATIGA participated GPSA Grantee Workshop in May 2023. There was no GPSA grantee workshop in 2024 & 2025
INTERMEDIATE RESULTS INDICATOR 4												
Number of people participating in the project's collaborative social accountability process(es) among the following stakeholders: civil society and targeted public	Counts the total number of participants from civil society and targeted public sector counterparts engaged in project-led social accountability processes. This group includes: - Number of Fatayat team in 8 districts (7x8)	Number	0	92	92	92	92	125	110	106	223	In 2022: 56 Fatayat cadres, 50 stakeholder representatives in 8 locations, 19 stakeholders at national level In 2023: 56 Fatayat cadres+ 50 stakeholder representatives in 8

Indicator	Operationalization	Unit of Measurement	Base line	Targets				Achievement				Notes
				2022	2023	2024	2025	2022	2023	2024	2025	
sector counterparts.	- Number of stakeholder representative at local level in 8 districts (4 at each district) - Number of national level stakeholders (4 from each) Data sources: Stakeholder meeting notes											locations, 4 at national level In 2024: 56 Fatayat cadres+ 50 stakeholder representatives in 8 locations In 2025: 56 Fatayat cadres + 136 stakeholder representative in 8 locations + 4 national level Fatayat + 27 stakeholder national level The number reflected the actual number of stakeholder representatives engaged both through individual stakeholder meetings and in multistakeholder meetings. The number in 2023 and 2024 slightly declined because these years focused more on key stakeholders

Indicator	Operationalization	Unit of Measurement	Base line	Targets				Achievement				Notes
				2022	2023	2024	2025	2022	2023	2024	2025	
INTERMEDIATE RESULTS INDICATOR 5												
The CSOs involved in the project have identified and agreed upon the causes of service delivery failure through a political economy analysis	Checked annually, the meetings between Fatayat at local and national level stakeholders identified and agreed on problems. A "Yes" is recorded if the meetings result in identification and agreement on the main causes of service delivery failures; otherwise, "No." Data sources: Cadres' monthly reports Minutes of monthly online meetings	Yes/No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Causes of backlog for PBI registration delays were discussed and agreed between Fatayat cadres and AKATIGA during regular online meetings and with stakeholders in the multistakeholder meetings
INTERMEDIATE RESULTS INDICATOR 6												
There is evidence of uptake (as defined by the GPSA by public sector institutions, the Bank or other donors/development actors to which the project has contributed	Checked annually on evidence that there are other institutions that want to uptake this project's approach Data sources: Meeting minutes with public sector institutions (BPJS Health)	Yes/No	No	No	No	Yes	Yes	No	No	No	Yes	In July 2024, following up the project's dissemination event, BPJS Kesehatan initiated talks with PP Fatayat to recruit Fatayat's cadres in PESIAR program. BPJS Health began with a pilot in six districts from the project locations (Muaro Jambi,

Indicator	Operationalization	Unit of Measurement	Base line	Targets				Achievement				Notes
				2022	2023	2024	2025	2022	2023	2024	2025	
												Bandung, Tegal, Pati, Kediri, and Blitar)
INTERMEDIATE RESULTS INDICATOR 7												
The project has made course-corrections based on learning and evidence	Checked annually. Basis for correction can be from the project's findings or from other GPSA programs Data sources: AKATIGA – PP Fatayat meeting minutes	Yes/No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Adjustment in data collection from cadres: from online form to monthly reports augmented with monthly online meetings Adjustment in cadres' capacity building: from in-class training to close coaching (WhatsApp groups and regular field meetings) and through cross peer learning

Annex 2: List of documents and data sources

GPSA Grantee Progress Report

GPSA Grantee Six-Monthly Narrative Report April – September 2021.

GPSA Grantee Annual Progress Report July 2021 – June 2022.

GPSA Grantee Mid-year Technical Progress Report July 2021 – December 2021.

GPSA Grantee Mid-year Technical Progress Report July 2022 – December 2022.

GPSA Grantee Mid-year Technical Progress Report July 2023 – December 2023.

GPSA Grantee Annual Progress Report July 2023 – June 2024.

Aide Memoire

The World Bank GPSA, Aide Memoire: Implementation Support Mission, October 28-November 1, 2021.

The World Bank GPSA, Aide Memoire: Implementation Support Mission, November 21-25, 2022.

The World Bank GPSA, Aide Memoire: Mid-Term Review Mission, May 1-11, 2023.

The World Bank GPSA, Aide Memoire: Implementation Support Mission, October 16-23, 2023.

The World Bank GPSA, Aide Memoire: Implementation Support Mission, July 15-17, 2024.

Project meeting minutes

Meeting minutes: Project team discussion in Kediri, May 13, 2024.

Meeting minutes: Project team discussion in Blitar, May 14, 2024.

Meeting minutes: Project team discussion in Ternate, May 15, 2024.

Meeting minutes: Project team discussion in Tegal, May 15, 2024.

Meeting minutes: Project team discussion in Pati, May 17, 2024.

Meeting minutes: Project team discussion in Muaro Jambi, May 22, 2024.

Meeting minutes: Project team discussion in Jambi, May 22, 2024.

Meeting minutes: Project team discussion in Bandung, June 7, 2024.

Meeting summary: Project local team discussion June 5, 2024.

Meeting minutes: Learning and work plan – February 23, 2024 (PowerPoint Presentation).

Project area profiles

Profile of project area: District of Tegal.

Profile of project area: City of Ternate.

Profile of project area: City of Jambi.

Profile of project area: District of Bandung.

Profile of project area: District of Muaro Jambi.

Profile of project area: District of Pati.

Profile of project area: District of Kediri.

Profile of project area: District of Blitar.

GPSA MERL reference material

AKATIGA, GPSA Baseline Report October 13, 2022.

AKATIGA, GPSA Revised Baseline Report November 28, 2022.

The World Bank GPSA, Implementation Support Mission: Monitoring, Evaluation, Learning November 21-25, 2022 (Power Point Presentation).

The World Bank GPSA, Implementation Support Mission: Kick-off meeting November 21-25, 2022 (Power Point Presentation).

The World Bank GPSA, M&E Manual for AKATIGA and Fatayat NU project.

The World Bank GPSA, Ripple Effect Mapping in a Nutshell (Training material).

Wadeson, Alix. Orientation Session: Monitoring, Evaluation, Reporting and Learning Guide for GPSA Grant Partners and Consultants (Power Point Presentation).

Wadeson, A. & Guerzovich, Florencia (2023). Monitoring, Evaluation, Reporting and Learning Guide for GPSA Grant Partners and Consultants. World Bank, Washington, DC.

Other project documents

AKATIGA, Pre Mid-Term Review material: Exercise Results of the Force Field Analysis (Power Point Presentation).

Dataset final project beneficiaries, areas (villages and subdistricts), stakeholders, clinics/hospitals.

Dataset GPSA 2023 & 2024.

Dataset GPSA Muaro Jambi.

GPSA Grantee Environmental & Social Management (ESM) and Stakeholder Engagement Plan (SEP) Report (Annex).

Project Theory of Change, May 8, 2023.

Results Framework Discussion, Meeting Notes May 8, 2023.

The World Bank, GPSA Project Paper to the AKATIGA Foundation, March 22, 2021.

The World Bank GPSA, The Global Partnership for Social Accountability (GPSA) (Power Point Presentation).

Book and research papers

Bamanyaki, Patricia & Holvoet Nathalie (2016). Integrating Theory-Based Evaluation and Process Tracing in the Evaluation of Civil Society Gender Budget Initiatives. Evaluation: The International Journal of Theory, Research and Practice - ISSN 1461-7153 - 22:1(2016), p. 72-90. Downloaded from: https://journals.sagepub.com/doi/10.1177/1356389015623657.

Beach, Derek & Rasmus Brun Pedersen (2013). Process-Tracing Methods: Foundations and Guidelines. The University of Michigan Press.

Bennett, A. & Jeffrey T. Checkel (eds) (2015). Process Tracing: From Metaphor to Analytic Tool. The Cambridge University Press.

Chazdon S., *et al* (2017). A Field Guide to Ripple Effects Mapping. University of Minnesota.

Chen, Huey T. (2012). Theory-Driven Evaluation: Conceptual Framework, Application and Advancement. In R. Strobl et al. (Hrsg.), Evaluation von Programmen und Projekten für eine demokratische Kultur, chapter, pp. 17-40, Springer Fachmedien Wiesbaden. Downloaded from: https://link.springer.com/chapter/10.1007/978-3-531-19009-9_2.

Erlangga D., *et al* (2019). The Impact of Public Health Insurance on Healthcare Utilisation in Indonesia: Evidence from Panel Data. Downloaded from: https://link.springer.com/article/ 10.1007/s00038-019-01215-2.

George, Alexander L. & Andrew Bennett (2005). Case Studies and Theory Development in the Social Sciences. BCSIA Studies in International Security. Cambridge: MIT Press.

Guerzovich, F. & Paula Chies Schommer (2018). Social Accountability and Open Government: Different Types of Collaborative Engagement. International Journal of Open Government [2018 – Vol 7], pp. 149-164. Link: http://ojs.imodev.org/index.php/RIGO.

Guerzovich, Maria F. & Maria Poli (2020). How Social Accountability Strengthens Cross-Sector Initiatives to Deliver Quality Health Services? Global Partnership for Social Accountability Note 17. World Bank, Washington, DC. Downloaded from: https://gpsaknowledge.org/uncategorized/how-social-accountability-strengthens-cross-sector-initiatives-to-deliver-quality-health-services/.

Jacobs, Bart (2011). Addressing Access Barriers to Health Services: An Analytical Framework for Selecting Appropriate Interventions in Low-Income Asian Countries. Health Policy and Planning 2012;27:288–300. Downloaded from: https://academic.oup.com/heapol/article/27/4/288/ 604184.

Kuppens, Miet (2016). Exploring the Social Accountability Concept: A Literature Review. Institute of Development Policy and Management (IOB), University of Antwerp: Working paper.

Lodenstein *et al* (2013). A Realist Synthesis of the Effect of Social Accountability Interventions on Health Service Providers' and Policymakers' Responsiveness. Downloaded from: https://systematicreviewsjournal.biomedcentral.com/articles/10.1186/2046-4053-2-98.

Lodenstein *et al* (2016). Health Provider Responsiveness to Social Accountability Initiatives in Low- and Middle-Income Countries: A Realist Review. Health Policy and Planning, 32, 2017, 125–140. Advance Access Publication Date: 3 July 2016. Downloaded from: https://academic.oup.com/heapol/article/32/1/125/2555394.

Marston C. *et al* (2020). Methods to Measure Effects of Social Accountability Interventions in Reproductive, Maternal, Newborn, Child, and Adolescent Health Programs: Systematic Review and Critique. Journal of Health, Population and Nutrition (2020) 39:13. Downloaded from: https://doi.org/10.1186/s41043-020-00220-z.

Naher N. *et al* (2020). Do Social Accountability Approaches Work? A Review of the Literature from Selected Low- and Middle-Income Countries in the WHO South-East Asia Region. Health Policy and Planning, 35, 2020, 176–196. Downloaded from: https://academic.oup.com/heapol/article/35/Supplement_1/i76/5960441.

Nobles, J., Wheeler, J., Dunleavy-Harris, K. *et al* (2022). Ripple Effects Mapping: Capturing the Wider Impacts of Systems Change Efforts in Public Health. *BMC Med Res Methodol* 22, 72 (2022). Downloaded from: https://doi.org/10.1186/s12874-022-01570-4.

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Tansey, Oisín (2017). Process Tracing and Elite Interviewing: A Case for Non-probability Sampling. University of Reading. Downloaded from: https://www.cambridge.org/core/journals/ps-political-science-and-politics/article/abs/process-tracing-and-elite-interviewing-a-case-for-nonprobabil ity-sampling/8EE25765F4BF94599E7FBD996CBFDE74.

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Widyaningrum, N., Isono Sadoko, and Charina Chazali (2025). Collaborative Social Accountability for Health Equity: The Role of Women's Faith-Based Organizations in Indonesia's National Health Insurance System. AKATIGA: Draft academic paper.

Annex 3: Evaluation Terms of Reference

FINAL EVALUATION OF THE WOMEN'S VOICES IN THE MONITORING AND IMPROVEMENT OF INDONESIA'S UNIVERSAL HEALTH CARE INSURANCE SERVICES PROJECT

A final independent evaluation of the GPSA project *Women's Voices in the Monitoring and Improvement of Indonesia's Universal Health Care Insurance Services Project* in Indonesia will be carried out before the project closes on 30 June 2025. The evaluation should answer the key evaluation questions included in this TOR (see below) with causal analysis. This should be informed by the GPSA's and Project's Theory of Action as well as analysis of the project-level Results Framework. It should use qualitative and quantitative data captured in the project baseline report, biannual project monitoring and mid-term assessment, analytical reports produced by Akatiga, as well as data collected specifically in relation to the final evaluation.

The evaluation must show results made in the project in a credible and transparent way. To do so, the evaluator will draft a research design for the final evaluation and will develop appropriate data collection tools and protocols, which will be cleared with the GPSA prior to implementation. The evaluator will collect data, conduct data analysis (theory-informed and causal), and draft and finalize the report.

A main goal of the final evaluation is to inform improvements to collaborative social accountability strategies for those working in the sector to utilize. The final evaluation is considered the grantee contribution to the GPSA global knowledge platform.

The final evaluation report should be of a high enough quality to share with donors, international agencies, and interested third parties engaged in collaborative social accountability processes. The finished evaluation report will be published on the GPSA's website, and a summary of the final evaluation report will be presented to Akatiga and Fatayat, the World Bank TTL and GPSA Secretariat in an online presentation.

Key evaluation questions

Key evaluation questions	Purpose of question	Suggested methodology
1. What did the project achieve in relation to its Project Development Objective?	Understanding and evidencing the overall results of the project- what changes it contributed to.	Ripple Effect Mapping with resultant stories substantiating the Project Development Objective
2. With a focus on processes, how did the project's components (capacity building and the project's use of collaborative social accountability processes/tools) contribute to/cause the identified results?[6]	Analytical focus to contribute to the wider learning on how, when, in what contexts, and under what circumstances collaborative social accountability produces change.	This is an analysis of the GPSA's Theory of Action which requires a theory-based evaluation methodology. A preferred one is process tracing (because it complements Ripple Effect Mapping nicely), but other

[6] This question is about validating the theory of action; thus it can be broken down into a series of questions that correspond to the various components of the theory of action (and indicators in the results framework) and the sequence of these components:

1. Were fit-for-purpose multi-stakeholder compacts established? Were the most relevant stakeholders included

Key evaluation questions	Purpose of question	Suggested methodology
Potential angles could be about: -the role of Fatayat, the role of Akatiga, and the role of Fatayat/Akatiga collaboration -the implications of doing collaborative social accountability in a context where change is focused at district level due to central ministry level collaboration being challenging		good ones are realist evaluation, contribution analysis, outcome harvesting, and qualitative comparative analysis.
3. What are opportunities and challenges regarding continued Fatayat-government collaboration? *Potential angles could be*: -can civil society-government collaboration be institutionalised within the existing situation and, if not, what is needed for this to materialise?	Provide useful learnings for Akatiga/Fatayat and the wider international community grappling with questions about institutionalization of collaborative processes.	An appropriate analytical framing can be found in the book "Scaling up development impact", chapter five. It focuses on three criteria that must be present for civil society innovations to be scaled through government: technical correctness (effectiveness), administrative feasibility (implementable), and political supportability (necessary buy-in).

Evaluator's Scope of Work

The evaluator is expected to conduct an independent evaluation on project *Women's Voices in the Monitoring and Improvement of Indonesia's Universal Health Care Insurance Services* implemented by AKATIGA and PP Fatayat. Detailed tasks include:

1. Develop Evaluation Design based on the ToR

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and how was this determined?

2. What additional capacity (if any) was built among project implementing organizations and how did this contribute to better and more strategic programming?
3. What (if any) additional capacity was built among members of the multi-stakeholder compacts and did this enable them to engage in joint problem-solving more effectively?
4. What CSA processes did the multi-stakeholder compacts use? Did these processes lead to meaningful engagement with relevant public bodies? What enabled these processes to be successful (hindered them from being successful)?
5. Did these CSA processes result in public bodies addressing the identified problems? What problems were addressed and how? What enabled this result to be achieved (hindered it from being achieved)?
6. Have any elements of the CSA processes been (or are likely to be) replicated in other locations or adopted/adapted in other policy areas by the government, the World Bank country office/other donors or civil society organizations? What enabled this scale-up to take place (hindered it from taking place)?
7. Did the project demonstrate ongoing adaptive learning by which changes for course correction were made by the project based on monitoring, evaluation and learning evidence and relevant shifts in the external context? If so, please provide specific examples. If not, why?

2. Conduct desk review
3. Conduct interviews/FGDs (ripple effect mapping sessions)
4. Draft final report
5. Present draft research design & draft final report

Deliverables

There are two deliverables for this evaluation:

1. Evaluation design and data collection plan
2. Final report

Qualifications

The evaluator should have these qualifications:

1. A minimum of ten-year experience in conducting program evaluation employing qualitative and/or mixed method. Familiarity with participatory evaluation approach is preferred
2. A tertiary qualification in a relevant discipline, such as social science, or equivalent of experience in a relevant field
3. Demonstrated strong analytical and writing skills, and the ability to present the results in a simple language and/or making use of visual aids (matrix or graphs)
4. Excellent command of written and verbal English

Timeline

This evaluation is scheduled on February – June 2024. This timeline, especially data collection phase, takes into account the Muslim calendar's event (Ramadhan and Eid Fitri) which will fall in March – early April 2025. Table 1 below provided estimation of work day.

Table 1 Estimation of Work Day

No	Activities	Estimated day(s)	Estimated dates
1	Desk study and initial interview	2	
2	Finalisation of evaluation guideline	1	Jan 30
3	Data collection (Group/individual interviews) - With AKATIGA team & Fatayat Team - With Fatayat Team - With local team & stakeholders (max 2 districts, including trip. Combined hybrid and field visit)	 0.5 0.5 8	Feb 28
4	Online FGD for clarification/future action	1	March 14
5	Analysis and reporting	5	April 15
6	Report revision	3	April 30
	Total	**20**	

The project closes on 30 June 2025. At project closure, all payments (including for the final evaluation) must have been disbursed. Therefore, it is important that a complete draft of the evaluation is submitted by the time the project closes. Thus, we advise that a first draft is submitted a few weeks before the project finishes. It will also be important to agree on an evaluation plan ahead of time and before data collection can start. That plan should contain, at least, the methodology and data collection strategy. If other sections of the evaluations are ready by then, such as context analysis,

project description, description of the theory of action, then those sections can be reviewed ahead of time.

Structure of the final evaluation report

The report should be approximately 50 pages long (including relevant annexes). The content should include:

- Executive summary
- Table of content
- Acronyms and abbreviations
- Introduction
- Section on methodology and data collection strategy
- Project description, including theory of action
- Context/political economy analysis (describing the problem the project sought to address and analysing how that problem plays out in the political/economic/social context of Indonesia)
- Findings (these can be several sections, one per salient finding)
- Conclusions and recommendations
- Annex: The full results framework

Please consult the GPSA template/style guide for more guidance.

Support along the way

From AKATIGA, the project team will help managing the evaluation logistics and planning, including facilitate contact with key partners and stakeholders of this project; facilitate the access of the evaluator to relevant data and documents; help with the logistical arrangement data collection, including for interviews and ripple effect mapping sessions; manage the contract/evaluation process and serve as a liaison with the evaluator; provide comments on the draft and final reports and approve them; and, participate in briefing and debriefing process for evaluator on the objectives of the evaluation. The primary contact person from AKATIGA will be the team's MEL coordinator.

From the GPSA Secretariat, Linnea Mills (M&E support) will provide support throughout the process and will review all iterations of the research plan and evaluation report. Saad Filali Meknassi (Capacity Building/Implementation Support) will review and provide comments on the draft evaluation report.