Transparency for Development Accountability for Health Policy Brief

Can communities play a role in strengthening service delivery? Does empowering citizens to engage in transparency and accountability (T/A) activities have the potential to improve health, education, and other development outcomes? A diverse array of voices within the international development field have promoted the potential benefits of community-led transparency and accountability, but the evidence that such approaches have an impact is mixed and incomplete. Working with local civil society partners across five countries, the Transparency for Development (T4D) project (2013-2019) was designed to answer the crucial question of whether community-led transparency and accountability programs can empower communities to improve health outcomes.

THE PROGRAM

The project began with the co-design of a new T/A program that built on existing evidence, research and practitioner experience. Working with local civil society organization partners in Tanzania (CHAI) and Indonesia (PATTIRO), T4D designed a new method by which communities could use information on service delivery problems to design and undertake social actions that had the potential to improve public services within those communities. This program focused on improving maternal and newborn health (MNH) in rural communities.

The co-designed program is an adaptation of a community scorecard with three major components, facilitated by local civil society organizations. First, community members are provided with **information** from both health facility surveys and household surveys highlighting potential problems underlying poor maternal and newborn health outcomes. Second, communities design and undertake **social actions** that they believe will mitigate the problems identified as the highest priorities. Finally, facilitators conduct three **follow-up meetings** with the communities to help them identify successes, solve challenges, and develop new actions to support local communities in continuing their work to improve health.

EVALUATION DESIGN

Alongside this program, the project implemented a mixed-methods evaluation to explore whether transparency and accountability can improve maternal and newborn health, community empowerment, and participation outcomes; in what contexts, and using what mechanisms. This evaluation combined randomized controlled trials with extensive qualitative methods including interviews, surveys, structured observations, and ethnographic studies. Building on the lessons from Indonesia and Tanzania, a second phase of research was undertaken in Ghana, Malawi, and Sierra Leone to pilot and analyze the potential of government-community collaboration

to improve the effectiveness of community-led action in improving health.

The impact evaluation design consisted of RCTs in Tanzania and Indonesia, with 100 treatment and 100 control villages in each country that were randomized by health facility. Using a repeated cross-section design, we conducted baseline health facility surveys and household surveys with a total of 5,398 women who had recently given birth (3,000 in Tanzania and 2,398 in Indonesia). At endline, we conducted surveys at the same health facilities and with new respondents in Indonesia and Tanzania who had recently given birth.

To complement the average estimates of impact from the RCT, we employed several qualitative methods to trace the context, process, and implications of the T/A program. These methods included structured observations of program meetings in 81 villages; key informant interviews with approximately ten key informants each in a sub-sample of treatment villages; and four ethnographic studies in which ethnographers lived in or near eight communities who were offered the program, as well as four in the control group who were not offered the program.

RESEARCH QUESTIONS

The T4D project was designed to answer the following core research questions:

1. What is the effect of the program on the **utilization of health care services** related to maternal and child health?
2. What is the effect of the program on the **content of health care services** related to maternal and child health?
3. What is the effect of the program on **health outcomes**?
4. What is the effect of the program on **citizen** empowerment and efficacy, both perceived and actual?

RESULTS

Participants in the 200 T4D program communities designed a total of 1,138 actions, an average of 5.5 per community. Villages in Indonesia designed 715 of these actions, and villages in Tanzania designed 423. **As of the third follow up meeting, approximately three months after the start of the program, participants self-reported most of the social actions as either complete (58%) or ongoing (29%).** Conversely, in Indonesia 9% of villages, and in Tanzania 2%, did not report completing a single action by the 90-day follow up meeting.

In terms of action goal, participants in an overwhelming majority of communities (99.5% - that is, all but one) designed an action with the overall goal of **increasing demand for health services**. Nearly half of the communities (45%) designed an action aimed at **increasing the ability to pay for services**, and just over a third (35%) designed an action using by-laws, partnerships, or other **interventions aimed at increasing health service uptake**. Participants in three-fifths (60%) of communities designed one or more actions aimed at **improving the patient experience**. Finally, participants in just over half (54.5%) of the villages designed an action geared towards **improving the health facility itself**.

The project assessed three types of outcomes: primary research project impacts, pre-specified prior to endline data collection; secondary outcomes; and intermediate outcomes. Box 1 lists each set of outcomes.

In both Indonesia and Tanzania, the T4D program had no statistically significant average impacts on any of our primary or secondary outcomes. In Figures 2 and 3, we present a summary of the program's average impact on primary outcomes in Indonesia and Tanzania, respectively.

For intermediate outcomes, on average the program did not have impacts in either country. Using data from the household and health facility

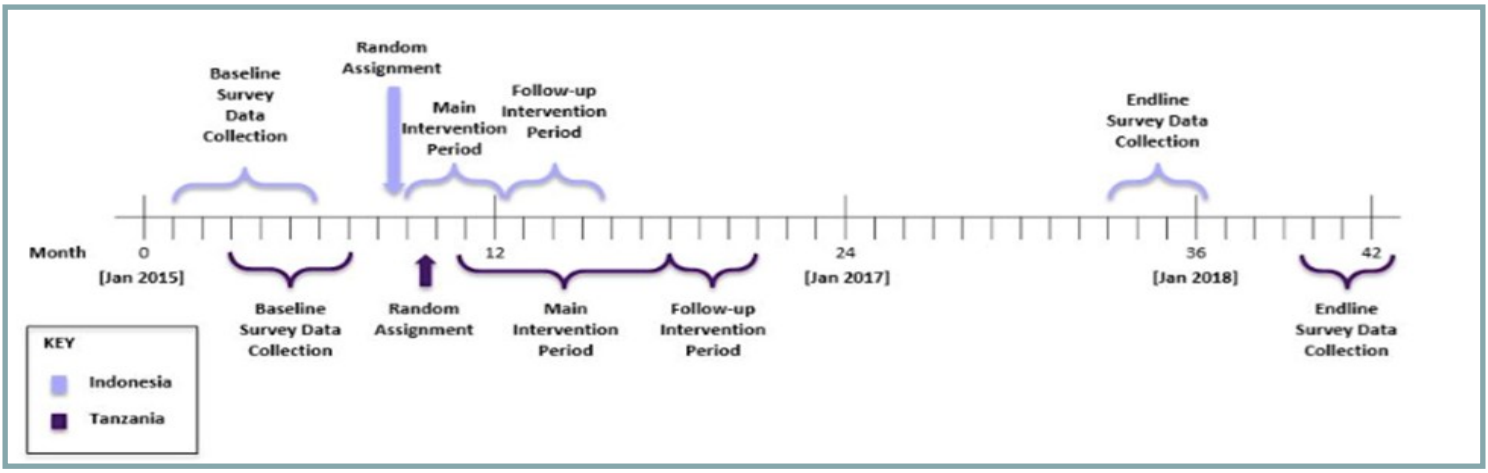


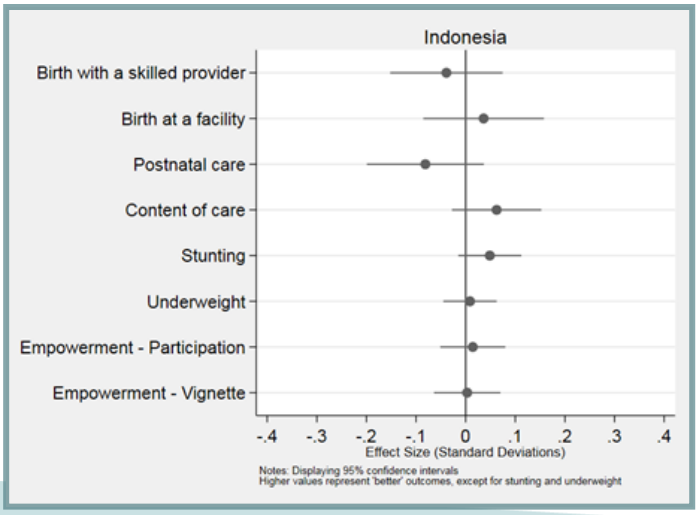
Figure 1: Impact Evaluation Timeline

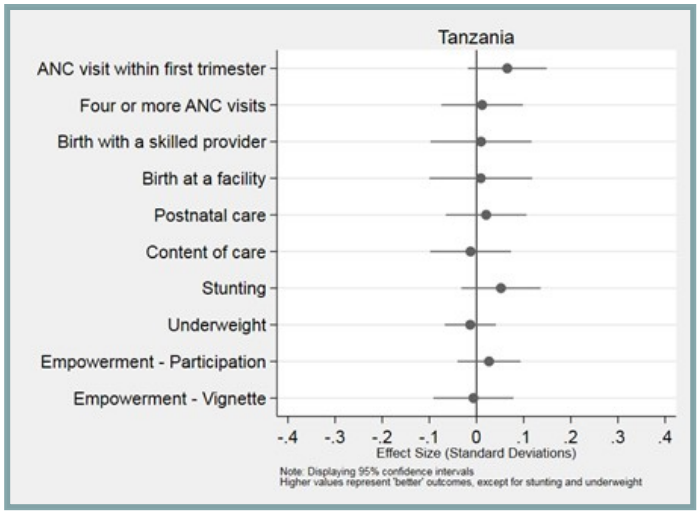
surveys, 106 intermediate outcomes in Indonesia and 126 intermediate outcomes in Tanzania were analyzed. We found statistically significant differences (at least at the 5% level) in eight cases in each country. However, considering the number of outcomes, one could expect five in Indonesia and seven in Tanzania to be significant purely by chance. The observed statistical significance does not survive correction for multiple hypotheses testing.

Yet, we found that participants in most communities reported high civic self-efficacy, that most were optimistic that they could sustain their progress, and that significantly more were confident after the program in their individual civic efficacy, even after controlling for individual differences. At the same time, interviews and meeting observations also suggest that participants had diverse experiences: a large minority told interviewers that they were less confident after the program in their capacities to improve their communities. In a large minority of communities, and a majority in Tanzania, participants seemed skeptical in meeting discussions that their efforts would improve their community's maternal and newborn health.

IMPLICATIONS

The results from the T4D evaluation build on a small but growing evidence base that highlights the challenges associated with utilizing social





Figures 2 and 3: Impact of T4D on Primary Outcomes in Indonesia and Tanzania

accountability interventions to improve health outcomes. Community-led transparency and accountability programs have the potential to improve citizen participation and empowerment. However, a major implication of the T4D project is that the **highly-scalable and short-term approach tested in this project did not show evidence of improving health outcomes** and, as such, should not be implemented as designed by those seeking to improve maternal and newborn health.

Despite this clear implication, the research is also seeking to understand how and why the program did not influence health outcomes, which would allow practitioners, donors, and policymakers to make more informed design choices that increase the likelihood that transparency and accountability approaches can improve health. While the program was not associated with changes in intermediate outcomes, the researchers did observe almost universal participation in social actions to improve health, participants in a majority of communities completed at least one of these actions, and participants in a large majority of communities were able to recall tangible achievements of at least one of their actions two years after the program ended. **This result highlights the potential of programs like this one in encouraging communities to take actions to improve health that they would not otherwise have led.**

More importantly, the research has revealed a set of key hypotheses of why implemented and completed community actions did not lead to improved outcomes. We are currently undertaking an analysis of these hypotheses to provide guidance that those working with social accountability programs might use to address missing links in the chain from information to participation to accountability—and concrete improvements in service delivery. **Hypotheses currently being explored include: (1) perceptions among communities that health care was not valuable or did not need improvement; (2) other health improvements that overwhelmed or "washed out" the impacts of participants' activities; (3) lack of responses by those with whom participants tried to engage, lack of**

Box 1: T4D Target Outcomes

PRIMARY:

- Four or more ANC visits (Tanzania)
- First ANC visit within the first trimester (Tanzania)
- Delivery with a skilled birth attendant
- Delivery at a health facility
- Post-partum and post-natal care
- Content of care
- Weight for age
- Height for age
- Participation
- Perceptions of empowerment

SECONDARY:

- Four or more ANC visits (Indonesia)
- First ANC visit within the first trimester (Indonesia)
- Birth preparedness
- Antenatal content of care (Indonesia)
- Birth weight
- Maternal depression

INTERMEDIATE:

- Awareness, knowledge, and community attitudes
- Facility access
- Ability to pay
- Bylaws, partnerships, or other interventions for health system uptake
- Provider attitude, effort, and trust
- Facility cleanliness
- Information transparency and complaint mechanisms
- Provider knowledge
- Facility infrastructure
- Availability of drugs and supplies
- Facility staffing

connections to officials who could support or complement participants' efforts, or other challenges that prevented participants from improving health outcomes—as well as several other hypotheses.

A set of pilots in Ghana, Malawi, and Sierra Leone were designed to test approaches to overcoming the final hypothesis by identifying district-level government champions who were interested in supporting community efforts to improve their care and providing spaces for government and citizens to jointly discuss actions to improve health. Analyses of these pilots is ongoing, and results are expected in summer 2019.

Overall the current results from the T4D project present a picture of social accountability that reveals some positive non-health outcomes (including community action implementation, participation and empowerment) but no clear evidence that this program improves health, highlighting the long and challenging causal chain linking community action to measurable health improvements. Future analysis from the T4D project will seek to identify changes in social accountability design and/or choices regarding contexts in which to implement these types of programs that could improve the potential of these approaches to improve health.

Box 2: Social Actions from Tanzania and Indonesia

Many action types were pursued during the intervention, often with mixed success. In one Indonesian village, the community representatives decided that an action was needed to help pregnant women who could not afford transportation to the nearest clinic. They began by listing all ten villagers who owned a car, approaching them individually to see if they would voluntarily drive women. A total of four people volunteered, and their names were shared with the community. At the same time, the representatives began tracking women they knew to be approaching their due date and checking in with them to discuss their birth preparedness plans. By the end of the intervention, one driver had already transported three women to the clinic while another had helped two. A midwife stated that this service "really help mothers who are going to give birth," while the village secretary stated that this action had been "the most important thing that [the group] have given the facility."

In one village, the community representatives decided that an anonymous suggestion box would be useful in tackling rude staff behavior at the local clinic. After securing support from the village authorities and clinic staff, each representative donated TSH 1,000 to pay for the construction of a wooden box that was then installed in the facility. After explaining to the community how it should be used, the group made plans to open the box and check for suggestions at least once a month. However, the first time the box was opened, they were surprised to find it empty. One representative stated that they "didn't understand" why this was the case, while a clinic employee provide their own explanation: "The people fear to put [in] comments." Nevertheless, the same employee stated that the presence of the box had challenged them to work harder and improve their performance.