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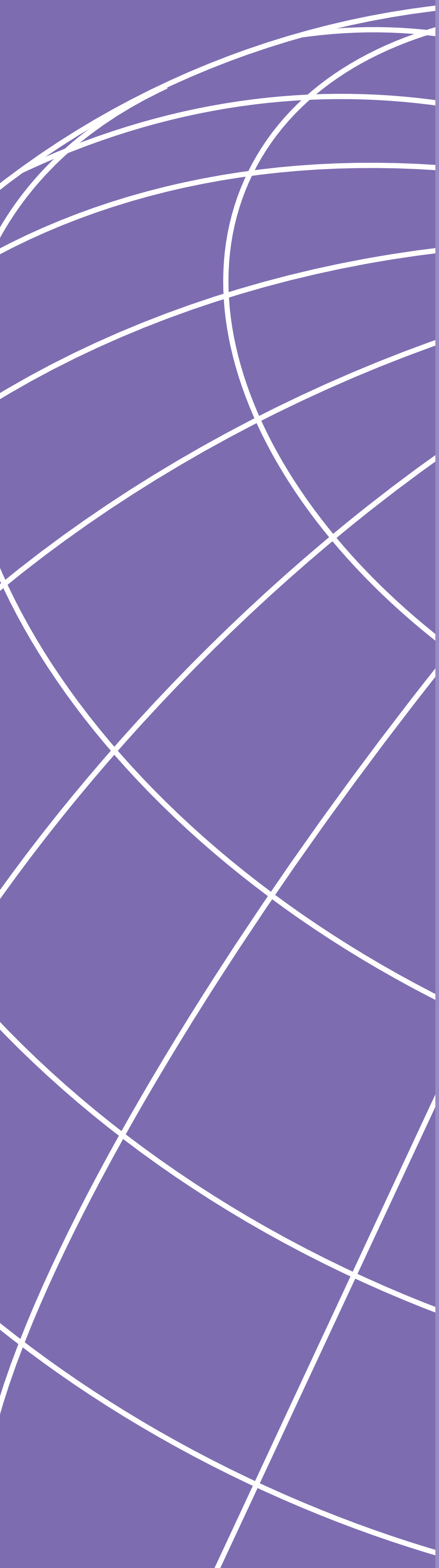

Citizen Voices, Community Solutions: Designing Better Transparency and Accountability Approaches to Improve Health

The Transparency for Development Team

August 2017

Ash Center for Democratic Governance and Innovation
Harvard Kennedy School

Ash Center Occasional Papers Series
Series Editor Tony Saich
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Letter from the Editor

The Roy and Lila Ash Center for Democratic Governance and Innovation advances excellence and innovation in governance and public policy through research, education, and public discussion. Three major programs support our mission:

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Transparency and civic participation are commonly seen as core to effective and responsive governance. In some respects, we live in an era of unprecedented transparency and participation; yet recent years have seen a marked closing of the space for average citizens to speak and be heard in many parts of the globe. At such a moment, there is a crucial need for rigorous, reliable research into global efforts to promote transparent and accountable governance, and the consequences of such efforts for the quality and responsiveness of the public services on which so much of global prosperity and progress depend.

The Transparency for Development project, led by the Ash Center in collaboration with Results for Development and the University of Washington, is undertaking one of the world's most ambitious research efforts into citizen-led accountability programs intended to improve health and health care. This paper details the program at the heart of the research. The program itself is designed to help citizens working to improve their public health care across a range of unique political and social environments; the paper describes the program and the design process that led to it. That design process was purposefully extensive and collaborative, involving intellectual contributions by researchers and practitioners at the three major partner organizations as well as partners in Tanzania (the Clinton Health Access Initiative) and Indonesia (PATTIRO). We hope that the paper provides insight into the questions and tradeoffs that governments and civil society organizations around the world may face in designing flexible, adaptive community-led efforts to improve global health care.

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The Transparency for Development intervention design and thus this report are the result of a collaborative effort that builds on the intellectual contributions of all of the people listed below.

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Contents

Executive Summary

The Transparency for Development (T4D) study was designed to answer the question of whether a community-led transparency and accountability program can improve health outcomes and community empowerment, and, if so, how and in what contexts. To answer this question, researchers and civil society organization partners began by co-designing a program that would activate community participation to address myriad barriers to proper maternal and newborn care, with the ultimate goal of improving maternal and newborn health outcomes. This report presents the design of the program that was then implemented in 200 villages in Tanzania and Indonesia and studied using a mixed methods impact evaluation. In addition to detailing the program, the report outlines how we got there—describing a number of principles that informed some distinguishing features of the program, as well as an iterative design process that defined other features through trial and error.

The program was designed to adhere to six principles: It was 1) co-designed with embedded and experienced in-country partners to be 2) health-focused rather than service delivery-focused, 3) locally relevant, 4) community-driven, 5) non-prescriptive, and 6) largely free of resources from outside the communities that received it. These design principles were defined by the researchers and partners seeking to use T4D to innovate in important ways that differed from the standard approaches commonly employed in transparency and accountability programs. First, the program was designed to mobilize citizens to solve health problems, rather than mobilizing them around a particular governance or service delivery problem. In doing so, the T4D program leaves open the possibility that communities might try to solve these problems by improving existing health services, self-help, or self-organizing or mobilizing other community members to increase the utilization of existing services.

Second, the T4D program leaves significant space for communities, rather than external experts or civil society organizations, to determine whom they will target with their actions (from frontline service providers to local politicians, to other community members, as well as regional or national politicians and health officials). It also allows communities to choose the nature of their actions, allowing them to educate, confront, or work with allies, or to take a different approach altogether. Finally, the program attempts to create space for communities to iterate and learn from their successful and less successful actions, in the hopes that iteration will improve their chances of achieving positive impact.

While these principles did guide a number of distinguishing features of the program, there were many other elements of the program whose specific design was determined through a process of discussion with partners and iteratively pilot-testing alternative designs. This process of iterative design was an attempt to ensure that the final form of the program reflected several rounds of trial and error, ideally enhancing the likelihood of its positive impact. Examples of questions the team faced included how to best foster community participation, how to structure the information gathering and sharing component, how to facilitate social action in communities, and how to ensure communities iterate on their successes and failures in implementing social actions. In this report, we describe the building blocks and design principles of the program, the final form of the program, the iterative design process that we undertook with partners, and the tradeoffs faced in the design.

The T4D study is a led by the Roy and Lila Ash Center for Democratic Governance and Innovation at Harvard University's John F. Kennedy School of Government in collaboration with the Results for Development Institute (Washington, DC) and the Evans School of Public Policy and Governance at the University of Washington. The team of principal investigators leading this work include Archon Fung and Dan Levy of Harvard University; Stephen Kosack of Harvard University and University of Washington; and Jean Arkedis and Courtney Tolmie of the Results for Development Institute, with Jessica Creighton of Harvard University serving as Program Manager. The study was made possible by generous financial support from the Bill and Melinda Gates Foundation, the William and Flora Hewlett Foundation, and the Departnment for International Development (United Kingdom), under the coordination of the Transparency and Accountability Initiative.

I. About the Transparency for Development Study

The Transparency for Development (T4D) study was designed to answer the critical questions of whether community-led transparency and accountability (T/A) programs can improve health outcomes and community empowerment, and if so, through what mechanisms and in what contexts. Stronger and more actionable evidence on the effectiveness of T/A programs in improving health and other development outcomes has the potential to increase the impact of civil society organizations, donors, and policymakers using these approaches.[1]

The T4D study has five main components:

1. **Development of a theoretical framework to guide T/A program design and evaluation.** One of the first undertakings of the project was the development of a testable theoretical framework to help guide research and practice in this project and beyond. The resulting "Five Worlds Framework" identifies several background conditions important to the effectiveness of community-led T/A programs, as well as a typology of five local contextual "Worlds" that vary according to three major contextual factors: the willingness and reform-mindedness of service providers, the willingness and reform-mindedness of policymakers, and whether citizens have a choice in where to seek services. In each of these worlds, we hypothesize that a best-fit T/A approach will trigger a distinct pathway to improved service delivery.

2. **Co-design of a T/A program that is adaptable to multiple contexts**. Building on the theoretical framework, our team has worked intensively with partners in Tanzania and Indonesia to design a community-led T/A program to improve maternal and newborn health outcomes.

3. **Rigorous mixed-method evaluation of the impact of the T/A program.** The first phase of T4D involves designing and implementing a mixed-methods impact evaluation in both Tanzania and Indonesia to assess whether the programs implemented in these contexts improve health outcomes and citizen empowerment and, if so, how and under what conditions. A randomized controlled trial (RCT) of the program, conducted in 100 randomly selected communities in each country, will estimate the impact of the program on primary maternal and newborn health outcomes, intermediate outcomes such as health-care utilization and quality, as well

as measures of citizen empowerment and community participation. The qualitative components of the evaluation integrate structured observation and coding of program meetings, surveys to gauge perceptions of participants' empowerment, key informant interviews of participants and targets, and ethnographic research in a subset of villages. The integration of the quantitative RCT with the qualitative components is designed to investigate whether the program improved outcomes as well as assess the likely pathways and mechanisms underlying any improvements. The Phase 1 Evaluation Design Report is detailed in a separate report and is available on the T4D website at t4d.ash.harvard.edu.

4. **Generation of further evidence on the generalizability and other approaches to improve T/A and development outcomes.** Building off the experience and early evidence from the co-designed program and evaluations in Tanzania and Indonesia, a subsequent phase of work will involve adapting and testing programs in a number of other countries, providing additional evidence on questions about important tradeoffs in the program's design as well as the generalizability of the earlier findings to other contexts.

5. **Targeted outreach and dissemination of the results to key audiences.** The evidence generated by the T4D study will only influence the work of T/A and health practitioners, donors, and policymakers if results and lessons are disseminated in a way that is tangible, relevant, actionable, and timely for stakeholders. In particular, the study seeks to engage two main audiences: those who undertake and/or support T/A programs, such as civil society organizations, donor agencies, and T/A capacity building or technical support organizations; and those undertaking and/or supporting policy or operational improvements in the health sector. Insights and lessons are shared with these audiences at key moments throughout the study, as will be the final results.

As of the date of publication, the study is launching the fourth component of this work as well as launching the endline survey for the RCT that is part of the third component detailed above. This report focuses on the second component of the T4D study: the co-design of a community-led T/A program adaptable across multiple contexts. The purpose of this report is to share the details of the program developed with partners in Indonesia and Tanzania as well as the theory, principles, and tradeoffs that shaped it. The report also discusses the process of collaborative design and piloting which the T4D team and partner organizations used to arrive at the program design to be evaluated.

II. Program Points of Departure

Contextualizing T4D: A citizen-led transparency and accountability program

Improving government responsiveness and accountability has been an objective of a growing set of T/A actors for several decades. These actors have employed a diverse set of strategies and tactics, including global efforts for "open government" and very local efforts seeking to hold frontline service providers accountable for high quality delivery.[2] For the purposes of the T4D study, we began with the decision to focus on a citizen-led T/A program with a health problem focus. Each of these building blocks of the program (described in more detail below) led to a skeleton of how the ultimate program would be structured. This skeleton was built out further using a set of program design principles, which we outline later in this section. Ultimately these building blocks and design principles served as guidance for the co-design process that we undertook with civil society partners in Indonesia (PATTIRO) and Tanzania (the Clinton Health Access Initiative) to develop the final program.

A citizen-led program

Within the field, one of the major considerations for practitioners is what role citizens play in T/A efforts. In some cases, civil society organizations (CSOs), think tanks, policymakers, or other actors rely on information and feedback from citizens to advocate for policy change at the subnational or national levels. In these cases, CSOs or other actors function as a representative of citizens' voices but do not necessarily directly involve citizens in the advocacy work. In other cases, CSOs or others work directly to mobilize or facilitate citizens and then broker efforts to bring about change, often at the local level but also sometimes at the subnational or national levels. The two ends of this spectrum are well-represented in current T/A practice.

While there is value to both of these models, the T4D program takes a citizen-led approach where the role of the CSO partner is to facilitate citizens in taking actions themselves. There are a number of reasons why the research team decided to design and evaluate a citizen-led T/A program.

First, with regard to program design, achieving greater citizen participation and empowerment (rather than focusing on citizens as a beneficiary of T/A efforts) is seen increasingly as a critical pathway for effective T/A. On the one hand, the field has been influenced and inspired by indigenous CSOs—such as the famous example of MKSS, a "people's movement" founded in

Rajastan, India in 1990, which successfully used T/A-based approaches to empower citizens, improve services, and help citizens exercise their rights and access entitlements.[3] On the other hand, the rise of externally-financed service delivery-oriented T/A programs represents an attempt, at least in part, to operationalize some of the ideas from the 2004 World Development Report "Making Services Work for Poor People." The 2004 WDR importantly pointed to the potential of citizen-driven accountability as a potential complement to the top-down supply-side strategies that donors had typically pursued. This form of accountability could take two forms: "short route" in which citizens seek to change service provider efforts by targeting them directly and "long route" in which citizens target their elected officials to pressure or hold service providers to account. While there is broad acceptance in the field that the long and short routes of accountability are an oversimplification of real T/A relationships, the importance of citizens themselves as active accountability actors remains a central tenet of T/A practice.

A second reason for focusing on citizen-led T/A is practical with regard to the evaluation design. Across both the T/A field and those working in health and other sectors, there is an increasing call for rigorous evidence on the causal relationship between T/A and health, education, and other development outcomes. This parallels the mandate of the donor collaborative that commissioned the T4D study: to create generalizable knowledge about the impact of T/A programs. Thus, our treatment had to be one that could be applied broadly, across a variety of contexts. It had to be a treatment that would highlight the unique effect of T/A, and be amenable to serious, systematic analysis of that effect—analysis that would allow a trustworthy answer to our core questions of whether, how, and in what circumstances T/A programs would improve health. Among other implications, this mandate favored the use of RCTs in our evaluation, the gold standard for rigorously evaluating causal relationships. Using a RCT to evaluate a program focused at any level above the village or community would have likely been cost-prohibitive and ultimately would have hampered the ability for the evaluation to rigorously assess the causal relationship between the T/A program, citizen empowerment and engagement, and ultimately health outcomes.

A final consideration that contributed to our decision to design and evaluate a citizen-led program is that of scalability. One of the objectives of the T4D project is to identify evidence that is actionable and could be widely adopted to improve T/A efforts globally and at a large scale. Local-level T/A programs that rely heavily on the capacity, leadership, and brokering of national-level CSOs face constraints in achieving scale; time and effort that CSO leaders invest in one community are resources that cannot be invested in other communities. As such, we sought to design a program that reduced the time requirements for our CSO partners (outside of co-design), moving the CSO from a broker role to a facilitator role. The leadership and actions that would traditionally be undertaken by the CSO are instead undertaken by citizens, with standardized and relatively limited facilitation by the CSO partners. Consequently, we seek to test whether a relatively small investment by a CSO facilitator could result in citizen participation, action, and ultimately, improvements in outcomes. The benefit of designing and testing this citizen-led approach is that—if the program proves to be effective—there is a greater ability to bring this to scale without running against the constraints of the time and capacity of a single national CSO.

A transparency- and accountability-focused program

While the decision to design a citizen-led program answered the question of *who* would lead this work, a second overarching question we had to answer was *how* to make this program T/A-driven. To answer this question, we undertook a systematic review of T/A programs to understand common features that we would include and which we would adapt in the design process.

While the T4D program incorporates a number of specific evidence- and experience-based design choices (detailed in subsequent sections of this paper), it shares many common features with traditional T/A programs. Over the past several decades, the theories of how citizens can engage with T/A (including via the long and short routes of accountability and more recently through accountability ecosystems) has led to the development of a number of T/A or social accountability “tools”[4]: programs with semi-standardized components that vary in their goals and are often developed for different local contexts. Examples of these tools include community scorecards, social audits, and public expenditure tracking surveys.

Though these tools vary in the specific governance, accountability, and service delivery problems they seek to address, as well as the mechanisms they typically seek to trigger to address them, they tend to share a common underlying theory of change and thus common steps or core features. The typical T/A theory of change involves three major steps: (1) gathering information on common service delivery problems, (2) sharing this information with citizens (or groups of citizens)—a process that is often facilitated by an external organization such as a CSO, and (3) to stimulate those citizens to undertake actions that improve accountability, service delivery, and ultimately, outcomes. The T4D program shares these core features, described in more detail below.

Gathering information. Citizen-led T/A approaches share a simple and intuitive idea: information makes citizens more powerful, and, in particular, information about service delivery makes citizens more informed and capable of assessing the degree to which those services are responsive to their needs and preferences. The particular purpose of the information varies: it may, for example, correct information asymmetries that prevent citizens from holding providers and government officials to account, help citizens gauge the quality of services and diagnose problems, or motivate citizens to take actions themselves to correct those problems or otherwise influence improvements. Depending on how T/A practitioners conceive of the particular purpose of the information, practitioners make additional choices, such as source of the information (for example, firsthand information collected from health facilities on drug stocks, statistical data from district health offices or CSO reports, or publicly available information on citizen rights to services), who will collect the information, and the specific type of information to collect.

Information sharing. A second major component of citizen-led T/A programs is the sharing of information with citizens. As with information gathering, this component can take many forms. In some cases, information is gathered by the organization implementing the program and then shared with citizens. Others employ a “participatory” model through which citizens themselves share information that they have collected with their fellow community members, learning about problems in the process. Regardless, all citizen-led T/A programs must also decide which citizens to involve and how to share the information with them, whether as individuals (as, for example, with citizen-led learning assessments) or in some kind of facilitated collective forum.

Stimulating social action. In recent years, activists and advocates have spent substantial effort trying to increase access to information, whether by legislating openness through Freedom of Information Acts or partnering with governments to “open” their accounts. But few practitioners or researchers would claim that information alone is sufficient for achieving better development outcomes. Thus citizen-led T/A programs generally include—either implicitly or explicitly—a third critical component: efforts to stimulate social, and sometimes political, action to address the highlighted problems. Organizations involved in facilitating a citizen-led

T/A program vary considerably in the degree of choice they offer citizens in deciding which social actions to pursue. For programs such as public expenditure tracking surveys and absenteeism monitoring, the choice of social action is open and implicit; these T/A programs identify and share information about a specific type of service delivery problem, while leaving citizens and other stakeholders free to decide what (if any) follow-on corrective actions to take. Other programs specifically prescribe certain social actions, such as an interface meeting between providers and beneficiaries (in the case of the community scorecard) or a public forum in which citizens confront officials (in the case of the social audit).

Identifying a health starting point

A final decision that the T4D team and our partners had to make before undertaking the detailed design process was the health problem on which the program would focus. Many T/A-focused programs focus on primary health care broadly without highlighting a specific health outcome that accountability actors are seeking to improve. These programs also tend to prescribe the course of action being directed at the facility. We were interested in testing an alternative approach. We wanted to understand whether focusing citizens on a more discreet, but salient health problem, might motivate them to take on a broader range of actions, beyond targeting their local facility. We also hypothesize that this "problem-driven" approach would maximize the engagement of the community in iterating more productively on different courses of action to improve the chosen problem.

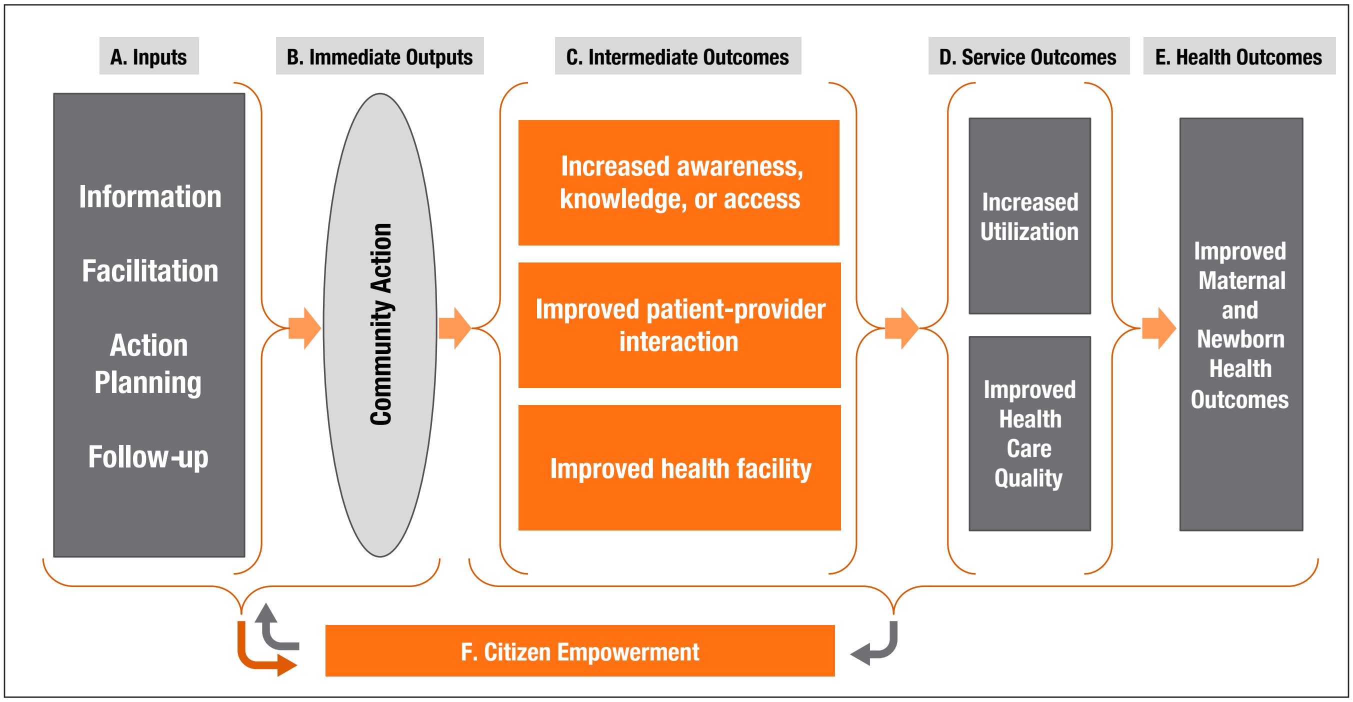
In deciding which health problem to focus on, we began by assessing different options, applying a number of criteria to this decision:

- The health problem had to be significant. For our purposes, this meant both that the targeted outcomes had to represent a significant portion of the burden of disease in the communities and that the change in these outcomes had to be seen as significant for global health policy;
- The communities had to find the problem salient; and,
- It had to be plausible that the community action would be able to trigger a change in outcomes.

Additionally, although we did not want to require communities to engage with providers or to try to effect change at the facility or elsewhere in the health system, we also had a preference for health outcomes where the public sector played an important role in delivering services. This was an important consideration because we sought to develop a program in which accountability problems would be addressed to the extent that communities saw them as being a barrier to improved health outcomes.

After conducting extensive desk research as well as consultations with experts, we narrowed our focus to either child health or maternal and newborn health, and ultimately we selected maternal and newborn health in consultation with our partners. An important element of this decision was understanding how T/A at the community level could improve maternal and newborn health outcomes. While the very nature of T/A programs requires a long causal chain through which to have an effect on health outcomes, we were able to develop a plausible evidence-based logic model for how a citizen-led T/A program focused on maternal and newborn health could improve outcomes (Figure 1).

Figure 1: Logic Model for the T4D Program



By focusing on a program design that sought to build a program around inputs such as information sharing and action planning (Column A, Figure 1), we would seek to trigger citizen and community action (Column B) focused on improving concrete intermediate outcomes associated with improved health services and utilization (Column C). The literature provides a significant pool of evidence that achieving the full range of intermediate outcomes in Column C can be activated with properly designed and implemented community actions. One example comes from the state of Andhra Pradesh in India, where community scorecards helped increase household and provider knowledge; improve satisfaction and trust with providers, facilities, and services; and even affect concrete issues like facility cleanliness and availability of transportation and medicines.[5] In addition to traditional community scorecards, there is vast research on differing types of community actions—from collaborative problem solving with service providers to complaints about illegal fees—that achieved concrete improvements in one or more intermediate health outcomes relating to demand for health services, supply quality, and/or interactions between the demand and supply side.[6]

This evidence highlights that community action can improve individual aspects or perception of care; however, for these improvements to translate to improved maternal and newborn health outcomes, they need to first translate to increased utilization of health services and improved content of care (Column D). In the case of maternal and newborn health, specifically, this means that there needs to be evidence that improving community knowledge of proper care, patient experience, and availability of proper supplies, equipment, and human resources results in more women giving birth in health facilities and getting adequate antenatal and postnatal treatment for themselves and their babies. As with the previous steps in the logic model, there is strong evidence that these pathways can be activated. Randomized controlled trials in Nepal and India demonstrated the connections between increasing household knowledge via participation in self-help groups to attendance at antenatal care appointments, facility birth, and use of safe homebirth kits.[7] Recent meta-analyses support these connections as well.[8]

Because actions are entirely designed and undertaken by community members, the program may also improve citizen participation and sense of empowerment (F), particularly to the extent that the actions facilitate unfamiliar experiences where community members engage with each other and with providers and public officials in an attempt to diagnose and alleviate problems with a public service that they value (columns A–B). To the extent that these actions are successful in improving that service, they can create a positive feedback loop: participants become aware of their ability to improve their health care, which fosters further empowerment and encourages participation in additional or more sustained efforts to diagnose and alleviate problems, thereby increasing the improvement of community health service and outcomes (columns C–E).[9]

In order to improve maternal and newborn health outcomes (Column E), the World Health Organization recommends a package of services and related interventions that women and newborns should receive during and immediately after pregnancy.[10] These include receiving quality antenatal care, receiving appropriate medical attention during delivery (for example, with a skilled birth attendant in a quality health facility), as well as postnatal care for the mother and baby (Column D).

This package of services and interventions informed the design of the information component of the program, making it plausible that communities would seek to target their actions at improving either the uptake or the quality of these services. To affect health outcomes, however, the logic model recognizes the link between uptake and quality: patients have to not only take up more antenatal care, choose to deliver in facilities or with skilled attendants, and seek postnatal care, but providers also have to deliver a number of essential services during these interactions to make utilization translate into lower rates of maternal and newborn mortality and morbidity, and better overall health. For example, antenatal care visits are the opportunity for women to seek, and providers to give, counseling on birth preparedness,[11] nutritional advice and micronutrient supplements important for fetal development and to prevent anemia in mothers,[12] and monitoring for other complications. In countries such as Tanzania where HIV and malaria are prevalent, antenatal care visits are also when women can receive prophylaxis for malaria which can lead to low-birth weight babies, maternal anemia, and other complications, as well as testing for HIV so that transmission to the baby during birth can be prevented.[13] Similarly, most maternal and newborn deaths occur during delivery or within the 24 hours following birth.[14] Appropriate medical attention during delivery can prevent death to the mother or newborn when complications arise. The month following childbirth is also a critical time in the lives of mothers and babies, as most maternal and infant deaths occur during this period.[15] Postnatal care allows for identification of infections in newborns, a major cause of neonatal mortality. Postnatal and postpartum care is also essential to monitor underweight babies, counsel mothers, and otherwise monitor newborn growth and development.

T4D program design principles

Upon establishing the building blocks and health focus of the program described above, the design of the T4D Phase I program was further refined through a process of co-design and co-experimentation with CSO partners, which will be described in the next section of this paper. This process was heavily influenced by the tacit knowledge and previous experience of the research team and CSO partners, evidence in the literature, and theory developed for this project and elsewhere. Along the way, we were guided by a set of core program design principles. Some principles were ones that we began with, while others we developed as we progressed in the design process. But all derive from the basic purpose of our investigation: to develop a general understanding of whether, how, and in what circumstances the class of programs typically grouped under the label "transparency and accountability" would improve health and health care, while also maximizing the potential that the final program would work, both in the short and long term. This meant collecting and offering participants information they would find interesting, useful, and potentially empowering and motivating to undertake actions that they believed would improve health in their communities (rather than what we or other outsiders believe to be most effective). It also meant staying true to the underlying philosophy of T/A, including its focus on empowering citizens to participate because they see the intrinsic value in doing so.

In the end, we designed the program based on six core principles:

1. *Co-designed with in-country partners:* Building off local CSO knowledge, particularly of what was appropriate and likely to work in their local context.

2. *Health-focused, not health-service-delivery-focused:* Focusing on problems that, if addressed, were likely to improve health care and health outcomes (at least given current knowledge and experience in the health field).

3. *Locally relevant:* Useful to communities in widely different places and circumstances while focusing on a common area of health care that was a concern for the communities and countries where we were working, as well as in the global health community.

4. *Community-driven:* Emphasizing the importance of the community using its existing knowledge and capacity to understand and fix problems, and thereby focus on their own efficacy and increase the likelihood of sustainability.

5. *Non-prescriptive:* Providing information to communities about problems and potential ways they might think of fixing them, but without suggesting or urging any particular course of action.

6. *Largely free of outside resources:* Limiting, to the extent possible, introducing new material (e.g., supplies or help for providers), and technical (e.g., new technologies or techniques for delivering care) and relational (e.g., connections to officials) resources to the communities so as to assess whether a truly citizen-led effort could be successful.

Co-designed with in-country partners

Our first guiding principle was that the program should be co-designed with local partners. Many studies evaluate programs that have either been designed exclusively by practitioners or developed by researchers for the purpose of evaluation. We instead sought to balance our program's reliance on local and outsider knowledge by co-designing the program with CSO partners in the two countries. In Indonesia we worked with PATTIRO, an organization focused on improving governance, service delivery, and public participation, and in Tanzania we worked with the local office of the Clinton Health Access Initiative, which works on critical health issues worldwide; more on each partner can be found in Box 1.

This co-design process, detailed in Chapter 4, allowed us to leverage existing global knowledge and experience about the design and efficacy of T/A programs while also taking account of the tacit knowledge of organizations with experience in the settings where we were implementing our study. Just as citizens are inherently in a better position to understand their context and capacities than outsiders, experienced and embedded in-country partners are at an advantage for understanding what sort of design parameters would improve T/A's resonance in their environment. This co-design process allowed us to check our own intuitions and understanding with partners that have on-the-ground experience. It was also instrumental to the collaboration and experimentation of the iterative piloting process described in Chapter 5, which allowed us eventually to reach a model that showed promise across the highly varied contexts within and across the two countries where we implemented our study.

In practice, this co-design process meant that the program is subtly different in the two countries. These differences, noted in the detailed description of the program (Chapter 3), reflect both differences in context and in the experience and capacities of our partners. But we also sought to keep the designs highly similar in all important respects in the two countries. These very similar programs offer the opportunity to understand the implications of the program when implemented by two different partners in two very different settings, and therefore allow a trustworthy answer to our core questions of whether, how, and in what circumstances T/A programs would improve health.

Box 1: Program Design and Implementation Partners

Indonesia: **PATTIRO** (Center for Regional Information and Studies) was founded in 1999 in Jakarta as a research and advocacy organization dedicated to improving governance, service delivery, and public participation in Indonesian politics. Its particular focus is on improving the quality of governance following Indonesia's decentralization, through three strategic focus areas: social accountability, transparency, and public finance management reform. PATTIRO has worked or is currently working in 17 provinces and more than 70 regencies and cities in Indonesia. PATTIRO also manages the PATTIRO Network, which consists of 15 chapters and five project offices spread across Indonesia.

Tanzania: **The Clinton Health Access Initiative, Inc.** (CHAI) was founded in 2002 with the goal of helping to save the lives of millions of people living with HIV/AIDS in the developing world by dramatically scaling up antiretroviral treatment. CHAI's focus is transformational work that creates a fundamental change in the way actors approach and realize goals. To do this, the degree of impact of a CHAI program must be dramatic, the scale must be at the national or global level, the breadth must change the way others approach the problem, and the sustainability must allow for CHAI's eventual exit without erosion of impact. Today, CHAI operates in 33 countries across the developing world and more than 70 countries are able to access CHAI-negotiated price reductions, vaccines, medical devices, and diagnostics.

Health-focused, not service delivery-focused

Our second design principle was to develop a program that anchored communities on a *health outcome* (or several outcomes) that citizens and civil society largely agreed needed improving, rather than focusing on specific problems with service delivery—a lack of supplies or absenteeism among providers, for example. We discuss earlier how the health focus (maternal and newborn health) can be linked to community-driven T/A actions (Figure 1 above); however, it is worth noting that this is different from the service problem-approach that many traditional programs take. While many T/A programs focus on specific service delivery problems, such problems are only one type of potential contributor to poor health outcomes. As such, fixing problems with service delivery may directly improve health outcomes, but only if the breakdowns in service delivery are the main or sole roadblocks to better health outcomes. If, instead, major breakdowns lie with community knowledge or access to health care rather than or in addition to accountability failures, focusing on service delivery alone may not trigger significant improvements to the ultimate health outcomes we seek to affect.

To put this principle into practice, we began by identifying “levers”—key service or health indicators related to maternal and newborn health—that could then be related to “barriers”—the specific breakdowns that communities could directly act upon or seek action from others to fix. In each country, the selected levers met two basic criteria. First, we identified levers that medical evidence suggests lead to healthier babies and mothers, such as basic ante- and postnatal care or delivering at a health facility with a skilled medical professional. Second, the levers on which we focused are indicators that, for a wide variety of reasons, have low uptake in rural communities in Tanzania and Indonesia. The health barriers were identified through careful consultation with CSO partners, health experts, desk review, and piloting, ultimately leading to an extensive list of breakdowns (including service quality, knowledge, and access) that was used in the program scorecard.

This focus on a general health problem whose specific manifestations and pathways to impact might vary widely between communities suggests that in order to have a chance of impact at scale, the T4D program needed to be highly adaptable across contexts. This led us to three further principles: that the program be 3) locally relevant and 4) driven by the communities themselves via 5) actions that the communities develop rather than are prescribed.

Locally relevant

While government services are generally designed to be beneficial to citizens, people do not always value or perceive a large enough problem with the delivery of these services to act to improve them using their scarce time and resources. This is even the case for government services generally viewed as international priorities given the importance to people’s lives (for example, the Millennium Development Goals and Sustainable Development Goals). This presents a major challenge for citizen-led T/A programs: to trigger citizen action, the program has to convince citizens that they should want the service to be improved—and that they are able to take actions to improve that service.

In order to have the best chance of being useful to the communities where the program was implemented, we first had to identify a set of government services that citizens already wanted to see improved. Maternal and newborn health is such an area. In societies worldwide, care around birth is a focal point that is accorded special emphasis and important beliefs, rituals, and ceremonies. The challenges that many low- and middle-income country health systems have in providing adequate maternal and newborn health care are therefore likely to be, for many citizens, among the most distressing failures that can befall a health system. Furthermore, in both Tanzania and Indonesia, improving maternal and newborn health are high priorities for the national government. Our supposition, therefore, was that problems with maternal and newborn health care would be felt to be substantial to enough citizens in most, if not all, communities such that many citizens would have an inherent demand for improving maternal and newborn health care and thus that a T/A program with this focus had a good chance of resonating.

Community-driven

Although the T4D program was co-designed by researchers and CSO partners, our ultimate objective was to design a program that, when implemented, would be led not by researchers or even CSOs but by local citizens. We sought to improve the relevance of the program to the particular citizens in the (widely different) communities where it would be implemented by designing it to emphasize the importance of community members using their knowledge and capacity to understand and fix the problems. These citizens have lived experience in the particular communities in which the program would be implemented, including knowledge of specific difficulties with their maternal and newborn health care and of different actors' willingness and capacity for making improvements.

The final design, described in Chapter 3, incorporates this principle in a number of ways, each aimed at reducing the reliance of participants on the CSO facilitator (or anyone else associated with the study) in using the information presented in the scorecard, diagnosing the problems it revealed, and considering and experimenting with actions that might alleviate those problems. In addition, the training of facilitators repeatedly emphasized this point: facilitators were urged to be explicit, and repeatedly reiterate, that participants knew more about their situation and how to make it better than the facilitator. The facilitators stressed that the program would go on for only a short time and provide no external resources, so any improvements, as well as the sustainability of those improvements, were up to the community members themselves. Furthermore, the facilitators highlighted that the program and the facilitators would provide some ideas but the participants should make their own choices (including the choice not to participate).

By adhering to this principle, we hoped to increase the adaptability of the program across a range of different contexts that different communities face. Every community is inherently unique, and even within a relatively small region, communities can differ widely on numerous dimensions such as cultural beliefs, education, knowledge and experience, skills, wealth, natural resources, and countless others. Likewise, the political economy context varies widely across communities. Some communities are fortunate to have institutional structures that are highly attuned and responsive to the needs and demands of average citizens; others must cope with institutions that are insulated and unresponsive. Some communities have nurses, midwives, and other frontline service providers who are inherently open to making health care more effective and responsive to citizens' needs; others have providers who are more easily discouraged or resentful of the difficulties of working in low-resource settings, or who look down on average citizens as uneducated and ignorant and are unwilling to consider and respond to their complaints or suggestions for improvement.

The T4D program seeks to be adaptable across these differences by relying primarily on those who are inherently likely to be in the best position to know the salient features of the context (such as the will of government officials and service providers) and to know citizens' capacities to maneuver within it: the citizens themselves. Citizens have the most experience with the responsiveness of their institutions and with the willingness of their frontline providers to improve performance, and the most experience with what happens when citizens act to seek improvements. Building the program to leverage existing citizen knowledge and capacity allows it to be flexible to the specific context and the particular knowledge and capacity of different citizens in different communities.

Non-prescriptive in social actions

The fifth design principle follows from the third and fourth. To keep the program adaptable across contexts, it was designed to avoid prescribing any specific actions on the part of the community participants—or even requiring any actions at all. This is different from how many T/A programs approach community-led actions. In addition to providing information and a forum for discussing it, many T/A programs prescribe or urge actions for participants to engage in, such as an interface meeting with providers to discuss the information (in an effort to trigger collaborative problem-solving) or a public hearing in which participants confront providers or officials with evidence of their underperformance.

Prescribing actions would have meant that participants' decision-making about what actions to take would be less community-driven and less reliant on the community's advantage in understanding what was likely to work in its particular context. Further, prescribing actions would have reduced the adaptability of the program to different contexts in an additional respect: if a particular action was appropriate for the contexts of some communities but not others, prescribing that action might not improve the problem that communities were trying to address (and could, in fact, have a negative effect on the problem in some contexts). This, in turn, could have a negative effect on empowering citizens and communities in places in which the prescribed action was inappropriate for the local context. For these reasons, we designed the program to be non-prescriptive: to provide information about areas where maternal and newborn health care might be improved and insight into potential reasons for underperformance but not suggest particular actions for participants to take.

There are tradeoffs to leaving social actions open and flexible. In particular, the persistence of a problem may suggest that the community has not yet realized how to fix that problem or developed the capacity to fix it. By prescribing an action that has worked in other places, many T/A programs seek to expand the repertoire of actions that community members consider and help them to think more creatively about what actions are possible. The T4D program's design seeks to mitigate this tradeoff by including a series of social action stories for the community to consider. These stories (described in Chapter 3) provide ideas for different types of actions that participants might take, without prescribing or recommending which they should try. We selected the stories to be both realistic—as described below, each was a true story of a community like theirs affecting improvements to public services through a different method—as well as to cover a range of approaches suggested by our theoretical framework as potential pathways to improved public services, including collaborative and oppositional approaches to allies and opponents along both the long and short routes to improvements. To mitigate the capacity constraint, the program includes a series of follow-up check-in meetings (described in Chapter 3). One reason for these follow-up meetings is to encourage participants not to be discouraged if their initial approach did not bear fruit, but rather to learn from the experience and experiment with a new approach.

Largely free of outside resources

T/A programs often include additional elements to motivate or facilitate participants to take action to improve services or government accountability. These elements may include resources, such as grants, to be used for community projects; the introduction of new technologies that might help; the brokering of relationships between citizens and other actors; or monetary incentives for individuals to participate in the program.

These factors have the potential to be strong motivators. However, in this study, we sought to answer the question of whether communities and individual citizens could be empowered and ultimately encouraged to participate in improving governance and health for the benefit of improving public health services, *without* the added incentive of outside resources such as payment. We did so for several reasons. First, a central goal of T/A is to inform and empower citizens, encouraging self-efficacy. If outside resources are always part of the process, however, then a program that might otherwise empower can just as easily encourage dependency on those resources. Second, it is possible that external resources are the sole motivating factor that leads to participation, rather than one of many factors. It is important to understand this relationship to be able to effectively design programs that encourage citizen action and participation; the pairing of T/A with outside resources makes it difficult to identify the effect of T/A separately from the incentives these outside resources create. Finally, providing external resources has implications for scalability (highlighted above): if effective, a program that is less reliant on outsider resources is likely less costly to implement.

Thus, while in practice no program such as ours can be completely devoid of outside resources, we sought to design a program that would be as free of external resources—including technical, relational, and financial—as possible. With regard to technical resources, we designed a program in which CSO facilitators received training to collect information and then guide discussions with community members; however, no additional technical resources were provided to community members to facilitate their participation. With regard to relational resources, the program was designed to prevent the CSO facilitators from providing any type of brokering role with citizens. This is a significant departure from many T/A models in which the CSO may act as a broker for, or even voice of, citizens. In the T4D program, all relationships and interactions are decided upon and undertaken exclusively by the community members.

Finally, we sought to greatly reduce the provision of external financial or material resources for citizens in the program. In both countries, there are no payments or resources to help citizens carry out social actions that they may design, meaning that any costs associated with actions such as holding meetings or engaging with the media have to be financed using the local resources of, or identified by, citizens. In Indonesia, citizens participating in the program were only provided with snacks during the major program meetings (described in detail in Chapter 3); no money was provided for transport or other expenses. In Tanzania, where NGOs have a long tradition of providing allowances to participants that is firmly embedded in community expectations, finding the right balance took lengthy discussion and experimentation; eventually we decided to provide snacks at meetings (as in Indonesia), as well as a small allowance to compensate the community representatives for their transportation for only the first two program meetings, though not for subsequent meetings or any social actions participants undertook.

The design principles described above—in conjunction with the building blocks of the program—are at the heart of the ultimate program design that resulted from the lengthy co-design process in each country. They served as important guidelines when the T4D team and CSO partners faced tradeoffs in specific components of the design. The resulting design and the process through which our partners and we used these principles to design the program are described in Chapters 3 and 4, respectively.

III. Detailed Description of the T4D Program

Guided by the principles described above, the T4D program was co-designed to achieve two related but distinct goals: (1) to improve maternal and newborn health outcomes in the communities in which it is implemented and (2) to increase citizens' sense of empowerment and efficacy in these same communities. While these goals are complementary, they do not always point to the same design decisions. Because the program seeks to improve both health and empowerment, it was designed to help community members learn about and discuss underlying problems with maternal and newborn health and to develop social actions that the communities themselves could take to overcome these problems, with the implementing CSO partner playing a facilitation role that is more limited than what is seen in some T/A programs. The description below highlights the role CSO facilitators play in the program; the remainder—any part of the program that is not described as being led by the facilitator—is designed, led, and implemented by the community itself as a result of the program.

In this section, we begin with a detailed overview of the program design, focusing on its seven major components. After presenting the overview, we discuss some of the specific design questions that we faced and how we resolved them.

Overview of the program's components

The bulk of the program takes place over approximately six weeks, followed by three follow-up meetings at 30, 60, and 90 days. In all, the program has seven major components:

1. Entering the village
2. Conducting facility and household surveys on maternal and newborn health
3. Identifying community representatives (CRs) or community activists (CAs)
4. Survey results/scorecard and social action meetings
5. Open meeting
6. Social action[16]
7. Follow-up meetings

The process of the program is displayed in Figure 2 for Indonesia and Figure 3 for Tanzania. As noted above, one important goal of the co-design process was to develop a program that would be effective in two very different countries. Thus while the programs in the two countries were designed to be as similar as possible, in keeping with the principle that the program should be adaptable across contexts, they could not be exactly the same; important differences between our two CSO partners and in the health problems and cultures of Tanzania and Indonesia required subtle differences in the two programs. The figures reflect these subtle differences, which are noted explicitly in the descriptions below.

Figure 2: T4D Program (Indonesia)

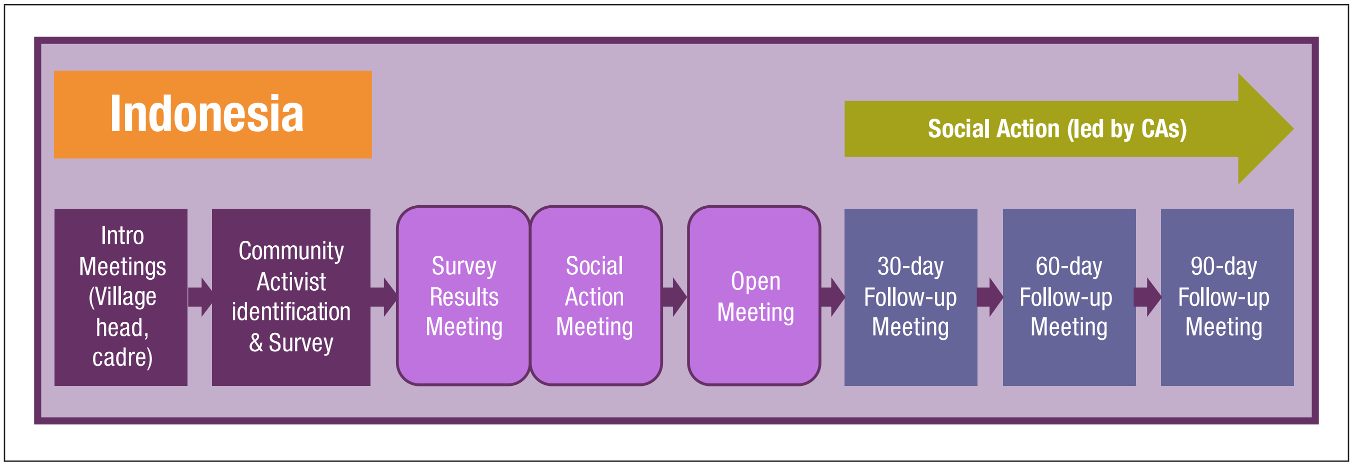
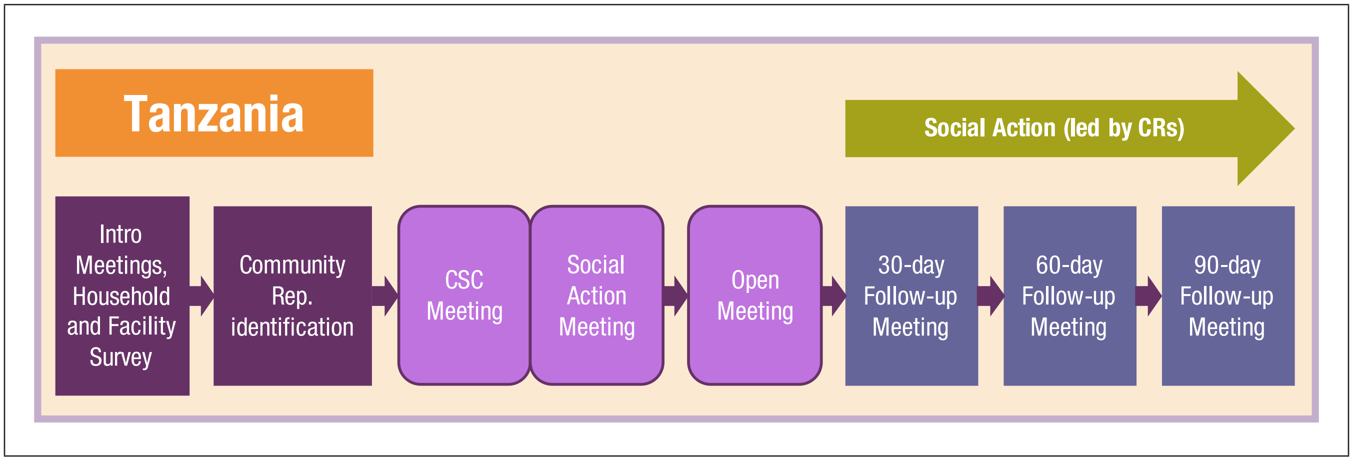


Figure 3: T4D Program (Tanzania)



1. Entering the village

The first component of the program involves the CSO facilitators entering the village. The main objectives of this component are (1) to obtain necessary permissions and buy-in from village government officials and (2) to inform health officials about the program and the importance of building empowerment of people in the village to improve service delivery in maternal and newborn health. In addition, the facilitators use these initial meetings to begin identifying people with whom to engage in the next two program steps, including women who have recently given birth (to be interviewed for the scorecard) and potential community activists (CAs; Indonesia) or community representatives (CRs; Tanzania) to participate in the program.[17] In the remainder of the program, facilitators work in pairs; however, village entry is largely undertaken by the primary facilitator in each village.

First, the facilitator meets with the village head (Indonesia) or village executive officer (Tanzania). The facilitator introduces the program and asks about the state of maternal and newborn health in the village. In addition, the facilitator asks for the village leadership's help in developing a list of women who have recently given birth (for the scorecard survey) and people who could potentially be good community representatives.

While the village head meeting is the only required introduction meeting with village leaders, facilitators may decide to undertake additional introduction meetings. In pilots that we undertook as part of the co-design process (described in Chapter 4), we found that in some villages there were additional formal and informal leaders with whom it was important for facilitators to meet and secure buy-in. When these meetings occur, they largely follow the same agenda and have the same objectives as the village leadership meeting.

In Indonesia only, our partner CSO identified two additional sets of stakeholders with whom introductory meetings are typically necessary: the village midwives and the volunteer health workers (called "health cadres"). The primary reason for these meetings is that midwives and cadres are not invited to be community representatives due to the potential of these actors to dominate discussions and decisions made by the CRs. As such, it is important for the facilitators to introduce the program directly to these individuals and to explain why it is important for community members to take on the role of supporting better maternal and newborn health services independently. In addition, these meetings are held to help generate a list of women who have recently given birth.

2. Conducting facility and household surveys on maternal and newborn health
The second component of the program is the collection of data on the uptake and quality of maternal and newborn health services, and the barriers to care, for use in the "survey results" (Indonesia) or "community scorecard" (Tanzania) meetings.[18] Many community scorecard (CSC) programs include a scorecard comprised of data about the management and conditions of local facilities, as well as citizen perceptions of the services delivered. Although the T4D scorecard does include information on local facilities, it differs from a typical scorecard in focusing first and foremost on health levers: the coverage of a range of key maternal and newborn health services and uptake of those services among women who have given birth in the last two years. The

focus on health levers (first described in Chapter 2) is in accordance with the design principle of being health-focused rather than service delivery-focused. Specifically, the scorecard includes levers on proportion of women who:

1. Attended four antenatal care (ANC) appointments including one in the first trimester (Tanzania only)
2. Developed a comprehensive birth preparedness plan (Indonesia only)
3. Gave birth in a health facility with a skilled birth attendant
4. Sought proper and timely postnatal care for the mother and newborn

These levers were selected because current medical guidance establishes these as the standard of care necessary for improving maternal and newborn health outcomes.[19] Differences in the first and second indicators reflect differences in the country contexts: ANC uptake is high in Indonesia and thus not emphasized in the scorecard, whereas birth preparedness planning is seen as an important intervention to address the strikingly low rates of facility births as compared to neighboring countries of similar income levels.

To collect the data for these indicators, the facilitator(s) for each village administer a household survey to between 20 and 30 women who have given birth in the last two years. These women are identified through a number of techniques and discussions led by the facilitators. Facilitators speak with trained health workers as well as informal leaders and traditional birth attendants to ensure that survey respondents include both women who have sought maternal and newborn care in the formal health system as well as women who did not use the formal system. The objective is to compile a complete and unbiased list of women who have recently given birth. Facilitators then administer the survey to a random sample of women from this list.

In order to contextualize the coverage rates of the levers, the survey also asks about women's experiences with, decisions about, and perceptions of ANC, delivery, and postnatal care. For women who sought care in the formal system, the questions focus on their experiences with the system, while women who did not are asked about the reasons that they did not use the formal system. These questions estimate the prevalence of potential barriers to proper maternal and newborn care, including obstacles related to knowledge and culture (such as women not knowing the importance of giving birth in a facility or not having spousal support), access barriers (such as distance or cost of care), and facility barriers (such as availability of medicine and privacy of the delivery room). A full list of barriers is included in Annex 1.

Like most CSCs, the T4D program also includes a facility survey to provide additional information on facility-level barriers that might prevent higher coverage rates such as supply of medicines and equipment, privacy and availability of infrastructure, facility staffing and open hours, and cleanliness. The facility survey includes questions that facilitators answer through observation as well as questions asked directly to a midwife or nurse.

The data from these surveys are then analyzed to provide village-level statistics to contextualize poor maternal and newborn health outcomes in the form of the levers, as well as the major barriers to achieving higher coverage rates that would likely improve these levers in the village. In total, the surveys provide data on the three country-specific levers, as well as approximately 25 potential barriers. The surveys used in the two countries differ based on the local health contexts and major barriers in Indonesia and Tanzania.[20]

3. Identification of community activists (CAs) or community representatives (CRs)
While administering the surveys, facilitators in the villages are also working to identify potential community activists (Indonesia) or community representatives (Tanzania). CAs and CRs share the same characteristics; thus, for the remainder of this report we will refer to them as CRs. In each village, facilitators seek to identify 15 to 16 CRs, who will be the primary participants in the program.

In seeking CR candidates, facilitators look for community members with several important characteristics, including individuals who have a personal interest in maternal and newborn health, who have time and are willing to volunteer to be involved in the meetings and social actions, and who are enthusiastic about improving the village. Formal leaders and health workers are excluded so as to ensure that CRs are typical community members from outside of the formal health system. From among the individuals with these characteristics, facilitators work to bring together a group of CRs that is a balanced cross-section of the community: a mix of regular village members and informal village leaders of different ages, genders, and from different parts of the village. (The recruitment process differs some between Indonesia and Tanzania; these differences are discussed in the section below on tradeoffs.)

After facilitators identify potential candidate CRs, they approach the candidates to share more about the roles and responsibilities of being a CR and to assess both interest and potential fit. Based on these interactions, the facilitators select a final set of 15 or 16 CRs. In Indonesia, the names of the CRs are then publicly announced; piloting revealed that this was important for building their legitimacy within the village.

4. Community scorecard and social action meetings
After selecting the CRs, the facilitators lead them through an intensive two-day set of meetings. These meetings allow the CRs to hear and discuss information about the major maternal and newborn health problems in their community, to learn about how other communities have undertaken social actions to address service delivery problems, and to design their own detailed social action plans to improve maternal and newborn health in their village. Facilitators conduct these and subsequent meetings in pairs, allowing them to trade off and support each other. Throughout the meetings, the facilitators employ a number of tactics to engage the CRs and to help participants feel comfortable sharing their experiences and ideas. These tactics are detailed in the Tanzania and Indonesia facilitator manuals,[21] and include icebreakers and small group work to encourage greater participation.

Community scorecard meeting
The first meeting is the community scorecard meeting. This is the "transparency" part of the program: the meeting focuses largely on sharing and discussing the village-specific data and information collected from the facility and household surveys. The pair of facilitators begins by introducing problems with maternal and newborn health care, presenting some key national-level statistics on maternal and newborn mortality rates, and asking CRs to share their personal experiences with problems with maternal and newborn health.

After establishing the importance of addressing maternal and newborn health in the country and the village, the facilitators shift to a discussion of the specific health levers, the barriers in the village to improvements in these levers, and maternal and newborn health as a whole. The facilitators start by asking the CRs for their opinions about the reasons why maternal and newborn health levers (such as proper ANC and postnatal care, birth preparedness planning, and facility births) are low in the village. They then use statistics from the surveys to bolster the discussion: when a CR shares a barrier for which the facilitator has a village statistic from the survey, this statistic is presented. The discussion continues until CRs have identified all the barriers they think may be responsible for lack of progress on maternal and newborn health. When the CRs can no longer think of any more barriers, the facilitators present any barriers that came up in the surveys but had not been mentioned by CRs.

This discussion inevitably leads to a long list of barriers, far more than the CRs could realistically address in the timeline of the program. Thus, the facilitators next lead the CRs through an exercise to winnow the list of barriers to those they think are most important in the village and that they would like to focus on improving. The goal is to decide on five or six "top" barriers. (The process to select these barriers is somewhat different in Indonesia and Tanzania; each is detailed in the facilitator manuals.[22])

The meeting concludes with a discussion of stories of other villages taking actions to improve health and other public services in their community. These stories, which also play a prominent role in the next meeting, serve both as encouragement—underlining the ability of community members like the CRs to make improvements on their own, without outside assistance—and as a source of ideas for how to make progress on the barriers the CRs have chosen to try to improve. They are real examples of social actions of nine types:

1. Choice (individuals making choices regarding service providers—for example, choosing a provider that is further away but provides better service);
2. Individual complaint, petition, or supplication (individuals complaining to providers or to government officials about services);
3. Collaborative problem-solving (working with providers or officials to develop a collaborative solution to the barrier);
4. Examining better performing services (learning from other places where services are working better);
5. Social demonstration, protest, or group assembly to express a demand;
6. Developing and advocating for reforms to improve services;
7. Talking to journalists or local media to publicize problems;
8. Working through a "broker" who links community demands with allies in the government; and,
9. Highlighting well-performing providers or naming and shaming underperforming providers.

To aid in understanding, the partner in Indonesia decided to also present all of the stories in the form of a cartoon. The stories and associated cartoons are included in Annex 2.

The first meeting concludes with the facilitators offering the CRs copies of the social action stories to take home and consider as they deliberate on how to make progress on the barriers to improved maternal and newborn health that they have chosen.

Social action meeting

The program resumes the following day. The goal of the second meeting is for the CRs to develop a detailed plan for social actions that they will carry out to overcome the maternal and newborn health barriers that they identified the previous day. This process is complex and takes many hours to complete.

During the social action planning, the facilitator generally divides the CRs into small groups, each of which works on actions to address a subset of the barriers. The small groups brainstorm social actions that they think are most likely to be feasible and successful in addressing those barriers based on their knowledge and experience of their community. They then work through a detailed plan for each action, with the support of facilitators as needed. Each social action plan includes:

- Specific steps that the CRs will take to complete the action;
- A CR who will take charge of each step;
- A list of tools and/or resources needed to complete the step, and how these resources will be mobilized;
- A deadline for completing the step; and
- A way of evaluating whether the action was successful.

The template used for village social action plans is included in Annex 3.

In the course of developing these plans, the facilitators help the CRs work through the steps they need to take and the advantages and disadvantages of different approaches. But all decisions regarding the social actions are made by the CRs. Facilitators are never the person to lead or undertake any step in any social action, nor do facilitators provide any resources or connections to enable or assist the CRs in undertaking any action.

At the end of the social action meeting, the pair of facilitators wraps up by facilitating the selection of several CR leaders, who will help to ensure the overall implementation and success of the set of social actions they have planned. Selecting the leaders helps the CRs to begin building a plan for sustainability after the facilitators are no longer involved—a process that continues during the follow-up meetings described below.

5. Open meeting

Shortly after the scorecard and social action meetings, the CRs and facilitators lead an “open meeting,” in which the CRs present their social action plan to the larger community, often including village leaders. This is a critical step to take before the CRs begin conducting the social actions as it allows the CRs to gain broader community buy-in for their social action plan, and begins to build their legitimacy as social action leaders. At the meeting, the CRs present the maternal and newborn health barriers that they have decided to address and the social action plans that they intend to undertake. They also seek input from the broader community into the social action plans, and ask for any volunteers from the community who are interested in working on or supporting the actions.

6. Social action

Following the open meeting, the facilitators leave the community. While the CRs are not required to undertake any of the social actions that they designed, the first potential output of the project is the CRs leading the actions they have planned after the facilitators exit the community. No additional resources or support are provided to the CRs, with the exception of three follow-up meetings; it is completely up to the CRs to organize themselves to conduct the social actions, to assess their effectiveness, and to adapt or update their plans based on the actions they try to undertake.

7. Follow-up meetings

The final prescribed component of the program is a set of three follow-up meetings, led by the facilitators and held approximately 30, 60, and 90 days after the open meeting.

These meetings have two goals. First, they provide a structured forum for the CRs and facilitators to discuss progress on the social action plan and improve or adapt their approach. Second, over the course of the three meetings, the facilitators work with the CRs to build a sustainability plan to ensure that the actions continue after the facilitator is no longer interacting with the CRs.

In each meeting, the CRs walk through each of the social actions from their original plan and discuss which steps were completed, why or why not, and whether the action was successful. For actions the CRs have completed, the facilitators guide the CRs through a discussion of whether they want to add new social actions to address the five or six maternal and newborn health barriers they originally selected at the start of the program. The facilitators also prompt the CRs to consider any new barriers that may have become clear as they undertook the actions. In cases in which social actions have not been successful, facilitators lead a discussion about whether and how the CRs would like to adapt their approach in response to the challenges they faced.

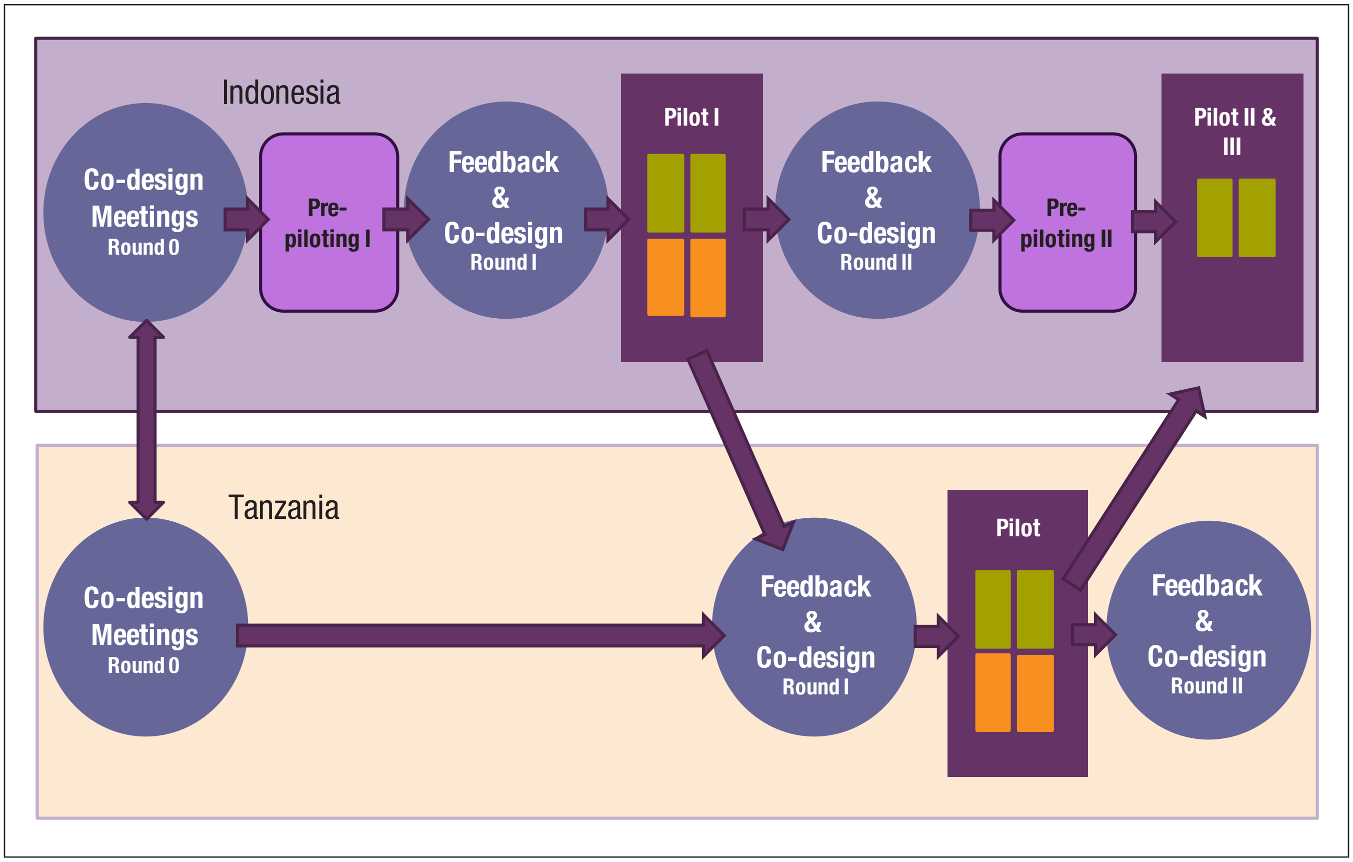
Throughout these meetings, the facilitators also focus the CRs on the sustainability of their approach, encouraging them and helping them plan to stay active. At the concluding 90-day follow-up meeting, the facilitators work with the CRs on a final sustainability plan for continuing to work on remaining social actions without the facilitators' guidance and participation. By the conclusion of the 90-day follow-up, the facilitators' goal is for the CRs to be committed to undertaking social actions and adapting their approach, so that they continue working on improving maternal and newborn health in their community long after the program ends.

IV. "Crawling the Design Space"[23]: Co-design and Iterative Piloting

The design principles described above, evidence from evaluations of other Transparency and Accountability programs and in other literature pertaining to the field, and the experience of the partners involved in co-designing the program all heavily shaped the final design described in detail in the previous chapter. However, even with all of these inputs into the program's final design, there still remained many uncertainties about the optimal form of different components.

Rather than design something fully on paper and move quickly to a rigorous impact evaluation, we experimented, using a process of trial and error to "crawl the design space." We felt that this process was particularly appropriate for T/A programs that have long causal chains. The early stages of T/A programs, including inputs and short-run outputs, have the potential to fail fast; for example, if community members do not show interest in the information being presented or do not show up for meetings to design social actions in the first weeks of the program, it is very unlikely that intermediate and ultimate outcomes in health will be triggered by the program. While we did not necessarily set out to conduct multiple rounds of piloting, it took several rounds of empirically testing our assumptions and redesigning based on feedback before we reached a design that we had sufficient confidence could trigger a variety of causal chains between transparency and accountability across diverse settings.

Figure 4: The Co-design and Iterative Piloting Process



The specific co-design and piloting process we ultimately followed in Tanzania and Indonesia is pictured in Figure 4. In the figure, "co-design meetings" refer to in-person sessions, usually lasting several days and involving members of the T4D research team and key staff from our partner CSOs; these meetings were used to debate, discuss, design, and redesign based on the results of earlier pilots. In between these focal discussions, local T4D field staff were able to continue working with partner organizations and to coordinate with them to quickly experiment in a handful of villages with one or more of components of the program.

As we followed this process, we began to distinguish between a "pre-pilot,"[24] which we came to define as a quick test to validate a core assumption of the program or to test out one component, and a more-complete "pilot," which involved running the entire program from start to finish (or until it was clear that the program was no longer working). Examples of how we utilized pre-piloting as well as larger-scale pilots are included in Boxes 2 and 3, respectively.

Box 2: "Pre-pilot" to Explore Appropriate Health Outcomes and Indicators in Indonesia

The first pre-pilot that we conducted in the design process was used to explore whether maternal and newborn health would be an appropriate health-focus for the program by gauging the initial responses of rural villagers in Indonesia to information presented on problems with maternal and newborn care. Although PATTIRO and we believed that maternal and newborn health was a good candidate for the health-focus, we wanted to validate this belief by exploring whether and which aspects of maternal and newborn health would resonate with citizens similar to those who would be participating in our program.

To answer this question in a rapid feedback approach, we developed a basic scorecard that drew on existing data sources such as the Indonesia Demographic Health Survey and the Indonesia Family Life Survey. While we later concluded that this kind of exclusively national-level objective information was suboptimal for community diagnosis and action (discussed more in Chapter 5), the data revealed two important lessons. First, the topic of maternal and newborn health overall engaged participants and appeared to motivate concrete discussion of what actions they could take; these observations were thus sufficient for us to validate that maternal and newborn health was a health problem that was likely to resonate with citizens. Second, some levers related to maternal and newborn health (such as exclusive breastfeeding) proved to be too technical and not amenable to developing T/A-driven actions; as such, the pre-pilot also helped us refine the contents and presentation of the scorecard itself.

Box 3: Piloting to Identify Optimal Approaches to Scorecard Data Collection

One design question we faced was whether to have CSO facilitators or CRs lead the collection of facility and household data for the scorecard. For this component of the program, we were seeking to balance competing logics. On the one hand, being involved in data collection might be an important way for CRs to "own" the information, which might affect its resonance with them as well as increase their level of commitment to implementing actions based on the information and/or getting other members of the community involved. On the other hand, CRs might have a difficult time collecting quality data.

We could not use simple pre-piloting to answer this question for two reasons. First, the process of data collection was more involved than recording responses in a simple meeting, and as such we would need, at the least, to test the full data collection process with community members. Second, we anticipated that potential negative effects of citizen-led data collection might not bear out until later in the program process, either by other CRs not believing data collected by their neighbors or by those collecting the data feeling overtaxed by the process and thus dropping out later in the process. As such, we decided to include this question in our pilot process in Indonesia.

Ultimately, the pilot demonstrated that it was important to bring local data to the communities, but that CRs were not well-equipped to collect data themselves. Based on this experience, we adapted our data collection process in the Tanzania pilot, opting to have the CHAI facilitators instead of CRs collect the data. When this approach proved promising in Tanzania, we used it in a subsequent round of piloting in Indonesia, which verified its viability, and thus become a feature of the design.

The example in Box 3 illustrates a final aspect of the iterative piloting process that emerged organically: the experience of a pilot in one country often informed, and in some cases shaped, what we did in the other. While no co-design meeting explicitly brought together our Tanzanian and Indonesian CSO partners, the iterative design process allowed the research team to work with one partner on design choices based on experiences in that partner's setting and then bring these to the other partner to discuss their relevance and applicability in the other partner's setting. In addition to allowing learning across a greater number of pilot experiences, this approach helped increase the likelihood that the resulting program was flexible enough to encourage community engagement and action across very different country contexts, which improved our confidence that it would also be flexible and adaptable across the wide variety of contexts within Indonesia and Tanzania in which we implemented the full rollout (design principle 3).

V. Program Design Questions and Tradeoffs

As described in the previous chapter, the final program design required our team and our CSO partners to answer many specific design questions, which we addressed through a combination of existing evidence, partner experience, and observations from iterative pre-piloting and piloting. In this chapter, we detail some of the major questions that we faced in the program design; what we learned about them from existing evidence and experience, our discussions with our partners, and the results of our piloting; and the decisions on which we eventually settled.

Program level question (Program component 1: Entering the village)

Before launching the program, we had to decide where the program would take place—at the village level or the health facility catchment level. Many T/A programs that seek to solve service delivery problems choose to focus programs at the level of the facility catchment area to ensure that communities and citizens that are affected by the facility-level problems are engaged in the program process.

We considered taking a similar approach with the T4D program; however, as discussed above, one of the important design principles for the program is that it is health-focused rather than service problem-focused. As such, we sought to create space for citizens to address problems that may not have their root causes at the health facility. In determining the proper level at which to focus the program, we sought to understand what people perceive as their lived community or network. Based on discussions with our partners, the lived community where citizens seem to connect with each other to improve their collective lives is the village. Ultimately, this led us to choose to focus the program at the village level rather than the facility catchment area.

One tradeoff to this approach is that the voices from a single village may not be enough to trigger change at the facility level for any facility-level problems that CRs do choose to address. This is a tradeoff that we will be able to research in greater detail based on the actions that CRs choose to take in the treatment villages and the response to these actions.

Information questions (Program component 2: Conducting a survey on maternal and newborn health)

Our first set of questions focused on what information to offer to communities—the “transparency” component of our T/A program. In addition to the decisions of health outcome, levers, and barriers (discussed in earlier sections), we needed to decide on 1) the specific information to be presented to communities and 2) who would collect this information.

The information: What specific information should the program present to communities?

After identifying the focus health outcome (maternal and newborn health), we had to consider what type of information to collect and to share with the communities. Specifically, we considered whether to collect and provide:

- Information on outcomes, outputs, or inputs
- Objective, subjective, or experiential data

While we mapped out a full set of outcomes, outputs, and inputs related to maternal and newborn health in Tanzania and Indonesia, sharing all of this information had the potential disadvantage of overwhelming program participants with extraneous and potentially irrelevant information. On the other hand, different kinds of information might be necessary to trigger both interest and action on the part of CRs. For example, existing evidence suggests that communities might not find output information alone meaningful because they might not be accustomed to thinking about the connections between delivering in a facility and being healthy or having a healthy baby, while providing only input data might focus participants' attention too narrowly on issues that might not be relevant to maternal and neonatal health care in their area and thus might not empower them to take action.[25]

Thus, deciding on what information to present required extensive piloting, which offered us several lessons that we built into the final program design. First, we found that, if presented in the right way, information on outcomes, outputs, and inputs can each inform and motivate communities in different ways. Information on outcomes (such as statistics on maternal mortality rates) is an important starting point to make participants aware of the severity of the ultimate problem and in many cases motivate them to be concerned about these issues. However, information on maternal mortality is unlikely to provide a sense of the specific problems closer to home that are contributing to poor outcomes. That is where information on inputs can make a difference, by allowing communities to consider the very specific underlying issues with their local care that are connected to maternal and newborn health and which they can actually help to address. We reframed this information as "barriers" to make it easier for CRs to understand the concept. Finally, information on outputs, such as our "levers" above, highlights major coverage gaps for maternal and newborn health and draws an important link between motivating statistics (on outcomes) and actionable problems (barriers).

Second, we found it most effective to present a combination of objective, subjective, and experiential information. We found that this combination helped to motivate discussion far more than any one of these facets did, and that this was particularly the case for certain types of barriers that were likely to motivate specific community actions. While statistics on barriers did not always focus prominently in the discussion regarding the problems on which to focus the social actions, they were an important starting point for participants to discuss their experience with issues that, in our pilots, often led to particular actions to make progress on those problems, including the facility being far away, perceived negative attitudes of health facility staff, and their cultural beliefs around pregnancy.

Thus, in the end, we designed the program to collect and present communities with a variety of objective, subjective, and experiential information:

1. *Objective* data on facility inputs, maternal and newborn health levers, and regional and national health outcomes (from national surveys and direct observations of facilities);
2. *Subjective* data on community perceptions, such as the opinion of women on the attitudes of health workers (from surveys of women who have recently given birth); and
3. *Experiential* information on the experience of women who sought or chose not to seek care in the formal health system (from surveys of women who have recently given birth).

The information gathering process: Who collects the data?

A second design question we considered was who should collect the data, meaning who should administer the facility and household surveys from which the scorecard data were drawn (a process that is described in Box 3 of Chapter 4). Upon deciding that we would collect data rather than use existing data, we considered three options for who would administer the surveys upon which the scorecard would be built: the community representatives, the CSO facilitators, or the research team (using data that we were already collecting for the baseline randomized controlled trial (RCT) survey). Ultimately, we decided that the first and third options were not optimal (for reasons described below) and that the best people to collect the data are the facilitators.

During piloting we identified several drawbacks to community members collecting their own data. The data was difficult for them to collect, and its quality was therefore often poor: the surveys required systematic observation as well as compiling a list of all women who had recently given birth—including those who had not sought care in the formal system—and asking them a long set of questions. Attempting to gather the data also took a significant amount of time and effort. We initially thought that this might be a positive factor—that involving participants in an extensive data-gathering effort might increase their familiarity with the data and the general context of maternal and newborn health care in their community and thereby improve their buy-in. Instead, we saw signs that the data collection led to participants feeling overwhelmed and overcommitted.

We also considered using data that was already collected for the baseline RCT survey, an approach that many researchers take when doing evaluations of scorecards. The main drawback with this approach is that it is not replicable outside of an evaluation setting. If we were seeking to scale up such a program, we would not do so by having a data collection firm collect data that would then be provided to the CSO to use in a scorecard. Instead, we sought to test a program that could be easily replicated in another setting without the need for a survey firm collecting such data. As such, we made the design choice to have the facilitators collect the scorecard data.

Questions on the identification of community representatives (Program component 3)

As a citizen-driven program, the success of the program relies on the participation and actions of citizens—the CRs who are involved in the discussions about maternal and newborn health and who design and undertake the social actions to improve health. Thus, we faced an additional set of crucial design questions around who these participants would be. Specifically: 1) what is the right profile and mix of CRs, 2) how should participants be recruited, 3) how many should participate, and 4) should health workers and volunteers be included? Here we consider how we approached each of these questions.

What is the right profile and mix of CRs?

In the T4D project, recruitment of CRs is the responsibility of CSO facilitators; it is a task they were asked to complete alongside the data collection, as they got to know the community over the course of the preparatory phase of the program. With the exception of health workers and formal government officials (such as village executive officers, discussed in question 4 below), we asked facilitators to bring together a diverse set of individuals with different strengths necessary for the success of the program. In particular, we wanted to be sure to include those with direct experience with maternal and newborn health care, respected voices in the community (e.g., informal leaders), and those with the time to and interest in being "doers" (engaging in the social actions). Facilitator training and guidelines asked facilitators to ensure that all potential CRs had interest and time to commit—that they expressed a significant interest in improving maternal and newborn health in their community (whether they had direct experience or not) and that they could at least commit to involvement in the two full days of scorecard and social action meetings. But beyond these overarching guidelines, we found that it was helpful to ask facilitators to find a balance across a number of categories, including gender, age, those who are "vocal" and "active," and informal leaders as well as average citizens with no leadership position.

It is important to note that this question in particular is one that we explored during the piloting phase of the project; however, the overall question of whether the right CR group was selected will need to be explored more in the evaluation, and is likely to vary across treatment villages. The guidelines that we developed with our partners during the program design are ones that mitigated against clear downfalls we saw in recruiting CRs in the pilot but may not capture the exact mix and profile of a good CR group.

What is the best way for the facilitators to recruit community representatives? Based on different approaches tested during our piloting, we found it most effective to ask the facilitator to work to develop a locally appropriate group of CRs within the guidelines above. This task ended up requiring significant time and effort. We experimented with a number of "light touch" approaches that would in theory have made the process more consistent and less difficult, but found all to be less effective than allowing the facilitators more discretion. In some pilots, the facilitators made announcements and calls for volunteers to be CRs, but found many individuals to be reluctant or disinterested unless they were directly asked to join—preferably by someone they knew. In other villages, the facilitators were asked specifically to consult with village leadership. In some places, this produced a motivated and diverse group; in many places, however, the leadership chose those who were political allies without regard to their interest and ability to commit rather than individuals who met the criteria and therefore would have been the better choice for the role. Additionally, there were often candidates who seemed to be "ideal" on paper—motivated, outgoing community members with experience as informal leaders and with strong social networks—but who were ultimately too busy to fully commit to the T4D program.

Ultimately, we found no way around the significant time and effort facilitators needed to spend to recruit CRs. While facilitators did not conduct a complete stakeholder mapping of the community, we did ask them to collect suggestions and seek volunteers at many points in the early stages of the program. Specifically, the design we settled on provided guidelines for facilitators to look for potential representatives during the long process of conducting the household survey, ask for suggestions from the village leadership and health workers, and ask people they happened to meet. The guidelines then asked facilitators to screen candidates to ensure they were available for the core program meetings and had time to commit to the full program. We found that this multipronged approach allowed facilitators to find individuals who were most likely to be motivated, capable, and representative of diverse voices in the community relevant to improving maternal and newborn care.

What is the right number of community representatives?

In the T4D program, the target number of CRs is 15 to 16. We do not argue that this is necessarily the ideal number. But in our piloting, we experimented with more than and fewer than 15 representatives. In theory, the greater the number of participants, the greater the number of voices and perspectives they will represent. Yet as the number of CRs increased to above 20, we observed that participants became less focused and that there were voices that were not heard. On the other hand, we needed a large enough number not only to ensure a mix of skills and diverse perspectives, but also to account for attrition. We found some attrition to be inevitable, as the T4D program is relatively intensive for participants, requiring substantial thought and effort over a number of months, and ideally beyond. In the end, 15 to 16 representatives provided a balance: a small enough group to make sure that the conversation was focused and all voices could be heard, but one large enough such that a substantial number were likely to remain committed to the social actions through the 90-day follow-up meeting and beyond.

Should certain people be excluded as community representatives?

Overall, we sought a diverse group of CRs who were motivated, interested, and able as a group to undertake actions to improve health. However, there were some obvious candidates (such as health workers and community volunteers) who would be good candidates by these criteria but who had other disadvantages that we had to consider. During pre-piloting, we identified several drawbacks to including these individuals formally in the program as CRs. Both formal health workers (such as midwives) and community health volunteers often dominated the discussions, blocking out the voices of other women in the community who had given birth recently and discounting the experiences they shared in the discussion. Further, some of the barriers related to maternal and newborn health outcomes relate directly back to formal health workers, and including health workers in the discussions made consideration of these barriers difficult. Thus, we decided not to include formal health workers or community health workers as CRs.

We faced a similar debate regarding the inclusion of traditional birth attendants (TBAs). Some of the levers used were in direct opposition to the work that was being done by TBAs, such as giving birth in a health facility with a skilled birth attendant. As such, there was the potential that including TBAs could lead to discussions that were counter to medically-safe maternal and newborn health practices. However, in some places, TBAs have a culturally important role in society, and many programs have sought to include them in the birthing process in partnership with skilled attendants as a way to reach women who would prefer to give birth with a TBA. Ultimately, our partners in Tanzania and Indonesia took two different approaches to this question; in Tanzania, TBAs were included as potential CRs, whereas in Indonesia they were not included in the CR group.

A final group that was excluded from the CR group was formal village government leaders. This decision stems from many of the same concerns described above regarding health workers, specifically that formal leaders might dominate discussions and that some of the problems with the health system might link back to formal leaders themselves. This decision was further tied to our program design principle of being non-prescriptive in nature. We wanted to provide CRs with complete choice regarding who they involved in the social actions, and including formal leaders (common targets of actions) in the CR group would remove the choice not to work through these individuals.

With regard to these excluded groups, it is worth noting that exclusion from the CRs does not mean that the program always excludes health workers and formal leaders; in practice, many of the actions CRs choose to undertake involve engaging with health workers and formal leaders. But we designed the program to allow the nature and intensity of this engagement, and indeed whether it happens at all, to be left entirely up to the CRs themselves. This is an important difference between the T4D program and common T/A approaches, which often involve structured interface meetings between the community, health workers, and government officials. As part of the evaluation, we will be further investigating the question of how these individuals were involved in the program, either through social actions or if there were cases in which the guidelines for CRs were not adhered to.

Questions on the community scorecard and social action meetings (Program component 4)

The focal point of much of the T4D program is the set of two meetings in which facilitators share information and facilitate social action planning led by the CRs. These meetings are critical to laying the foundation for the design of realistic social actions and encouraging CRs to actually undertake them. In designing this part of the program, we sought a balance between providing enough guidance and structure from CSO facilitators so that they could successfully engage the CRs in similar ways across all the treatment communities while also ensuring that the social actions remained community-driven and community-specific. In particular, we needed to decide on 1) the length, timing, and content of the meetings, 2) the structure of the social-action planning component, and 3) how to allow the diversity of voices among CRs to be heard across the process.

What is the right length, timing, and overall content of meetings?

We began by deciding on the objectives of this major component of the program. In addition to providing information about maternal and newborn health, and facilitating the design of social actions, we also considered a number of additional objectives including undertaking a stakeholder mapping exercise with CRs and working with them to build their capacity to undertake actions. These are often a part of T/A programs, and capacity building in particular is a common approach in many traditional programs.[26] But an important goal of the T4D program was to be scalable and flexible across different contexts (design principle 3). In addition, experiences with capacity building both in our pilots and in other projects suggested to us that anything more than capacity building often led participants to look to facilitators for advice and leadership of actions.[27] This in turn reduces the community-driven nature of the process and limits the extent to which participants rely on their own firsthand understanding of how their community works and how problems there can be alleviated (design principles 4 and 6). As such, we decided with our partners to test what CRs could achieve by providing them with only very basic facilitated discussions around maternal and neonatal health problems and actions to undertake, without intensive training and capacity building.

This set of objectives ultimately led us to design two days of intensive meetings: one focused on the first goal of sharing information and the other on the second of planning social actions. We tested spreading out the meetings and breaking them into four or more shorter (half-day) meetings. However, we observed that breaking apart the meetings resulted in representatives losing steam and forgetting what was accomplished in earlier meetings. In contrast, holding the two meetings back-to-back provided a level of intensity that allowed participants to more fully absorb the information and sufficient time to think creatively about social actions they might undertake. We also observed that the two-day commitment was a good indication of the level of commitment that the CRs would have for the entirety of the program, including the social actions.

How do we provide ideas but not guidance for social actions?
As with the community scorecard meeting, we sought to design a social action discussion with a particular kind of balance. On the one hand, we tried to design the discussion to rely on the capacity and local knowledge of the CRs to design the social actions they thought would work in their particular setting. As discussed in Chapter 2, one of the core design principles for the program is that it is non-prescriptive and thus, unlike many social accountability programs, does not require or integrate any specific type of social action that citizens have to undertake. At the same time, we and our CSO partners recognized and observed in the pilots that the participants' experiences and ideas were often limited, and thus that ideas from outside could motivate communities to consider new types of actions that might be more effective than those that they came up with entirely on their own.

Our solution was the set of "social action stories" described in Chapter 3. We decided to introduce these stories to provide ideas but not guidance—to help the discussion be as creative as possible while also keeping it community-driven and non-prescriptive (design principles 3 and 4). The social action stories are from real communities and illustrate nine different types of actions that can be undertaken to alleviate similar problems to those that the CRs might be tryng to address. As such, the stories provide a set of ideas for actions that CRs might consider, including several that they may not have seen in their village. While these stories serve as potential ideas, the CRs are not required to choose from among them—they can devise any social actions they believe will work in their community. Also, the decision regarding which social actions that the CRs undertake is not made by the CSO facilitators but is completely in the hands of the CRs themselves.

How do we ensure that all community representatives have an opportunity for their voice to be heard?

As discussed above, we worked with our partners to ensure that multiple viewpoints and strengths were being brought into the meetings by assembling a deliberately diverse set of community representatives in each village. However, including a diverse mix of individuals does carry a potential downside that we observed in several of our pilots: including people from groups that could be generally more or less empowered than others in the meeting increased the potential for one or two representatives from more empowered groups to dominate the discussions and decisions. Such a dynamic could ultimately disrupt the goal of bringing together a group of citizens who, in addition to being diverse, can work together as a cohesive group in pursuit of actions that might improve their health and health care.

We tried to mitigate this potential risk in three ways. First, CSO facilitators received training and instruction regarding how to handle especially dominant voices in the meetings, including asking directly for differing opinions and posing questions that would help all people feel comfortable speaking. Second, we tried to incorporate structures into the meeting sessions that would allow people to be in safer spaces for discussing their experiences and ideas. For example, at several points in the meetings, the facilitators break the full set of representatives into small groups in which those who are quieter are deliberately not paired with those who are more vocal or dominant, and each group is given assignments that require different people to give ideas and input. Finally, we sought to overcome the challenge of including some CRs that only speak tribal languages. While we were unable to always identify facilitators who spoke the specific local dialects, facilitators engaged in strategies such as finding CRs that were comfortable with both the local dialect and the national language to help with translation so that every person could feel comfortable speaking in the language that they preferred.

Questions on the follow-up meetings (Program component 7)

The final component of the program is designed to create an environment that maximizes the potential for the social actions to continue after the facilitator leaves the community. Our goal was for the program to include a component that would 1) increase the sense of community and the legitimization of the CRs (both within the group and across the community), and 2) make it more likely that their activities would continue—and evolve—after the program concluded. The second objective presented several design challenges for a relatively light-touch program of this type.

How to build the sustainability of community representatives?

We worked with our CSO partners to identify several ways to increase the sustainability of the CRs as a group dedicated to diagnosing and fixing problems with their community's health and health care. In part, ensuring sustainability is linked to building the legitimacy and ownership of the CRs. By having facilitators check in with the CRs at 30, 60, and 90 days, the program design provides enough time to accomplish steps of actions (even if not complete actions). The follow-ups also occur frequently enough that facilitators can help CRs think through how to change or update actions that are not working before the actions are completely abandoned due to frustration or apathy on the part of the representatives. To that end, the follow-up meetings focus on celebrating the successes of the CRs (helping them and the community see them as valuable contributors) as well as on motivating the representatives to continue undertaking actions—either the original actions if they have not made progress on these, or new actions if they have run into difficulties or their approach has evolved. In this way, the meetings seek to sustain the CRs' interest, excitement, and commitment to undertaking actions that are intended to alleviate community problems, and that will therefore help build the legitimacy of the CRs.

We also decided to end each follow-up meeting with a specific discussion of sustainability. After discussing progress on the social actions—successes as well as challenges and course-corrections—the facilitators turn the discussion toward a set of specific sustainability questions, including:

- Will you continue to meet as a group?
- Who is invited? (the original 15 CRs, or are others being added?)
- Where are you going to meet?
- How often are you going to meet? Is this a set date (e.g., first Monday of every month, or on ad hoc basis)?
- Who is going to notify that a meeting is going to happen (e.g., roles of current leadership going forward)?
- If you face challenges, who are you going to contact?

Finally, the follow-up meetings are designed to increasingly have the discussions led by the CR coordinators rather than the facilitator. To this end, the facilitator scripts for the final few follow-up meeting explicitly encourage the CRs to plan for and take ownership over all future follow-up meetings.

Sustainability remains a key question that we will investigate in the scale-up of the program; however, our hope is that building this in as an explicit discussion over several meetings will encourage many communities to continue their efforts after the facilitator leaves.

VI. Conclusion

Can a community-led transparency and accountability program improve health outcomes and community empowerment—and, if so, how and in what contexts? Although the existing literature clearly demonstrates the promise of T/A programs, the overall record is decidedly mixed and suggests that not every existing program works in every context. Thus to answer the core questions of the T4D study, we began by developing a new citizen-led program, one based on existing approaches and lessons from them, but also designed to be more flexible across contexts and responsive to particular problems in health (or other public concerns). We designed this program to adhere to a number of core design principles: it was 1) co-designed with embedded and experienced in-country partners to be 2) health-focused rather than service delivery-focused, 3) locally relevant, 4) community-driven, 5) non-prescriptive, and 6) largely free of resources from outside the communities that received the program. Several rounds of pre-piloting and piloting allowed us to "crawl the design space" that remained within these principles, providing answers to myriad specific design questions such as how to ensure a capable, committed, and diverse group of participants; how meetings should be structured; what information should be presented; how to provide participants with ideas for actions to take while ensuring that the whole process was citizen-led; and how to encourage participants and foster sustainability of their efforts. Along the way, the T4D team and CSO partners in Tanzania and Indonesia began a process that revealed several potential lessons for practitioners, researchers, and donors alike that are seeking to improve health by strengthening transparency, accountability, and empowerment. We conclude this report by describing several of these lessons.

Build on what works. We began this report by outlining the building blocks that created the skeleton of the T4D program, which included the general building blocks of T/A approaches. While our review of existing T/A programs revealed many gaps preventing one approach from always being successful, it also revealed core building blocks—gathering information, sharing information, and stimulating social action—that serve as the backbone of any effective T/A program. The T4D design remains true to these basic building blocks, even as it includes adjustments that we hope improve its impact.

Finding a program that works across contexts requires a more flexible design. It is not a surprise that many existing T/A programs work in some places, contexts, and sectors, yet are not effective in others. This predictable irregularity presented a substantial design challenge in developing a program that can provide generalizable knowledge about whether T/A can improve health through community empowerment, but it also provided an opportunity for the team to think outside of the normal bounds of T/A. This led the team to two conclusions, which were at the core of several of the design principles that we discuss in Chapter 2.

First, a program that had the potential to be effective in different places had to allow citizens to identify and develop plans to deal with the specific problems that their community faced—and that might be different than those faced by neighboring communities. Even with a common objective of improving maternal and newborn health, the specific barriers that stand in the way of improving outcomes differs between Tanzania and Indonesia—and even across regions and villages within a country. As such, designing a program that could be applied in multiple contexts required adherence to several of our design principles, including that the program be *health-focused* (not service delivery-focused) and that it be *locally relevant*.

Second, the program had to allow for multiple types of social action, any one of which was unlikely to be effective in every context. Many existing T/A programs build in a specific type of action, such as a confrontational forum between community members and duty-bearers or an interface meeting between citizens and service providers. While these approaches have merit, each one is also more amenable to some situations than others. As such, we designed the T4D program to be *non-prescriptive* to allow those who would be undertaking the action itself to decide what action would be best to undertake, and to facilitate learning and iteration.

Scalability and sustainability recommend a citizen-led design. The questions of how to achieve scalable and sustainable results are two of the biggest questions in the T/A field, after "what impact does T/A have?" A citizen-led approach, in addition to its other merits, is inherently more scalable and sustainable if effective. Many T/A programs involve a significant role for national-level CSOs, as facilitators, decision-makers, brokers, and doers. While the role of CSOs is an important one at higher levels of government and policymaking to which communities may not have access, organizations operating at the national level are likely not the best placed to address issues that arise at the village level. By instead frontloading CSO efforts to empower citizens, and making the decisions and actions themselves *community-driven*, we are testing a program that—if effective—has a greater potential to be brought to scale over time as it requires less sustained effort on the part of CSOs. In addition, by seeking to empower citizens *without bringing in significant outside resources*, we are further testing an approach that could be expanded with less outside support over time.

A true co-design process avoids pitfalls and vastly improves promise. Our first design principle is that the program be *co-designed with in-country partners*. For many of the questions and tradeoffs that we faced, including those detailed in Chapter 5, existing evidence did not provide a clear answer of what would work and what would not; and in many of these instances, our CSO partners could point to clear examples from their local knowledge and experiences leading T/A programs and community-driven health initiatives to provide guidance as to what design choice would be most appropriate. Further, while we sought to design a program that would largely be consistent across the two countries, our partners identified components that required slightly different designs in each country. While the co-design process required additional time, especially in working with two different partners, the final design is one that benefited from a combination of existing evidence and the direct experience of T/A implementers.

Building in time and resources to experiment with T/A component designs may increase the likelihood of scaling up successful programs. Even with a growing evidence base of "what works" in T/A, and further theory-building work to inform design choices, actually getting a T/A program to have an impact in a particular place is a function of both the program's design and the success of the partner in delivering that program. Ultimately, the challenge for donors in looking for high-impact T/A work is that it is rarely going to be a simple process of replicating a "proven" approach. Rather, while researchers and practitioners continue to build knowledge within the field of T/A about what works, the process of spreading that knowledge and implementing it in new contexts might mean that partners and donors will want to explicitly adopt an “experimentalist approach” similar to the one that we described in Chapter 4 as a core feature of the rollout of new programs.

Annex 1. Maternal and Newborn Health Barriers

Below is a compiled list of potential barriers to maternal and newborn health care that were included in the scorecard surveys. Community representatives suggested additional barriers during village meetings that are not included in this list.

- Value—does not think it is important
- Knowledge—does not know it is important
- Superstition or other cultural barriers
- No family support
- Fear safety of medical care
- Prefer traditional birth attendant
- Care is too costly
- Service provider disrespectful
- Service provider difficult to see/not available
- Dissatisfaction with service provider
- Transportation barriers
- Difficulty accessing health facility
- Service provider lacks skills or knowledge
- Poor-quality space for patients in facility
- No privacy in facility
- Lack of medicine supplies
- Facility dirty
- No water available in facility
- No toilet in facility
- No placenta pit
- No reliable electricity/refrigeration in facility
- Missing or poor equipment in facility
- Lack of cost information
- Lack of information on operational hours of facility
- Lack of female midwife

Annex 2. Social Action Stories

Below are the Social Action Stories and corresponding cartoons. Note that the versions included below are those from Indonesia. The Tanzanian social action stories focus on the same action types but provide stories that are more local to Tanzania. All of the stories are available on the T4D website.

Story 1: Individual Choice

In some communities, people who are unhappy with the health care they are receiving choose to go to a different provider:

Dogiyai: Bad Service Has Led the Community to Shift to a Different Provider

DOGIYAI, 20 Oct. 2013 – The Head of Dedemani Puskesmas in Dogiyai District, Papua, told the media that 15,000 community members in Dogiyai District chose to seek medical attention in the District's Health Hospital (RSUD) Dogiyai, despite the longer distance, instead of their local Puskesmas. They made this decision due to the lack of doctor availability at the local Puskesmas—the assigned doctor was often absent from the Puskesmas.

"I really regret what happened, due to doctor's absenteeism people no longer seek health care in my area," the Head of Dedemani Puskesmas said. "I will do my best to improve the services here so people will come back and seek the health care in the Puskesmas."

The head of the sub-village (dusun) in Dogimani, Piter Tagi, shared his own bad experiences in going to the local Puskesmas: "The doctor came very late, so it's too bad that I have to seek medical treatment in another place. I actually want to appreciate and love the health facility in our own area, but this is necessary to make the Puskesmas improve their service." (PAPUA POS NABIRE)

Summarized from http://www.papuaposnabire.com/index.php/kabar-dari-papua-tengah/21-dogiyai/509-dokter-tak-ditempat-warga-dogiyai-memilih-berobat-ke-rsud-dogiyai

Story 2: Individual Complaint, Petition or Supplication

In some communities, people who are unhappy with the health care they are receiving complain to the providers or to officials and ask them to make improvements.

Cipayung: Voice Complaints by Writing to 'Reader's Letter' in Poskota

CIPAYUNG, November 2013 – Community members complained about the quality of the service of Puskesmas staff in Cipayung Village. After receiving these complaints, the Health Department Officials for East Jakarta, Yudhita, went to investigate the Puskesmas directly.

"We have assembled a team to check the reports from the community members," she stated. One of the complaints regarding the Puskesmas was in the format of a Reader's Letter in the newspaper Poskota, which detailed the case. "The Puskesmas in Cipayung Village was closed at 11:30, even though it should be open from 08:00–12:00 and 13:00–16:00. I came back at 13:00 and it was still closed. When I asked why it was closed, one Puskesmas staff said 'the doctors are in a meeting.'" The investigation report said that the doctors at the Puskesmas had to complete another task (to check the health of those who will go to Mecca – Haji). Yudhita promised that the quality of the Puskesmas will be improved and encouraged the community members to report any problems with the Puskesmas. When Pos Kota (local media) returned to the Cipayung Puskesmas approximately one month later, the Puskesmas was open during operational hours, and they found that it was well organized. (POS KOTA)

Summarized from http://poskotanews.com/2013/11/07/pelayanan-puskesmas-cipayung-dikeluhkan-warga/

Story 3: Collaborative Problem-solving and Mutual Commitment to Implementing Solutions

In some communities, people who are unhappy with the health care they are receiving arrange for meetings with doctors and nurses or health officials. During these meetings, they work together to develop solutions to problems with health service delivery, and then they agree to implement those solutions.

Garassikang Community's Cooperation Results in Access to Clean Water

People of Garassikang in Jeneponto Regency have had a problem with access to clean water for a long time. Many women and children had to walk and carry the water for miles every single day. They have been trying to write a proposal for digging a well through the National Program for Community Empowerment (PNPM) and Village Development Planning (Musrenbang). Unfortunately, this plan was never approved nor implemented.

Finally in 2011, several community members decided to take the matter into their own hands. They gathered and discussed what they can do to improve the situation. The discussion began with distributing the task of finding funding and labor to build the well. They fundraised and were able to collect around Rp 500.000 for initial capital. This was used to hire people to start the digging process for the well. When the digging process started to show some results, they informed the rest of the community so that the larger community could also contribute to this effort. They received positive responses and more residents joined the effort. The men contributed their labor and money, while the women helped prepare meals for all of the workers and donated rice, vegetables, and food. A community member also donated the land used to build the well because he realized that it was for the common good.

Now, the people of Garassikang are able to access clean water easily through a collaborative effort of the community. They also formed a committee for water management and agreed on well management regulation so that the water will be enjoyed for a long time. (DIDIK / STAFF PATTIRO JAKARTA)

Story 4: Examining Better-performing Services

In some communities, people who are unhappy with the health-care services they receive visit places where health care is working better, so they can learn what they can do to improve their own health services.

African Community Studied Health Facility in Neighboring Village and Lobbied for Funding

In one district in Africa, community members noticed that the clinic in their village was very poor quality, while the clinic in the neighboring district was much better. Their clinic was unhygienic and only had two staff members serving around 4,000 patients, while the clinic in the neighboring district had five staff members and better equipment.

They asked to meet with the medical officer in charge of their clinic to discuss why the clinic's quality in the neighboring district was better than their own clinic.

During the meeting the health-care workers learned about the community's concerns and the community members came to better understand the problems facing their clinic. Together, they wanted to improve the services in the clinic by learning what the neighboring district had done. The health-care workers and the representatives of the community gathered data on the condition of the neighboring clinic through personal visits and meetings with health officials there.

They learned that the clinic in the neighboring districts were able to access the district's fund, which allowed them to have more staff and better equipment. Upon learning this, the clinic and community members tried to voice their concerns to the district.

After this effort, the community successfully convinced the district to provide funds to construct a new health clinic. Once the clinic was built, four new staff members, including two midwives, were recruited, and the district purchased new equipment. The clinic now serves 11,000 people out of a catchment area of 7,000–10,000, meaning many people from outside the district come to the clinic due to its good quality. Of the women who have received antenatal services, 70 percent have returned to the clinic to give birth and receive more services, far surpassing the government target of 50 percent. (WORLD VISION)

Summarized from http://www.worldvision.com.au/Libraries/3_3_1_Children_PDF_reports/Citizen_Voice_and_Action_Civic_demand_for_better_health_and_education_services.pdf

Story 5: Social Demonstration or Protest

Citizens could demonstrate to target underperforming providers or civil servants, like the district medical officer, who are not doing enough to improve health care.

Yanomami and Yekuana Indians: Demonstration to Reelect Health Coordinator

Yanomami and Yekuana Indians are the indigenous community in the Amazon rainforest in Brazil. For years, they had enjoyed good quality health care through a health coordinator who had been living there for years and was familiar with their health concerns. The Indians are particularly vulnerable as they have little resistance to outside diseases. With thousands of gold miners coming in and operating illegally on their land, polluting their rivers and transmitting diseases, it is very important that they have a health coordinator who understand their specific needs.

However, a new health coordinator was appointed in 2011. The new person had little experience with the indigenous community, was unable to speak their language, and thus was unable to provide good quality service. It seemed clear to the community that the new health coordinator had been nominated solely for political reasons.

The Indians were outraged by this nomination. They led protests for weeks so that they could continue to receive good health care. Their protests included sending letters to the Brazilian authorities and the U. N., urging them to take action on this serious issue. They even seized an airplane used by health workers in the Yanomami territory as part of their protests against the corruption in the health system. Their protests led to the appointment of their preferred candidate for health coordinator: the same person who had worked closely with the Yanomami for years and who has been providing good quality healthcare. A Yanomami spokesman said, “Now we Yanomami are very happy with our fight for our right to receive good health-care services.”

Summarized from http://www.survivalinternational.org/news/7394

Story 6: Developing and Advocating for Reforms to Improve Health Care

People who are unhappy with the health care they are receiving could brainstorm solutions and then take those proposals to their fellow community members to be implemented. Sometimes they need to do this repeatedly, but eventually they get what they are asking for.

Grobogan Village: Community Members Work in a Team to Reduce Open Defecation

In 2010, the community members of Grobogan Village worked with a local organization to improve the village's sanitation. Indonesia has long tried to battle the issue of sanitation through providing public toilets. However, the simple availability of toilets did not always change the mindset of people, who were used to open defecation. There was no sense of ownership of government-constructed public toilets, and nobody bothered to maintain them. Often, the toilets were used as chicken coops or storage spaces, while villagers continued to defecate in the fields and by water sources.

Members of the Sanitation Entrepreneurs Association of Grobogan (Papsigro) try to reduce open defecation by ensuring that every household has a toilet. Papsigro was established in 2011 and consisted of a watermelon seller, a rice farmer, a mason, a retired government health official, and a kyai or Islamic scholar from different villages within the district. They came individually to a training offered by a local organization to set up sanitation-related businesses, and then the 30 members divided themselves into groups specializing in different areas. Fifty-year-old Pak Pardiyanto focuses on manufacturing the actual closets, which he sells for as little as IDR 40,000 ($4). Forty-four-year-old Pak Suminto, the "latrine package" specialist, sources toilets and installs them. Sixty-seven-year-old Pak Iwan, a retired health department specialist, keeps up with the latest toilet research. There are technicians, fiberglass mould makers, and even a local Islamic scholar, 39-year-old Pak Umar.

Ibu Siticoma, mother of five grown children, cannot stop giggling with embarrassment when talking about the latrine. "We used to just go outside, under the trees," she says before covering her mouth in a fit of laughter. "But my son thought it was dangerous. We could slip and fall, or get bitten by snakes. So he asked Pak Suminto to build us one [toilet] inside." She breaks out into another round of laughter. "It's very good now. Safe and comfortable, even if it's raining." Within two years, 150 of the 153 target villages in Grobogan were open defecation-free. (THE HINDU TIMES)

Summarized from http://www.thehindu.com/todays-paper/tp-opinion/indonesias-toilet-trojans/article5412345.ece

Story 7: Talking to Journalists / Local Media to Publicize Problems

Often local journalists and media can be powerful allies in helping citizens publicize problems with health services, which can put pressure on underperforming service providers to improve.

Media Reports Raised Awareness on Vaccine Unavailability in Ngada Regency

In Ngada District, NTT, people successfully proposed an anti-rabies vaccine budget allocation of Rp 40 million in the 2013 local government budget amendment. Previously, Ngada Regency relied on the vaccine stocks from the Special Allocation Fund of Health from the central government. Unfortunately this was never adequate due to the high number of dog bite cases in the area. The fund from the central government was apparently only enough for 175 patients, which was not close to enough for a year. By May of 2013, the vaccines were already out of stock. Realizing that this was a huge problem, the community members sought the local mass media to publicize it. The bad news on vaccines was then prominently featured and published in the local media Ngada Mandiri and was reported by other local journalists organized in Bajawa Media Club (BMC). Finally, the district government listened to their complaints and approved the budget changes in early November of 2013. Now, Ngada District has enough vaccines to cure the community members who have been bitten by dogs.

(DIDIK / STAF PATTIRO JAKARTA)

Story 8: Working Through a 'Broker' Who Could Link Community Demands with Allies in the Government

A community that is unhappy with the quality of the health care they are receiving can ask for help from a member of their community who is good at getting government officials to be responsive to community needs.

Cikulur: Pak Oni, a Community Activist

Pak Oni is a regular community member in Lebak District, Banten. He learned about his rights as a citizen to petition the government for better services and gained significant advocacy skills from an NGO. He knows a lot about different persuasive methods: asking persistently, invoking religious duty, and shaming. He also knows about a lot of government programs that should be accessible to citizens, such as annual grants to establish and run ECCD (Early Childhood Care and Development) centers in the village, health insurance, and programs to get equipment for the Rice Farmers' association (Gapoktan). Moreover, he spent a lot of time writing letters to government agencies to ask for information regarding their programs and their budget plans. Once, he managed to initiate road construction after a series of advocacy efforts with the Public Works office.

Although Pak Oni does not formally hold any position in the village, the villagers have come to know him as the go-to-guy to talk to about community problems with because he can connect them to specific government employees. His village did not have a health facility and community members had to travel to the Puskesmas to access even the most basic health care. Community members sought help from Pak Oni to address this issue. Pak Oni organized meetings between the community members who felt strongly about having a Poskesdes in the village, with the district's Health Department and several other donors to provide funding. Pak Oni also organized open donations for community members who wanted to provide support (such as cement, woods, and rocks) for the construction. The Poskesdes was completed in 2012, and is now used by community members in the village.

(PANDJI & ANYEP / STAF PATTIRO BANTEN)

Story 9: Highlighting High-Performing Providers or Naming and Shaming Underperforming Providers

Citizens could reward high-performing providers with praise or other social recognition and/or sanction poorly performing providers by failing to include them in village events or by ignoring/shunning them.

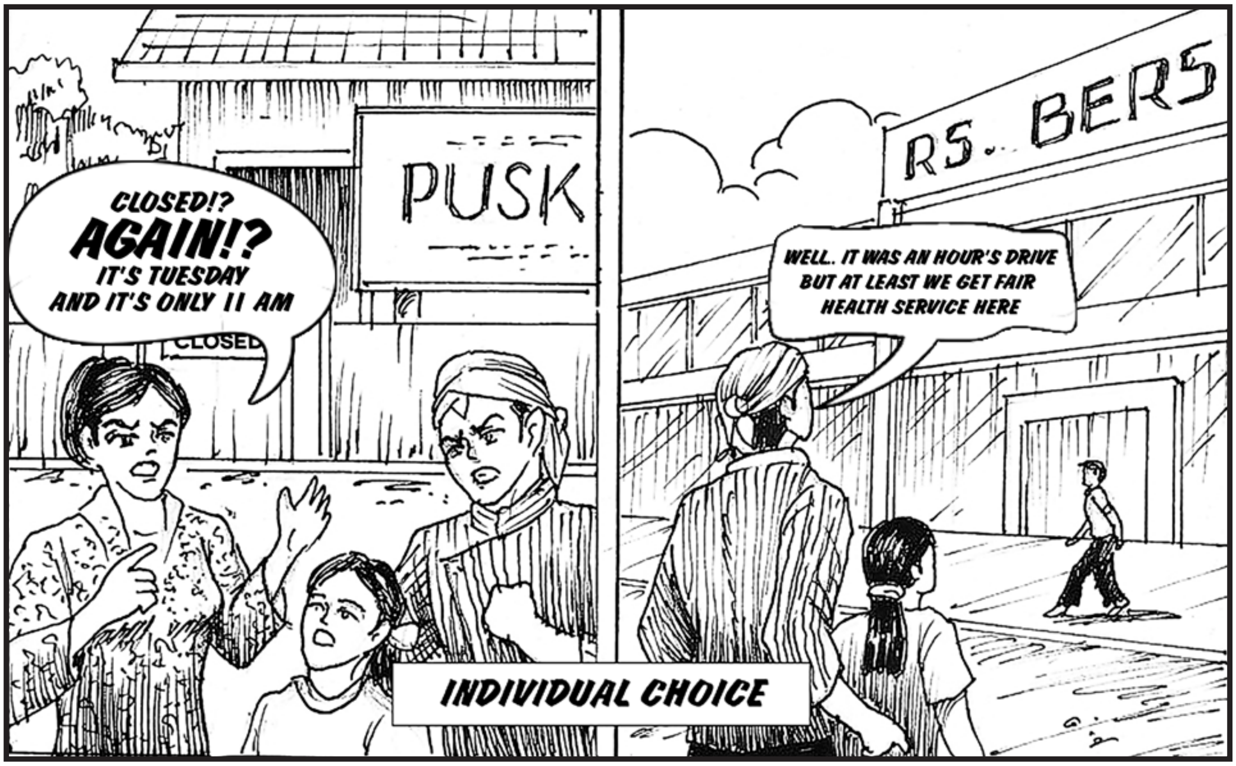
Banyuasin Residents Reported Outstanding and Underperforming Government Service Providers

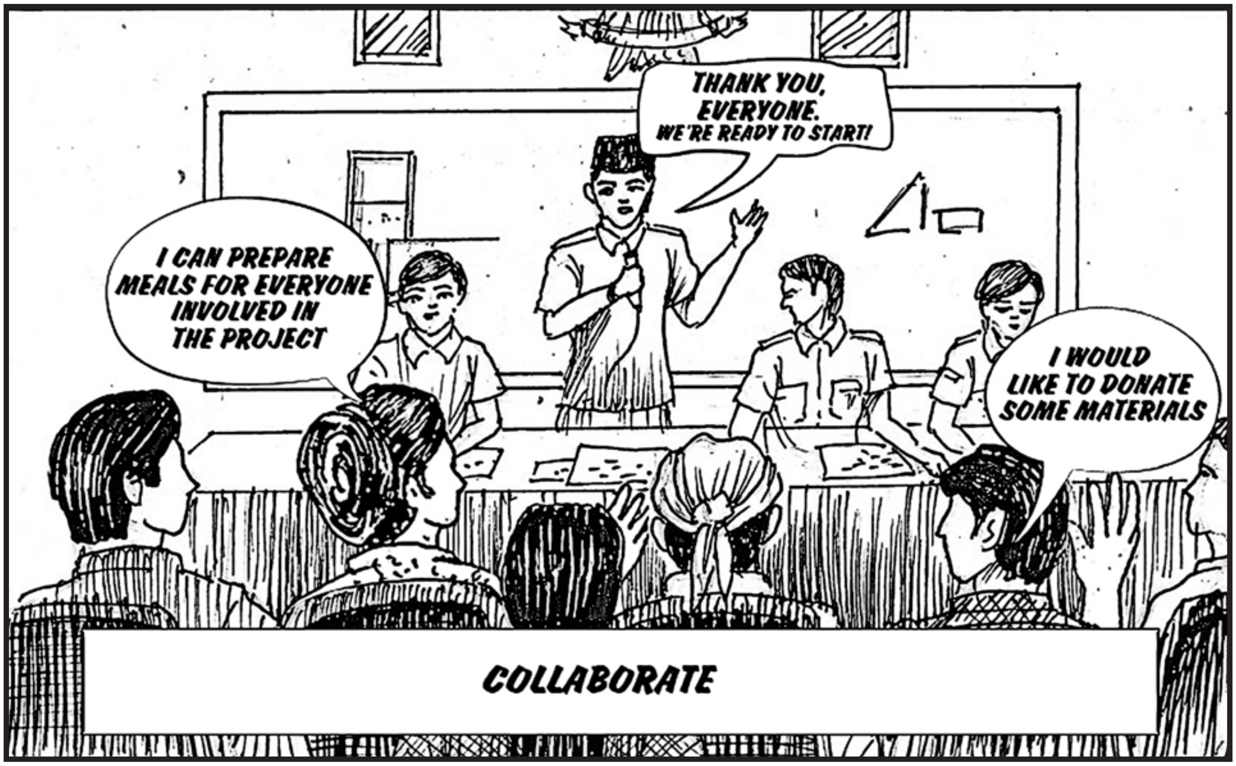
Community members in Banyuasin District recognized that not all of the government officers in their area were working diligently. In some cases, the community members went to meet officials but couldn't find them in their offices. Community members then met with a local organization (Pengabdi Putra Banyuasin/PBB) regarding this issue. Based on the discussion, it was agreed that it is important to name the high-performing officials to encourage them to keep up the good work, and also to name the underperforming officials in order to shame them into performing better.

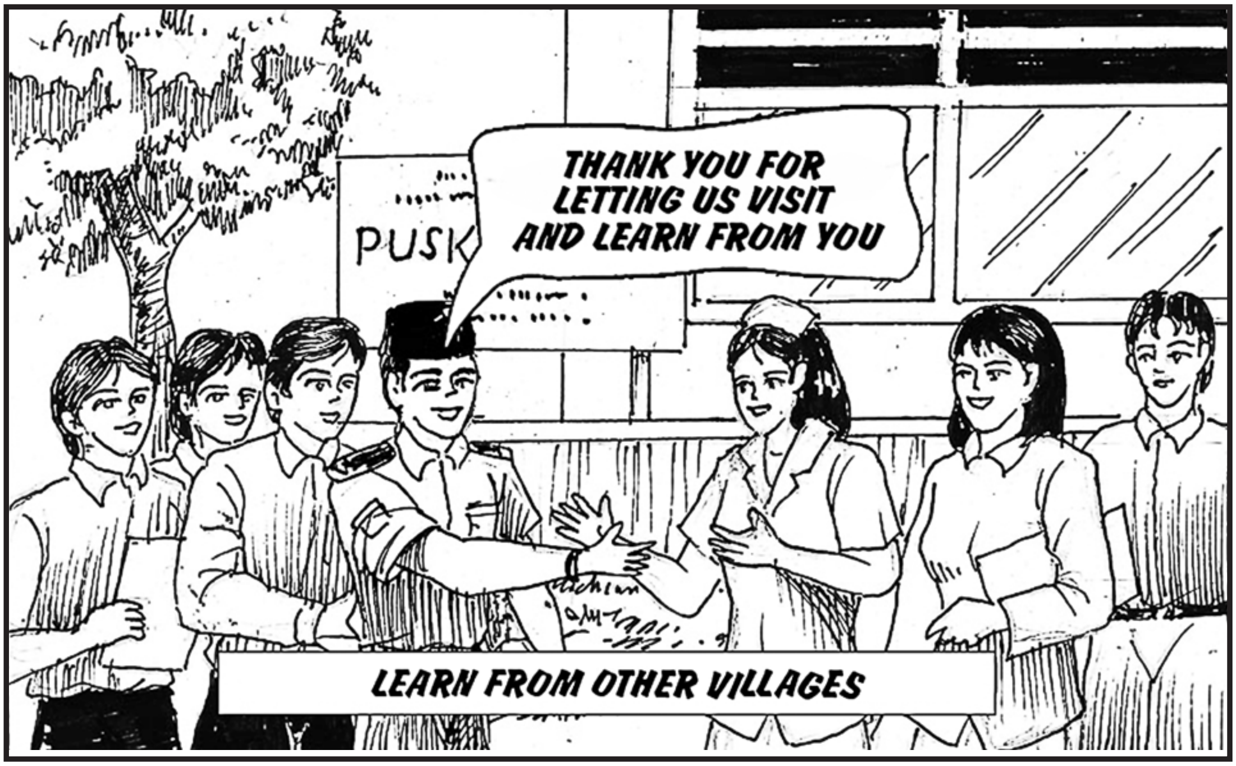
The head of PBB then held a press conference to publicize these findings. He criticized several Department Heads in Banyuasin District for absenteeism. Community members provided him with information on the department's performance throughout the year. With this information, he named the underperforming Department Heads and praised several of the departments that were performing well. According to the community members' report, the Department Head of PU (Public Works) received the most complaints for absenteeism and for being unavailable for meetings. (PALEMBANG POS)

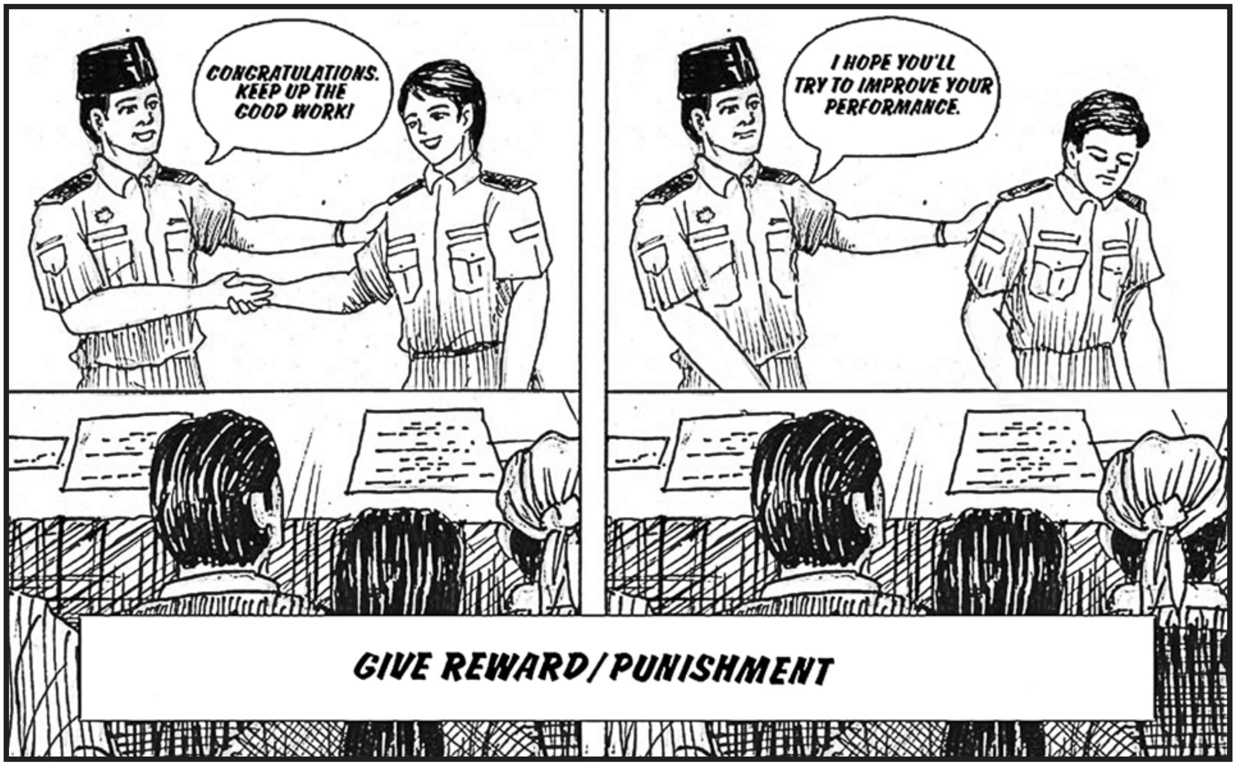
Summarized from http://palembang-pos.com/index.php?option=com_content&view=article&id=6350:kadis-puck-dituding-jarang-ngantor&catid=49:sumsel-raya&Itemid=62

Social Action Illustrations[28]



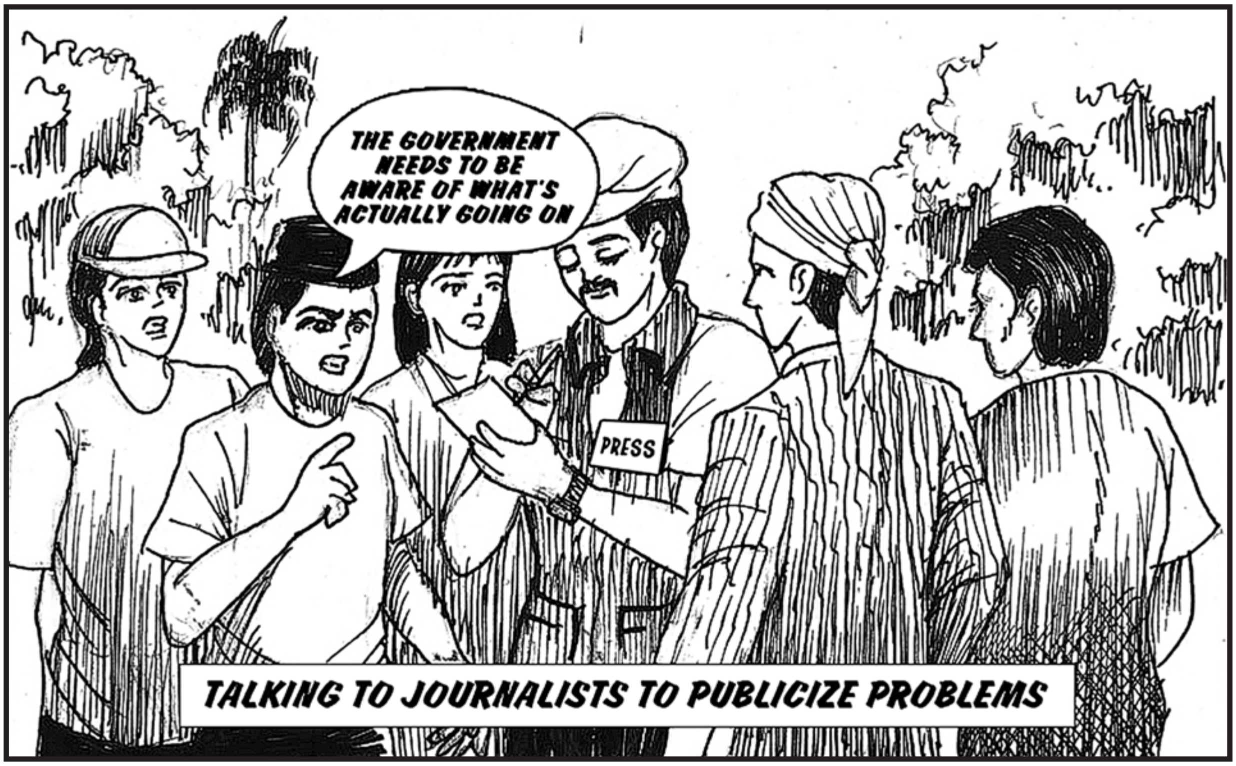

THANK YOU, EVERYONE. WE'RE READY TO START!
I CAN PREPARE MEALS FOR EVERYONE INVOLVED IN THE PROJECT
I WOULD LIKE TO DONATE SOME MATERIALS
COLLABORATE

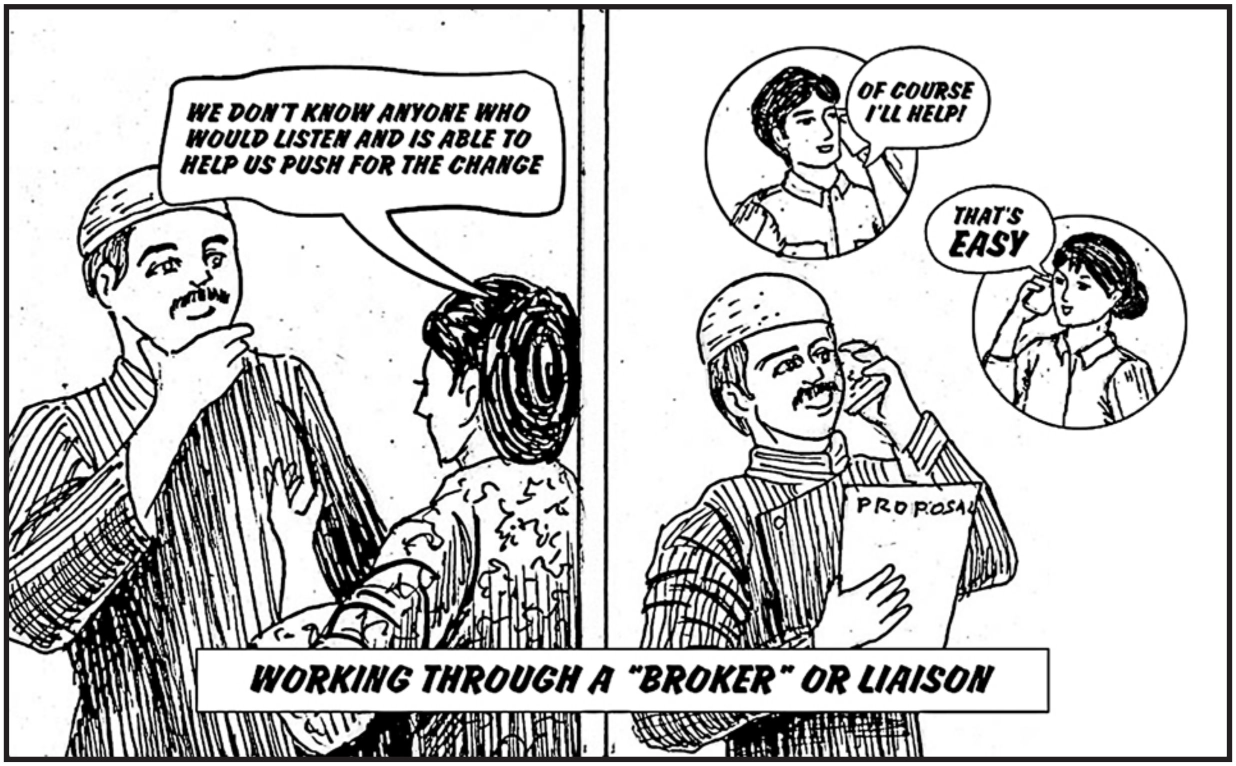

PUSK
THANK YOU FOR LETTING US VISIT AND LEARN FROM YOU
LEARN FROM OTHER VILLAGES


CONGRATULATIONS. KEEP UP THE GOOD WORK!
I HOPE YOU'LL TRY TO IMPROVE YOUR PERFORMANCE.
GIVE REWARD/PUNISHMENT


DEMONSTRATION
GENUINE CARE OVER POLITICAL WIN
CALLING FOR REASSIGNMENT OF HEALTHCARE COORDINATOR


EACH HOUSEHOLD WILL HAVE ITS OWN CLOSED TOILET
DEVELOPING AND ADVOCATING FOR REFORMS


THE GOVERNMENT NEEDS TO BE AWARE OF WHAT'S ACTUALLY GOING ON
PRESS
TALKING TO JOURNALISTS TO PUBLICIZE PROBLEMS


WE DON'T KNOW ANYONE WHO WOULD LISTEN AND IS ABLE TO HELP US PUSH FOR THE CHANGE
OF COURSE I'LL HELP!
THAT'S EASY
PROPOSAL
WORKING THROUGH A "BROKER" OR LIAISON

Annex 3. Social Action Plan—Example

Below is an example of a social action plan, included in the facilitator manuals to provide guidance to facilitators and community representatives.

ACTION TITLE		**Socialization to women on the importance of making birth preparedness plan and to do postnatal checks**			
What is the MEASURE OF SUCCESS for this overall action?		**All pregnant women in the village have birth preparedness plan and all mothers who have just given birth check their health and their babies' health with the skilled provider**			
Action Person in Charge (PIC):		**Novi**			
Steps:	**Responsible Person(s)**	**What tools, community resources are needed? How will they be mobilized?**	**Timeline/Deadline & Frequency**	**How is success measured?**	**Progress**
1. Meet with Village Head to: • Get permission for the event and places. • Discuss funding/other resources needed. • Invitation.	Ani	Funding for snacks during socialization, funding for the price of quizzes (during socialization), funding to copy the invitation.	14 June–17 June	Get permission. Place is secured. Willing to sign the invitation. Resources are available.	
2. Prepare invitations.	Oji	Computer, printer, funding for copies.	20 June–21 June	Invitation draft is ready.	
3. Secure the resource person (midwife).	Pandji		23 June–24 June	Resource person is secured.	
4. Coordination between CA and the midwife and the village head to discuss event.	Wawan	Materials (flipchart, markers).	25 June	Socialization agenda is planned and tasks are divided.	
5. Spread invite.	Didik	Motorcycle, fuel.	26 June–27 June	Invitations are received.	
6. Hold Socialization.	Novi		30 June	People come and understand materials.	

Notes

1. For the purposes of this report, we are using the term "study" to describe the overarching T4D project, which includes the co-designed program, evaluation, and dissemination and outreach. We use the term "program" to described the intervention that was designed with and is being implemented by civil society organization partners in Tanzania and Indonesia, specifically.
2. Kosack and Fung 2013.
3. Jenkins & Goetz 1999.
4. Khadka and Bhattarai 2012.
5. Misra & Ramasankar 2007.
6. George 2003; Malhotra et al. 2005; Misra & Ramasankar 2007; Banerjee, Duflo, and Glennerster 2008; Kaseje et al. 2010; Renedo and Marston 2011.
7. Manandhar et al. 2004; Tripathy et al. 2010.
8. Nair et al. 2013; Bohren et al. 2014.
9. See Ackerman 2004, Fox 2007a, Fox 2007b, J-PAL 2011, Joshi & Houtzager 2012, World Bank 2004 and McGee & Gaventa 2011. Transparency and accountability is also closely related to participatory or community-driven development, one goal of which is to foster similar dynamics of empowerment for more inclusive and sustainable development; see, e.g., Barron et al 2011, Gaventa & Barrett 2011, Khan 2012, Mansuri & Rao 2013, United Nations 2008, World Bank 1994).
10. "WHO Recommendations on Health Promotion Interventions for Maternal and Newborn Health 2015" (Geneva, Switzerland: World Health Organization, 2015), http://apps.who.int//iris/bitstream/10665/172427/1/9789241508742_report_eng.pdf?ua=1.
11. The number of ANC visits is linked to delivery in a health facility (See: Statistics Indonesia et al., "Indonesia Demographic and Health Survey 2012.").
12. Bhutta et al. 2008; Peña-Rosa et al. 2012.
13. Giving antiretrovirals during the antenatal period, and postnatally for a short period, is associated with a 30–40% reduction in HIV transmission from mother to child. (See Siegfried et al. 2011.)
14. World Health Organization, Jhpeigo 2015.
15. World Health Organization, Jhpeigo 2015.
16. The social action is included here as a component of the program; however, it is worth noting that this is actually a goal of the program. The program seeks to use the other components to encourage community members to undertake social action, but these actions are entirely up to the community and no social actions are guaranteed to result.
17. Community activists (Indonesia) and community representatives (Tanzania) play the same role, despite the partners in each country choosing a different name.
18. The scorecard meeting was referred to as "survey results" in Indonesia because the T4D scorecard has many key differences from a traditional community

scorecard. For the purposes of this report, we will refer to this meeting as the "community scorecard" for both countries.

19. World Health Organization, Jhpeigo 2015.
20. Country-specific surveys are available at http://t4d.ash.harvard.edu/articles/8.
21. Facilitator manuals are available at http://t4d.ash.harvard.edu/articles/8.
22. Facilitator manuals are available at http://t4d.ash.harvard.edu/articles/8.
23. The term "crawling the design space" is from Pritchett, Samji and Hammer 2013.
24. Our pre-pilots are similar to the notion of testing the "minimum viable product." See, for example, Ries, Eric, *The Lean Startup.*
25. Joshi 2013.
26. Mansuri & Rao 2013; World Bank 1994.
27. Mansuri & Rao 2013.
28. Social action cartoon were designed and created from the project by Sylvia Kartowidjojo.

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