TRANSPARENCY FOR DEVELOPMENT

# T4D Phase 2 Concept Note
2016

## I. Introduction, Design Activities, and Phase 2 Design Criteria

The Transparency for Development (T4D) initiative was designed to answer the question of whether community-led transparency and accountability can improve development (and specifically health) outcomes and – if so - in what contexts and through what mechanisms. Phase 1 of the initiative will provide answers to these questions in two countries (Indonesia and Tanzania) and in one sector (maternal and newborn health), providing evidence that goes beyond a single context.

In designing Phase 2 of the project, we sought to stay true to the original objectives of the overall T4D initiative as well as build off of the learning from Phase 1 of the project. Phase 2 provides an opportunity to further explore the generalizability of what shows signs of working well in the Phase 1 intervention; to change elements of the Phase 1 design to address mechanisms that we do not see being triggered; and/or to explore new and emerging questions regarding the effectiveness of transparency and accountability that are prominent in the field today.

Based on the feedback provided by the Steering Committee during our December 2015 meeting, our team has sought to refine the potential design of Phase 2 and, to improve the design and potential value to the field, has consulted with a diverse set of experts to provide input into the Phase 2 design. The activities undertaken as part of these consultations include:

- (January 20, 2016) The team convened a meeting of the T4D Advisory Committee. The purpose of this meeting was to receive feedback on our Phase 2 proposal. A brief containing takeaways from this meeting was shared with the SC earlier this month and is included in Appendix A of this note.

- (February 2016) Members of the T4D team met with nine potential partner organizations in four countries[1] that work in Malawi, Mozambique, Tanzania, Uganda, Zambia, and Zimbabwe. These meetings focused on:

    - Learning about the organizations' current and former activities, with a focus on projects similar to T4D; and,

[1] Malawi, South Africa, Uganda, and Zimbabwe.

  - Seeking feedback and ideas on the models outlined in the previous version of the Phase 2 concept note (shared with the Steering Committee before the December 2015 meeting).

- (Late February 2016) The T4D team held a daylong in-person working meeting to integrate feedback from the Advisory Committee and the partner meetings. This resulted in the revised Phase 2 approaches (described in detail below).

- (March 2016) Members of the T4D team traveled to Ghana to meet with two additional potential partner organizations.

- (Upcoming – April 2016) Members of the team will meet with additional potential partners for Phase 2 in person during a trip to Indonesia.

The feedback and input of CSO practitioners and members of the Advisory Committee have all contributed to potential Phase 2 designs described in this note.

*Criteria for Potential Phase 2 Approaches*

In designing potential Phase 2 approaches, we utilized a set of criteria to guide potential designs. These are:

- *Similarity to Phase 1 design (generalizability).* To the extent that we are most interested in assessing the generalizability of our ultimate Phase 1 results, we would need to design Phase 2 to vary as little as possible from our original Phase 1 intervention design.

- *Building off of early lessons from Phase 1*. Our monitoring data from the pilot and Phase 1 intervention have highlighted that the co-designed intervention model is largely achieving the outputs and very short-term intermediate outcomes (such as citizen participation) that are necessary to trigger the accountability mechanisms that lead to changes in health outcomes in our logic model. Based on the evidence that this design works operationally, this provides a valuable opportunity to "crawl the design space" with this Phase 1 model by identifying a small number of design modifications that could help trigger greater vertical accountability in some contexts which would be worth exploring in Phase 2.

- *Consistency with original Phase 2 design*. While we will not be able to use final analysis of the impact of the Phase 1 intervention to inform the design of Phase 2, one criterion we have considered is keeping within the spirit of the

original Phase 2 design by developing a plan that tests the potential generalizability of the Phase 1 design.

- *Relevance for policy and practice.* We believe that the Phase 1 findings will provide significant evidence to inform practitioners, donors, and others in their design, implementation, and funding of transparency and accountability activities. Phase 2 provides an opportunity to design a second intervention (potentially similar to Phase 1) that maximizes the value for policy and practice lessons of the resources we have for this phase, and this was a key consideration in designing potential approaches for Phase 2.

- *Operational feasibility*. The final criterion is critical as we want to ensure that we are designing a Phase 2 that can be completed in a high-quality way with the remaining time and funding allocated for this project.

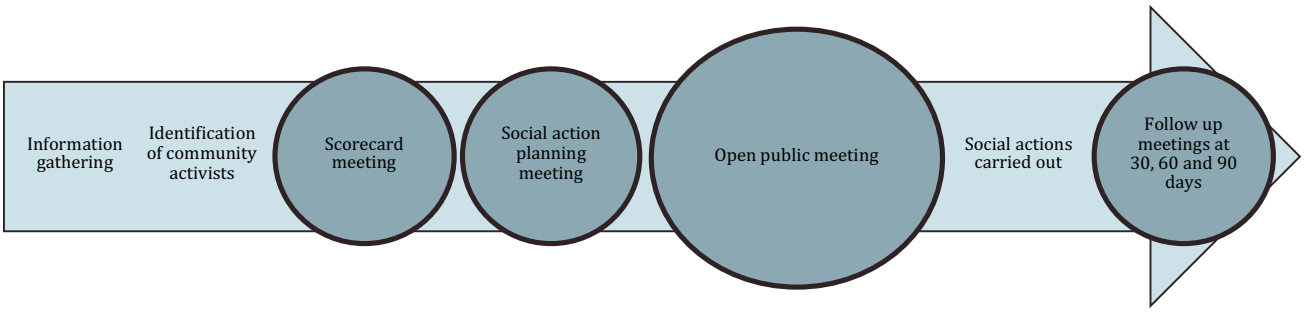
Ultimately, this set of criteria led us to an overarching design for Phase 2, described in detail below.

## II. The Phase I Model and Justification for the Phase 2 Approach

The Phase 2 design is a direct adaptation of the Phase 1 intervention that our team co-designed with partners at Pattiro (Indonesia) and CHAI (Tanzania). Because Phase 2 uses Phase 1 as a starting point, we first describe the Phase 1 model and share what we have learned so far from Phase 1. Sections III precedes to detail, in turn, the proposed adaptation and justification for the Phase 2 approach.

The T4D Phase 1 intervention is an adapted community scorecard comprised of four main activities: (1) information gathering and identification of intervention participants, or "community activists"; (2) facilitation of community meetings to share information on the uptake of MNH services and condition of the local health facility, discuss "social action stories" of problem solving approaches other communities have taken, and develop a social action plan; (3) community-led social action; and (4) a series of facilitated follow-up meetings. In each country, T4D has partnered with a civil society organization (CSO) to co-design and administer the intervention.

*Figure 1 – Phase 1 Intervention Model*




*Initial Insight from Phase 1*

One way the Phase 1 intervention explores transparency and accountability is providing evidence that will help to validate and refine the Five Worlds Framework. Baseline data, analysis of initial Phase 1 social action plans, and information from the pilots indicate that many communities have choice in health providers (World 1) and many others are choosing actions consistent with Worlds 2 and 3 (limited choice but willing providers and limited choice and unwilling providers):

- We know from baseline data that at least 15% of our sampled villages in Indonesia and 20% in Tanzania utilize two or more health facilities for maternal and newborn health (MNH) services (World 1).

- Information gleaned from the pilot in Tanzania points towards a number of individuals choosing to bypass the local health facility, instead delivering at a further but (perceived) better facility (World 1).

- Initial action plans for Phase 1 villages in Indonesia are comprised almost exclusively of community and facility-directed actions (actions consistent with Worlds 2-3).

Based on our review of social actions that have been designed and implemented in a subset of Phase 1 scale-up villages, very few communities have chosen at least one long-route approach *outside* the village (actions consistent with Worlds 4-5: limited choice but willing government and limited choice and unwilling government). These are only initial plans; as such, we cannot draw conclusions, especially because we expect the social actions to evolve over time. The plans do, however, give us a

glimpse into what communities perceive as available channels for action and offer an indication of what we can expect.

Based on these initial plans, we do know that there would be value in exploring adaptations to the Phase 1 intervention model that do more to facilitate and/or encourage direct interactions between citizens and government actors to better understand World 4 and 5 scenarios. Phase 2 has been designed to enable us to further explore the Five Worlds Framework, with a focus on World 4. This model would investigate:

*Whether the involvement of the government—particularly exposure at the end to what communities have done in an effort to improve their health services—leads to an institutional response.*

One of the potential advantages of government involvement is that government attention opens the possibility of a systemic response—going beyond the level of improvements that citizens in a single community can make to their health. This response may not be positive (and indeed there are prominent examples of T/A triggering a negative systemic response that undermines the initial impact), but World 4 is a place where a positive governmental response is particularly likely.

## III. Phase 2 Model

The Phase 2 model was designed to make two types of adaptations to the Phase 1 intervention to achieve two things. The first set of adaptations, which the T4D research team is requiring, is a set of interactions with district-level government "champions" to create pathways for greater citizen-government engagement. The second set of adaptations is more open to our CSO partners in Phase 2, focusing on approaches they have and continue to propose to improve either the overall effectiveness of the intervention design in improving health outcomes or the responsiveness of government officials to citizen demands. The approach would be implemented in a total of fifteen villages across three districts total, one each in three countries

*Required Adaptations for Government Interactions*

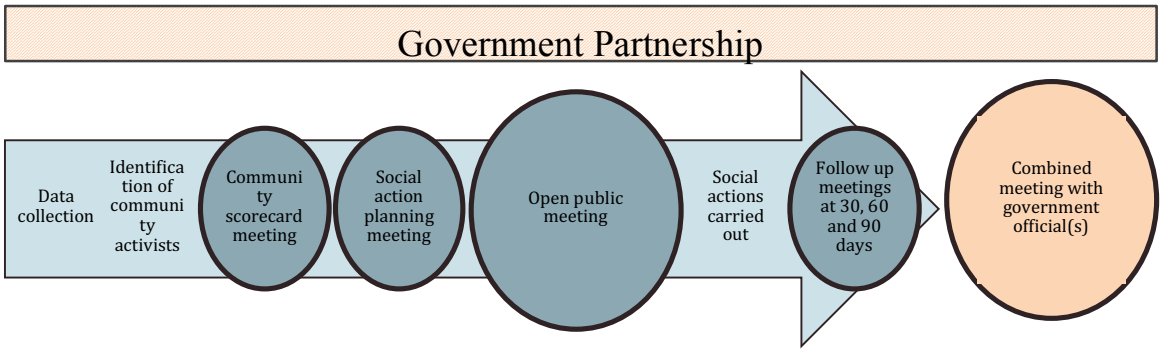
The intervention itself is largely based on the Phase 1 design, but it starts with three changes that focus on increasing pathways for citizen and government interactions that we did not see in Phase 1:

1. We would work with our CSO partners to cultivate buy-in from district-level governments in intervention areas, ideally in the form of a partnership.

2. Throughout the intervention, CSO facilitators would make it clear to participants that the intervention is being administered in partnership with the government.

3. There would be a single, CSO-facilitated, district-level meeting between the community activists from *all* intervention communities and the government champion, at which the participants would have an opportunity to discuss their diagnoses of service problems and the actions that they had undertaken as part of the intervention.

*Figure 2 –Intervention Model*[2]




*Further CSO-driven adaptations*

In addition to the adaptations that our team has proposed to the Phase 2 model, we have heard many ideas from CSOs for improving components of the model to make it more effective in improving health outcomes or in improving the responsiveness of government to citizens. Preliminary discussions with these partners have pointed to a number of possible adaptations that CSOs believed would improve the potential impact (including government responsiveness) of the model:

1. *Building in a "health governance rights" or "literacy" component into the intervention*. This is a piece of advice we heard from every CSO with which we met. Citizens are often not aware of their rights to certain services, the differing services at each level of the health system, and which parties have responsibility within the health governance chain. A health literacy

[2] Note here that the government-citizen interface meeting is shown at the end of the intervention; however we will work with partners to identify whether this is the right time for such a meeting to take place.

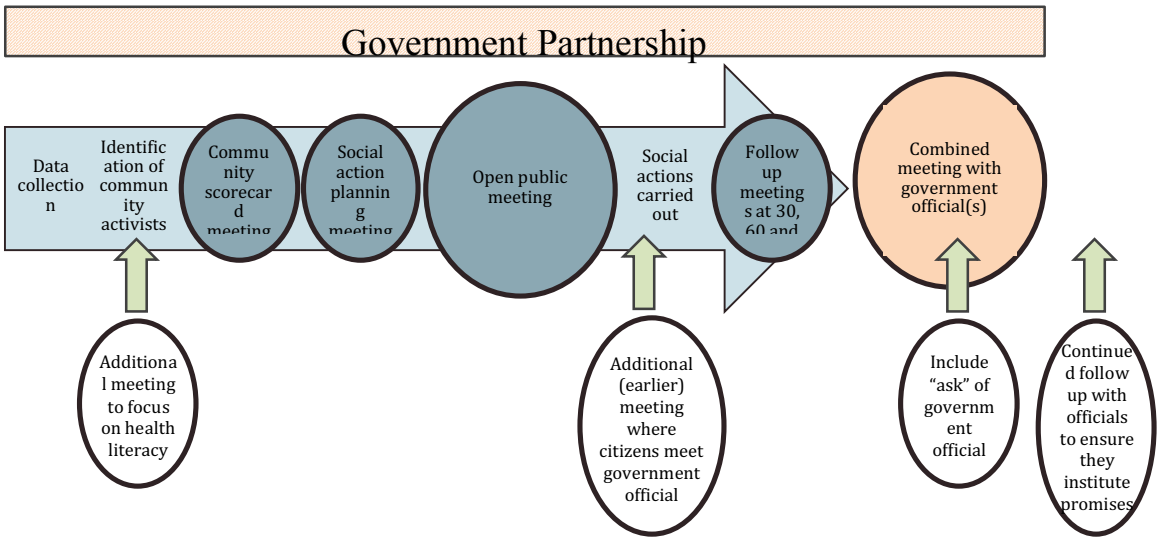
component of the intervention would give participants insight into where to put pressure on the system and base-level knowledge to enhance confidence when asking questions.

2. *Engaging regularly with government officials throughout the process, either in the form of stewardship during the intervention and/or through proactive follow-up on promises after the government-community meeting*. A number of partners mentioned that a "willing" government actor is not enough; to get a true response it is necessary to cultivate a relationship with the actor. Some partners recommended several meetings with the actor before the intervention starts and others recommended inviting the government actor to engage with citizens during the intervention (for example, attending one or more of the meetings). Still others stressed the necessity of follow up: an official may promise response at the government-community meeting, but for the promise to become a reality the citizens need to follow up.

3. *Reframing the government-community meeting from one where citizens report on their activity to one where they ask something from the government*. Several partners mentioned they would work with citizens in advance of the government-community meeting to ensure they are not only prepared to highlight the actions they have taken, but to also formulate an "ask" for help from the official.

4. *Being strategic about timing*. Being purposeful about when the intervention takes place to ensure it lines up with budget or other policy-making cycles could increase the likelihood government promises will make it on the agenda.

*Figure 3 – Example of Expanded Phase 2 Intervention Model*




We would propose working with our selected partners to identify and systematically vary (or hold constant) these further adaptations to improve the overall intervention with the constraints of our original intervention design principles.

*Justification for this model*

One main purpose of this approach is to further test World 4 through purposeful engagement with the government. As mentioned earlier, we have seen very few Phase 1 communities choose long-route approaches *outside* of the village. One way to engage government is to do so directly, like we propose in Phase 2. The underlying hypothesis of this model is that the most effective way to engage government actors, and ultimately incite institutional response, is to take both a direct and a bottom-up approach. As such, this model enables us to test *whether the involvement of the government leads to an institutional response.*

In addition, this branch will allow us to test an additional important question: *Whether additional changes to the Phase 1 intervention – in the form of scaffolding on the community side – leads to more citizen-government interaction.* We will measure this by looking at the frequency of both *proposed* and *attempted* above-village long route actions. We will also assess the effectiveness of these actions.

Finally, the proposed Phase 2 model allows us continued *use of a co-design process in three new countries.* One of the cornerstones of the T4D project is the use of co-design to leverage the experience and local knowledge of CSOs who have a successful track record of working at the intersection of transparency, accountability, and service provision. The flexibility of the Phase 2 model allows us to work with partners to tailor the intervention to specific context and to maximize citizen-government interaction with the aim of creating government institutional response.