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# Does incorporating participation and accountability improve development outcomes? Meta-analysis and framework synthesis

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International  
Initiative for  
Impact Evaluation

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## Executive summary

Does engaging citizens in the planning, management and oversight of public services – such as health care, social protection or physical infrastructure – that are critical to enabling large-scale development of populations impact the quality of and access to services and citizens' quality of life? This systematic review examined high quality evidence from **35 citizen engagement programmes** in low- and middle-income countries that promote the engagement of citizens in service delivery through four routes: **participation** (participatory priority setting); **inclusion** of marginalized groups; **transparency** (information on rights and public service performance); and/or citizen efforts to ensure public service **accountability** (citizen feedback and monitoring); collectively, **PITA mechanisms**.

The findings suggest that interventions promoting citizen engagement via the “short route,” improving direct engagement between service users and service providers, are often effective in stimulating active citizen engagement in service delivery and realizing improvements in access to services and quality of service provision. However, in the absence of complementary interventions to address bottlenecks around service provider supply chains and service use, citizen engagement interventions alone may not improve key wellbeing outcomes for target communities. In addition, interventions promoting citizen engagement by shortening the “long route” – improving governance by increasing citizen pressures on politicians to hold service providers to account – are not usually able to influence service delivery.

### Included studies

Sixteen citizen engagement programmes evaluated citizen **participation** in the design and implementation of public services, grouped into two intervention sub-groups:

- eight *participatory priority setting*, planning or budgeting interventions, wherein citizens participated in setting the priorities for and/or the planning of local services. These include support for participatory budgeting in municipal governments in Brazil, Mexico and Russia, and support for participatory planning in India and Pakistan. It also included requirements for inclusive participation in two fragile contexts, Afghanistan and the Democratic Republic of Congo (DRC).
- seven *community-based natural resource management* (CBNRM) interventions, wherein citizens form local collectives and take over the management of a shared resource, for forest management in Nepal, Madagascar and Tanzania; water user associations in Brazil, China and the Philippines; and rangeland conservancies in Namibia.

Eleven citizen engagement programmes evaluated **transparency** mechanisms, which specifically aimed to disclose and/or disseminate information that would shift the power balance between service providers and users, comprising two intervention sub-groups:

- five evaluations of *rights information* interventions, which enable users to demand minimum standards for access to services, such as for social protection services in Indonesia (food subsidies) and India (public works), maternal and child health care in India and freedom of information in Pakistan.
- six evaluations of public official or service provider *performance information* interventions, such as the dissemination of municipal government performance

scorecards in Brazil, the Philippines and Uganda, and monitoring information provided in police stations in India.

Ten evaluations of **accountability** mechanisms were included, which specifically comprised citizen feedback or monitoring mechanism interventions, i.e. those that solicited feedback regarding and/or actively engaged citizens in the monitoring of service delivery, to hold public service providers and institutions responsible for executing their powers and mandates according to appropriate standards. These included community report cards in infrastructure (Afghanistan, Indonesia and Colombia), health (Ghana, Malawi and Uganda), agriculture (Uganda) and the security sector (DRC), and individual citizen 'feedback loops' in Guinea, Kenya and Uganda.

Finally, nine of these citizen engagement programmes also addressed **inclusion of marginalized groups**. Studies in Afghanistan and DRC focused exclusively on the mandated incorporation of women into community groups. Other programmes targeted inclusion of women or poorer groups in Brazil, Indonesia, India, Malawi, Mexico, Pakistan and Uganda.

## Key Findings

Citizen engagement efforts improved access to and quality of public services by an overall pooled effect size of 0.10 standard deviations, but did not systematically improve service use. Such efforts led to improvements in well-being by 0.10 standard deviations, for some health outcomes (disease incidence) and livelihoods (income), but these overall changes tended to be small in magnitude and were not observable consistently across all outcomes analyzed. Satisfaction with and confidence in state society relations improved in some cases, but the diversity in experiences made it difficult to draw strong conclusions.

The analysis of citizen engagement outcomes found that interventions are usually effective in engaging service users, e.g., improving meeting attendance, contributions to community funds, and general knowledge about services. The average pooled effect on user engagement was an increase of 0.23 standard deviations in the typical outcome measure across all PITA mechanisms and interventions. Yet, the ability of interventions promoting citizen engagement to realize effects on *provider* actions was limited. Only interventions targeting public services delivered by frontline provider staff, such as healthcare, were able to trigger improvements in service provider staff actions. Interventions targeting services delivered without public interaction, such as infrastructure, may only be effective in triggering provider responses if civil society organizations with high local social capital are engaged to shift the balance of power between service providers and service users.

The review does not draw conclusions for different populations (socio-economic groups and gender) or geographic groups, due to the small sample of studies that incorporated such analysis across a wide range of geographies, interventions and outcomes.

Amongst participatory planning interventions, three factors improved the likelihood of achieving results along the causal chain:

- Strong local buy-in from front-line service providers for the intervention;

- Incorporating specific, culturally appropriate measures that address local barriers to the participation of vulnerable groups; and
- Interventions designed to spur the growth of local civil society and capacity for collective action.

Interventions informing citizens of their rights were more likely to succeed where they targeted the provision of a service citizens access directly from front-line providers; created a sense of common knowledge about people's rights to the service among citizens and providers; and built an appropriate level of social sanction risk for providers. However, it is critical that interventions based on rights information ensure that a lack of information is the key local barrier to service access and use; where service supply chains or service costs are driving low access to services, rights-information interventions are unlikely to be effective.

Citizen feedback and monitoring interventions were more successful at achieving results where some or all of the following factors were present:

- Interventions targeted a service that citizens accessed through interactions with front-line providers;
- A phased, facilitated approach that jointly engaged citizens and service providers in monitoring;
- Performance benchmarks;
- Creation of common knowledge of feedback or monitoring results; and
- Working through local community organizations to strengthen community members' voices.

Interventions providing performance information for public servants or services were not usually successful in impacting service delivery, as the causal chain remains too long. Politicians may claim plausible deniability of their individual capacity to influence service delivery change, and such interventions do not engage many key actors involved along the public service delivery supply chain.

Finally, four key contextual factors were found to influence the effectiveness of community-based natural resource management (CBNRM) interventions:

- The type and intensity of local resource use targeted by the intervention, noting that community management may not be appropriate in contexts prone to illegal logging or poaching, where attempts to enforce regulations may endanger community members;
- The extent to which local resource management public officials supported the intervention, particularly where the intervention aimed to realize large shifts in resource control;
- The clarity of the national CBNRM policy context, and the extent to which local officials could exploit loopholes or contradictions in different policies or legislation; and
- The provision of external support to facilitate changes in resource use, such as alternative livelihoods, particularly where interventions sought to strengthen the sustainability of resource use.

Because only four studies presented any data on intervention costs, there was limited potential to compare cost-effectiveness across programmes and designs.

## **Implications for policy makers and practitioners**

Although interventions to improve governance via the “short route” between service users and service providers are often effective in engaging citizens in service delivery and improving access to and quality of services, citizen engagement interventions alone are not likely to improve key well-being outcomes for citizens.

Interventions that work through local civil society and stimulate capacity for collective action, particularly amongst vulnerable groups, may be more effective than those that rely on engaging unorganized citizens. This is particularly critical for services wherein citizens do not engage regularly with the providers while using the service, such as infrastructure, and thus pose weaker social sanction threats.

Citizen-service provider engagement is more effective when implemented through phased, facilitated processes that are framed collaboratively, as opposed to one-off accountability meetings that are interpreted as confrontational.

Interventions that do not incorporate specific measures to facilitate the inclusion of vulnerable groups may not realize equitable outcomes for those groups in the short-term. Barriers to vulnerable groups’ inclusion varies widely by context, and inclusion components should be adapted in response to local contexts and needs.

## **Technical Aspects**

The review followed Campbell Collaboration standards to systematically search for published and unpublished literature, critically appraise, and synthesize findings, based on a peer-reviewed protocol. The approach built on existing methods to incorporate theory into systematic reviews by analyzing evidence along the causal chain and incorporating qualitative evidence to identify intervention mechanisms.

The review aimed to answer the following five questions:

1. What are the effects of interventions that aim to strengthen PITA mechanisms on social and economic wellbeing of participants (intermediate and final outcomes)?
2. What are the effects of interventions that aim to strengthen PITA mechanisms on participatory, inclusive, transparent or accountable processes (immediate outcomes)?
3. To what extent do effects vary by population group and location?
4. What factors relating to programme design, implementation, context, and mechanism are associated with better or worse outcomes along the causal chain?
5. What evidence is available on programme costs and incremental cost effectiveness in included studies of effects?

Authors carried out a systematic search of key academic databases, donor and practitioner websites, including results in any languages from any low- or middle-income country. The search returned more than 10,000 papers produced from 2000 through 2018, from which 50 impact evaluation reports corresponding to 35 programmes met the criteria for inclusion. All included evaluations were critically appraised.

To answer Review Questions 1-3, authors extracted effect size data measuring the change in outcomes under the citizen engagement intervention, as compared to groups

who received 'standard public service delivery'. A statistical meta-analysis was conducted to calculate a 'pooled average effect size' measuring the average change in outcomes across studies, which was structured along the intervention results chain. To answer Review Question 4, realist-informed framework synthesis of all included studies plus supplemental qualitative and programmatic documents was conducted, to identify systematically the key barriers, facilitators and moderating factors that could explain why an intervention was more likely to achieve its expected results in a given context. Finally, evidence on costs from the included impact evaluations and supplemental documentation was collected to answer Review Question 5.

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## Abbreviations and ancroyms

3ie	International Initiative for Impact Evaluation
ATE	average treatment effect
ATET	average treatment effect on the treated
CBNRM	community-based natural resource management
CI	confidence Interval
DID	difference-in-difference
EAP	East Asia and Pacific
IE	impact evaluation
IV	instrumental variables
ITT	intention-to-treat
LAC	Latin America & Caribbean
LATE	local average treatment effect
L&MICs	low- and middle-income countries
MENA	Middle-East & North Africa
NGO	non-governmental organization
OLS	ordinary least squares
PITA	participation, inclusion, transparency, accountability
PSM	propensity score matching
RCT	randomized controlled trial
RDD	regression discontinuity design
SA	South Asia
SMD	standardized mean difference
SSA	sub-Saharan Africa
WLS	weighted least squares

# 1. Introduction

## 1.1 The problem of unaccountable government systems and poor service delivery

The sustainability of global development investments depends on strong institutions, citizen engagement, accountable governments, and equitable economic growth (World Bank, 2017). Goal number 16 of the Sustainable Development Goals explicitly recognizes the importance of the development of effective, accountable and transparent institutions at all levels, and of ensuring responsive, inclusive, participatory and representative decision-making at all levels (UNDP, 2016). In the Paris Declaration on Aid Effectiveness, donor and partner countries committed to improving their mutual accountability and transparency in the use of development resources, with partner countries further committing to systematically involve diverse stakeholders in national development priority setting processes (OECD 2005). Many development challenges, such as poor service delivery, corruption and slow growth, persist because of the political context around them; they are as much about power dynamics as they are technical challenges.

Improving the governance of public institutions and service delivery has long been a central tenet of strategies for achieving or supporting development; World Bank *World Development Reports* since the late 1990s have included elements of improving governance as central to their theories of change (Grindle, 2004). In the decades since, mainstream approaches to realizing good governance have shifted in focus, away from privatization of service delivery and towards a focus on increasing the engagement of constituents, particularly vulnerable groups, with public institutions and service providers in such ways to increase the effectiveness, appropriateness, and quality of service delivery. The 2004 *World Development Report* (WDR) highlighted the insight that public spending on service delivery in developing countries often primarily reached the better-off minority of citizens; for example, in India, curative health subsidies were primarily going to the richest 20 per cent of the population, who received three times the subsidies of the poorest 20 per cent (World Bank, 2004). This insight remains pertinent. For example, a recent evaluation of an e-governance intervention in India that aimed to improve transparency in a fiscal transfer system for a social benefits programme suggested that while the intervention was successful at reducing leakages, the savings did not translate into improved outcomes for beneficiaries (Banerjee et al., 2017). One of the authors later posited that this may have been because the intervention did not empower the ultimate beneficiaries to ensure that financial gains from reduced corruption were converted into increased outcomes for the poor (Page and Pande, 2018).

There are many definitions of governance. For the purposes of this review, we use the recent definition employed by the World Bank, where governance is defined as “the process through which state and non-state actors interact to design and implement policies within a given set of formal and informal rules that shape and are shaped by power” (World Bank, 2017). Where characteristics of good governance are weak or absent from public processes and service delivery, the effectiveness and sustainability of development interventions is likely to suffer (World Bank, 2016). Barriers to access to public services for vulnerable groups exacerbate inequality, with potential long-term

repercussions for a society's development (Easterly, 2007). Fraud and corruption are pervasive across low- and middle-income countries, and the negative consequences on quality of life and core development outcomes are well documented (Svensson, 2005; Molina et al., 2016). Where state and public actors cannot be effectively held accountable, a culture of impunity develops that normalizes fraud and rent-seeking practices. The World Bank's *World Development Report 2017* highlighted key repercussions of power asymmetries, including: exclusion of large portions of society from services, institutions or resources, which is correlated with violent conflict: elite and/or interest-group capture of policies in order to serve interests, resulting in poor targeting and ineffective or inappropriate policies, which can lead to poor or stagnant growth, condemning economies to an under-developed state; and clientelism, which often leads to rent-seeking and poor service delivery, which have long-term repercussions on societies' growth (World Bank, 2017).

Despite the decades of acknowledgement of the importance of good governance, progress has been slow; the Worldwide Governance Indicators show limited to none or even negative progress on key governance indicators amongst aggregates of low and lower-middle income countries from 2006 to 2016 (World Bank, 2018). The repercussions of continued governance failures are high, and well documented; for example, in Nigeria, unabated corruption led to the squandering of billions of dollars by the National Petroleum Company, jeopardizing the country's long-term growth potential and financial stability (World Bank, 2017).

Approaches to improve governance have generally either focused on mechanisms to strengthen the effectiveness and institutionalization of public institutions, or on external pressures to improve service delivery despite weak institutions. While each approach has yielded valuable insights, translating insights from theory into practice has been challenging. There is some evidence that at times, failures could be due to an over-emphasis of the demand side of governance by service users, citizens and civil society, which ignores the constraints faced on the supply side by politicians, bureaucrats and service providers (Brinkerhoff and Wetterberg, 2015), or of the power of information (Wibbels and Keohane, 2018). More recently, insights are emerging into the value of system-based approaches that look at both the supply and demand sides of governance as actors in a single system, drawing on power analyses and social network theories (McCloughlin and Batley, 2012; Fox, 2014; Halloran, 2015; Wibbels and Keohane, 2018).

USAID's Democracy, Human Rights and Governance (DRC) Center identified *participation, inclusion, transparency and accountability* (PITA) as critical principles that could be incorporated into interventions within and across sectors to improve development outcomes, and in line with the Doing Development Differently global initiative (USAID, 2016). We define participation as efforts to involve citizens in the design, monitoring and delivery of policy and programmes upstream (Quick and Feldman, 2011). Transparency is a "characteristic of governments, companies, organizations and individuals of being open in the clear disclosure of information rules, plans, processes and actions" (Transparency International, 2009: 44). Accountability is the concept that individuals, agencies and organizations are held responsible for executing their powers according to a certain standard downstream (McGee and Gaventa, 2011). Inclusion means a particular focus on marginalized and vulnerable citizens in policy and programming upstream or downstream (Quick and Feldman, *ibid*).

## **1.2 Interventions for participation and accountability to strengthen good governance**

### **1.2.1 The universe of interventions promoting PITA mechanisms**

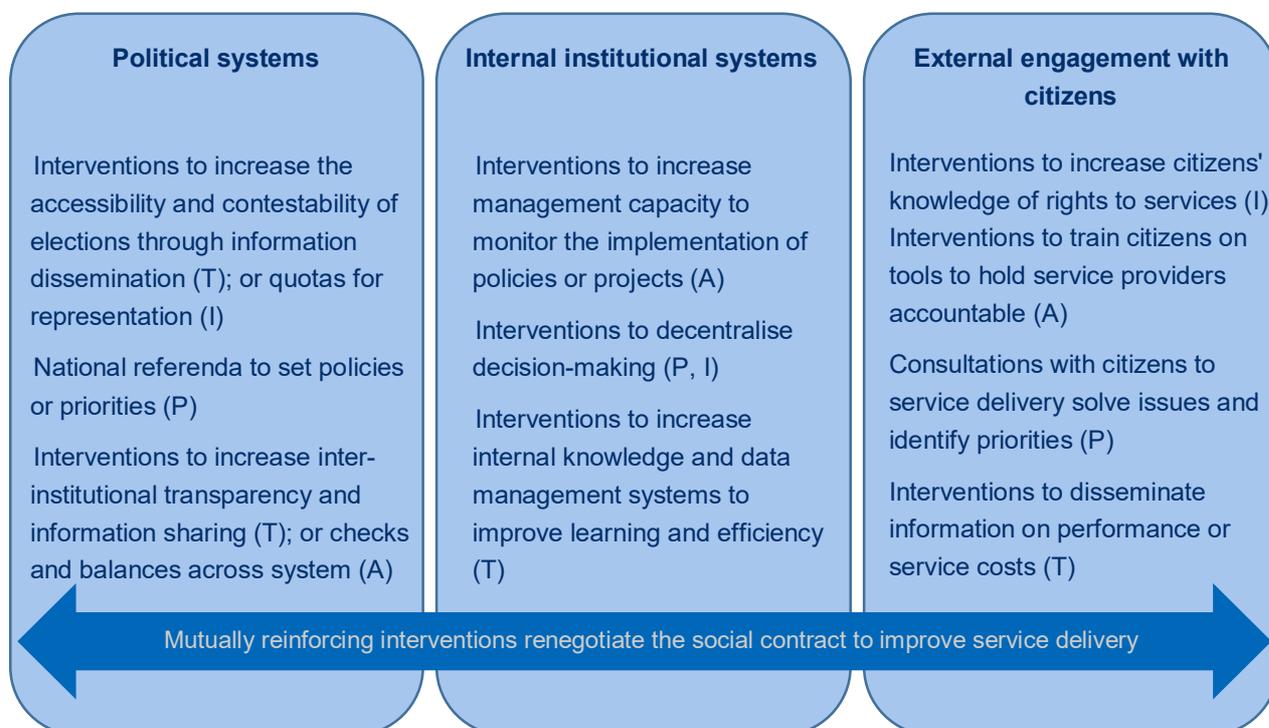
A recent evidence gap map (EGM) on “state-society relations” highlighted a number of interventions to improve governance (Phillips et al., 2017). These were broadly grouped into interventions for inclusive political processes and leadership (e.g. community-driven development, electoral monitoring, and quotas for women and minority representation in political institutions), and interventions for responsive and accountable institutions and service delivery (e.g. audits, land reform and public servant performance incentives).

Drawing on Phillips et al. (2017), as well as insights from the literature, we theorized good governance can come about through sustained improvements across three domains: within the political system; within the management and administration of public sector offices and institutions; and in the ways in which public officials and service providers engage with service users (external engagement) (Waddington et al., 2018). In this framing, good governance interventions attempt to influence the social contract that mediates the relationships between government and citizens, regarding who has access to what power and in return for what accountability for service provision, through the three domains:

- *Influencing how the broader political system functions:* The broader political system dictates access to and contestability of the policy arena (World Bank, 2017). This primarily comprises the checks and balances, or “horizontal accountability” between institutions, yet also includes political representation systems and thus, as an extension, elements of “vertical accountability” that are exercised through electoral systems (TAI 2017). Increasingly, good governance interventions seek to influence *how* this system functions, rather than the specific form it takes (World Bank, 2017).
- *Influencing how a specific public service or institution’s system functions internally:* Many good governance interventions aim to improve service delivery through the institutionalization of public services and institutions. These interventions foster “internal accountability” of institutions, and include, but are not limited to, strengthening human resources management, systems of upwards accountability of staff and management or between different levels of government, and supply chains for infrastructure, goods, and financial flows (Finan, Olken and Pande, 2015).
- *Influencing how a specific public service or institution engages externally with constituents:* These interventions aim to mediate the ways that citizens engage with government and public service providers outside of the “long route” of electoral processes (World Bank, 2004). They work to improve service delivery through “external accountability”, by increasing the engagement between service providers and service users to improve the responsiveness and effectiveness of public services. This comprises the informal processes of vertical accountability, through which citizens, CSOs and the media may attempt to influence political and public service actors directly, as well as efforts towards “diagonal accountability,” formalized processes in which citizens are engaged in horizontal accountability efforts (TAI 2017). In addition, it may include approaches which aim to “shorten the long route” by providing information on performance of public servants.

Many good governance interventions are designed to improve service delivery for citizens. This is often done through interventions that embody one or multiple PITA characteristics, which seek to address power dynamics between the state, civil society and citizens to make service delivery more effective and equitable (USAID, 2016). PITA characteristics influence the functioning of the social contract and its systems throughout each of the three accountability domains, and thus, good governance interventions may target one or more of these (**Figure 1**). For example, within the political system domain, the PITA characteristics have a direct impact on who has access to the electoral systems and who can contest the policy arena. Elected officials must exercise some basic level of downwards accountability towards the constituents who elected them (or, in non-democratic states, who grant them legitimacy), and sideways accountability to their fellow statesmen through the checks and balances built into the system. Interventions targeting PITA mechanisms in this domain tend to focus on *creating a fair system*. Within the internal system domain, interventions tend to focus on *creating an efficient system*, such as through improving the upwards accountability of officials and service providers to management, or through improving the relevance of service provision at local levels through decentralization. Finally, in the external engagement domain, the characteristics of a service or institution mediate the means through which it engages with citizens, civil society, and business/interest groups. These interventions aim to address a more diverse set of system attributes, primarily the *relevance, effectiveness and inclusivity of the service delivery system*, and are further differentiated from those in the previous domains through their reliance on soft power. The following figure (**Figure 1**) provides some examples of interventions which target the different domains of good governance.

**Figure 1: PITA throughout the three domains of good governance**



Notes: P: Participation. I: Inclusion. T: Transparency. A: Accountability.  
Source: Authors.

The effectiveness of interventions that target the PITA characteristics within one domain will be mediated by the context of the other domains as well, the power relations and constraints, and also by other interventions aiming to improve good governance and service delivery, particularly those that target service delivery supply chains. There is increasing scholarship that suggests that while interventions improving the PITA characteristics of public services and institutions, particularly in the external engagement domain, may be *necessary* for achieving sustainable improvements in service delivery and a stable social contract, they may not be *sufficient* (e-Pact Consortium, 2016). On the other hand, while interventions that target strengthening PITA characteristics within internal institutional systems may be sufficient for improving governance within the system, the impact of those governance improvements may not reach the ultimate beneficiaries (citizens/service users) without the incorporation of interventions strengthening the system's external PITA characteristics (Page and Pande, 2018).

*The focus of this review on external engagement with service users (citizen engagement interventions)*

While recognizing the interactions of interventions promoting PITA mechanisms across each domain and with complementary good governance and service delivery initiatives, it has been pointed out that to attempt to cover the entirety of good governance interventions in a single review would be “exceedingly ambitious” (Sáez, 2013). Thus, this review analyzed the value-add of interventions in the third domain, interventions focusing on external engagement of public services and institutions with citizens.

Interventions promoting PITA mechanisms can be implemented as stand-alone interventions or as part of a larger programme working to strengthen governance and service delivery. They may be implemented either on the supply or demand side of service delivery, or may target both simultaneously, such as a public audit process that trains community members on tools to hold public officials accountable, and works with public officials to increase their understanding of the importance of downwards accountability. An intervention may strengthen one or multiple PITA characteristics of the ways public services and institutions engage with their constituents.

For the purposes of this review, the definitions of PITA were operationalized as follows:

- **Participation:** The intervention promotes or formalizes continuous citizen input in the design and implementation of public services, processes or policies. Participation interventions create specific opportunities or processes for citizens to provide meaningful input into public policy or strategy design and planning. An example of a participation intervention is the introduction of participatory budgeting so that citizens may directly contribute to the development of a budget proposal (Touchton & Wampler, 2014). A community-level example could be the creation and capacity building of a representative community-based natural resource management committee that is mandated to develop and monitor locally agreed standards and regulations for the use of common property.
- **Accountability:** The intervention encompasses monitoring and soft/social accountability mechanisms to encourage or actively hold individuals, public service providers and institutions responsible for executing their powers and mandates according to a certain standard. Accountability interventions create opportunities or processes for constituents to monitor the government and public

service providers. An example is a project to encourage and build the capacity of civil society to hold government accountable for the sustainable and equitable management of natural resources (USAID, 2016), or a citizen report card intervention, in which a community group is taught the quality standards to which they are entitled and how to monitor the quality and performance of service delivery, and then to work with the service providers to address any identified issues through a mutually agreed action plan.

- *Transparency*: The intervention involves the disclosure and/or dissemination of information about rights of public service users, to promote participation, and/or performance of public service providers, to promote accountability. Transparency interventions included in our review have the explicit aim of changing the way that citizens and service providers or public officials interact and the power relations between service providers and users. An example is local clinics posting information about patient rights, service fees and standards, and budget execution (USAID, 2016), which restricts the scope for service providers to charge bribes.
- *Inclusion*: The intervention includes particular strategies to promote the opportunities and capacities of marginalized and vulnerable groups such as women, ethnic minorities or lesbian, gay bisexual, transgender and intersex (LGBTI) people to engage with the management of public institutions and service providers. Hence, we define inclusion specifically as a component of an intervention that targets a change in participation, transparency or accountability. An example of an intervention to promote inclusion is ensuring that a certain proportion of places in a community governance group are reserved for women (Humphreys et al., 2012).

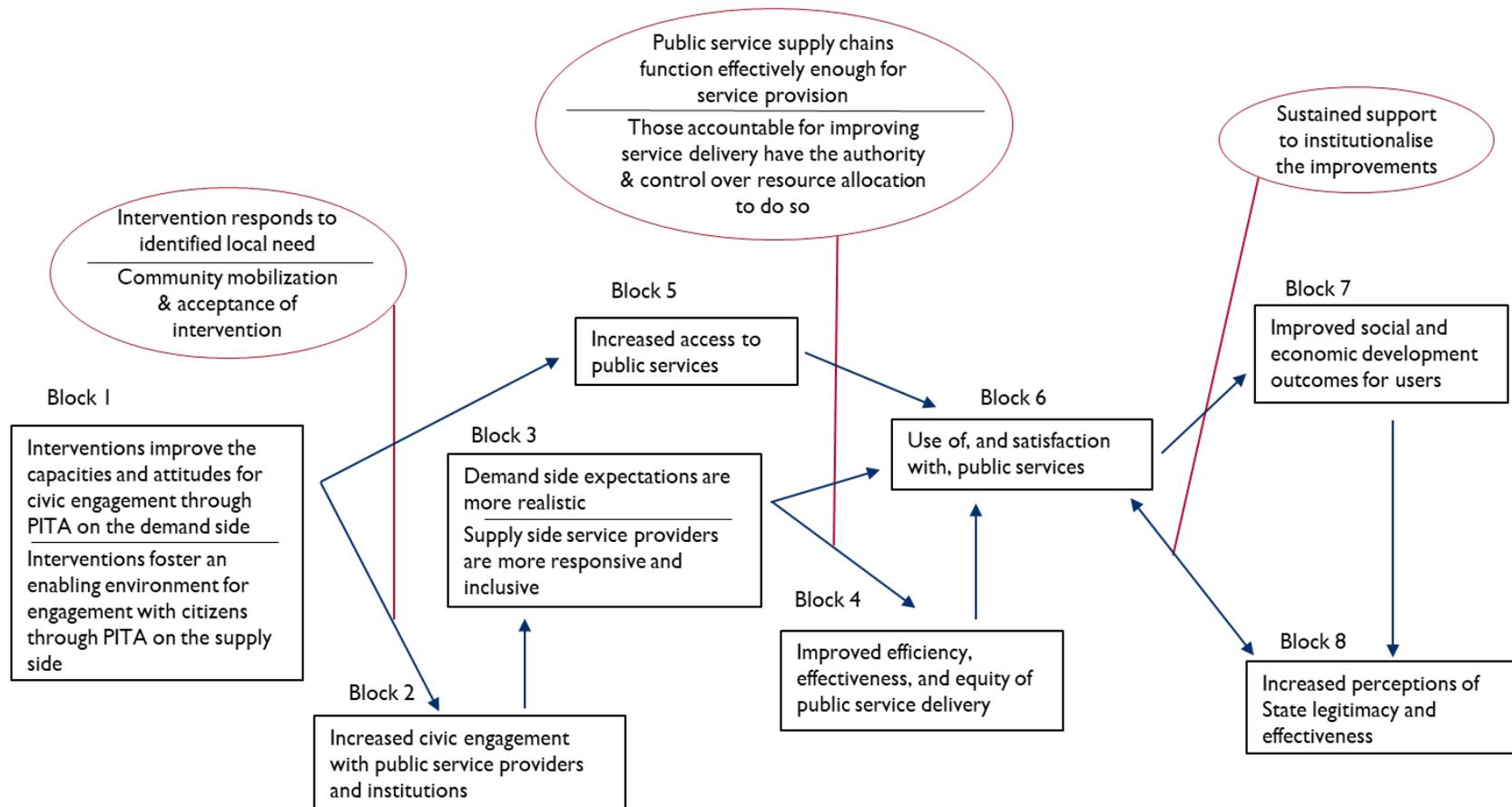
The intervention categories are described in more detail in the Methodology section (**Appendix A**). While most interventions contribute primarily to a single PITA mechanism as described above, there is often significant interplay between the PITA characteristics to which an intervention contributes. Though efforts have been made to make the definitions mutually exclusive, a single intervention may contribute to strengthening multiple PITA characteristics. The obvious cases here are interventions for transparency and inclusion. For example, a transparency intervention that improves access to information about users' rights may aim ultimately to improve user participation, while one aiming to improve information about public service performance ultimately aims to improve accountability. Further, interventions included in the review that are designed to improve the access of a marginalized group of citizens (inclusion) to a decision-making process aim, at an intermediate outcome level, to improve the group's input into the process by providing increased opportunities for consultation (participation), or service delivery monitoring (accountability).

### **1.3 How interventions promoting PITA mechanisms might work**

We developed a stylized model showing an indicative theory of change for how the interventions may work at the protocol stage (**Figure 2**). The theory of change is represented as a series of "blocks," though the authors recognize that change is not always linear. The numbering of the boxes represents typical hypothesized progression, and enables signposting to the key stages of the change process in the text. Circles are

used to represent underlying assumptions and key factors that facilitate, moderate or create bottlenecks along the casual chain. This preliminary theory of change developed in the systematic review protocol (Waddington et al., 2018) drew on insights from the literature and programmatic best practices. In particular, the framework built on the 2004 *World Development Report* (World Bank, 2004) theory of change, which articulated the importance of pro-poor governance practices that actively engage end users for effective outcomes, and Rahman and Robinson (2006) who articulated the importance of local ownership and long-term support. The assumptions and moderating factors drew on insights from Fox (2014), Page and Pande (2018), and the 2017 WDR (World Bank, 2017), among others. We have not taken a “rights-based approach” that views improvements in PITA characteristics as the end objective. While recognizing the value of PITA characteristics in and of themselves, the focus of this review is on the value-add they bring to improving development outcomes through improved service delivery.

**Figure 2: Indicative theory of change for citizen engagement interventions**



**Demand-side stakeholders:** Community leaders; wider community members, including marginalised groups; civil society groups  
**Supply-side stakeholders:** Public and civil servants; public officials; public service providers  
**Context:** Low levels of education and capacity amongst frontline supply and demand side stakeholders; high turnover of supply-side stakeholders; resource poor communities; high levels of inequality; weak state capacity or reach; frequent access challenges, due to remoteness and/or insecurity; and endemic corruption.

We note here a useful distinction between the demand and supply side of governance. Implementers may target stakeholders on the demand-side of governance, such as through efforts to improve the capacity of civil society to monitor government service delivery, or the supply-side, such as by training public officials on pro-poor development planning. Other interventions may be geared to affecting both demand- and supply-sides, such as a participatory budgeting process in which government officials are trained on the value of participatory budgeting, while community members are trained and supported to participate in the process.

The indicative theory of change presents the hypothesized causal chain, from changed opportunities and capacities, followed by behavioral changes on both the supply and demand side of governance, ultimately leading to improved service delivery performance and enhanced quality of life outcomes for citizens. The indicative causal chain was developed in the systematic review protocol stage to articulate the main causal pathways through which interventions targeting public services' and institutions' external engagement with citizens may lead to improved development outcomes. Some interventions may contribute to all the pathways; others may only contribute to particular ones. We build on, and further refine, theories of change for particular interventions in the framework synthesis (Review Question 4).

Beginning with the intervention on the left-hand side, the figure follows a primary causal chain, with immediate, intermediate and endpoint outcomes indicated in boxes, and key assumptions in bubbles. The theory of change starts with critical assumptions of the design, inception and implementation phases: first, that the intervention designed is relevant and addresses an identified local need; second, during inception that wider community acceptance for the intervention has been sought and received from key social, religious and political leaders; and finally, that community mobilization activities are undertaken during implementation. Similar to how the quality of PITA characteristics in the public planning and service delivery spheres contributes to strengthening the corresponding development outcomes, the strength and quality of the PITA characteristics of the intervention itself are suggested to contribute to its efficacy.

The exact form of the intervention (Block 1) will vary widely, yet the majority aim to create an enabling environment for increased and mutually empowering interactions between service providers and citizens through changes to their knowledge, attitude and practices (KAPs). On the demand side, this may include efforts to improve citizens' knowledge of the services to which they are entitled; their capacity to demand those services through key tools; and/or their sense of self-efficacy and empowerment to do so effectively. An intervention focused on a technical skill such as participatory budgeting may start with capacity building on budgeting processes and the role that citizens can play; interventions that aim to increase inclusion of marginalized groups often start with community campaigns to raise awareness amongst the target households.

On the supply side, either in addition to demand-side efforts or independently, interventions aim to strengthen openness from and active engagement with supply-side stakeholders in efforts to improve service delivery. These may target the actors implementing or managing the service in question, but also other key stakeholders in the community and throughout the system. Seeking and attaining community acceptance prior to implementation is a widely-applied best practice for ensuring that development

projects do no harm and that they will have sufficient buy-in from the community to be successful. There is some evidence that suggests that this may be particularly critical for PITA mechanisms. Securing buy-in from stakeholders at the point of intervention, upstream and downstream along the service delivery / good governance supply chain may create an enabling environment for interventions to successfully navigate the social network and power differences within which the intervention is implemented (McCloughlin and Batley, 2012).

Different tools implemented as elements of interventions may require different conditions to be effective; the framework synthesis process aimed to identify these. The context also influences what works and how; for example, if a political player can increase his or her own personal power through framing an improvement in service delivery as a personal “win,” then she or he may be more motivated to work for its improvement (e-Pact, 2016).

The first immediate outcome (Block 2) posits that through engaging in the interventions, citizens will increase their engagement with State and public service officials. This is often an explicit aim of citizen engagement interventions, as it is a critical precursor to the higher-level outcomes. Through the increased engagement, the next level of change (Block 3) posits that citizens develop a better understanding of processes, services, and the constraints faced by service providers, while simultaneously, service providers gain a deeper understanding of the needs of their constituents and appreciation for the engagement process.

In subtle ways, these changes reflect renegotiations of power relations between the State, civil society and citizens, mitigating the power imbalances. This happens as the citizen engagement interventions shift the dynamics of power by drawing on collective and representative voice.

- Participation interventions address power relations by building in meaningful opportunities for citizens to provide input over the direction of policies that affect them and the supply of services they rely on.
- Inclusion interventions address power relations by bringing marginalized voices to the table.
- Transparency interventions address power relations by limiting the government and public service providers’ capacities to use their positions for personal gain, and addressing the power difference caused by knowledge gaps.
- Accountability interventions address power relations by increasing the risk and severity of informal social sanctions against poorly performing bureaucrats and service providers.

Power relations are dynamic; they can change quickly, both for the better and worse, and gains are not necessarily secure. A key assumption here is that supply-side actors are fully engaged throughout the process; otherwise, the attempts to increase soft power by citizens may be seen as confrontational rather than collaborative, which could de-incentivize service providers from the process to avoid being seen to give up any of their power (World Bank 2004). Where PITA processes are seen as collaborative, they can be mutually empowering, creating changes in the interactions between state and society that simultaneously give citizens greater input into the provision of the services they rely on, and strengthen the standing of the service providers in the community (Fox, 2014).

Where interventions are unsuccessful at building coalitions to facilitate an enabling environment for change, they may not be successful at changing power relations, as actors may adapt to new systems (Halloran, 2015). For example, though advancements in the field of information and communications technology (ICT) offer exciting possibilities for strengthening external PITA characteristics, a change in technology that is not complemented by supporting interventions that create an enabling environment may fall flat (Hogge, 2010).

As the power relations are shifting and engagement is increasing, a core intermediate outcome of the interventions will emerge (Block 4): public service delivery will improve in efficiency, effectiveness, and equity. Once public officials and service providers are taking into account the input of community members, the selection and targeting of services will improve. This will improve the effectiveness and appropriateness of public service delivery. Inclusion interventions improve the equality of service provision, as they increase access to services and processes for the most vulnerable community members. Transparency initiatives increase the efficiency of public service delivery, as they streamline costs and processing times, and make it harder for politicians and officials to demand inflated payments for services. Finally, accountability initiatives can have direct benefits to the performance of public service delivery, as citizen feedback mechanisms such as Public Audits end with joint workshops between the service provider, citizen representatives, and other key stakeholders to come up with an actionable plan to which all parties can be held to account for how they will address the major issues identified and improve service delivery.

The key assumption here is that institutions have the capacity to respond to the priorities requested and issues raised by constituents. This is a critical assumption, because in its absence, the interventions risk doing harm by having a negative consequence on perceptions of State effectiveness resulting from raised and then unmet expectations. For example, the 2017 WDR highlights the risk that investments in service provider capacities may not be enough to improve service delivery, if power relations within the institution are not addressed (World Bank, 2017). Further, depending on the structure of the intervention, improvements may be related to a one-off change in the situation that is not sustained; many interventions are designed as experiments, whose study design may capture short-term gains that revert back to the baseline conditions with time. Fung et al. suggest that transparency interventions contribute to improvements only when the information provided becomes embedded in the decision-making process (2005).

In some cases, citizen engagement interventions, particularly those that focus on improving access to services for marginalized groups (I), may not lead to the active, empowered engagement between citizens and service providers that leads to mitigated power differences and improved services. However, they could still lead to increased access to public services, particularly amongst vulnerable populations (Block 5). This comes about as a direct result of inclusion and transparency (information dissemination) interventions, but also through the other interventions; as communities are mobilized to engage with their local government and services, they become more invested in the services that they are attempting to improve. And thus, they are more likely to take advantage of those services, as they understand the importance of ensuring high quality service provision for themselves and their families. However, increased access for marginalized groups is not a given outcome of citizen engagement interventions; there

likely needs to be concerted, targeted efforts to reach and engage these groups in order for the impacts to reach them (E-Pact Consortium, 2016). Similarly, interventions targeting services where changes are relatively immediate and visible may be more likely to encourage buy-in and support from supply-side actors (ibid.).

The joint effects of changes from Blocks 4 and 5 lead to improved use of public services and user satisfaction (Block 6). Further along the causal chain, wellbeing outcomes may also improve (Block 7). Wellbeing outcomes will vary by intervention sector (e.g. health, social protection, justice, natural resource management), and are more likely to improve in complementary enabling environments. In the majority of PITA programs, the PITA characteristics interventions are add-ons to core interventions and outcomes in a public service sector. In the long run, all three intermediate outcomes contribute to wellbeing outcomes. A key assumption is that sustained support is provided to the institutions or service providers charged with maintaining the implementation of the intervention, such that it becomes institutionalized. As noted above, power differences are dynamic and constantly evolving. Thus, a short-term project may well change outcomes in the short-term, but without proper support those gains may easily be lost.

Finally, it is increasingly thought that citizen engagement interventions, through the immediate outcomes increasing engagement with government and public officials and mitigating the power differences, can have a positive impact on perceptions of state effectiveness – or state-society relations – when services and development outcomes improve as a result (World Bank, 2017) (Block 8). As citizens engage with public processes and services, they learn more about the constraints under which these institutions operate. As they see increased responsiveness of public officials, and subsequent real improvements in the quality of services they receive, their perceptions of State effectiveness and legitimacy will increase. This is particularly critical in fragile and post-conflict States, where the State may still be vying with other actors for legitimacy over governing and control. There may also be reinforcing feedback from improved state-society relations (block 8) to use of services (block 6).

The context in which this theory of change, or elements of the same, are implemented has strong ramifications on the ways in which the interventions must be designed, implemented and supported in order to ensure success. Governance programmes are generally implemented in resource-poor contexts, where there are entrenched problems around low levels of education and capacity, high turnover amongst public officials, and endemic corruption. Target communities are frequently difficult to access, either due to remoteness and extreme weather, or to conflict and insecurity. It is precisely because of these challenges that governance interventions are so strongly needed in such areas, but they must be taken into account during the design phase to ensure risks are appropriately mitigated. These factors breed vicious cycles of weak public service supply, which leads to weak demand, which in turn facilitates weaker public financial management, and so on. In an ideal world, the interventions would create a virtuous circle of active community engagement in their government and service provision.

Interventions tailored to the specific context in which they are implemented, that target both the demand and supply sides of good governance, are more likely to be successful, particularly when the interventions are supplemented by complementary ones that target the technical side of service delivery and/or service delivery supply chains. For example,

in the Philippines, a project focusing on improving access and quality of maternal and child health and family planning included social accountability mechanisms in the form of Quality Assurance Partnership Committees, which Brinkerhoff and Wetterberg (2015) argue led to more effective service delivery that improved the client-focus of providers and increased service use.

Additional factors that may influence an intervention's results include top-down political will, which is key to ensuring that local government officials and service providers have the capacity to implement the changes they agree to with their constituents is having the support of the higher levels of government, which can ensure that funds are appropriately allocated. Political will further influences the sustainability of the results, and the possibility of a change in administration poses a risk to programmes that may be cut due to high association with the outgoing regime.

It is important at this point to also highlight two broad issues which determine the effectiveness of programs, relating to intervention design and implementation fidelity. There are two main reasons why we might not expect to see the intended impacts of a programme implemented in the 'real world' (Bamberger et al., 2010). The first is that the programme design is inappropriate – that is the underlying mechanisms that drive change are not appropriate for the context in which the programme is based, or for particular groups of participants in that context (Pawson, 2006). According to van der Knaap et al. (2007: 3), “mechanisms are the engines behind behavior, which are often not immediately recognizable... They [include] people's efforts to give way to group pressure (groupthink), people's efforts to be status-congruent with others or to avoid or reduce cognitive dissonances, or people's desire to be an early adopter of an innovation. [T]he action of mechanisms to some extent depends on the context in which they are used... Behavioral change is achieved through this context”.

An example would be a community driven development programme that is supposed to rely on community participation to foster social cohesion, but is unable to support the appropriate level of participation, and therefore cohesion, because people are not comfortable speaking in public meetings due to elite capture (White et al., 2018). Similarly, interventions to decentralize decision making in schools are less likely to be effective in low income, low education contexts where communities have low status relative to school staff (Carr-Hill et al., 2018). Another example would be a women's empowerment programme which is ineffective in reaching a particular group of participants (e.g. women from Muslim households) because it does not take into consideration the need to involve community leaders in design of the programme targeting strategy.

Such “failure mechanisms” will vary based on intervention design and targets; for example, in some cultures, traditional community leaders may be critical stakeholders to engage in interventions seeking to change the equity of or access to services, despite the disconnect between their de facto and de jure power – but only depending on the service targeted. Baldwin and Raffler (2016) argued that traditional leaders are often highly socially accountable for public services such as conflict resolution or natural resource management, but less so for services such as education or health care. In that case, an intervention targeting equitable access to and use of public land may fail if it does not engage traditional leaders, but a similar intervention simply targeting equitable

access to and use of health services may still be successful. Failures may also come in the form of unintended consequences; for example, Chong et al. (2014) found that increasing the dissemination of corruption information to voters in Mexico decreased support not only for exposed corrupt politicians, but also for all political parties, and led to a decrease in voter turnout.

The second reason is due to implementation failures for a programme that otherwise (in theory) would be effective in the implementation context. Examples would be technical and logistical problems relating to project delivery (e.g. inadequate training and support to practitioners); weaknesses in implementer systems (e.g. human resource, financial or monitoring); or due to external factors (e.g. conflict, natural disasters).

#### **1.4 Why this systematic review is relevant**

The 2017 *World Development Report* (World Bank, 2017) posits that rather than asking which policies to implement, the global development community needs to ask what enables policies to achieve sustainable outcomes, the answer to which being better governance. This report is timely in a context in which donor reporting suggests a movement away from stand-alone governance projects. Data from the OECD Creditor Reporting System of Official Development Assistance (ODA) shows declining funding in “government and civil society” sector, from US\$ 14.5 billion in 2009 to around US\$ 12 billion in 2015, a decrease of almost 20 per cent. During the same time period, overall ODA increased from US\$ 103 billion to US\$ 118 billion (OECD, 2017). Therefore, it appears that the share of aid to governance and civil society has fallen from around 14 per cent to 10 per cent, or an increasing share that was traditionally counted under governance is instead being incorporated into sector programming (health, education, agriculture, infrastructure, etc).

Governance programmes are implemented in complex socio-political contexts, and involve many challenges in realizing, demonstrating, and attributing improvements towards key outcomes. USAID (2017) notes that the lack of consistent definition of governance and poor understanding and weak documentation of evidence of governance-related interventions contribute to a reticence to invest in such programs. This could explain why donors are shifting their attention towards other sectors; over the same time period (2009 to 2015), funding for economic infrastructure and services increased by US\$ 7.5 billion, while funding for health programmes increased by US\$ 700 million (OECD, 2017).

In addition, prominent single study evidence has questioned the viability of bottom-up, community-based approaches, as compared to top-down government accountability (Olken, 2007). However, it is not clear whether the findings from single studies are transferable to other contexts. This points to the need to strengthen the synthesis and dissemination of the evidence base, and to encourage decision makers to draw on systematic evidence collected from the implementation of programmes in multiple contexts.

This systematic review examines interventions that promote more effective and responsive public services and institutions, defined under Sustainable Development Goal number 16 as institutions that “deliver equitable public services and inclusive

development at the central and local levels, with a particular focus on restoring core government functions in the aftermath of crisis and attention to local governance and local development” (UNDP, 2016).

The review makes two main contributions. The first is to provide systematic evidence on PITA for external engagement in development programming (outside of the education sector) in L&MICs. Molina et al. (2016) presented a systematic review of community monitoring studies in L&MICs. King et al. (2010) and White et al. (2018) reviewed community driven development. Hanna et al. (2011) systematically reviewed anti-corruption interventions and Lynch et al. (2013) reviewed of the effect of interventions that improve community accountability on service delivery and corruption.<sup>1</sup> Other systematic reviews focused on education governance (Guerrero et al., 2012; Carr-Hill et al., 2015; Snilstveit et al., 2015). Relevant non-systematic evidence syntheses include Olken & Pande (2013), Azulai et al. (2014), Dal Bó and Finan (2016), Brinkerhoff et al., (2017) and the Metaketa project (EGAP 2018).

The second main contribution of the review is to undertake the systematic review and meta-analysis to Campbell Collaboration standards while also aiming to extract the mechanisms underlying programmes and reporting those systematically. We did so by including certain types of comparison groups that would enable us to extract the effect of the PITA mechanism over standard access to public services (or a different PITA mechanism). We also systematically extracted information about the contextual factors and mechanisms and through which programmes operate systematically, based on the included studies and related programme and project documents, and synthesized those using a framework synthesis approach.

As policy makers and implementers work to ensure the sustainability of their investments and interventions, institutionalizing good governance practices will become increasingly important. This systematic review assesses the effectiveness of interventions that target participation, inclusion, transparency and accountability in the design and delivery of public services and institutions on development outcomes. Analysis of causal pathways and mechanisms will shed light on the contexts in which these interventions can be successful and corresponding enabling factors. The review aims to provide evidence on what is generalizable, what is context specific, in what ways, and for whom in external accountability governance programming.

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<sup>1</sup> Killias et al. (2016) are registering a review on the effectiveness of anti-corruption measures. The study protocol is available from the Campbell library: [https://www.campbellcollaboration.org/media/k2/attachments/Killias\\_Corruption\\_Protocol.pdf](https://www.campbellcollaboration.org/media/k2/attachments/Killias_Corruption_Protocol.pdf).

## 2. Methodology

The objective of this review is to identify, appraise and synthesize evidence that answers the question: to what extent are programmes targeting effective and responsive public services and institutions that incorporate PITA characteristics into their design effective in achieving their objectives, as compared to otherwise similar programmes that do not?

We compared the effectiveness of different types of programmes that incorporate PITA characteristics, both by intervention type, and by which PITA mechanism(s) the intervention incorporates, using an innovative, integrated mixed-methods approach that drew on both quantitative meta-analysis (Review Questions 1-3) and qualitative realist-informed framework synthesis approaches that were then reintegrated with the meta-analysis (Review Question 4).

We aimed to answer the following specific review questions:

1. What are the effects of interventions that aim to strengthen the PITA characteristics of public services or institutions on social and economic wellbeing for participants (intermediate and final outcomes)? (*Review Question 1*).
2. What are the effects of interventions that aim to strengthen PITA characteristics on participatory, inclusive, transparent or accountable processes (immediate outcomes)? (*Review Question 2*).
3. To what extent do effects vary by population group and location? (*Review Question 3*).
4. What factors relating to programme design, implementation, context, and mechanism are associated with better or worse outcomes along the causal chain? (*Review Question 4*).
5. What evidence is available on programme costs and incremental cost effectiveness in included studies of effects? (*Review Question 5*).

We focused on five main intervention categories: participation interventions (participatory budgeting, community-based natural resource management), transparency interventions (performance information, and rights information), and accountability interventions (citizen feedback mechanisms). We also analyzed interventions according to whether they incorporated inclusion of disadvantaged groups.

We followed Ie, Campbell and Cochrane Collaboration guidance to systematically search for published and unpublished literature on programmes in low- and middle-income countries, critically appraise and synthesize findings, and incorporate mixed-methods (quantitative and qualitative) evidence using a causal chain approach (Shadish & Myers, 2004; Higgins & Green, 2011; Waddington et al., 2012; Snilstveit et al., 2012; The Steering Group of the Campbell Collaboration, 2016; Kugley et al. 2017; White et al., 2018). To address review questions 1, 2 and 3, we collected counterfactual evidence provided in quantitative causal studies (impact evaluations). We used analysis of effect size data (statistical meta-analysis) to explore the central tendency and heterogeneity for outcomes measured along the causal chain (immediate, intermediate and final outcomes).

To address review question 4, the approach drew on realist synthesis (Pawson, 2006; van der Knaap et al., 2008) and framework synthesis (Carroll et al., 2013), and incorporated multiple types of evidence, including programme and project documents to

provide information about context and mechanism characteristics. The review also presents cost data from included impact studies (question 5). The criteria determining eligibility of studies in the review are grouped by population, intervention, comparison, outcome and study design (**Table 1**). Full details of methods used are provided in the **Appendix A**.

**Table 1: Summary of criteria for including and excluding studies**

<b>Criteria</b>	<b>Definition</b>
<b>Population</b>	Programme participants in L&MICs were included. Programme participants in high-income countries were excluded.
<b>Interventions</b>	Interventions with PITA components that targeted the means and mechanisms through which public institutions and services engage with constituents (service users) were included. Interventions that bundled PITA components alongside other programme components such as block grants (e.g. community-driven development), or that aimed to strengthen internal or sideways PITA, or those in the education sector were excluded.
<b>Comparisons</b>	Populations that received 'business as usual' service access, or an intervention with a different type or degree of PITA were included.
<b>Outcomes</b>	Intermediate and endpoint, intended or unintended outcomes at participant and project level were included. Outcomes relating to political processes (e.g. voting) were excluded. Immediate outcomes relating to citizen engagement (e.g. participation in meetings) or public service response (e.g. public spending) were eligible for the review provided that outcomes relating to access to services (e.g. facilities construction) or intermediate outcomes (e.g. service use) or final outcomes (e.g. health, nutrition, state-society relations) were also reported.
<b>Study designs</b>	Counterfactual studies (research questions 1-4), including relevant programme and project documents providing information on design and implementation (research question 4) and cost evidence provided in counterfactual studies (research question 5) were included.

### 3. Results of search and critical appraisal

This section summarizes the results of the search, presents descriptive information about the included studies, and discusses findings from the critical appraisal of impact evidence.

#### 3.1 Description of studies

##### 3.1.1 Results of the search

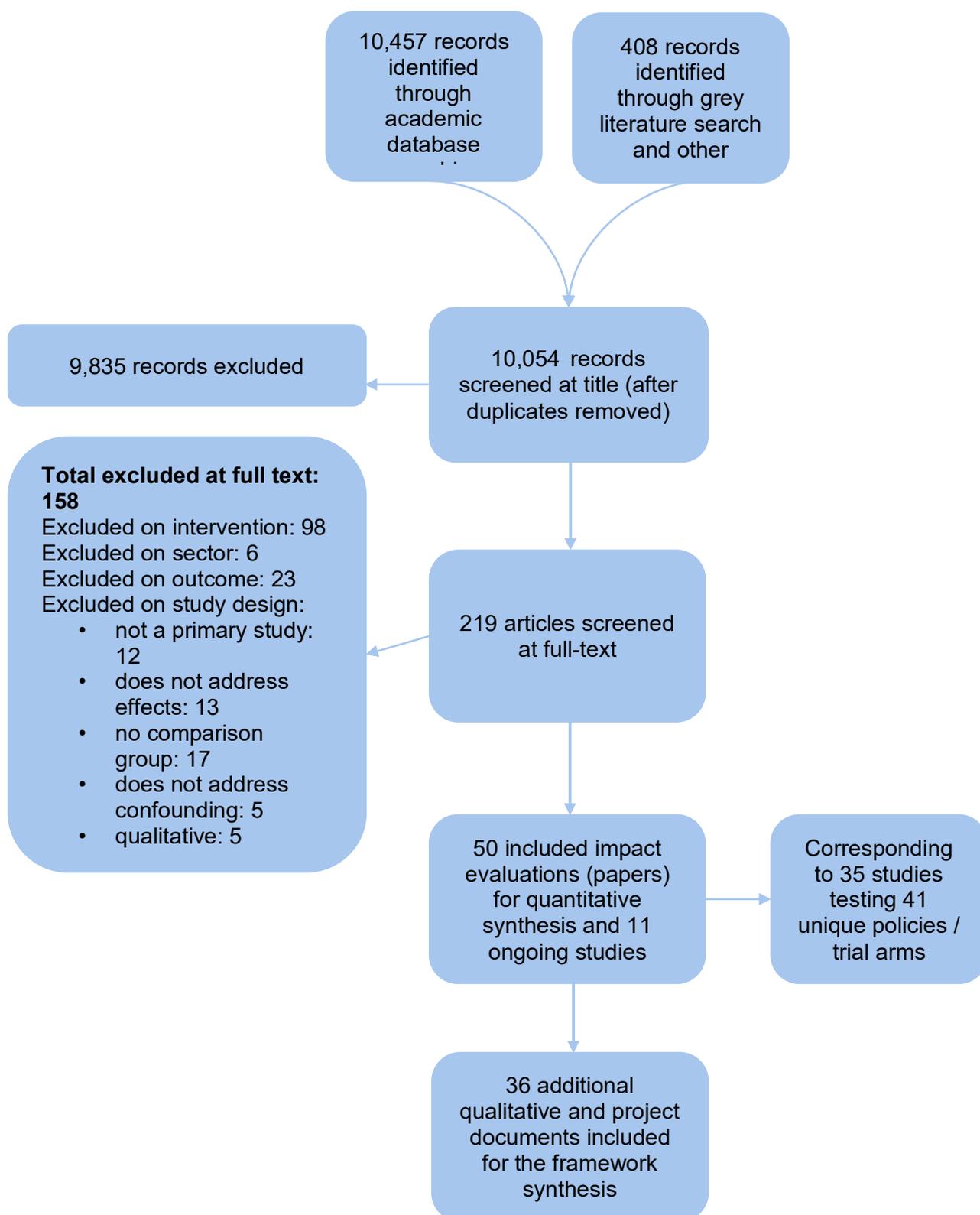
The results of the search and screening process are shown in the study search flow diagram (**Figure 3**). The initial academic search resulted in 10,457 hits while the searches of grey literature resulted in 408 hits. In addition, we took the relevant included studies from the state-society relations EGM, which added an additional 348 studies, leaving us with a total of 10,865.

Following the removal of duplicates, we were left with 10,054 studies to screen at title and abstract. As described in the methods section in more detail, we used text mining in EPPI-Reviewer 4 to reduce the initial screening workload. We first independently double screened approximately 10 per cent of the search results. We then used the priority screening function to develop a classifier that classified studies into groups based on their probability of being included in the review, using data from the 10 per cent of screened studies. We decided to automatically exclude studies with less than a 20 per cent probability of being included, corresponding to 7,241 of the search hits. We screened a random 10 per cent of the 0-9 per cent and 10-19 per cent group to check the quality of the classifier but identified no studies that had been wrongly excluded. We double screened all studies classified as 20-99 per cent probability of being included. In total, we excluded 9,835 at title and abstract.

This left 219 papers to screen at full-text. After independent double screening, sometimes involving a third reader, we included 57 impact evaluations in the first stage. We undertook forward and backward citation tracking on this initial set of studies to identify studies missed by the initial search, identifying an additional 10 papers. After detailed reading of the complete set, we excluded 17 further studies on intervention or outcome. In the end, we found 50 eligible papers corresponding to 35 unique studies. We also found 11 ongoing studies, a list of which is presented in **references to ongoing studies**. Reasons for exclusion are discussed in more detail below.

Following the search for impact evaluations, we undertook a targeted search for qualitative and project documents associated with the programmes evaluated in the included impact evaluations. We carried out a keyword search including intervention name, implementer and country, on Google, implementer and funder websites. In total, we identified 76 additional documents, of which 36 contributed to the qualitative synthesis. These are discussed in more depth in the section on framework synthesis.

**Figure 3: Study search flow diagram**



### 3.1.2 Excluded studies

Studies were often excludable for more than one reason, but we did not search for all possible reasons for exclusion once a study met one exclusion criteria. We excluded 98 papers at full-text for not meeting our criteria on intervention. With regards to those

excluded on intervention, we excluded five as they were classified as informal sector, that is, the programme was implemented independently of government. We excluded six as they only addressed service access for marginalized populations through the delivery of a new service. We excluded 24 as they were unable to isolate the PITA element of the intervention, that is, the evaluation measured the effect of a PITA mechanism packaged with other interventions. We excluded a further 63 papers for evaluating other irrelevant interventions. One of these studies excluded on intervention was of an ineligible 'recentralization' intervention which acted to reduce the level of citizen participation (Malesky et al., 2014).

We excluded an additional six because they evaluated a study of education or a participatory planning intervention alongside a block grant (CDD), 12 because they were not a primary study, 13 because the study did not address effects, five because they were qualitative, five because they did not address confounding and 17 for not using a comparison group. In addition, we were unable to access one paper.

A further eight studies were eligible for being included based on population, intervention and comparison, but only examined the effects of a PITA mechanism on one or more secondary outcomes of interest, that is, citizen engagement and/or provider response. These studies (Finkel, 2012; Gottlieb, 2016; Grossman et al., 2014; Grossman et al., 2016; Sexton, 2017; Sheely, 2015; Yanez-Pagans and Machicado-Salas, 2014) were excluded from the review.

After the full-text screening stage, we excluded a further two papers that appeared to be evaluations of eligible interventions, but that we discovered to be PITA mechanisms implemented alongside co-interventions that were not reported clearly in the original evaluation (Alderwish & Dottridge, 2013; Andres et al., 2017). We discovered the presence of the additional co-interventions in the additional documentation we identified through our targeted searches. Both papers evaluated community driven water provision. For Andres et al. (2017), we identified a 2009 World Bank Implementation Completion and Results Report associated with the project evaluated in the paper, the *Jalanidhi* project. The report described co-interventions that would likely have impacted the outcomes covered by the evaluation, including significant technical engineering assistance, infrastructure, and capacity building. The impact evaluation does not acknowledge these co-interventions, but rather presents the study as isolating the impact of the institutional form the water management system takes on the outcomes. Thus, based on the co-interventions the study did not isolate the PITA mechanism and was excluded from the review. Alderwish & Dottridge (2013) was a similar case in that a project document identified significant infrastructure interventions combined with the community water provision intervention. Examples of decisions for including and excluding similar types of studies are given in **Appendix Table 14**.

### **3.2 Description of included studies**

In this section, we describe the characteristics of the 35 included impact evaluations. Key characteristics of each included study are presented in **Appendix E**.

### 3.2.1 Setting

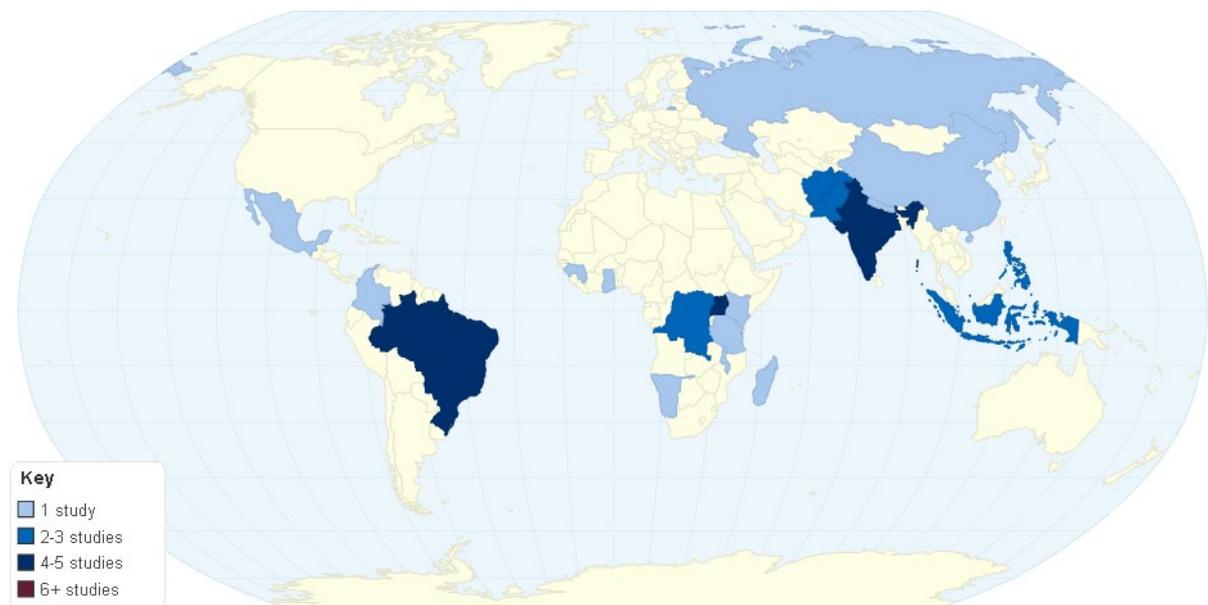
**Figure 4** shows the geographical spread of the included studies. The most studied area for included interventions is Sub-Saharan Africa (n = 13), representing almost 40 per cent of the included studies. We included five studies of interventions that took place in Uganda (Björkman et al., 2017, 2009; incorporating Donato & Mosqueira, 2016; Fiala & Premand, 2017; Grossman et al., 2017; Grossman & Michelitch, 2018; Humphreys & Weinstein, 2012), two from the Democratic Republic of Congo (DRC) (Humphreys et al., 2014; Palladium, 2015), one each respectively from Ghana (Alhassan et al., 2016), Tanzania (Persha & Meshack, 2016), Madagascar (Rasamoelina et al., 2015), Malawi (Gullo et al., 2017), Namibia (Bandyopadhyay et al., 2004) and a study that took place in both Kenya and Guinea (Bradley & Igras, 2005).

We identified nine studies from South Asia, four of which took place in India (Ananthpur et al., 2014 in Karnataka; Banerjee et al., 2014 in Rajasthan; Pandey et al., 2007 in Uttar Pradesh; Ravallion et al., 2013 in Bihar). The remaining studies took place in Afghanistan (Beath et al., 2013; Berman et al., 2017), Pakistan (Kasim, 2016; Giné et al. 2018) and Nepal (Tachibana & Adhikari, 2009). In addition, we identified five studies from East Asia and Pacific, including two from Indonesia (Olken, 2007; Banerjee et al., 2018), two from the Philippines (Capuno & Garcia, 2010; Bandyopadhyay et al., 2010) and one from China (Huang, 2014).

We included six studies from Latin America, of which four were from Brazil (Gonclaves, 2013; Touchton & Wampler, 2014; Barde, 2017; Timmons & Garfias, 2015), and one each from Colombia (Molina, 2014) and Mexico (Diaz-Cayeros et al., 2014).

Finally, we identified one study in Russia, a study of support for participatory budgeting (Beuermann & Amelina, 2014).

**Figure 4: Geographical distribution of included studies**



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Region	Number of Studies	Percentage
Sub-Saharan Africa	14	40%
South Asia	9	26%
Latin America and Caribbean	6	17%
East Asia and Pacific	5	14%
Eastern Europe and Central Asia	1	3%
<b>Total</b>	<b>35</b>	<b>100%</b>

### 3.3 Interventions and PITA mechanisms

We grouped the identified studies by five main intervention areas, presented in **Table 2**. Eleven studies provided information to citizens, either about citizen rights to access services or to participate in participatory processes (n = 5), or information about performance of politicians or public service providers, including report cards (n=7). We consider the main design mechanism for these categories to be transparency, either for increasing citizen participation or transparency to improve accountability. The majority of the studies providing performance information provided information about politicians or local governments, for example Humphreys & Weinstein's (2012) evaluation of the dissemination of a scorecard with detailed information on the performance of Ugandan Members of Parliament (MPs). We included these studies in the review as in all cases we would expect these interventions to have an impact on service delivery in politician's local areas as well as potentially having an impact on voting intentions of citizens. We also included Banerjee et al.'s (2014) RCT in this category, that placed two volunteers from the local community in police stations, as the objective of the study was for the volunteers to feed back their observations to the community rather than for them to give feedback to the police.

The intervention area with the greatest number of included studies is citizen feedback and monitoring mechanisms, where we identified 10 studies or treatment arms. This set includes evaluations of interventions to allow citizens to feedback concerns or priorities around service delivery to providers, and/or to introduce or facilitate monitoring of public service delivery. We consider the main design mechanism here to be accountability as it encourages or actively hold individuals, public service providers and institutions responsible for executing their powers and mandates according to a certain standard. Within this category, interventions largely fell into two groups, those with facilitated citizen feedback and those with unfacilitated citizen feedback. Facilitated citizen feedback covers interventions that solicited concerns from citizens through community meetings or focus groups in order to feed back to service providers, often using a local facilitator or civil society organization, for example Björkman et al. (2017; 2009) and Ananthpur et al. (2016). Unfacilitated feedback interventions gave citizens the tools or opportunities to give feedback or monitor but the collection of these concerns is not through a facilitated group meeting, for example Fiala & Premand (2017) which trains communities to monitor community CDD projects, as well as identify and make complaints about corruption and mismanagement, but does not set up forums to do so. We only identified one study that used technology to solicit feedback on service provision, namely Grossman et al.'s (2017) study of the U-Bridge programme in Uganda

that introduced a SMS-based service for citizens and local government officials to submit, monitor and respond to requests around public service delivery.

Seven studies evaluated a participatory planning mechanism to introduce or facilitate public participation in public institutions' decision-making processes, such as participatory budgeting. Two of these studies were different in that they introduced support for existing participatory planning mechanisms, namely Beuermann & Amelina (2014) that introduced training and technical assistance for an existing participatory budgeting system in Russia, and Ananthpur et al. (2014) which evaluated a citizenship engagement programme to encourage participation, and support, the existing ward *sabha* system in India. The other five studies compared the participatory planning mechanism to an area where the mechanism did not exist.

We identified a further two studies that evaluated mandating the participation of women into decision-making processes around service delivery, both in the context of community driven development (CDD) programmes. These are Humphreys et al. (2014) evaluation of Tuungane in the DRC and Beath et al.'s (2013) evaluation of the NSP in Afghanistan. It should be noted that we did not include the findings from these studies that evaluate the impact of the CDD programmes themselves which was outside the scope of this review, only the comparison between those groups that mandated participation of women and those that did not. We consider these sub-sets of the participatory planning intervention category.

We identified seven studies evaluating community management of natural resources, whereby there is some devolution of the management of a natural resource to a community group, but where the government retains some powers. These fell into two groups; those that involved management of water (Bandyopadhyay et al., 2010; Huang, 2014; Barde, 2017) and of forests or conservancies (Persha & Meshack, 2016; Rasamoelina et al., 2015; Tachibana & Adhikari, 2009; Bandyopadhyay et al., 2004). This intervention category differs substantively from the others in that communities are equipped with considerable more power to make decisions and implement public services than the other intervention areas.

Finally, nine of these citizen engagement programmes also addressed inclusion of marginalised groups. Studies in Afghanistan (Beath et al., 2013) and DRC (Humphreys et al., 2014) focused exclusively on the mandated incorporation of women into community groups. Other programmes targeted inclusion of women or poorer groups in Brazil (Goncalves, 2013), India (Pandey et al., 2007) Indonesia (Banerjee et al., 2018), Malawi (Gullo et al., 2017), Mexico (Diaz-Cayeros et al., 2014), Pakistan (Gine et al., 2018) and Uganda (Björkman et al., 2017).

**Table 2: Included interventions and associated PITA mechanisms**

<i>Intervention type</i>	<i>Intervention definition</i>	<i>PITA Mechanism(s)</i>	<i>Included studies</i>
<b>Rights information provision</b>	<p>Provides information about citizen rights to access services or rights to participate in participatory processes</p> <p>* Interventions that target the inclusion of marginalized groups</p>	Transparency (* Inclusion)	<ul style="list-style-type: none"> <li>• Olken (2007) – Indonesia, invitations only intervention group</li> <li>• Kassim (2016) – Pakistan</li> <li>• Ravallion et al. (2013, 2015) – Bihar, India</li> <li>• Banerjee et al. (2018) – Indonesia*</li> <li>• Pandey et al. (2007) – India*</li> </ul>
<b>Performance information provision</b>	<p>Provides citizens with information about performance of politicians or public service providers, including report cards</p>	Transparency	<ul style="list-style-type: none"> <li>• Humphreys &amp; Weinstein (2012) – Uganda</li> <li>• Grossman &amp; Michelitch (2018) – Uganda</li> <li>• Timmons &amp; Garfias (2015) – Brazil</li> <li>• Capuno &amp; Garcia (2010) – Philippines</li> <li>• Banerjee et al. (2014) – Rajasthan, India</li> <li>• Fiala &amp; Premand (2017) – Uganda, scorecard only group</li> </ul>
<b>Citizen feedback mechanism</b>	<p>Interventions to allow citizens to feedback concerns or priorities around service delivery to providers, and / or to monitor the delivery of public service delivery. This includes community scorecards and social audits.</p> <p>* Interventions that target the inclusion of marginalized groups</p>	Accountability (* Inclusion)	<ul style="list-style-type: none"> <li>• Olken (2007) – Indonesia, invitations + feedback group</li> <li>• Berman et al., (2017) – Afghanistan</li> <li>• Alhassan et al. (2016) – Ghana</li> <li>• Grossman et al. (2017) – Uganda</li> <li>• Björkman et al. (2009; 2017; incorporating Donato &amp; Garcia, 2016) – Uganda*</li> <li>• Palladium (2015) – DR Congo</li> <li>• Gullo et al. (2017) – Malawi*</li> </ul>

<i>Intervention type</i>	<i>Intervention definition</i>	<i>PITA Mechanism(s)</i>	<i>Included studies</i>
			<ul style="list-style-type: none"> <li>• Fiala &amp; Premand (2017) – Uganda</li> <li>• Bradley &amp; Igras (2005) – Kenya &amp; Guinea</li> <li>• Molina (2014) – Colombia</li> </ul>
<b>Participatory planning</b>	<p>Interventions to introduce or facilitate public participation in public institutions' decision-making processes, priority setting or budget allocation decisions, including participatory budgeting</p> <p>* Interventions that mandate or target the inclusion of marginalized groups in planning</p>	Participation (* Inclusion)	<ul style="list-style-type: none"> <li>• Touchton &amp; Wampler (2014) – Brazil</li> <li>• Goncalves (2013) – Brazil*</li> <li>• Diaz-Cayeros et al. (2014) – Mexico*</li> <li>• Beuermann &amp; Amelina (2014) – Russia</li> <li>• Ananthpur et al. (2014) – Karnataka, India</li> <li>• Giné et al. (2018) – Pakistan*</li> <li>• Humphreys et al. (2014) – DR Congo*</li> <li>• Beath et al. (2013) – Afghanistan*</li> </ul>
<b>Community-based natural resource management (CBNRM) committees</b>	<p>Devolution of some part of the management of a natural resource to a community group while the government retains some powers. This includes Water User Associations (WUAs) and Community-Based Forest Management (CBFM) organizations</p>	Participation	<ul style="list-style-type: none"> <li>• Bandyopadhyay et al., (2004) – Namibia</li> <li>• Bandyopadhyay et al., (2010) – Philippines</li> <li>• Persha &amp; Meshack. (2016) – Tanzania</li> <li>• Rasamoelina et al., (2015) (Rasolofoson et al., 2015) – Madagascar</li> <li>• Tachibana &amp; Adhikari (2009) – Nepal</li> <li>• Barde (2017) – Brazil</li> <li>• Huang (2014) – China</li> </ul>

### 3.4 Intervention funders

We attempted to capture information on the funders of the programmes or policies evaluated in the included impact evaluation, shown in **Table 3**. Almost 45 per cent of the programmes received funding from a public institution such as a national government, university or bilateral donor such as the Department for International Development or USAID. Over 25 per cent received funding from a multilateral institution, all of which received funding from a department from within the World Bank, in some cases

combined with funding from another multilateral institution. Three of the interventions were at least partly funded by an NGO and two by a foundation. In over 15 per cent of the studies, the intervention funders were not reported.

**Table 3: Intervention funding sources**

Funding source	Studies	Percentage
Public institutions (government agencies, universities etc.)	15	43%
Multilateral organisations (World Bank, UN, etc.)	9	26%
NGO	3	9%
Foundation	2	6%
Unclear / not reported	6	17%
Total	35	100%

### 3.5 Equity considerations

For each study, we captured information about if, and how, it addresses equity concerns, either through the design of the intervention or through the evaluation design and analysis methods. We considered an intervention to address equity if it targeted a marginalized or vulnerable group or was designed in a way to overcome local barriers to incorporate these groups into the programme. We considered an evaluation design and analysis method to incorporate equity if it undertook sub-group analysis for the marginalized group or reported on how those groups were able to participate in the programme.

Eighteen of the included studies did not explicitly address equity concerns.<sup>2</sup> Nine of the included studies evaluated an intervention that addressed equity concerns by design. Two of these studies focused exclusively on how the mandated incorporation of women into community groups affected service delivery outcomes. These were Humphreys et al.'s (2014) evaluation of how removing the gender parity component of the CDD programme, Tuungane, in the DRC affected outcomes, and Beath et al.'s (2013) evaluation of how the requiring female participation in the distribution of food aid in the context of a CDD programme in Afghanistan, the NSP, and through the traditional *jirga* system, affected delivery and corruption. Two of the citizen feedback studies, Björkman et al. (2017; 2009) in Uganda and Gullo et al. (2017) in Malawi, divided citizens into key social groups such as women, men, youths in order to get their perspectives over issues concerning service delivery and determine their preferences for change. The Diaz-Cayeros et al. (2014) evaluation in Oaxaca, Mexico assessed the *Usos y Costumbres* system, which formalizes participation of traditional forms of governance, typically of indigenous groups, in municipality level government decision-making. The participatory budgeting system in Brazil, evaluated in Touchton & Wampler (2014) and Gonclaves (2013), frequently adopts a "quality of life index", which allocates greater resources on a per capita basis to poorer neighborhoods. Banerjee et al. (2018) evaluates an information campaign on the Raskin rice for the poor programme in Indonesia, which is targeted at poor households who are entitled to the rice but do not receive it. Finally,

<sup>2</sup> We state they did not explicitly address equity concerns, as it is possible the intervention design considered marginalised and vulnerable groups, but it was not reported in the intervention description in the impact evaluation or additional documents.

Giné et al.'s (2018) evaluation of the initial community mobilization stages of a CDD programme in Pakistan actively targets the inclusion of women and poor households in the mobilization and community organization formation process.

Only eight of the included studies addressed equity issues by evaluation design. Just six of the included studies undertook sub-group analysis by a marginalized or vulnerable group. Palladium's (2015) evaluation of the community engagement component of the Security Sector Accountability and Police Reform (SSAPR) Programme in the DRC undertook sub-group analysis by men and women for outcomes around crime and feelings of security in the community. Ananthpur et al. (2014) undertook a sub-group analysis for the effect of the "People's Campaign" in Karnataka, India, on female and male agricultural wages. Ravallion et al.'s (2013) evaluation of an information campaign around NREGA (National Rural Employment Guarantee Act) assessed outcomes on service use and knowledge of rights for men and women separately. Bandyopadhyay et al. (2010) assessed the effects of the Irrigation management transfer (IMT) to Irrigation Associations in the Philippines on production of rice for both the asset rich and the asset poor. Persha & Meshack (2016) assessed how the Joint Forest Management policy in Tanzania affected women headed households. Finally, Pandey et al.'s (2007) evaluation of a rights campaign in India undertook sub-group analysis by people belonging to lower and mid- to high-level castes.

In addition to sub-group analysis, Ananthpur et al. (2014) also included a substantial ethnographic component, which considered the participation of particularly marginalized groups in the gram sabha system in India following the information campaign and considered how women had been mobilized by the intervention. Alhassan et al.'s (2016) evaluation of a citizen feedback mechanism in Ghana considered the gender dynamics of focus groups that were part of the intervention to identify gaps in service delivery in healthcare facilities. Finally, Diaz-Cayeros et al. (2014) considered how women's participation related to the Usos y Costumbres system in Mexico, including the share of the municipal council made up by women, and whether the current mayor is a woman.

### 3.6 Types of studies

**Table 4** shows the types of publications we included in the review. Just under 50 per cent were peer-reviewed journal articles. Almost 30 per cent were articles published in working paper series such as the World Bank Policy Research working paper series or Inter-American Development Bank Paper Series. We identified five organizational reports, for example reports published in the 3ie impact evaluation series or USAID. Finally, we included two conference papers and one PhD thesis (Kasim, 2016).

**Table 4: Type of publications**

Publication type	Studies	Percentage
Peer reviewed journal	17	49%
Working paper	10	29%
Organisation report	5	14%
Conference paper	2	6%
PhD Thesis / Dissertation	1	3%
Total	35	100%

Nineteen, or just over half, of the included studies were cluster RCTs, that randomized the allocation to the intervention or comparison group at the level of the public service, village, wider community or similar. Most of these studies used covariate-adjusted regression (n = 15), including fixed effects regression, methods of analysis. Six of these studies used difference-in-differences (DID) analysis with baseline data from the RCT. Alhassan et al. (2016) also used Propensity Score Matching (PSM) to analyze some outcomes for their RCT, presumably as there are imbalances between the treatment and control groups.

Timmons & Garfias' (2015) study from Brazil was the only included natural experiment. It evaluated a policy in Brazil that randomly audited sub-national government expenditure, the results of which were then published for citizens.

The remaining 14 studies used non-randomized, quasi-experimental designs. Ten of the studies used a comparison group with both pre-intervention and post-intervention data. Three of these used pseudo-panel with repeated measurement for groups but different individuals (Palladium, 2015; Persha & Meshack, 2016; Capuno & Garcia, 2010). The remaining seven used panel data on the same individuals, households or communities (Diaz-Cayeros et al., 2014; Touchton & Wampler, 2014; Gonclaves, 2013; Bradley & Igras, 2005; Huang, 2014, Barde, 2017; Tachibana & Adhikari, 2009). Six of these studies combined statistical matching with DID analysis, typically through covariate adjusted regression. The remaining studies only used covariate matching followed by a comparison of means or only covariate adjusted regression.

Finally, four of the included studies used a comparison group but only had one data point after the intervention had started. Three of these studies used statistical matching methods (Molina, 2014; Bandyopadhyay et al. 2010; Rasolofoson et al. 2015) combined with another analysis method such as covariate adjusted regression or simple comparison of means, while Bandyopadhyay et al. (2004) used instrumental variables regression only without statistical matching.

We discuss methodological aspects of the studies in the next section.

**Table 5** presents the follow up period for the assessment of outcomes after the start of the citizen engagement intervention. Most of the included impact evaluations assessed outcomes between one year and five years after the start of the intervention (n= 22). In six studies, the follow period was 12 months or less. The shortest follow up period was in Kasim (2016) which looked at outcomes after six months. Two studies assessed outcomes between five and 10 years after the start of the intervention. Six of the evaluations assessed outcomes 10 years or more after the initiation of the intervention. All these evaluations assessed long-standing national programmes: participatory budgeting in Brazil (Gonclaves, 2013; Touchton & Wampler, 2014), the *Usos y Costumbres* system in Mexico (Diaz-Cayeros et al., 2014), rural water user associations in Brazil (Barde, 2017) and community-based forest management in Tanzania (Persha & Meshack, 2016) and Nepal (Tachibana & Adhikari, 2009).

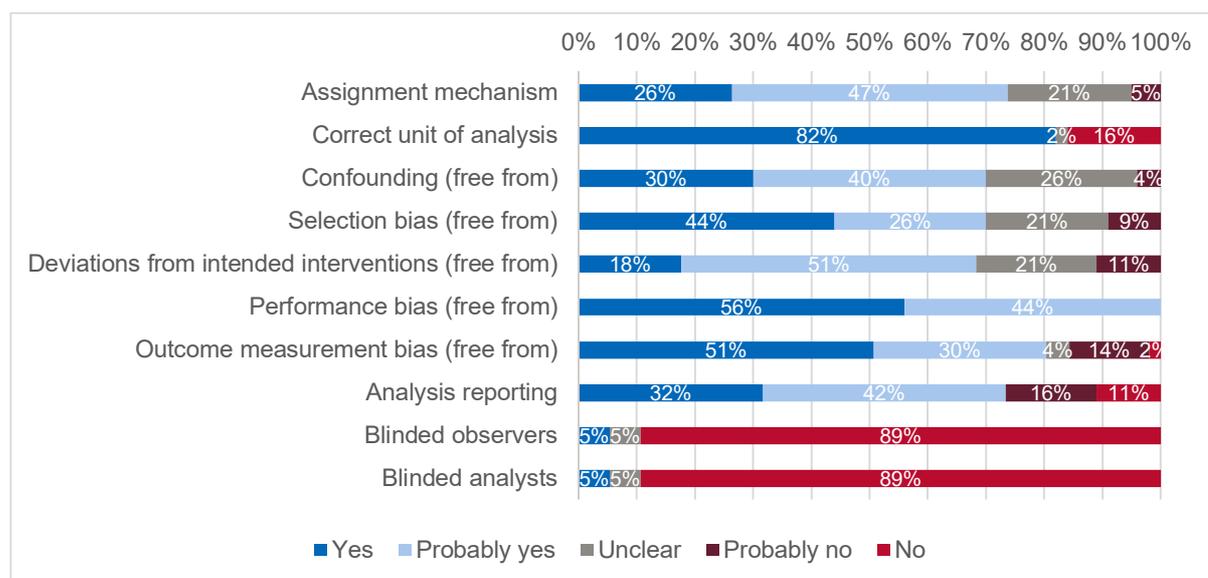
**Table 5: Follow up periods of included studies**

Follow up period	Study
12 months or less	Björkman & Svensson (2009), Olken (2007), Fiala & Premand (2017 scorecard intervention only), Kasim (2016), Pandey et al. (2007) Ravallion et al. (2013).
1 - 5 years	Alhassan et al. (2016), Björkman et al. (2017), Grossman et al. (2017), Gullo et al. (2017), Palladium (2015), Berman et al. (2017 - two follow ups), Fiala & Premand (2017 - two follow ups), Ananthpur et al. (2014), Beuermann & Amelina (2014), Giné et al. (2018), Bandyopadhyay et al. (2010), Bradley & Igras (2005), Bandyopadhyay et al. (2004), Capuno & Garcia (2010), Humphreys & Weinstein (2012), Grossman & Michelitch (2018), Timmons & Garfias (2015), Banerjee et al. (2014), Banerjee et al. (2018), Humphreys et al. (2014), Beath et al. (2013).
5 - 10 years	Huang (2014), Tachibana & Adhikari (2009 - environmental outcomes).
10 + years	Diaz-Cayeros et al. (2014 - several follow up periods), Touchton & Wampler (2014), Gonclaves (2013), Barde (2017), Persha & Meshack (2016), Tachibana & Adhikari (2009 - forest condition).
Unclear	Molina (2014), Rasolofoson et al. (2015).

### 3.7 Critical appraisal of included studies

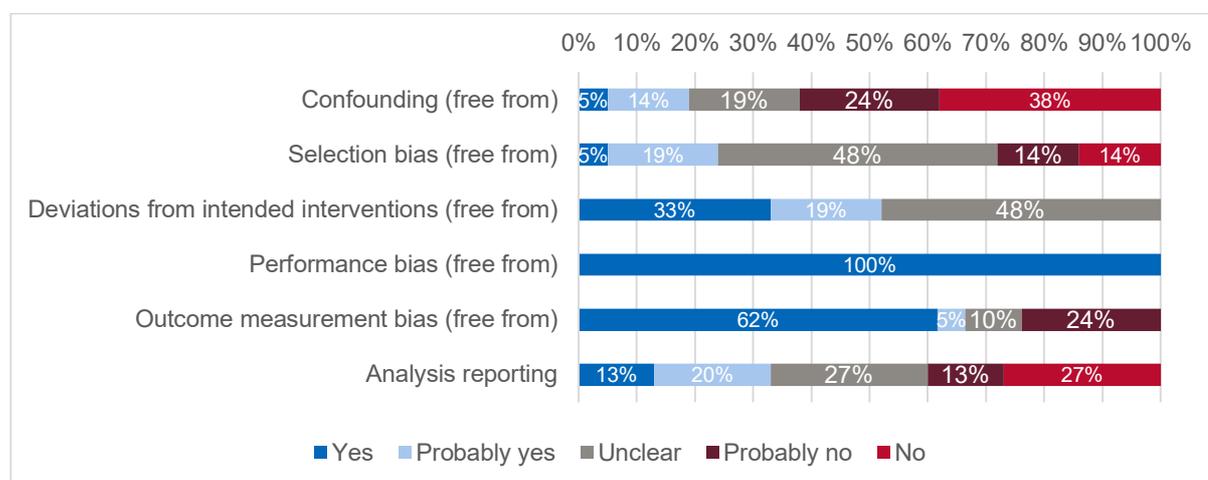
We assessed the risk of bias for all studies included in this review. **Figure 5** presents the results for each criteria across all randomized studies and **Figure 6** presents the results for non-randomized studies. The criteria related to the assignment mechanism, analysis reporting and blinding are assessed at the study level whereas all the other criteria are assessed at the outcome level. While selection bias and risks of confounding are usually assessed at the study level, it can be the case that some outcomes are more exposed to bias than others, depending on the data source or the analysis method (e.g. where outcomes data are collected based on participant self-reports rather than direct observation in non-blinded studies).

**Figure 5: Summary of risk of bias appraisal for randomized studies**



We found that out of the 166 outcomes assessed separately from non-randomized studies, 146 had high risk of bias, 19 had some concerns, and one had low risk of bias. Out of 386 outcomes assessed separately for randomized studies, 161 had high risk of bias, 83 had some concerns and 142 had low risk of bias. A detailed and overall assessment by study and group of outcomes is presented in **Appendix F**.

**Figure 6: Summary risk of bias appraisal of non-randomized studies**



### 3.8 Findings by risk of bias domain

#### 3.8.1 Assignment mechanism in randomized studies

For a large majority of the studies (73%), the assignment of clusters into the different study arms was random or probably random (**Figure 5**). For only one study (Kasim, 2016), although the assignment mechanism was reported as random and the sample was relatively large, significant imbalances at baseline suggests that there might have been a problem in the random allocation. While assignment seems to have indeed been random for 73 per cent of randomized studies (and is reported as such), 47 per cent lacked detailed information about the exact randomization method, such as whether the

sequence was generated by a computer or whether a paper-based lottery was organized. In one study, important information on the number of units of programme implementation within each cluster was missing (Berman et al., 2017).

Reporting of a baseline balance table on cluster characteristics and household characteristics is not done systematically. Five randomized studies did not report any balance table and one reported it only for balance on cluster characteristics, even though the outcomes were measured at the household level. Eight out of 14 non-randomized studies reported a balance table at baseline and when relevant after statistical matching. In some instances, it was not possible to assess baseline balance. For instance, in Ananthpur et al. (2017), the baseline data were collected after the start of the intervention in some villages, yet the analysis method used the difference-in-difference technique. The extent to which this undermines the results will depend on the proportion of observations affected, but the authors did not report the information required to assess the scale of the issue.

### **3.8.2 Selection bias**

The randomization ensures that the risk of selection bias into the study is relatively small. A majority of outcomes measured in randomized studies were considered free or probably free from selection bias (70%). However the sampling method used to collect survey data or differential attrition at the end of the study represent threats for RCTs and non-randomized studies. Given that tracking survey respondents over long time periods or preventing dropouts can be challenging, attrition is common across almost all studies to a certain extent. It is only a threat to validity if it represents a large proportion of the sample and is systematically larger for some study groups than others (and correlated with outcomes). This might be the case for eight per cent of outcomes and is unclear for 21 per cent of outcomes. Unfortunately, the lack of information reported on the reasons for attrition makes it hard to identify risks of selection bias out of the study. Authors do not tend to make attrition information very accessible. In three studies where attritions rates were particularly high (greater than 20 per cent of the baseline sample), authors do not report attrition rates across different treatment and control groups, or test of the relationship between covariates and treatment status, four neglect to comment on varying sample sizes between the initial sample and the results tables, and two do not provide enough information to calculate attrition.

An example of an unclear case is Giné et al. (2018), in which stunting could not be measured in one of the five districts included in the study, and no information was provided on the proportion of treatment and control communities per district. Excluding an entire geographical area because of the difficulty to collect data, could be selecting out of the study populations sharing similar characteristics, but it is not clear whether there was an equal proportion of treated and control communities which would prevent any bias from undermining the results. There could also be selection bias into the study if the sampling of survey respondents was not representative of the study sample, or too small. There is a risk that this bias exists for Kasim (2016), as the in-person survey was conducted only in one out of eight districts where the study was implemented.

Thirteen of the non-randomized studies are quasi-experimental studies using various econometric techniques to control for selection bias. One of the studies (Timmons and Garfias, 2015) is a natural experiment, which evaluates the impact of a programme

happening outside the researcher's control, but the selection process resembles random assignment. More than 70 per cent of non-randomized studies did not provide enough information on the selection process into the programme to reject the risk of selection bias, or failed to overcome the selection bias that was identified. Non-randomized studies included in this review typically evaluate programme like community-based natural resource management reforms, because they imply a long-term change in the management system which cannot be measured via a trial. The selection process for this type of programme is likely to be either the government's decision based on unknown criteria or through self-selection of the communities themselves. For outcomes in four studies (24%), where the design was likely to introduce selection bias, authors conducted an in-depth analysis of the selection criteria and convincingly argue that all characteristics that might affect outcomes were controlled for in the analysis. For these outcomes, the presence of unobservable characteristics that might affect the outcomes is unlikely, therefore these outcomes were rated as probably free from selection bias.

### **3.8.3 Deviations from intended interventions**

Any spill overs from one study group to the other, contamination of the study by another programme, or non-compliance to the assigned intervention status, has been assessed under deviations from intended interventions. Only two randomized studies have outcomes that had high risks of deviations. One of the outcome in Giné et al. (2018) was assessed at the level above the unit of randomization, the Basic Health Unit, which was served by control and treatment communities. Berman et al. (2017) mentions issues in the implementation of the random assignment leading initially assigned control community to receive the treatment. For 21 per cent of outcomes in randomized and 48 per cent of outcomes in non-randomized studies, authors did not report on the geographical distance between intervention and comparison groups, or failed to justify the absence of spill overs when there was a potential risk.

### **3.8.4 Performance bias**

Another potential bias occurring during the data collection process is performance bias: the fact that monitoring participants influences their behaviors because they are aware of being watched (Hawthorne effect). A majority of randomized studies are protected from this bias (56%). When a process evaluation of the intervention was conducted (Fiala & Premand, 2017) it was done on a subsample of the treatment group. Banerjee et al. (2014), which was also at risk of motivation bias due to the decoy visits used as a monitoring technique, overcame this risk by adding a pure control study arm (placebo group), free from monitoring visits.

### **3.8.5 Outcome measurement bias**

With regards to outcome measurement bias, which refers to cases where the way the outcome is being measured differs between treatment and control participants as a result of the intervention, it is worth noting that around 65 per cent of the primary outcomes in these studies are self-reported, increasing their exposure to bias. **Figure 5** and **Figure 6** illustrate this with 20 per cent of the study outcomes being unclear, probably not free or not free from outcome measurement bias for randomized studies and 34 per cent for non-randomized studies. An illustration of why this bias is greater when it is self-reported is a situation where the participants receive information about what the expected behaviors or beliefs are, and then are asked about their own behaviors and beliefs. This issue exists with Kasim (2016), where people receive text messages about their rights

with regards to certain institutions and are then asked to rate their trust toward these institutions. Measuring participants' trust in religious institutions, on which no information was provided as part of the intervention, worked as a placebo outcome to measure the effect of potentially biased answers.

Five studies included in this review evaluate community-based monitoring of health services (Alhassan et al. 2015 Alhassan et al. 2016, Björkman & Svensson 2009, Björkman et al. 2017, Fiala & Premand 2017, Gullo et al. 2017). Because the main intervention aims to engage citizen in monitoring health worker's performance, the service users in the intervention groups in these studies are more likely to remember the services they received over the past year because they paid attention to it (recall bias). Similarly, the service providers in this setting have incentives to over-report on their performance.

In situations where there are risks of measurement bias known from the start, four studies collect data from different sources so that they do not rely only on a biased estimate. This is what researchers have done in Berman et al. (2017) to measure road quality. Given that there is a high risk of outcome measurement bias in asking villagers who have been taught how to assess quality as part of the intervention, they have measured this outcome using both villagers report and a technical assessment.

The bias could also come from the outcome assessors, if they know the respondent's treatment status. This could still be a risk for all studies because none of them blinded outcome assessors except one (Pandey et al., 2007).

### **3.8.6 Analysis**

The randomized study designs ensured comparability of groups for the analysis of almost all outcomes. As a result, 70 per cent of all outcomes in randomized studies were free or probably free from confounding. However, depending on the sample size and the randomization procedures, some imbalances can occur by chance. The majority of authors identified these imbalances and controlled for relevant variables in the analysis method, whereas in 26 per cent of the cases, it was not clear whether imbalanced variables were controlled in adjusted analysis.

Although 12 out of the 14 non-randomized studies used the appropriate method to control for group differences given the data available, the existing selection bias into the programme and the lack of baseline data explains why more than 60 per cent of studies did not ensure group equivalence on all relevant variables. Despite the use of combinations of matching techniques with difference-in-difference estimations, it was sometimes unclear whether unobservable characteristics could be accounted for (19 per cent of the outcomes).

Out of all studies, only one blinded data analysts to the treatment (Humphreys et al., 2012).

### **3.8.7 Reporting**

Overall, for randomized and non-randomized studies alike, there is a lack of transparency and reporting. Non-randomized studies do not systematically report results using different analysis methods and specifications, which is often key to assessing the robustness of their model. Three studies out of eight using statistical matching reported

estimation from different matching techniques. The existence of a pre-analysis plan, published before the start of the analysis, or a trial registration is rare across all types of studies. None of the non-randomized studies and only three randomized studies reported having registered the trial or a list of outcomes (Pandey et al., 2007, Banerjee et al., 2018 and Fiala & Premand, 2017). Only three study reported having published a pre-analysis plan (Beath et al., 2013, Grossman et al., 2017 and Humphreys et al., 2012). The 42 per cent of randomized studies being probably free from analysis reporting are studies which have been reported transparently but have not registered either trial, outcomes or pre-analysis plan, therefore we cannot be certain that all relevant analyses are reported. Finally, two randomized studies failed to report analysis differentiating treatment arms (Alhassan et al., 2015; and Kasim, 2016).

More generally, as **Figure 5** and **Figure 6** illustrate, there is, for all criteria, a share of studies and outcomes which could not be assessed because of a lack of information (grey areas). Overall, it is sometimes the case that there is some doubt about a risk of bias, which could have been eliminated if more information on the issue was provided. These issues were particularly problematic for method of assignment (randomization procedures), reporting of baseline data and attrition.

### **3.9 Research ethics**

We also captured information on whether the paper explicitly stated that the authors had ethical clearance to undertake the study. Of the 35 included studies, the majority (28) collected primary data for analysis. However, just three of the included studies reported that they had sought and received ethical clearance for their studies. The rest did not report whether ethical clearance to undertake the research was sought or granted; they may well have done, but they simply do not indicate whether this was the case in the country where the data were being collected and (if different) where the research team was based. In addition, we looked for declarations of interest in the included studies, to capture for example if any of the authors related in any way to the funding or implementing institution. We found that only two studies included conflict of interest statements. In 18 of the studies, the authors did not include a statement or did not present a statement that clearly reported on possible conflicts (known or unknown) for all authors.

### **3.10 External validity**

Several factors need to be taken into account when assessing the external validity of studies such as the approach used by researchers to select the study population, whether the programme implemented was a small-scale pilot or a large-scale established programme, and the characteristics of the population and setting of the study. We captured information on the sampling strategies, as well as authors' discussions of generalizability of their findings.

#### **3.10.1 Selection of the study population**

We identified nine studies in which random sampling was used to either select the study's geographical areas such as regions and districts, or select the clusters or units of treatment such as communities, facilities and villages. Twenty-one used purposive sampling and four did not provide enough information on their method or the origin of the

data set used. **Table 6** shows which studies have used each of the sampling strategies, and separates the results by treatment assignment mechanism and whether survey respondents were randomly sampled.

Knowledge of the sampling method is not sufficient on its own and, more attention to each study is needed to be able to conclude on the representativeness of the populations selected. Of the studies which used random sampling, three did not include randomly selected regions but researchers selected the communities within the regions randomly. One decided to include a representative population of the country by randomly selecting regions or districts but then purposely selected villages.

Of the studies which used only purposive sampling, two reported specific exclusion criteria which might limit the generalizability of their results. For instance, Alhassan et al. (2016) mentions that health facilities were selected because they were less complex and easy to monitor. Gullo et al. (2017) selected areas where not many NGOs were already present to avoid contamination. Two studies had to drop communities or facilities from their sample because of constraints related to their randomization method (Gullo et al., 2017; Berman et al., 2017). Two studies selected areas specifically for their representativeness of the state or country population (Banerjee et al., 2014; Berman et al., 2017). Ananthpur et al. (2014) specifically targeted the poorest area in the state. Another selection criteria was availability of data, especially for non-randomized retrospective studies using existing data sets. A few authors mention that villages where survey or administrative data was already available from previous studies were selected to be part of the evaluation (Banerjee et al., 2018; Pandey et al., 2007; Gonclaves, 2013). Finally, three studies evaluating the impact of an established programme were restricted to the area or communities where the NGO or the government was implementing or had had the programme (Beath et al., 2013; Gine et al., 2018; Molina, 2014).

**Table 6: Sampling strategy used to select communities and villages**

Population selection	Random sampling of survey respondents	Random allocation to treatment	Non-random selection into treatment
Randomly sampled regions (or any geographical unit above cluster)	Yes	Beuermann & Amelina (2014), Björkman & Sevensson (2009), Humphreys & Weinstein (2012)	Capuno & Garcia (2010)
	No		Timmons & Garfias (2015)
Randomly sampled clusters within purposely selected regions	Yes	Ravallion (2013), Grossman et al. (2017)	Bandyoadhyay (2010)
	No		Huang (2014)

Purposive sampling of clusters	Yes	Gine et al (2018), Ananthpur et al. (2014), Beath et al. (2013), Banerjee et al. (2018), Banerjee et al. (2014), Grossman & Michelitch (2018), Humphreys et al (2014)	Tachibana & Adhikari (2009), Palladium (2015), Persha & Meshack (2016), Rasamoelina et al. (2015)
	No	Alhassan et al. (2016), Gullo et al. (2017), Pandey et al. (2007), Olken (2007), Berman, 2017	Touchton & Wampler (2014), Molina (2014), Goncalves (2013), Bradley & Igras (2005), Barde (2017),
Unclear		Kasim (2016), Fiala & Premand (2017)	Bandyoadhyay (2004), Diaz-Cayeros et al. (2014)

### 3.10.2 Author discussion of external validity

We found 11 studies where authors specifically discussed external validity. Among those studies, five acknowledged the limits to the generalizability of their findings, due to the small scale of the study or the sampling strategy. Four studies claimed generalizability of their findings, either to the level of an Indian state (Banerjee et al., 2014; Ravallion et al., 2013), or to other areas of the country under similar conditions, such as density of population or distance to a health facility (Touchton, 2015; Björkman et al., 2017). Finally, two studies claimed generalizability of their findings to other contexts, and potentially other countries (Fiala & Premand, 2017; Timmons & Garfias, 2015).

### 3.11 Summary results from critical appraisal

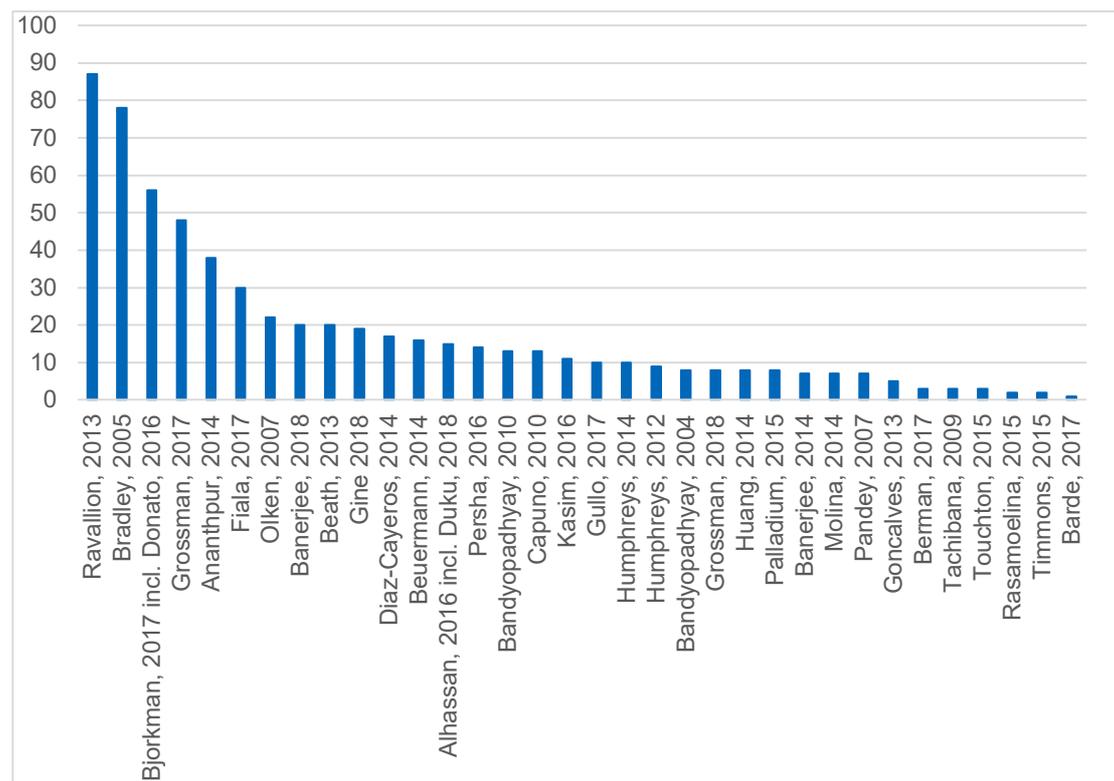
The quality of evidence from randomized studies is relatively high compared to non-randomized studies, and easier to assess due to standards of reporting for those studies. Prospective randomized study design helped ensured comparability of intervention and control groups according to observable characteristics, and protected threats from selection bias into the study in 70 per cent of the cases. For these studies, threats to internal validity are therefore more relevant at the outcome level, where concerns related to the way some outcomes are measured in the majority of studies. This is largely due to the use of self-report measures that are more likely to be biased in open studies where blinding (of outcome data collectors or participants) is not attempted or impossible. A majority of the non-randomized studies did not provide enough information on the selection process into the programme to reject the risk of selection bias, or failed to overcome the selection bias and confounding that was identified. Transparency in reporting is an issue for randomized and non-randomized studies alike given the limited pre-registrations of trial, outcomes or analysis plans. The use of methods such as placebo outcomes or groups, and blinding for outcome assessors or data analysts, is not common, though it seems relatively easy to implement and could reduce risks of biases. With regards to external validity, four studies still do not report their sampling strategies

clearly, and a surprisingly small share of all studies specifically discuss the extent or limits to generalizability of their findings.

#### 4. Results of meta-analysis (Review questions 1-3)

As discussed, we collected all effect estimates from each included study, on any eligible outcome, population sub-group or specification. Hence for some studies we collected large numbers of effects. **Figure 7** presents the number of effect estimates collected from each study that we were able to incorporate in meta-analysis.

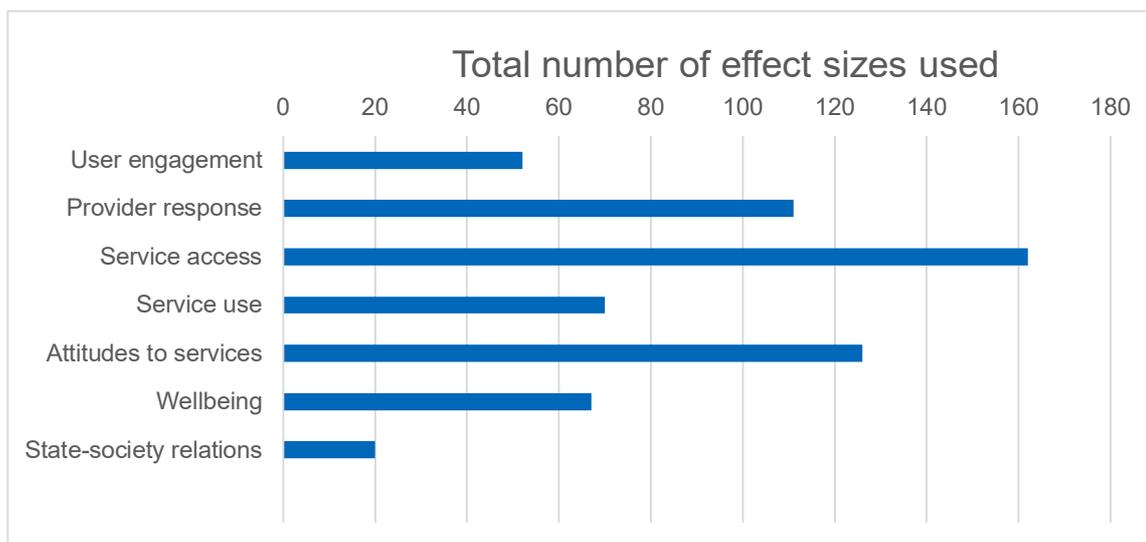
**Figure 7: Numer of effect sizes collected from included studies**



In total the 35 studies yielded 618 estimates of programme impacts that we incorporated in meta-analysis. All studies provided usable data for effect size calculations. In cases where pooled standard deviations were not available, we had to rely on t-statistic transformations to calculate  $g$  and its standard error. The effect sizes are unevenly distributed between studies. The largest numbers of effect sizes were from Ravallion et al. (2013) in Rajasthan, India, with 87 effect estimates used in the analysis, followed by Bradley & Igras (2005) in Guinea and Kenya with 78 effect estimates, Björkman et al. (2009, 2017; also incorporating Donato & Garcia, 2016) in Uganda with 56 effect estimates extracted, and Grossman et al. (2017) in Uganda with 48. However, the majority of studies presented far fewer effect estimates, usually less than 20.

We assigned specific sub-categories of outcomes (e.g. participation in meetings) to causal chain outcome groupings: intermediate outcomes (service access, service use and attitudes to services), final outcomes (wellbeing and state-society relations) (review question 1), and immediate outcomes (user engagement and provider response) (review question 2). **Figure 8** presents the number of effect sizes collected for each outcome.

**Figure 8: Number of effect sizes by outcome**



We drew on a recent review of community-driven development (White et al., 2018) in informing the outcome groupings along the causal chain, as presented here. **Table 7** presents the detailed description of variables included under each outcome area. As these may differ by projects, these are presented by main sector (health, social protection, justice and security, local infrastructure and economy, and natural resources). The full list of variables collected under each outcome category is presented in **Appendix G**.

**Table 7: Description of outcome variables included in meta-analysis**

	Immediate outcomes		Intermediate outcomes		Final outcomes	
	<i>User engagement</i>	<i>Provider responsiveness</i>	<i>Service access</i>	<i>Service use and attitudes</i>	<i>Wellbeing</i>	<i>State-society relations</i>
Health	Participation in project meetings Active participation (spoke at meeting) Knowledge of project processes (knows about meetings) Knowledge about services available (identifies services)	Public spending Provider actions (prepare plan, public monitoring or reporting such as staff duty roster, suggestion box) Project staff motivation (facility management, morale)	Access ( <i>Anganwadi</i> , lady health worker in village) Measured quality of service (health facility performance, wait time*, staff experiencing negative event*, lack of supplies*) Absenteeism (workers not present*, effort index) Cost of service (user fees*)	Use of services (health facility visit, immunization (partial or full), antenatal / postnatal care, family planning service, enroll in insurance) User satisfaction (perception of quality, complaint lodged*, friendliness of staff, felt able to convey concerns)	Illness* Death* (IMR, U5MR) Births Nutrition outcomes (stunting incidence*, wasting incidence*)	Corruption (perceptions about corruption, payment made to official*)
Social protection	Participation in project targeting (number people/women involved) Knowledge about services (women have right to participate, facilities knowledge)	Provider actions (reported change in procedure) Responses perceived by user (better targeting)	Access (received social security card) Measured quality of service (received entitlement, employment opportunities) Leakages (embezzlement*)	Use of nutrition services (used food subsidy, amount purchased) Use of employment services (participate in employment opportunities, wages) User satisfaction (complaints reported*, protests reported*, perceived quality of staff)	Income and expenditure Household/personal assets Employment (wages) Social capital (feelings of personal influence, social cohesion)	

Justice and security		Response perceived by user (change in police performance)		Perceived quality of service (perception of police awareness of crime)	Security (being a victim of crime*, trust, feeling safe against theft or attack)	Public confidence in institutions (fear of police, police responsiveness, trust government) Corruption perceptions
Local infrastructure and economy	Participation in project meetings Active participation (spoke at meeting)	Public spending Provider actions (meetings held) Response as perceived by user (e.g. priorities match) Politician performance (e.g. politician responds)	Access (construction of hand pumps/ tube wells roads) Measured quality of service (maintenance of facilities, visits from extension worker) Leakages/corruption (quality of infrastructure*)	Use infrastructure (water use) User satisfaction (satisfaction with roads, municipality cleanliness, sanitation service, Perceived quality of service (attitudes to community assets)	Yield/production	Public confidence (satisfaction with leaders, officials, politicians) Paid taxes
Natural resources	Active participation (prepare maintenance plan)		Access (access to natural resources)	Use of environmental resource (deforestation*, forest regeneration)		Public confidence (satisfaction in NRM committee, forest governance institutions) Paid taxes (contribution to community funds - e.g. irrigation service fees)

Note: \* indicates negative outcome.

## 4.1 Meta-analysis of service access and wellbeing outcomes (review question 1)

We present findings by primary outcome group and subgroups along the results chain (intermediate and final outcomes). In each sub-section, we first present an overview of the different outcome metrics used in each study included in meta-analysis (for the full list, see **Appendix G**) and then present the subsequent meta-analysis results including forest plots. When presenting the meta-analysis, we present sensitivity analyses to disaggregate findings by study design (whether randomized or non-randomized) and risk of bias status.

In general, the findings suggest that the interventions can be effective ways of boosting citizen engagement in service delivery governance and access to public services. But the evidence does not suggest that outcomes further along the results chain typically improve as a result of interventions to promote citizen engagement. In a few cases, particularly in health and infrastructure, there may be increases in service use and some wellbeing outcomes. For state-society relations, payment of taxes may increase.

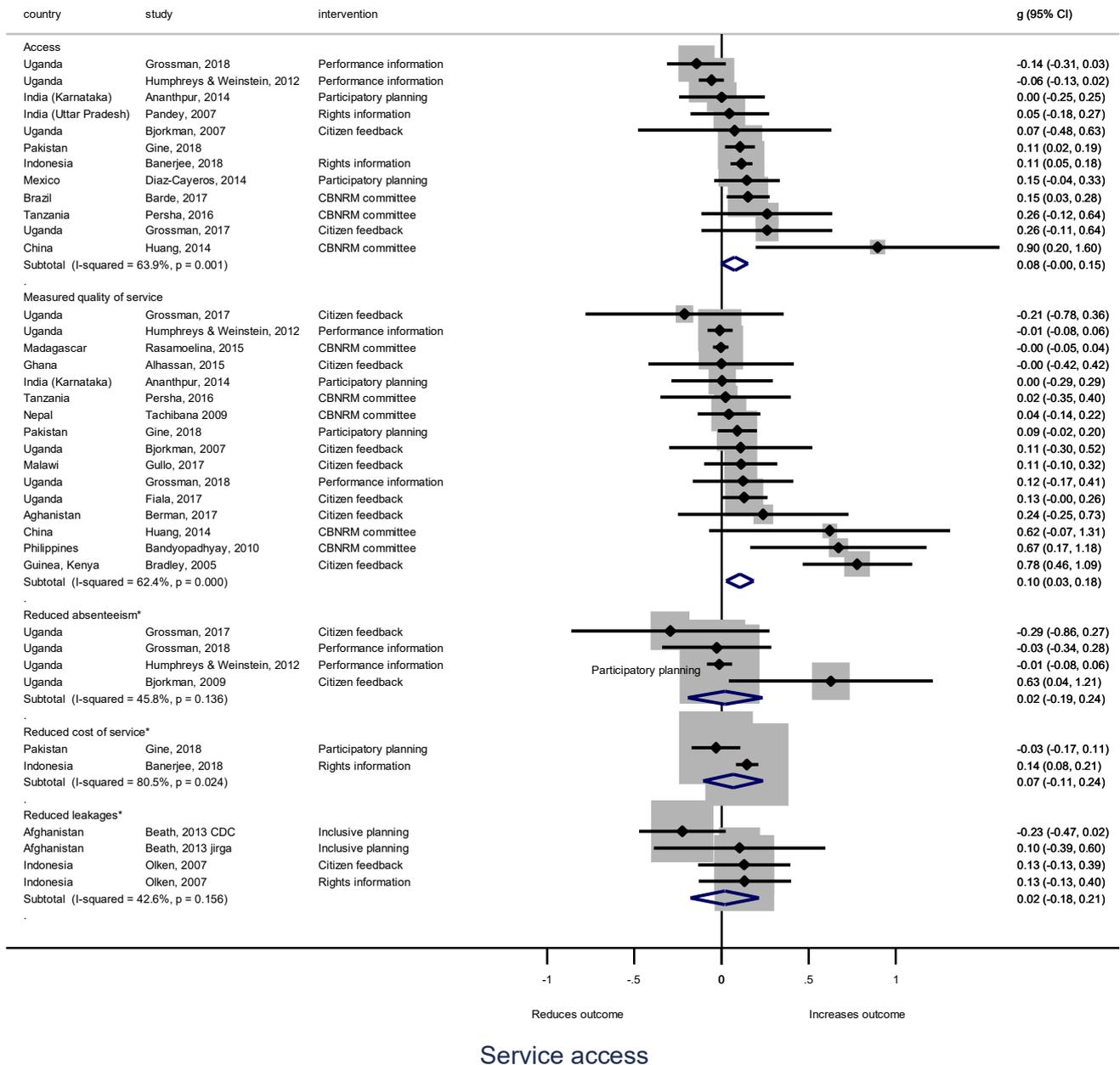
### 4.1.1 Service access

A mix of variables was used to measure physical access including new amenities available in the community, such as water sources (Ananthpur et al., 2014; Barde et al., 2017; Diaz-Cayeros et al., 2014; Grossman, 2017; Humphreys & Weinstein, 2012), roads, (Ananthpur et al., 2014), health units (Bjorkman et al., 2007), or new health staff posted in the community like *Anganwadi* (community creche) workers (Ananthpur et al., 2014) and lady health workers (Gine et al., 2018). Access is also measured through costs to consumers in two studies: subsidies received (Banerjee et al., 2018) and user fees paid in health (Gine et al., 2018).

Quality of service provision was assessed through measures of service provision performance such as whether there are employees in the *Anganwadi* or agricultural extension visits occur (Ananthpur et al., 2014), condition of health facilities (Alhassan et al., 2015; Bjorkman et al., 2017; Gine et al., 2018; Grossman, 2017; Gullo et al., 2017) or quality of health care received (Bradley, 2005), quality of roads (Berman et al., 2017) and irrigation provision (Bandyopadhyay et al., 2010), or environmental services like forestry cover (Persha & Meshack, 2016; Rasamoelina et al., 2015; Tachibana et al., 2004). Quality was also assessed by absenteeism in several studies in Uganda (Bjorkman et al., 2009; Humphreys & Weinstein, 2012; Grossman, 2017; Grossman & Michelitch, 2018), which we report separately. The final measure of quality in service delivery was measured by leakages of public goods from road construction (Olken, 2007) and food aid (Beath et al., 2013).

The overall findings suggest some improvement in access for some measures of service delivery (**Figure 9**). This is demonstrated by an increase in average effects of physical access (SMD=0.08, 95% confidence interval (CI)=0.00, 0.15; 12 studies), and service quality (SMD=0.10, 95%CI=0.03, 0.18; 16 studies). However, improvements in other outcomes were not apparent, including for absenteeism (SMD=0.02, 95% confidence interval (CI)=-0.19, 0.24; four studies), embezzlement (SMD=0.02, 95% confidence interval (CI)=-0.18, 0.21; four studies) or costs paid for access (SMD=0.07, 95% confidence interval (CI)=-0.11, 0.24; 2 studies).

**Figure 9: Forest plots showing service access outcomes**



Note: \* effect sizes for negative outcomes are inverted for comparability.

**Table 8: Service access by study design and intervention**

Outcome	Moderator	<i>g</i>	95%CI	<i>I-sq</i>	<i>Tau-sq</i>	<i>Q</i>	<i>P-value</i>	<i>N obs</i>	
Physical access	Total	0.075	- 0.001	0.152	63.9%	0.0084	30.49	0.001	12
	RCT	0.051	- 0.027	0.128	65.4%	0.0071	23.10	0.003	9
	NRS	0.297	- 0.014	0.609	52.6%	0.0396	4.22	0.121	3
	Low RoB	0.118	0.064	0.172	0.0%	0.0000	0.73	0.867	4
	Some concerns	0.057	- 0.184	0.299	70.7%	0.0308	6.84	0.033	3
	High RoB	0.081	- 0.069	0.230	74.7%	0.0157	15.82	0.003	5
Service quality	Total	0.105	0.026	0.184	62.4%	0.0103	39.94	0.000	16
	RCT	0.045	- 0.005	0.096	0.0%	0.0000	6.66	0.672	10
	NRS	0.287	0.031	0.544	84.7%	0.0716	32.78	0.000	6
	Low RoB	0.127	0.011	0.243	0.0%	0.0000	0.01	0.996	3
	Some concerns	0.018	- 0.153	0.190	0.0%	0.0000	0.69	0.405	2
	High RoB	0.127	0.023	0.232	72.5%	0.0141	36.42	0.000	11
Absenteeism	Total	0.022	- 0.193	0.236	45.8%	0.0216	5.54	0.136	4
	RCT	0.022	- 0.193	0.236	45.8%	0.0216	5.54	0.136	4
	NRS	-	-	-	-	-	-	-	0
	Low RoB	- 0.028	- 0.341	0.284	-	-	-	-	1
	Some concerns	- 0.294	- 0.863	0.274	-	-	-	-	1
	High RoB	0.240	- 0.372	0.852	77.9%	0.1591	4.52	0.034	2
Corruption/leakage	Total	0.019	- 0.177	0.215	42.6%	0.0167	5.23	0.156	4
	RCT	0.019	- 0.177	0.215	42.6%	0.0167	5.23	0.156	4
	NRS	-	-	-	-	-	-	-	0
	Low RoB	0.131	- 0.056	0.319	0.0%	0.0000	0.00	0.987	2
	Some concerns	- 0.132	- 0.424	0.159	27.4%	0.0149	1.38	0.241	2
	High RoB	-	-	-	-	-	-	0	
Cost of service	Total	0.067	- 0.105	0.239	80.5%	0.0127	5.13	0.024	2

Outcome	Moderator	<i>g</i>	95% <i>CI</i>	<i>I-sq</i>	<i>Tau-sq</i>	<i>Q</i>	<i>P-value</i>	<i>N obs</i>
	RCT	0.067	- 0.239 0.105	80.5%	0.0127	5.13	0.024	2
	NRS	-	-	-	-	-	-	0
	Low RoB	0.145	0.080 0.209	-	-	-	-	1
	Some concerns	-	-	-	-	-	-	0
	High RoB	-	- 0.107 0.033 0.172	-	-	-	-	1

Note: - not applicable.

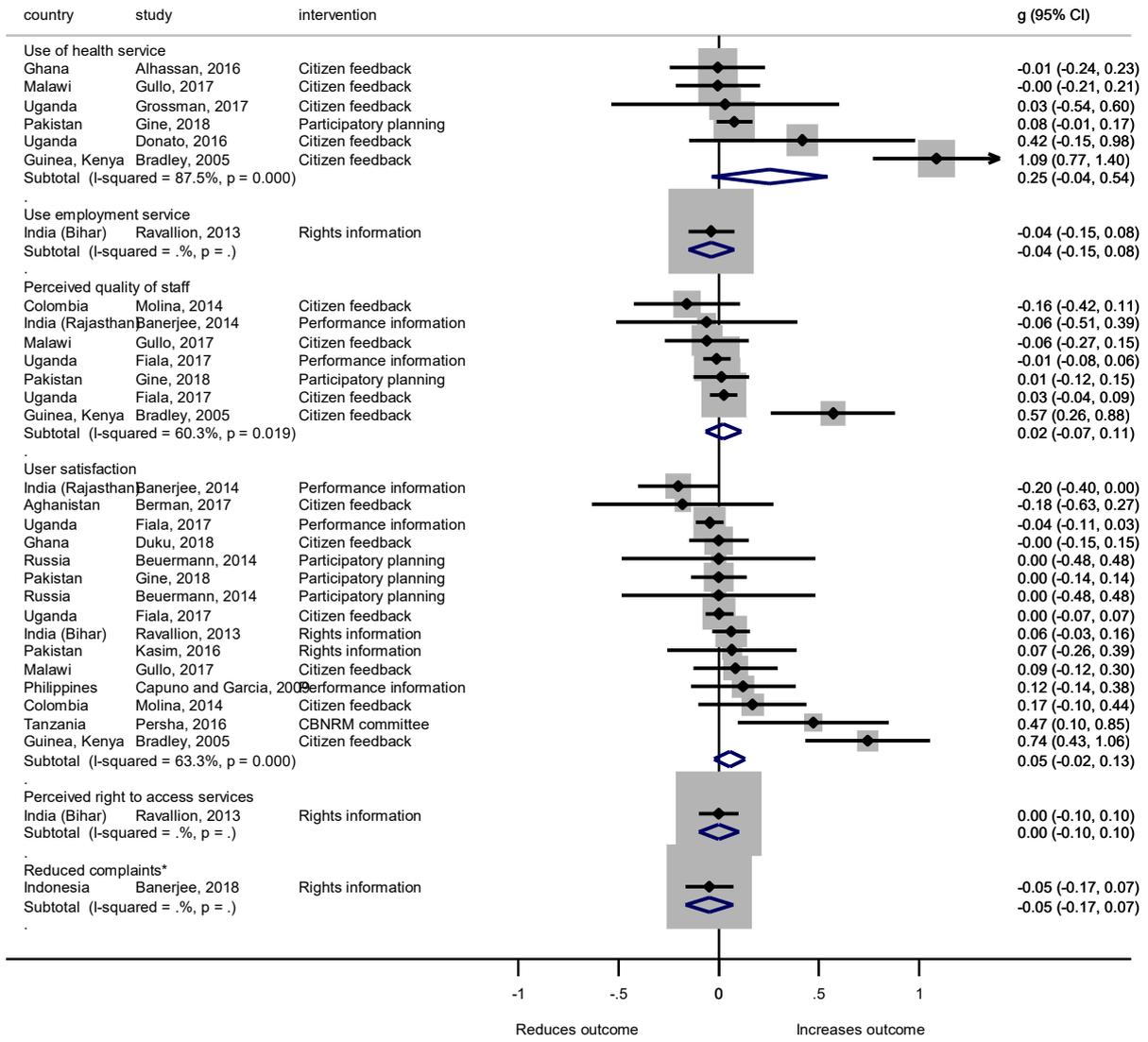
#### **4.1.2 Service use and attitudes to services**

Service use was measured in health and social protection sectors. Various measures of health care for children were collected such as immunization (e.g. Donato & Mosqueira, 2016; Gine et al., 2018) and nutrition supplements (Grossman, 2017), and mothers such as use of antenatal and postnatal care (Grossman, 2017; Gullo et al., 2017). In one social protection study, the authors measured participation in employment services (Ravallion et al., 2013).

User satisfaction was measured through satisfaction surveys in health (Duku et al., 2018; Gine et al., 2018), policing (Banerjee et al., 2014), general satisfaction with local amenities provided by government including infrastructure (Beuermann et al., 2014; Molina, 2014) and employment services (Ravallion et al., 2013), and complaints reported (Banerjee et al., 2018). User satisfaction with service delivery staff was also assessed in policing (Banerjee et al., 2014), health (Bradley et al., 2005; Gine et al., 2018) and family planning (Gullo et al., 2017) and in local leadership (Molina, 2014; Fiala et al., 2017). One study also measured perceived user rights to employment services for women (Ravallion et al., 2013).

The results of the meta-analysis indicate that we do not observe any changes in use on average for health services (SMD=0.25, 95% confidence interval (CI)=-0.04, 0.54; six studies), user satisfaction (SMD=0.04, 95% confidence interval (CI)=-0.04, 0.11; 12 studies) or perceived quality of service provision (SMD=0.03, 95% confidence interval (CI)=-0.08, 0.14; six studies). There also appeared to be significant heterogeneity in the findings although this was not related to study design or risk of bias (**Table 9**).

**Figure 10: Forest plots showing service use outcomes**



Service use and user attitudes

Note: \* effect sizes for negative outcomes are inverted for comparability.

**Table 9: Service use and satisfaction by study design and intervention**

<i>Outcome</i>	<i>Moderator</i>	<i>g</i>	<i>95%CI</i>	<i>I-sq</i>	<i>Tau-sq</i>	<i>Q</i>	<i>P-value</i>	<i>N obs</i>	
Service use	Total	0.254	- 0.035	0.544	87.5%	0.1011	40.00	0.000	6
	RCT	0.065	- 0.012	0.141	0.0%	0.0000	2.35	0.672	5
	NRS	1.086	0.769	1.403	-	-	-	-	1
	Low RoB	0.417	- 0.146	0.981	-	-	-	-	1
	Some concerns	0.078	- 0.011	0.167	0.0%	0.0000	0.03	0.874	2
	High RoB	0.349	- 0.269	0.967	94.5%	0.2809	36.43	0.000	3
User satisfaction	Total	0.035	- 0.042	0.112	66.9%	0.0097	33.18	0.000	12
	RCT	- 0.011	- 0.052	0.030	8.1%	0.0003	8.70	0.368	9
	NRS	0.336	- 0.034	0.707	80.9%	0.0867	10.49	0.005	3
	Low RoB	- 0.024	- 0.070	0.021	0.0%	0.0000	1.06	0.589	3
	Some concerns	- 0.053	- 0.309	0.204	81.3%	0.0282	5.34	0.021	2
	High RoB	0.147	- 0.032	0.325	69.8%	0.0382	19.90	0.003	7
Perceived quality	Total	0.027	- 0.082	0.136	66.9%	0.0091	15.11	0.010	6
	RCT	0.004	- 0.043	0.051	0.0%	0.0000	0.94	0.815	4
	NRS	0.202	- 0.511	0.916	91.8%	0.2434	12.23	0.000	2
	Low RoB	0.008	- 0.040	0.056	0.0%	0.0000	0.50	0.480	2
	Some concerns	- 0.061	- 0.512	0.391	-	-	-	-	1
	High RoB	0.108	- 0.292	0.507	85.9%	0.1064	14.22	0.001	3

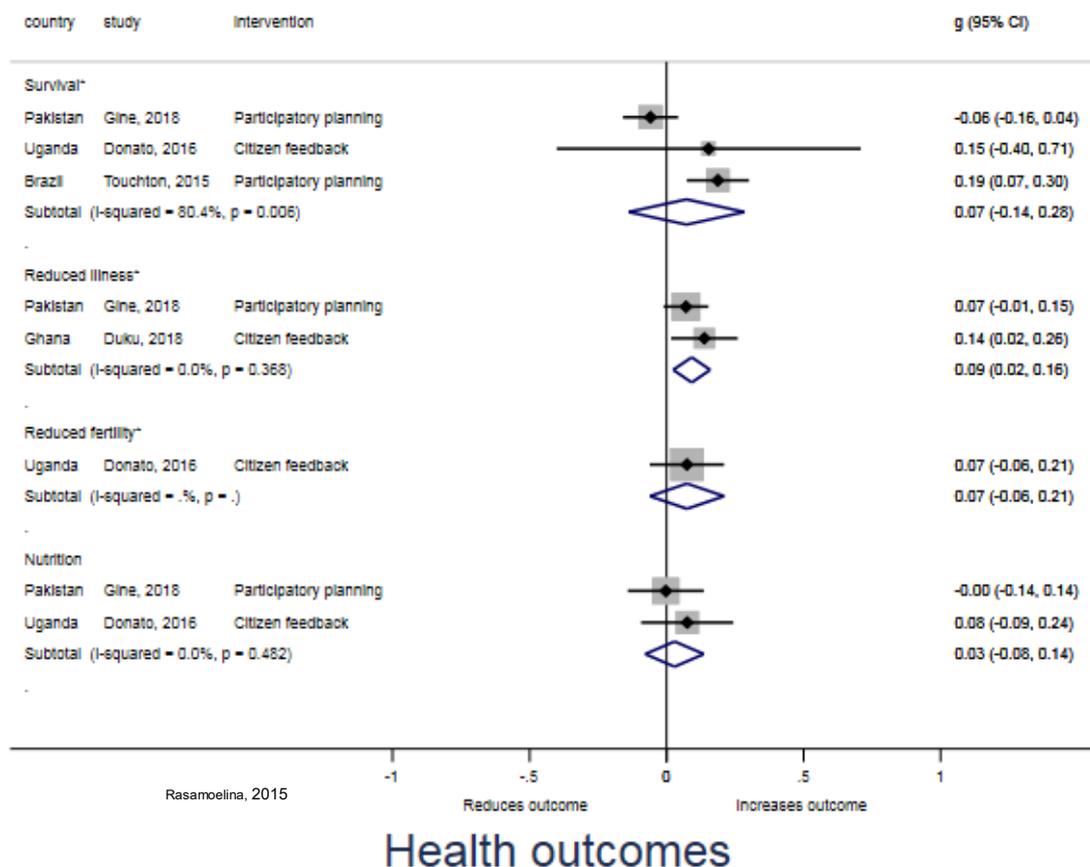
**4.1.3 Wellbeing**

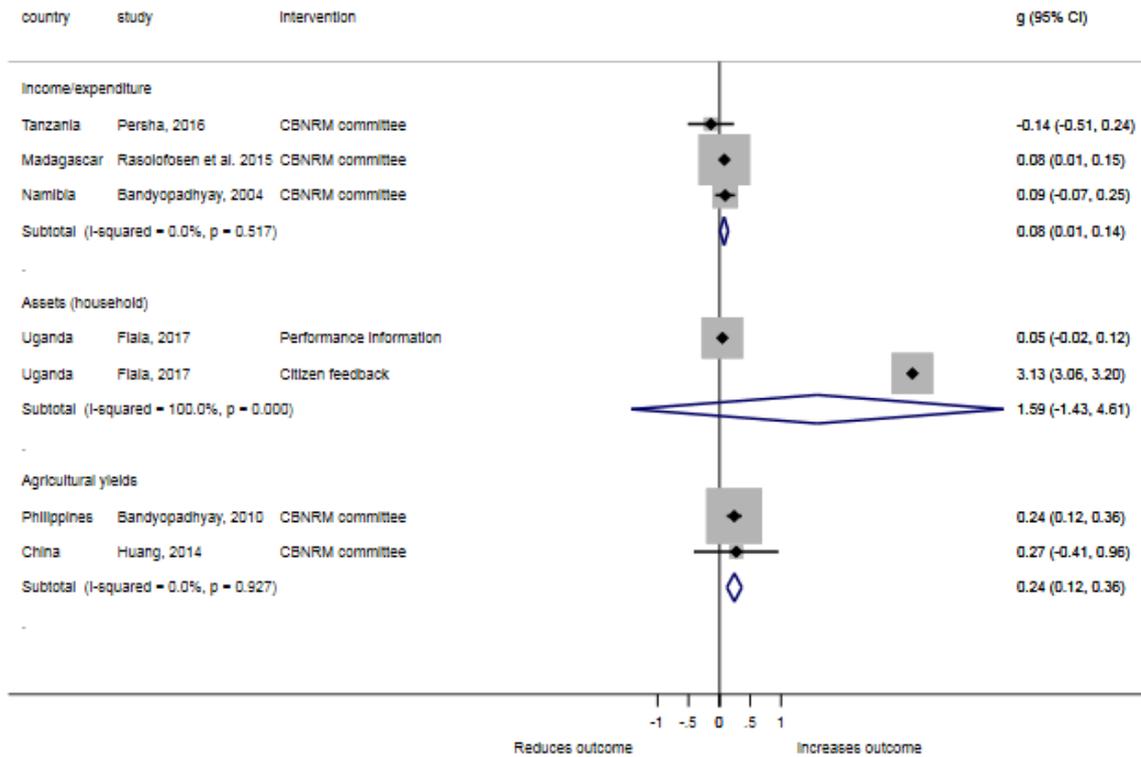
A variety of wellbeing outcomes among study participants were measured. Health outcomes included mortality (Touchton & Wampler, 2015; Bjorkman et al., 2017; Gine et al., 2018), illness (Duku et al. 2018; Gine et al., 2018), fertility (Bjorkman et al., 2017; Donato & Mosqueira, 2016) and anthropometry (Bjorkman et al., 2017; Gine et al., 2018). Several studies reported agriculture yields (Bandyopadhyay et al., 2010; Huang et al., 2014) and livestock (Fiala et al., 2017). Other studies measured feelings of

empowerment in and of the community (Humphreys et al., 2014; Fiala et al., 2017) and social cohesion via presence and membership of civil society organizations (Ananthpur et al., 2014; Capuno and Garcia, 2010; Touchton & Wampler, 2015) or trust (Kasim, 2016). Kasim (2016) also measured life satisfaction.

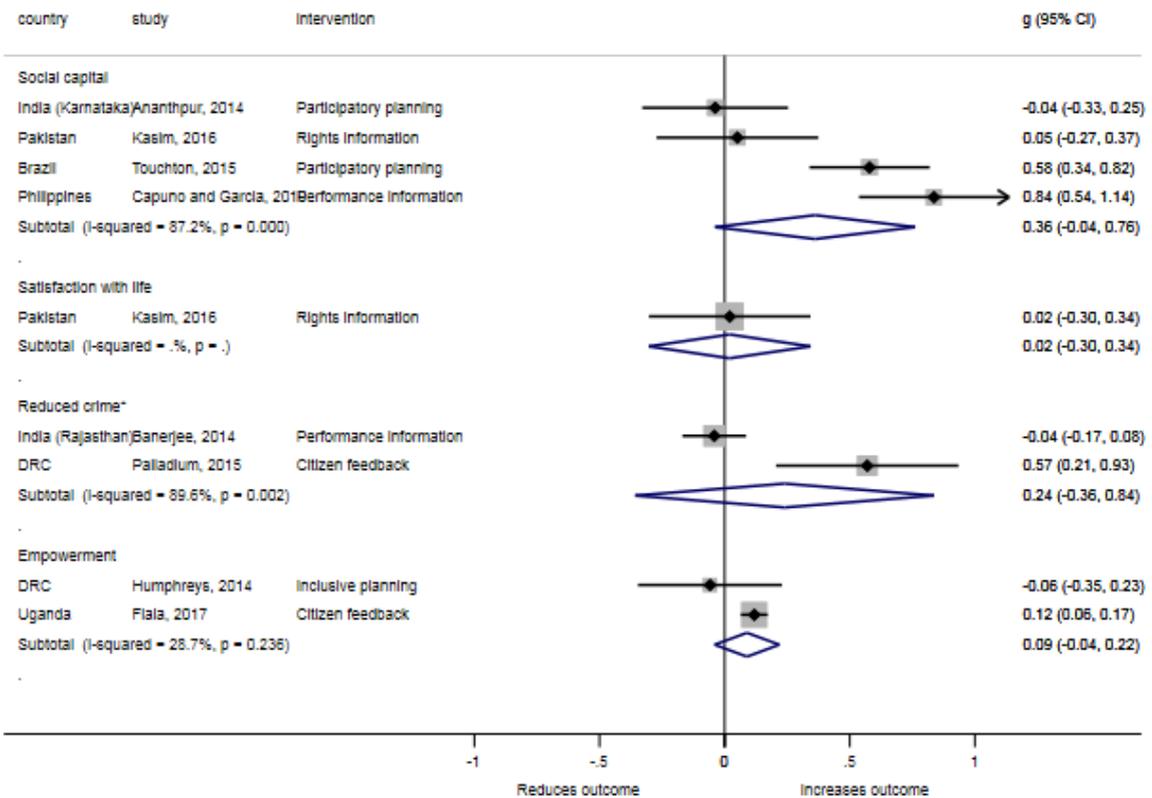
**Figure 13** presents forest plots for wellbeing outcomes (summarized in **Table 10**). These suggest outcomes may increase marginally, although usually not statistically significantly with the exceptions of reductions in disease (SMD=0.09, 95%CI=0.02, 0.16; 2 studies) in health. In the case of economic outcomes, there are improvements in yields (SMD=0.24, 95%CI=0.12, 0.36; 2 studies) and income/expenditure (SMD=0.08, 95%CI=0.01, 0.14; 3 studies). We do not see statistically significant findings for pooled effects in social wellbeing. It is also difficult to explore heterogeneity by study design in the cases of health and economic outcomes as health outcomes are mainly from RCTs while those in agriculture are all non-randomized. For social outcomes, the heterogeneity observed appears to be due to study design, although all studies (randomized and non-randomized) were assessed as being of high risk of bias. In general, there are too few outcomes of any type to draw conclusions.

**Figure 11: Forest plots showing wellbeing outcomes**





## Economic outcomes



## Social outcomes

Note: \* effect sizes for negative outcomes are inverted for comparability.

**Table 10: Wellbeing outcomes by study design and intervention**

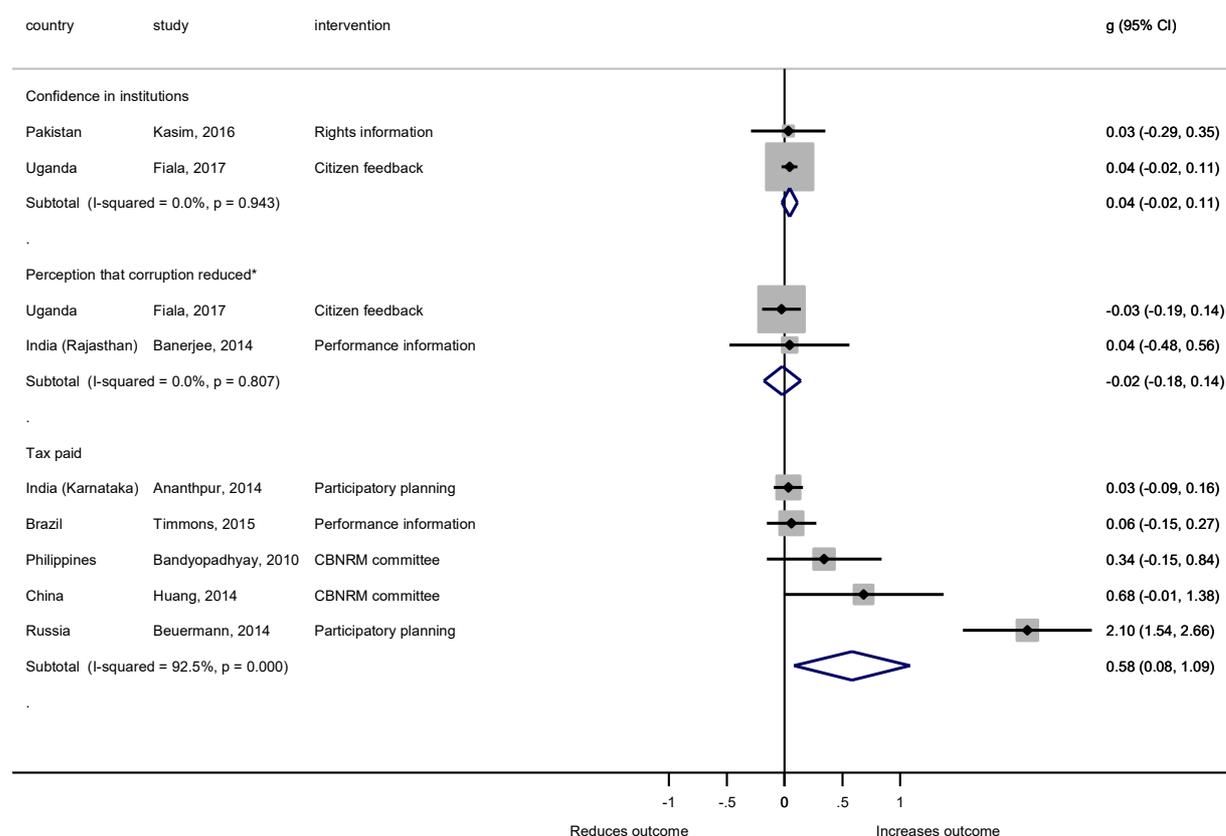
<i>Outcome</i>	<i>Sub-category</i>	<i>g</i>	<i>95%CI</i>		<i>I-sq</i>	<i>Tau-sq</i>	<i>Q</i>	<i>P-value</i>	<i>N obs</i>
Health	Mortality	0.073	-0.139	0.284	80.4%	0.0233	10.21	0.006	3
	Morbidity	0.092	0.024	0.159	0.0%	0.0000	0.81	0.368	2
	Fertility	0.074	-0.061	0.210	-	-	-	-	1
	Nutrition	0.029	-0.078	0.136	0.0%	0.0000	0.50	0.482	2
Economic	Income/expenditure	0.076	0.011	0.141	0.0%	0.0000	1.32	0.517	3
	Agricultural yields	0.241	0.120	0.362	0.0%	0.0000	0.01	0.927	2
	Assets	1.588	-1.429	4.606	100.0%	4.7391	3668.48	0.000	2
Social	Social capital	0.361	-0.039	0.761	87.2%	0.1447	23.38	0.000	4
	Empowerment	0.089	-0.041	0.218	28.7%	0.0045	1.40	0.236	2
	Satisfaction with life	0.020	-0.303	0.343	-	-	-	-	1
	Crime rates	0.239	-0.358	0.836	89.6%	0.1675	9.64	0.002	2

#### **4.1.4 State-society relations**

A few studies also measured the category of variable we have referred to (following Phillips et al., 2017) as state-society relations, which are principally measures of the relationship between citizens and government. We categorized these into variables measuring taxes paid (Ananthpur et al., 2014; Beuermann & Amelina, 2014; Timmons et al., 2015) or in the case of natural resource management contribution to local service fees (Bandyopadhyay et al., 2010; Huang et al., 2014); feelings of trust in leadership and institutions (Kasim, 2016; Fiala et al., 2017); and, relatedly, public perception of corruption among public servants (Fiala et al., 2017) including the police (Banerjee et al., 2014).

The results suggest that there have been improvements in taxes paid in individual studies and overall (SMD=0.58, 95%CI=0.08, 1.086; 5 studies) (**Figure 12**). There were no improvements for other outcomes, corruption perceptions (SMD=-0.02, 95%CI=-0.18, 0.14; 2 studies) or confidence in institutions (SMD=0.04, 95%CI=-0.02, 0.11; 2 studies). Sensitivity analysis indicates that the estimated increase in tax paid is mainly due to the RCT of participatory budgeting training and technical assistance in Russia (Beuermann & Amelina, 2014) (**Table 11**).

**Figure 12: Forest plot showing state-society relations outcomes**



## State society relations

Note: \* effect sizes for negative outcomes are inverted for comparability.

**Table 11: Wellbeing outcomes by study design and intervention**

Outcome	Moderator	g	95%CI		I-sq	Tau-sq	Q	P-value	N obs
Tax paid	Total	0.584	0.083	1.086	92.5%	0.2755	53.56	0.000	5
	RCT	1.048	-0.975	3.071	98.0%	2.0887	50.00	0.000	2
	NRS	0.246	-0.085	0.576	43.6%	0.0395	3.55	0.170	3
	Low RoB	2.099	1.541	2.657	-	-	-	-	1
	Some concerns	0.061	-0.152	0.273	-	-	-	-	1
	High RoB	0.238	-0.119	0.595	55.4%	0.0568	4.48	0.106	3

### 4.2 Meta-analysis of immediate outcomes (review question 2)

We grouped immediate outcomes into user engagement and provider response, in order to break down the mechanisms through which interventions operate. In general, the findings suggest that citizen engagement interventions can be effective ways of boosting citizens' engagement in service delivery governance, but not typically provider responsiveness. We conclude that we are able to go some way to explaining intervention mechanisms on demand and supply sides, articulating that the

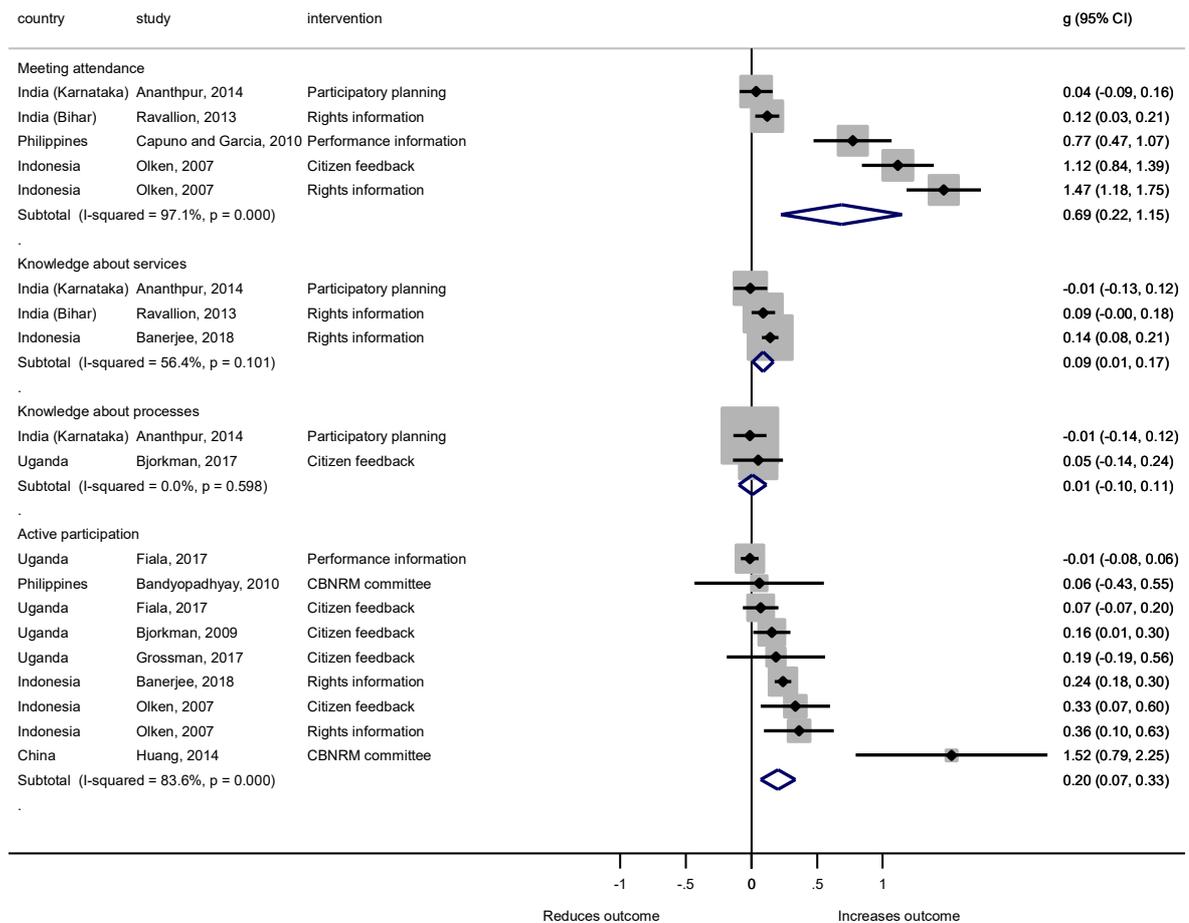
interventions are mainly successful in improve demand (user engagement) and not supply (provider engagement). However, heterogeneity in findings needs further explanation, which we return to in subsequent sections using moderator meta-analysis and framework synthesis.

#### **4.2.1 User engagement**

User engagement outcomes include knowledge about the processes of engagement with the intervention (Ananthpur et al., 2014; Bjorkman et al., 2017) or the services themselves that are available (Ananthpur et al., 2014; Ravallion et al., 2013; Banerjee et al., 2018). They also include measures of participation in the governance intervention, including meeting attendance (Ananthpur et al., 2014; Capuno and Garcia, 2010; Olken, 2007; Ravallion et al., 2013) and more active participation in processes such as public speaking (Olken, 2007; Bjorkman et al., 2009, 2017), and maintenance planning and expenditure (Huang et al., 2007; Bandyopadhyay et al., 2010). A few studies also measured knowledge about intervention processes (Ananthpur et al., 2014; Banerjee et al., 2018; Ravallion et al., 2013) or public services (Ananthpur et al., 2014; Bjorkman et al., 2018).

It is worth noting that because these are secondary outcomes, which are reported in studies that also measure primary outcomes, the findings for immediate outcomes are only generalizable to the population of studies that also report immediate and final outcomes. We first present overall findings for user engagement (**Figure 13**). The evidence suggests that interventions appear to be particularly effective on average in getting citizens to attend meetings (SMD=0.69, 95%CI=0.22, 1.15; 5 studies), and to a lesser extent participate actively in intervention processes like speaking at meetings (SMD=0.20, 95%CI=0.07, 0.33; nine studies), and improving knowledge about services (SMD=0.09, 95%CI=0.01, 0.17; 3 studies). The two studies measuring knowledge about intervention processes did not find significance effects (SMD=0.01, 95%CI=-0.11, 0.11; 2 studies).

**Figure 13: Forest plot showing service user engagement outcomes**



## User engagement

Note: effect sizes for negative outcomes inverted for comparability.

There was some heterogeneity in the findings which we explored in sensitivity analysis (**Table 12**). Most of the studies are RCTs so exploring differences by design were not especially useful. The findings suggested low risk of bias studies tended to have bigger effects than higher risk of bias studies.

**Table 12: User engagement outcomes by study design and intervention**

<i>Outcome</i>	<i>Moderator</i>	<i>g</i>	<i>95%CI</i>		<i>I-sq</i>	<i>Tau-sq</i>	<i>Q</i>	<i>P-value</i>	<i>N obs</i>
Meeting attendance	Total	0.686	0.224	1.148	97.1%	0.2643	139.59	0.000	5
	RCT	0.666	0.141	1.191	97.7%	0.2752	128.09	0.000	4
	NRS	0.771	0.472	1.070	-	-	-	-	1
	Low RoB	1.289	0.945	1.632	67.1%	0.0412	3.04	0.081	2
	Some concerns	0.120	0.029	0.212	-	-	-	-	1
	High RoB	0.390	-	1.111	94.9%	0.2566	19.70	0.000	2
			0.330						
Active participation	Total	0.203	0.072	0.334	83.6%	0.0248	48.64	0.000	9
	RCT	0.167	0.047	0.287	82.7%	0.0178	34.64	0.000	7
	NRS	0.766	-	2.200	90.6%	0.9705	10.60	0.001	2
	Low RoB	0.172	0.021	0.323	88.4%	0.0229	34.46	0.000	5
	Some concerns	0.186	-	0.560	-	-	-	-	1
	High RoB	0.492	-	1.141	85.0%	0.2687	13.31	0.001	3
			0.157						
Knowledge about services	Total	0.090	0.012	0.169	-	-	-	-	1
	RCT	0.090	0.012	0.169	-	-	-	-	1
	NRS	-	-	-	-	-	-	-	0
	Low RoB	0.144	0.081	0.206	-	-	-	-	1
	Some concerns	0.090	-	0.180	-	-	-	-	1
	High RoB	-	-	0.119	-	-	-	-	1
			0.008	0.135					
Knowledge about processes	Total	0.008	-	0.113	0.0%	0.0000	0.28	0.598	2
			0.098						
	RCT	0.008	-	0.113	0.0%	0.0000	0.28	0.598	2
			0.098						
	NRS	-	-	-	-	-	-	-	0
Low RoB	0.050	-	0.239	-	-	-	-	1	
		0.139							
Some concerns	-	-	-	-	-	-	-	0	
High RoB	-	-	0.116	-	-	-	-	1	
		0.011	0.138						

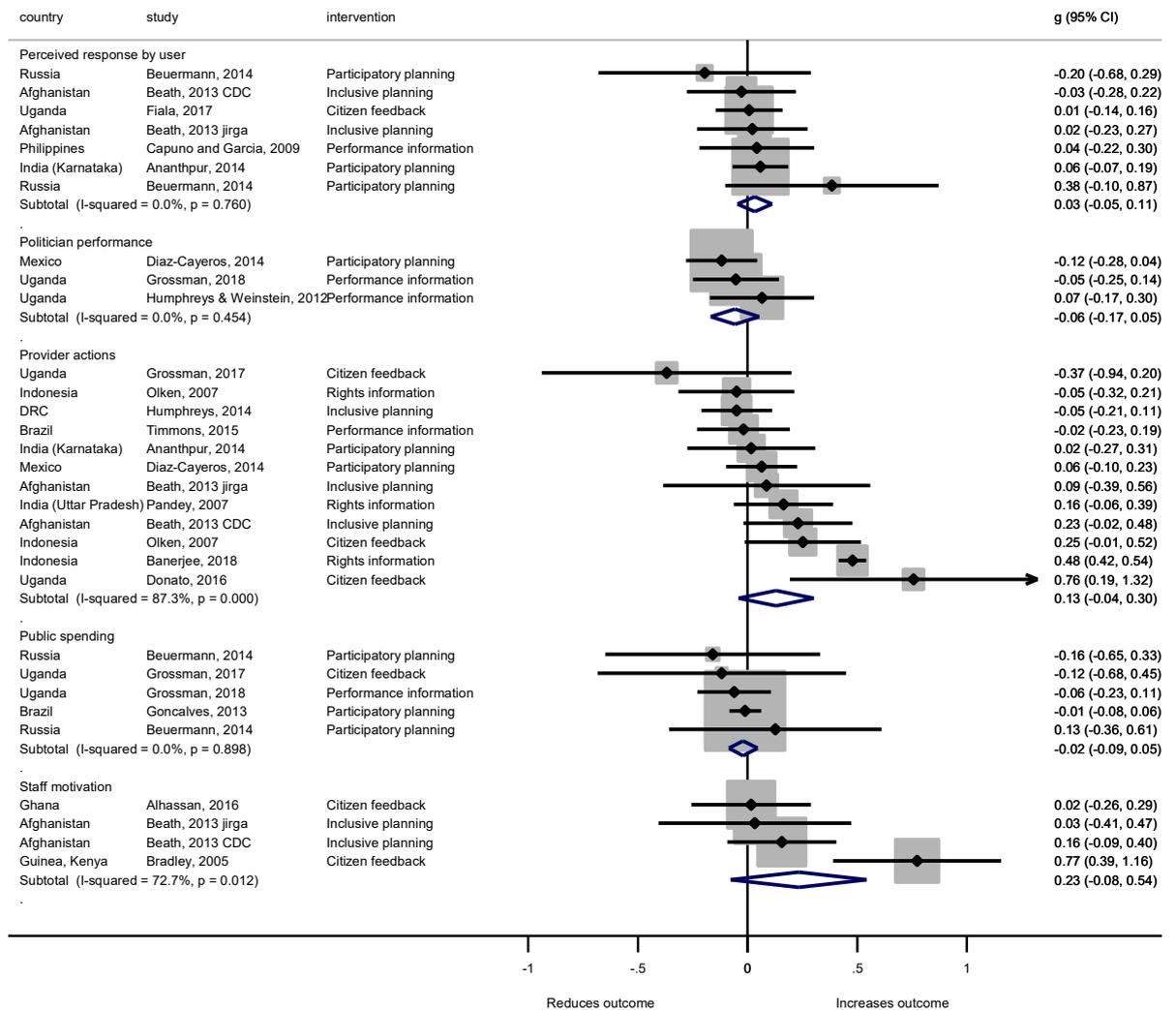
#### **4.2.2 Provider response**

We categorized provider response variables into groups of related outcomes. A number of studies measured changes in public spending in health (Bjorkman et al., 2017; Grossman, 2017; Touchton & Wampler, 2015) or more generally (Beuermann & Amelina, 2014; Goncalves, 2013; Grossman & Michelitch, 2018). We also defined other provider actions relating to the citizen engagement intervention such as holding meetings (Pandey et al., 2007) or adopting processes like participatory budgeting (Timmons et al., 2015); or resulting from the engagement, such as activities carried out by staff (Ananthpur et al., 2014; Bjorkman et al., 2017; Diaz-Cayeros, 2014) and projects selected (Humphreys et al., 2014). Two studies further measured variables relating to self-motivation of staff governing the intervention (Alhassan et al., 2016; Bradley et al., 2005) or perceptions about politician performance (Diaz-Cayeros et al., 2014; Grossman & Michelitch, 2018; Humphreys & Weinstein, 2012). Finally, a number of studies measured responsiveness of providers to the governance intervention as perceived by users (Ananthpur et al., 2014; Beath et al., 2013; Beuermann & Amelina, 2014; Capuno and Garcia, 2009; Fiala et al., 2017).

On average, across those studies primarily concerned with intermediate and final outcomes, the findings do not suggest that the interventions improved provider response. Thus, we were unable to find increases in public spending (SMD=-0.02, 95%CI=-0.08, 0.05; six studies), perceived response by users (SMD=0.03, 95%CI=-0.05, 0.11; 7 studies), staff motivation (SMD=0.23, 95%CI=-0.08, 0.54; four studies), and politician performance (SMD=-0.06, 95%CI=-0.17, 0.05; 3 studies).

In the case of provider actions, there is significant heterogeneity in the effect (SMD=0.13, 95%CI=-0.04, 0.30; 12 studies). We also analyzed the significant heterogeneity across studies by design and risk of bias. In general, the findings support the overall results that provider response outcomes are not significantly affected. There was some evidence that low risk of bias studies on average provided significant effects on provider actions (SMD=0.26, 95%CI=0.03, 0.48; six studies).

**Figure 14: Forest plot showing provider response outcomes**



# Provider response

**Table 13: User engagement outcomes by study design and intervention**

<i>Outcome</i>	<i>Moderator</i>	<i>g</i>	<i>95%CI</i>		<i>I-sq</i>	<i>Tau-sq</i>	<i>Q</i>	<i>P-value</i>	<i>N obs</i>
Public spending	Total	-0.019	-0.084	0.046	0.0%	0.0000	1.10	0.954	6
	RCT	-0.053	-0.196	0.090	0.0%	0.0000	0.83	0.934	5
	NRS	-0.010	-0.084	0.063	-	-	-	-	1
	Low RoB	-0.004	-0.321	0.312	0.0%	0.0000	0.68	0.711	3
	Some concerns	-0.065	-0.226	0.095	0.0%	0.0000	0.04	0.851	2
	High RoB	-0.010	-0.084	0.063	-	-	-	-	1
Provider actions	Total	0.131	-0.040	0.302	87.3%	0.0696	86.37	0.000	12
	RCT	0.156	-0.040	0.352	86.5%	0.0743	66.61	0.000	10
	NRS	0.034	-0.095	0.163	0.0%	0.0000	0.37	0.544	2
	Low RoB	0.286	0.047	0.525	82.8%	0.0549	23.26	0.000	5
	Some concerns	0.027	-0.074	0.127	12.8%	0.0021	5.73	0.333	6
	High RoB	0.017	-0.275	0.308	-	-	-	-	1
Perceived response by user	Total	0.033	-0.046	0.112	0.0%	0.0000	3.38	0.760	7
	RCT	0.032	-0.051	0.115	0.0%	0.0000	3.37	0.643	6
	NRS	0.042	-0.219	0.303	-	-	-	-	1
	Low RoB	0.039	-0.195	0.274	0.0%	0.0000	2.95	0.229	3
	Some concerns	-	-	-	-	-	-	-	0
	High RoB	0.038	-0.058	0.134	0.0%	0.0000	0.39	0.942	4
Staff motivation	Total	0.234	-0.077	0.544	72.7%	0.0712	11.00	0.012	4
	RCT	0.084	-0.085	0.254	0.0%	0.0000	0.62	0.733	3
	NRS	0.773	0.389	1.156	-	-	-	-	1
	Low RoB	-	-	-	-	-	-	-	0
	Some concerns	0.127	-0.089	0.343	0.0%	0.0000	0.23	0.633	2
	High RoB	0.382	-0.359	1.123	89.9%	0.2575	9.95	0.002	2

<i>Outcome</i>	<i>Moderator</i>	<i>g</i>	<i>95%CI</i>		<i>I-sq</i>	<i>Tau-sq</i>	<i>Q</i>	<i>P-value</i>	<i>N obs</i>
Politician performance	Total	-0.058	-0.168	0.053	0.0%	0.0000	1.58	0.454	3
	RCT	-0.005	-0.156	0.147	0.0%	0.0000	0.57	0.449	2
	NRS	-0.118	-0.280	0.044	-	-	-	-	1
	Low RoB	-	-	-	-	-	-	-	0
	Some concerns	-0.092	-0.217	0.033	0.0%	0.0000	0.25	0.615	2
	High RoB	0.066	-0.172	0.304	-	-	-	-	1

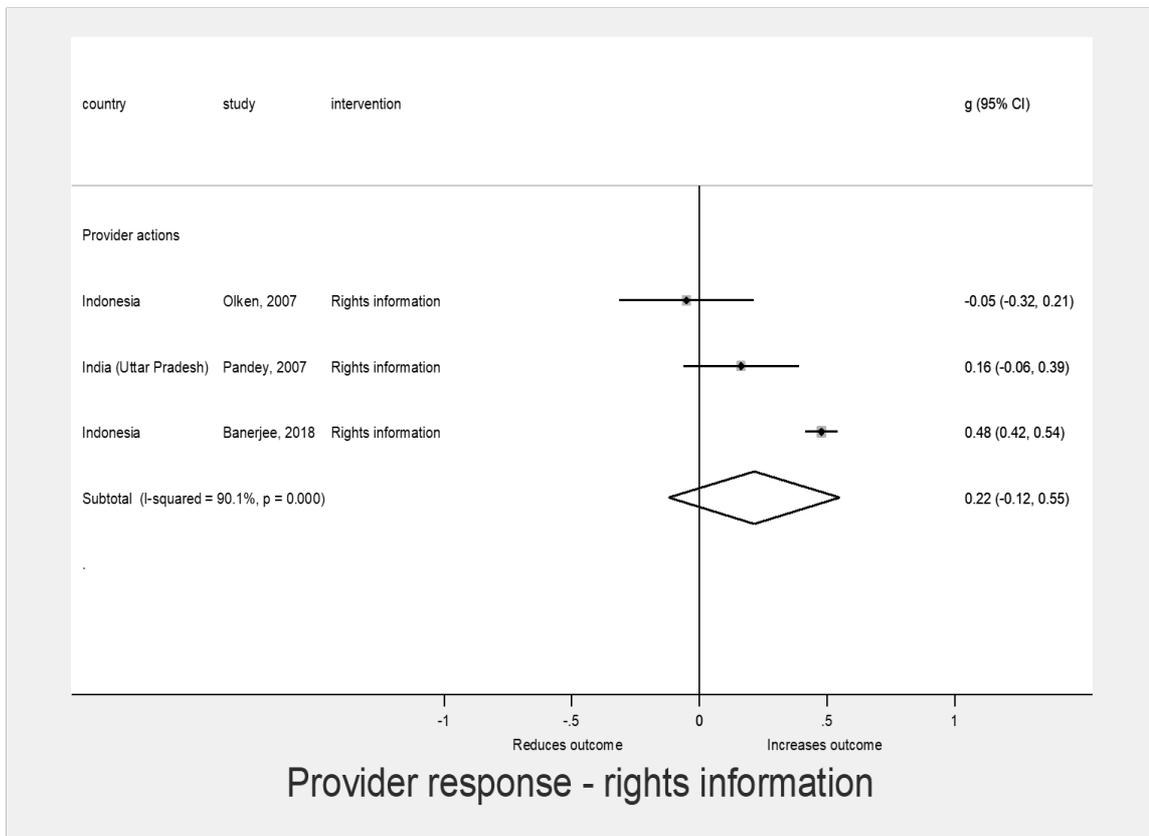
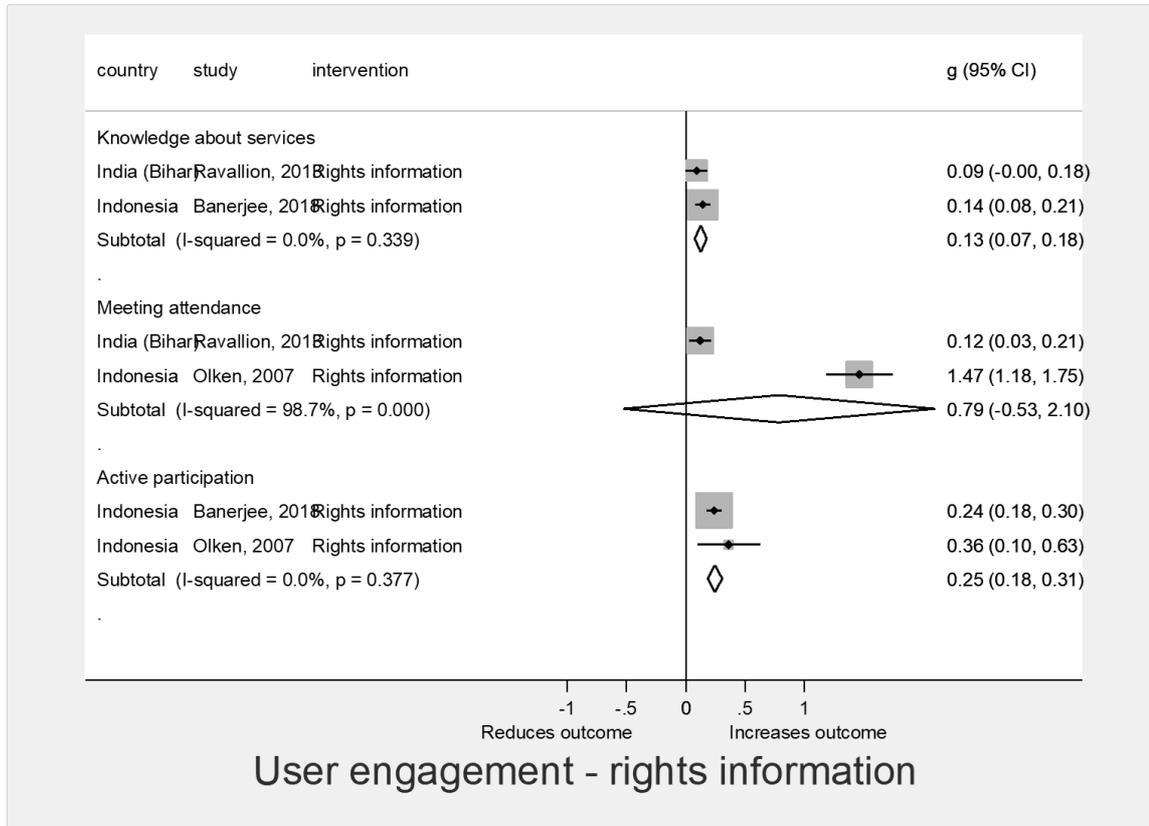
### 4.3 Moderator analysis: analysis by intervention group and inclusion dimension (review questions 1 and 2)

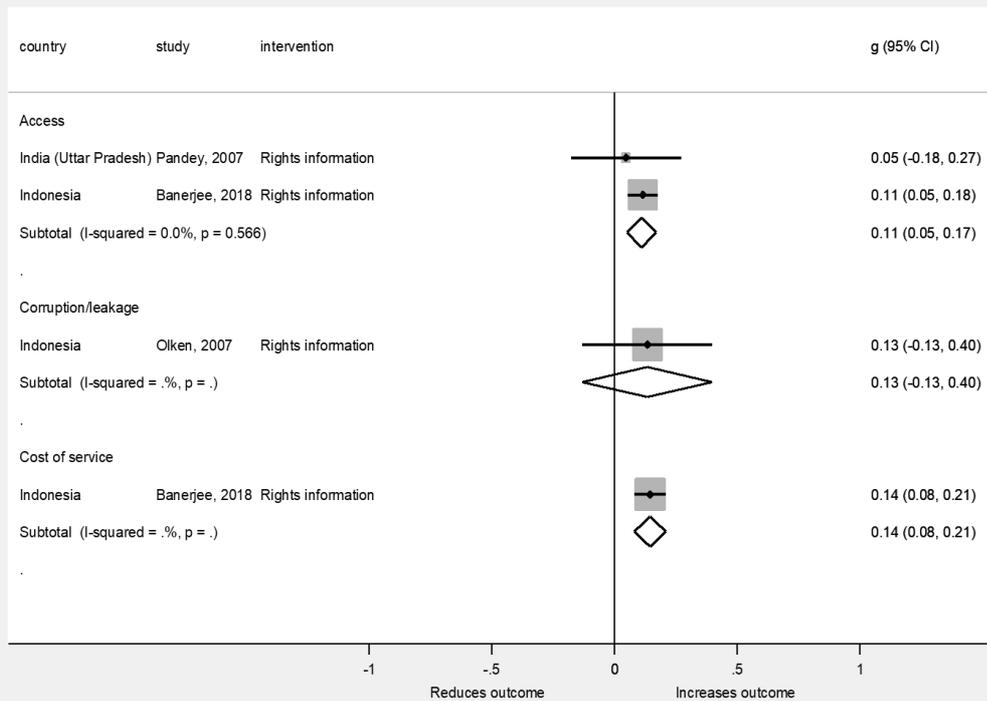
While these findings are instructive about the effects of governance interventions overall on intermediate and final outcomes, there is significant residual statistical and substantive heterogeneity. Here, we attempt to explain this by examining whether findings differ firstly by intervention group and secondly inclusion dimension. It is difficult to draw strong conclusions given the small sample sizes available at the individual intervention level. However, the findings suggest interventions focusing on rights information and community feedback appear may be effective in improving user engagement and service access. Interventions promoting participatory planning can be effective in improve service access, particularly where implementation is fully devolved through community-based natural resource committees, where wellbeing and state-society relations may also increase. On the other hand, interventions promoting performance information are not generally effective in improving any outcomes. Furthermore, most interventions have little if any effect on provider responsiveness and in most cases do not improve outcomes relating to use, wellbeing or state-society relations.

#### 4.3.1 Rights information

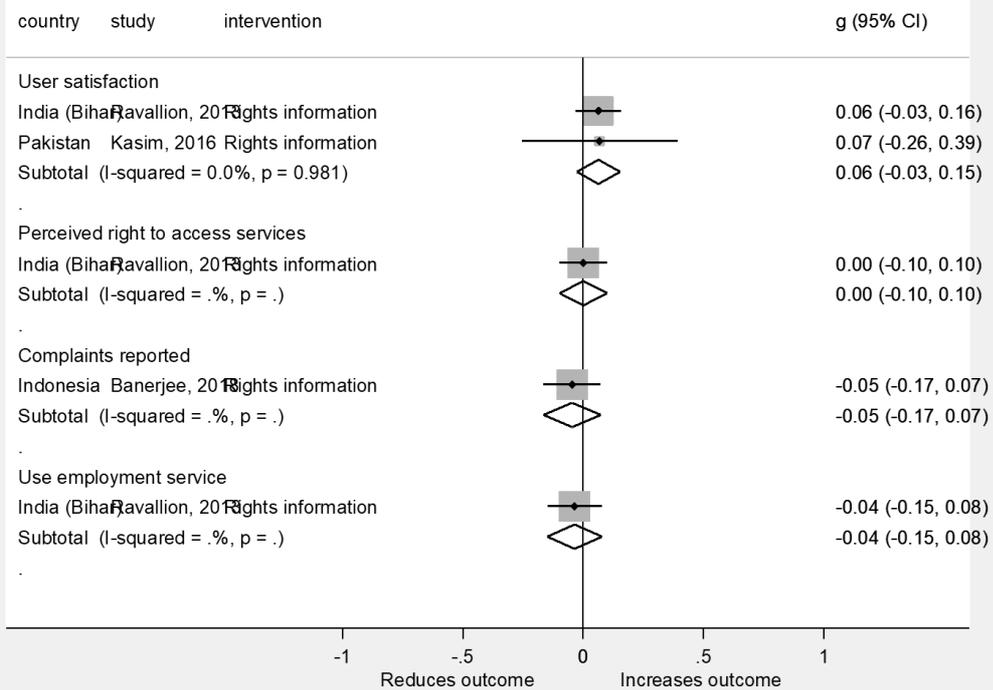
The evidence suggests rights information interventions improve active participation (SMD=0.25, 95%CI 0.18, 0.31; 2 studies), as well as knowledge about services (SMD=0.13, 95%CI=0.07, 0.18; 2 studies) and meeting attendance (individual effect estimates are positive and significant for Ravallion et al., 2013, and Olken, 2007) (**Figure 15**). Overall, the interventions do not necessarily improve provider responsiveness, although there is a significant improvement in the case of food subsidies in Indonesia (Banerjee et al., 2018). Service access also improves (SMD=0.11, 95%CI=0.05, 0.17; 2 studies) and costs fall (SMD=0.14, 95%CI=0.08, 0.21; one study, Banerjee et al., 2018) across the few studies available measuring those outcomes. However, the evidence does not suggest service use typically improves, with partial exception of user satisfaction that increases slightly but not significant across 2 studies (SMD=0.16, 95%CI=-0.03, 0.15; 2 studies). Only a single study (Kasim, 2016) measured any wellbeing or state-society relations outcomes, and did not report any significant changes (**Figure 16**).

**Figure 15: Forest plots showing immediate and intermediate outcomes for rights information**





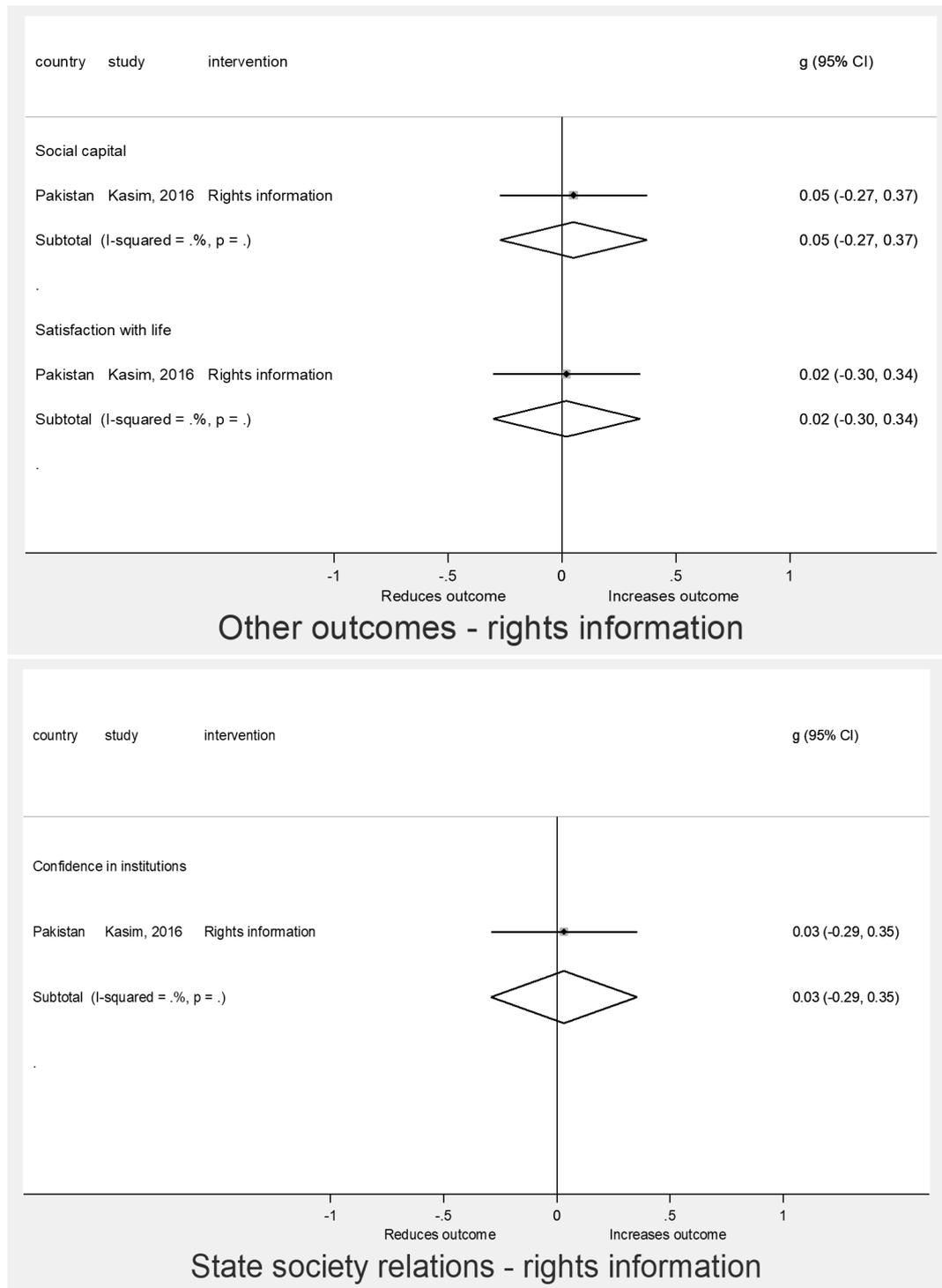
### Service access - rights information



### Service use - rights information

Note: effect sizes for negative outcomes are inverted for comparability.

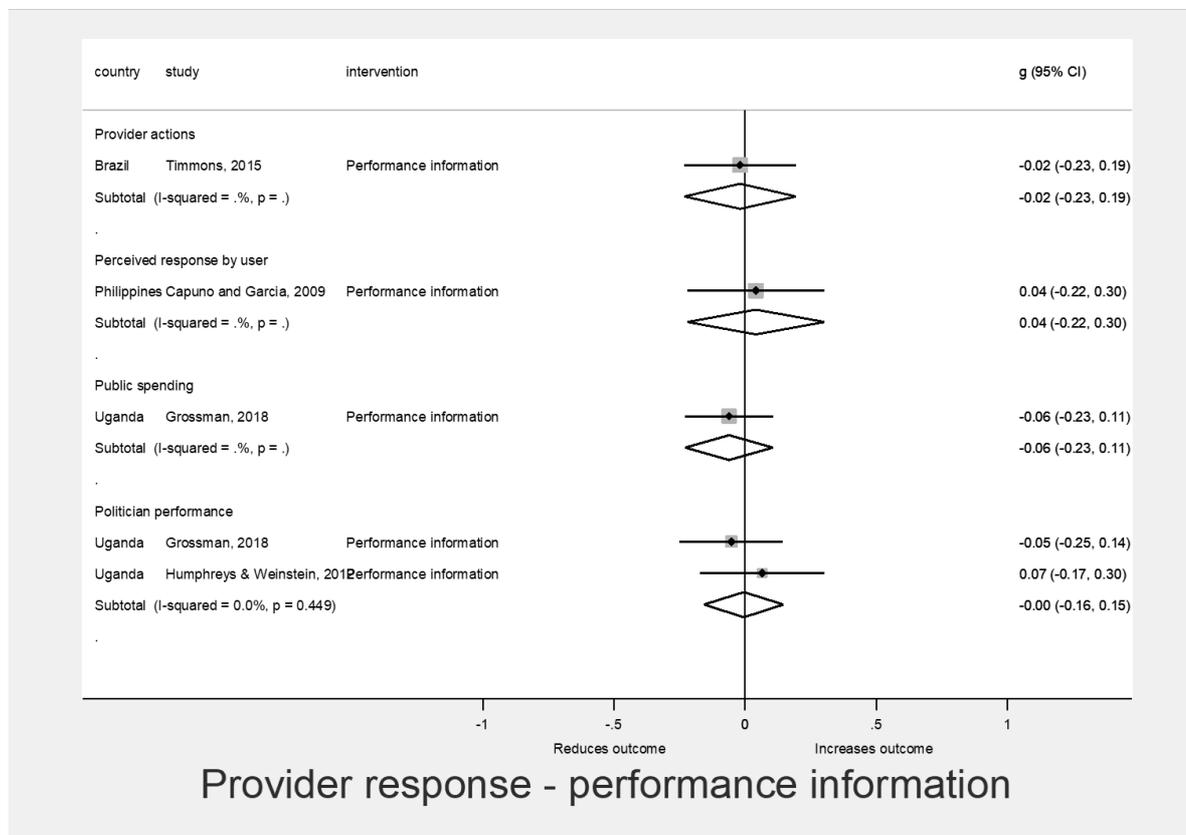
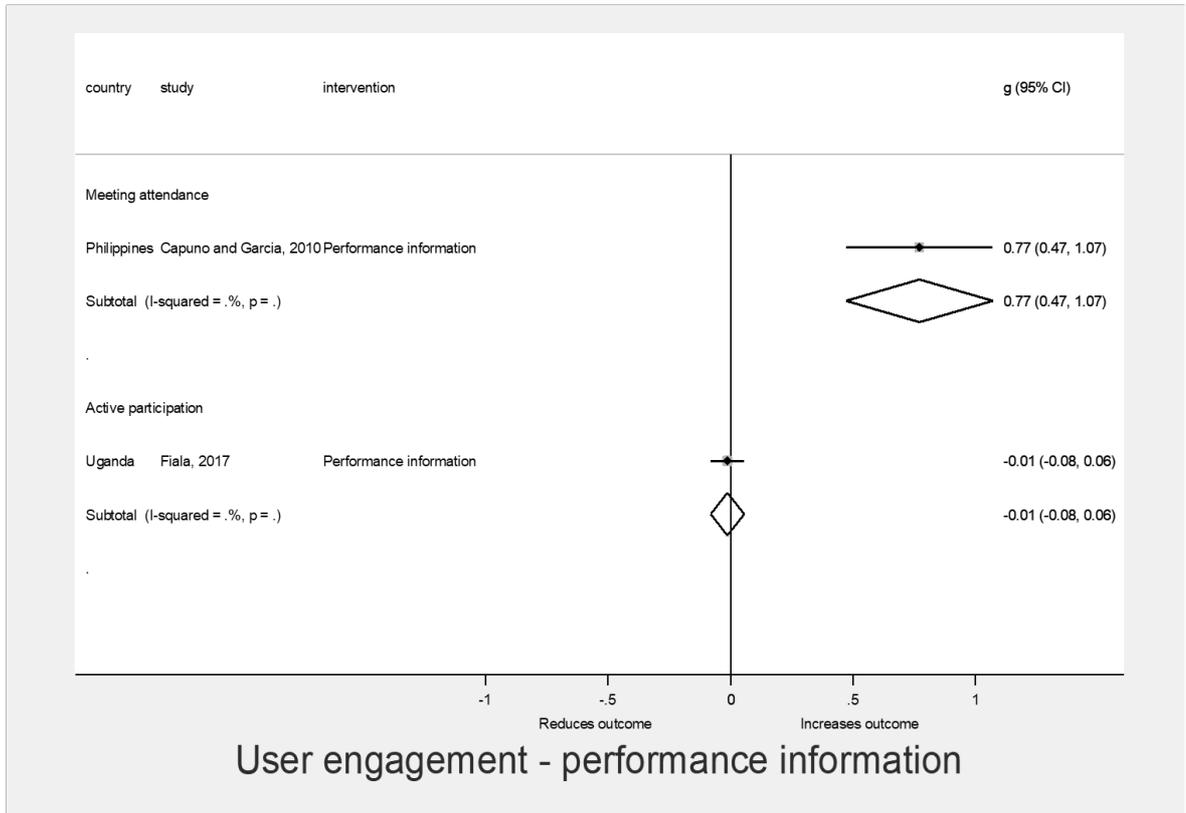
**Figure 16: Forest plots showing final outcomes for rights information**

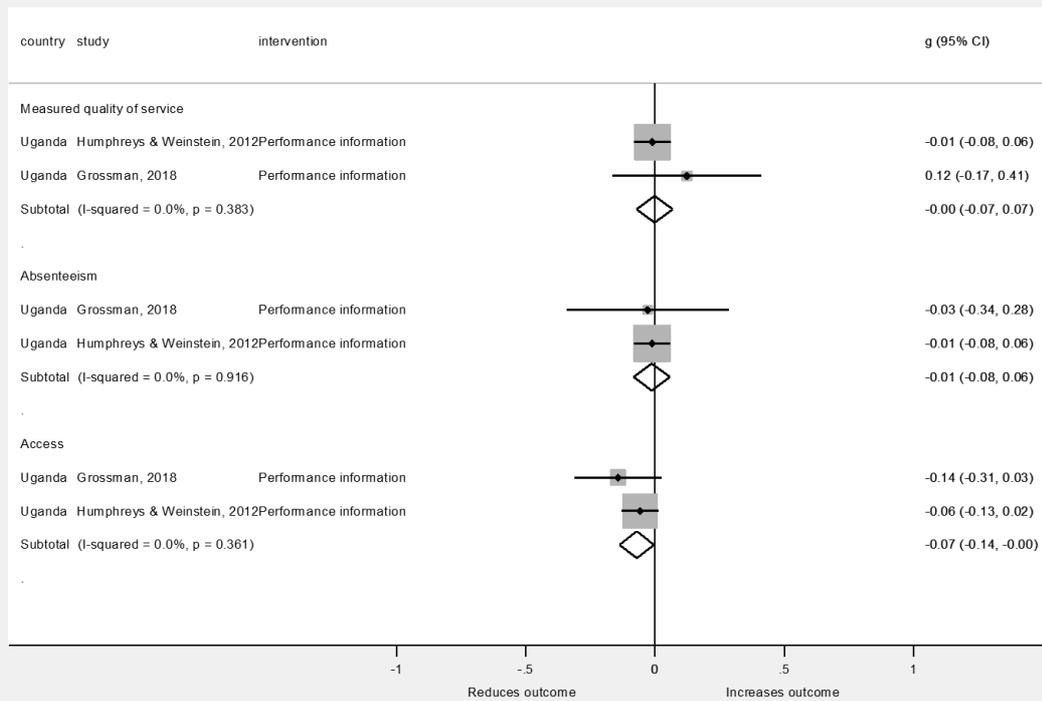


#### 4.3.2 Performance information

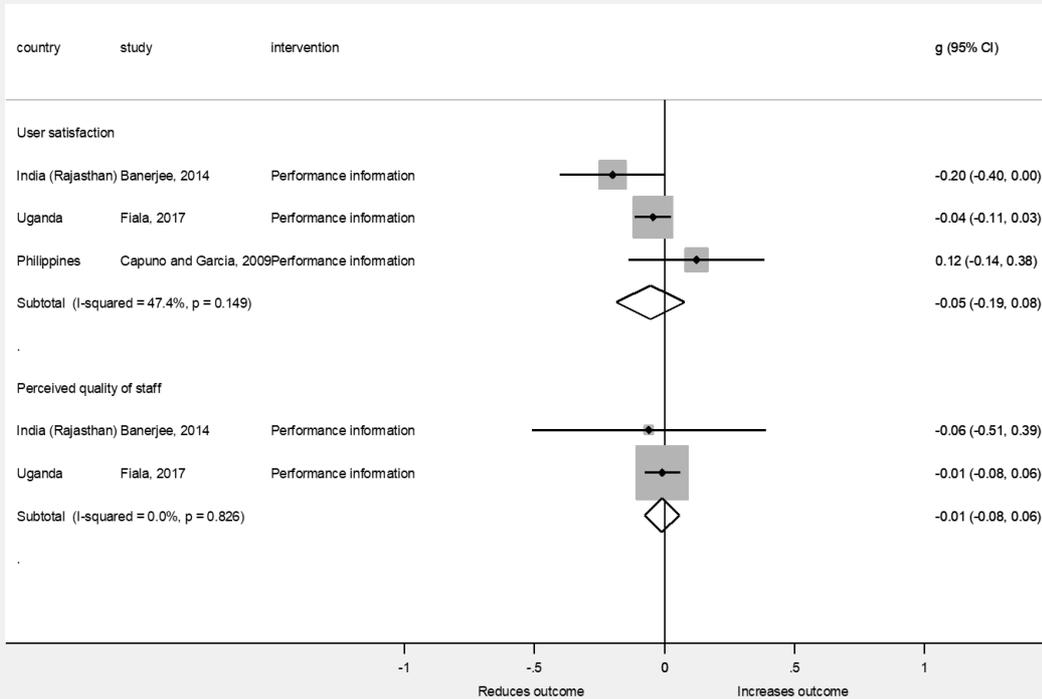
As regards performance information, the six studies that evaluated this intervention type measured a wide range of outcomes, making it difficult to do much pooling in meta-analysis. However, the evidence does not suggest intermediate, immediate outcomes or final outcomes in individual studies improve due to greater performance intervention (**Figure 17, Figure 18**). There is a partial exception in the case of one study (Capuno and Garcia, 2010).

**Figure 17: Forest plots showing immediate and intermediate outcomes for performance information**





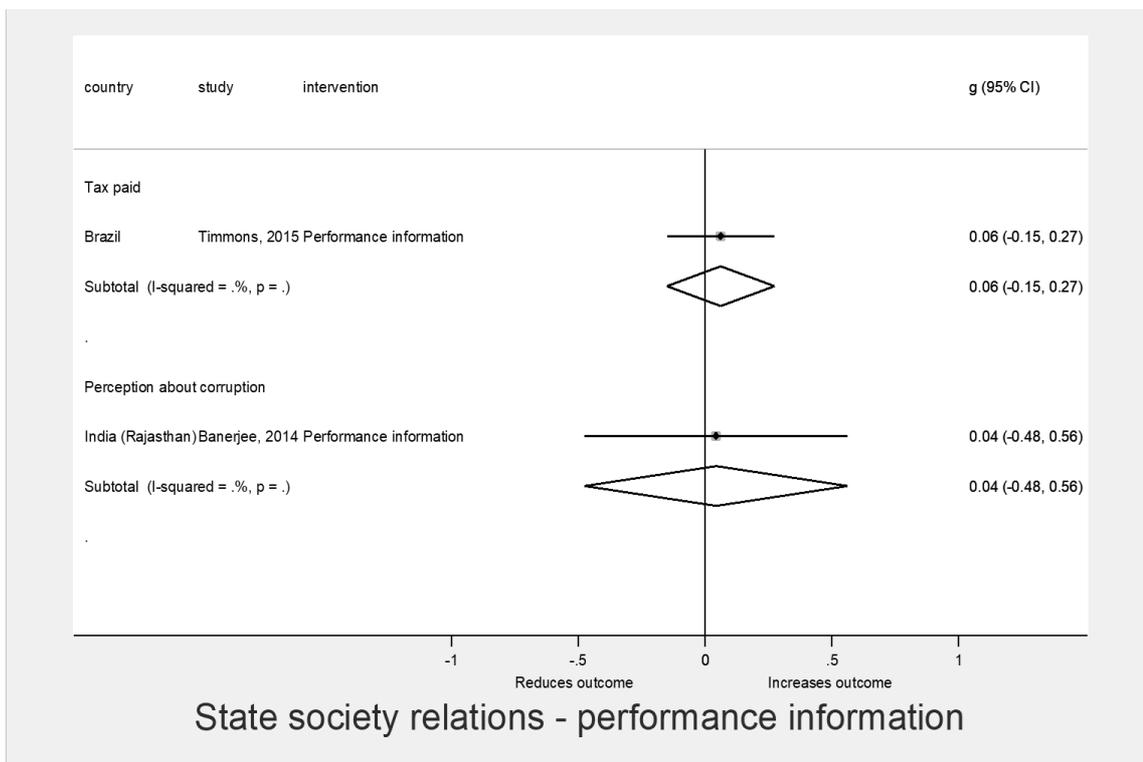
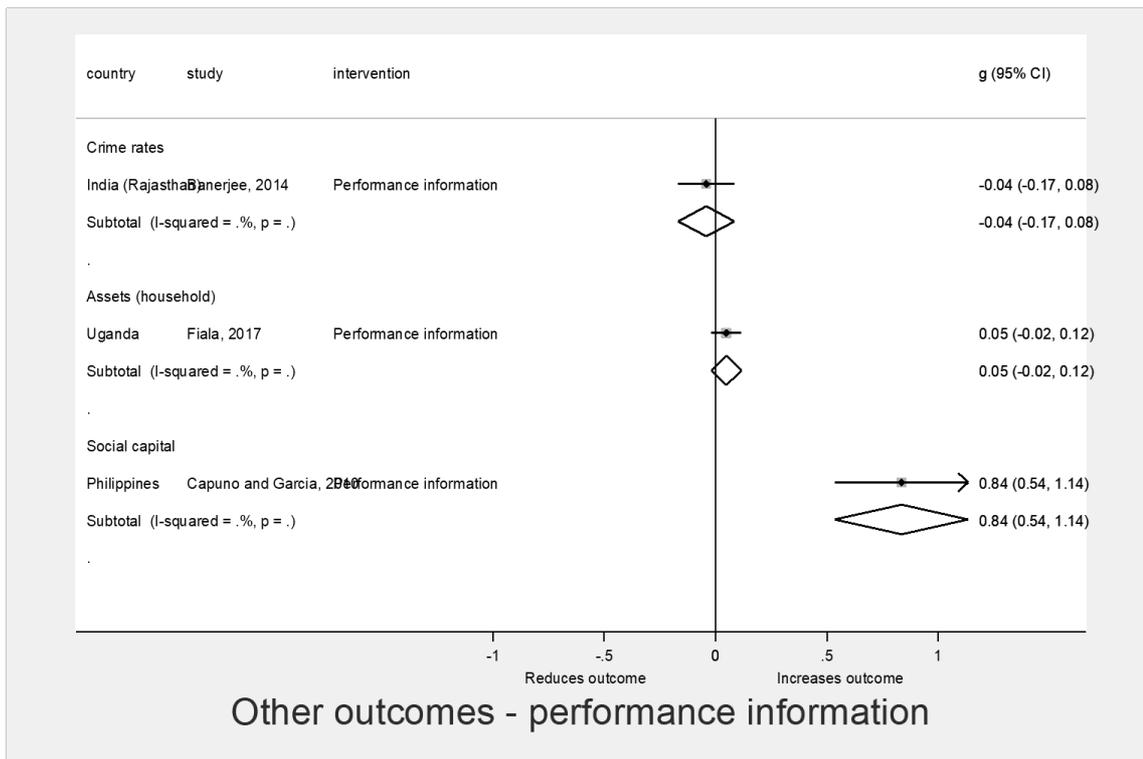
### Service access - performance information



### Service use - performance information

Note: effect sizes for negative outcomes are inverted for comparability.

**Figure 18: Forest plots showing final outcomes for performance information**



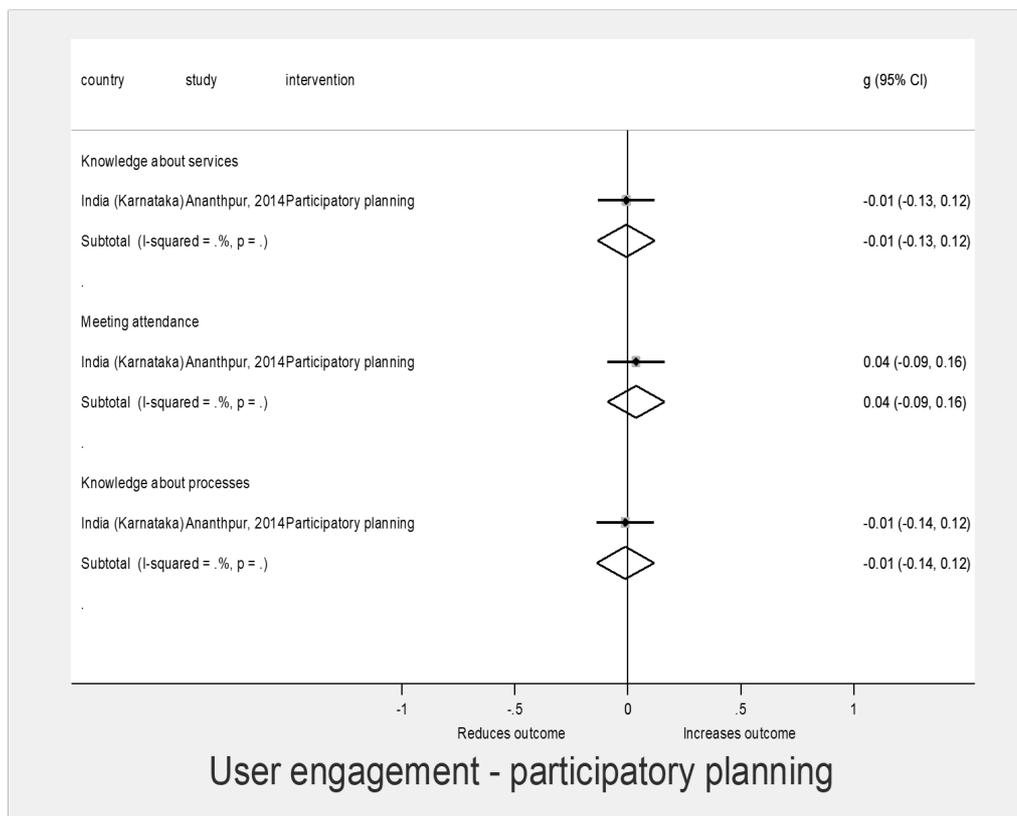
Note: effect sizes for negative outcomes are inverted for comparability.

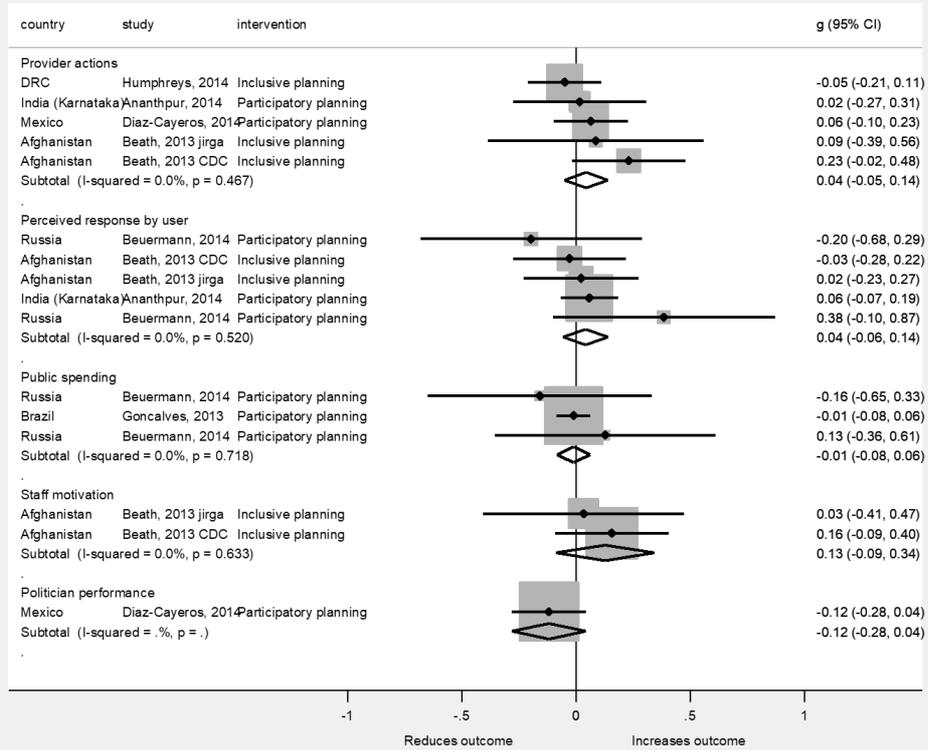
### 4.3.3 Participatory planning

For participatory planning interventions, where seven studies measured a range of interventions, the story is mixed but largely not a positive one. Physical access to services improves on average (SMD=0.10, 95%CI=0.03, 0.18; 3 studies) (Figure 19). A few other outcomes are positive but not statistically significant, for example quality of service delivery (SMD=0.08, 95%CI=-0.02, 0.18; 2 studies) and use of health services and morbidity in Gine et al. (2018). In general, however, the evidence does not support increases in outcomes for other intermediate and final outcomes, for any low risk of bias study groups.

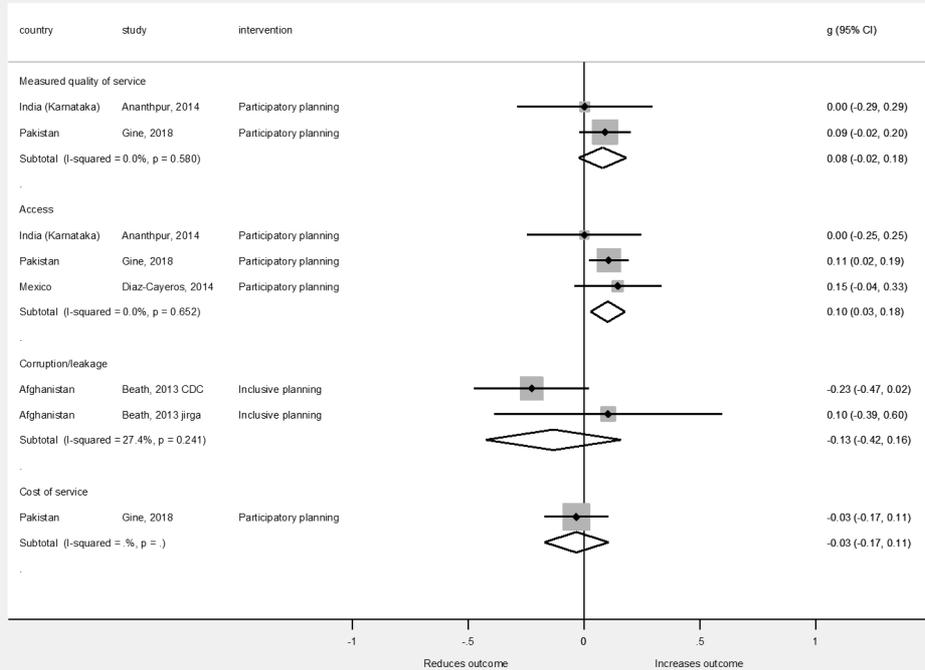
Only one study was able to measure user engagement outcomes (Ananthpur et al., 2014). However, it is noteworthy that a relatively large number of studies that measured service access and wellbeing outcomes also measured provider response outcomes (Figure 20). The evidence does not suggest provider response improves on average or in individual studies, whether measured by provider actions (SMD=0.04, 95%CI=-0.05, 0.14; 5 studies), public spending (SMD=-0.01, 95%CI=-0.08, 0.06; 3 studies), perceived response by users (SMD=0.04, 95%CI=-0.06, 0.14; 5 studies) or staff motivation (SMD=0.13, 95%CI=-0.09, 0.13; 2 studies).

**Figure 19: Forest plots showing immediate and intermediate outcomes for participatory planning**

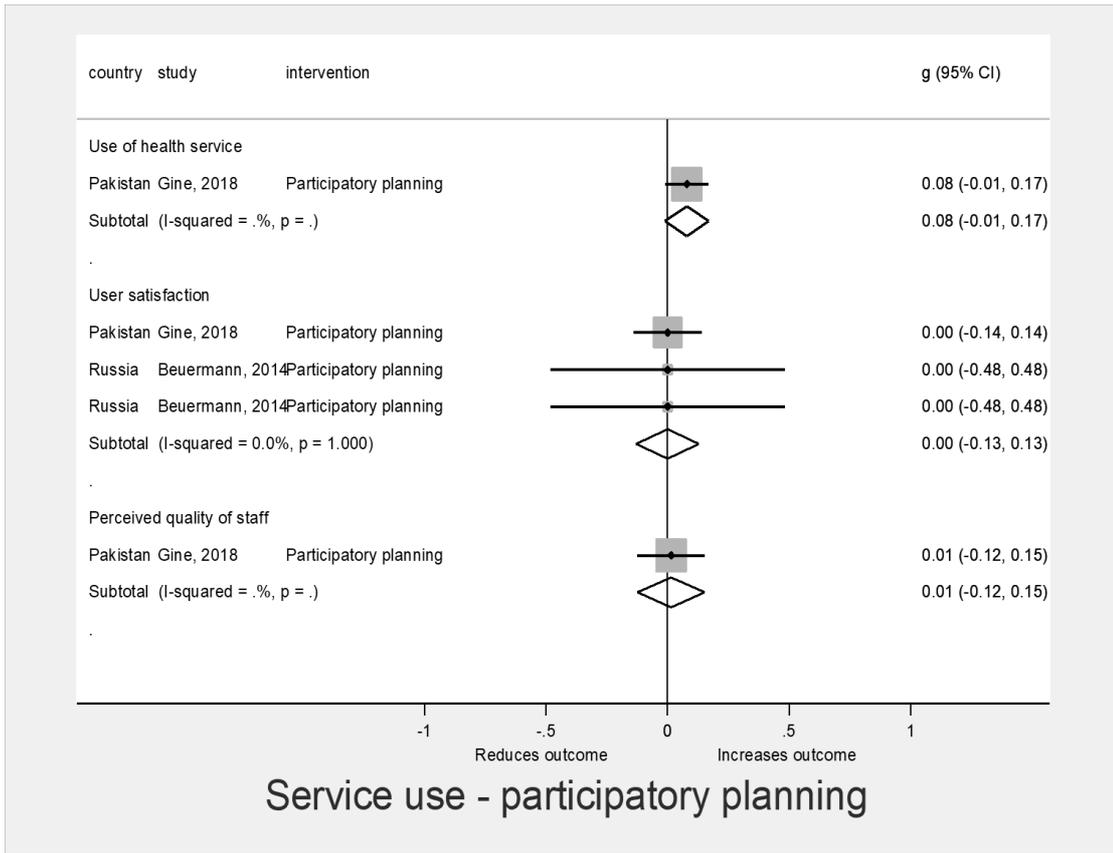




## Provider response - participatory planning

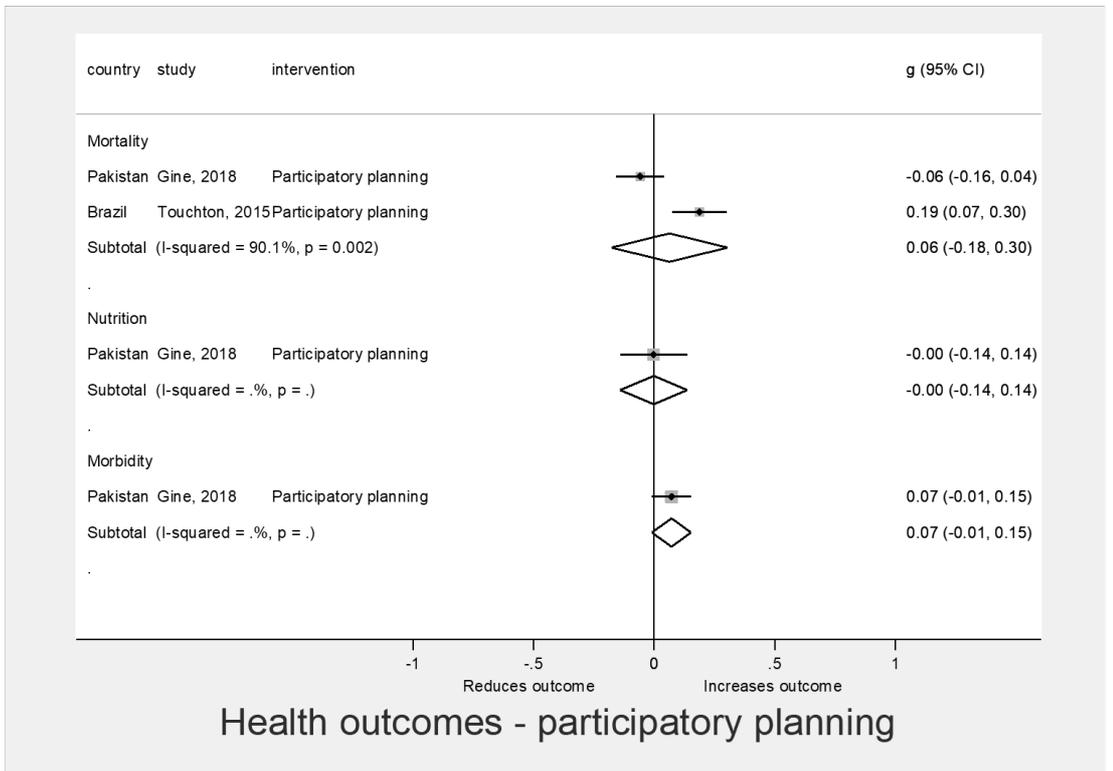


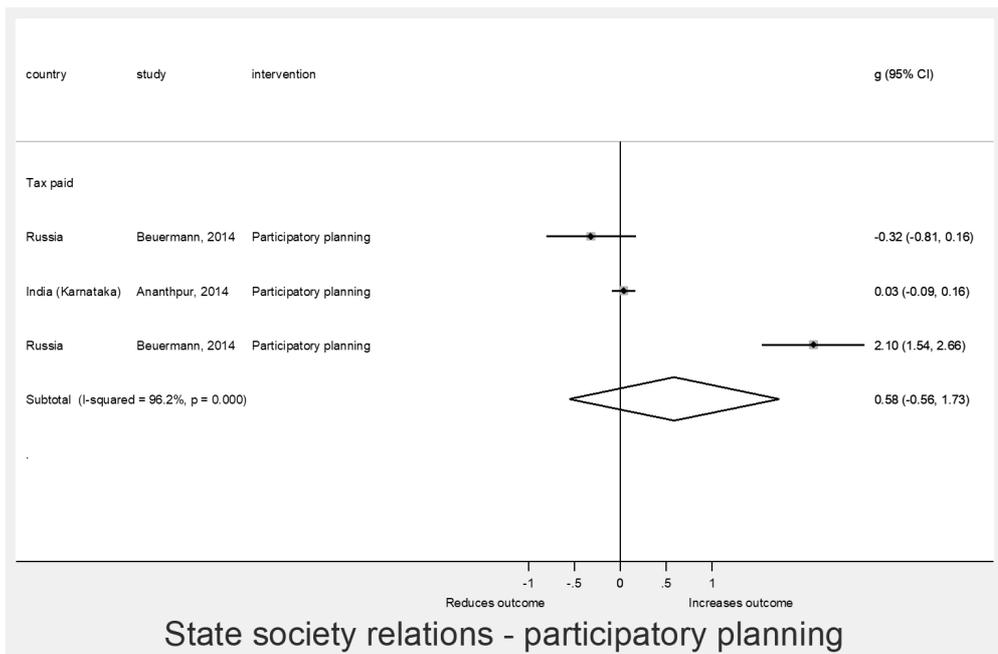
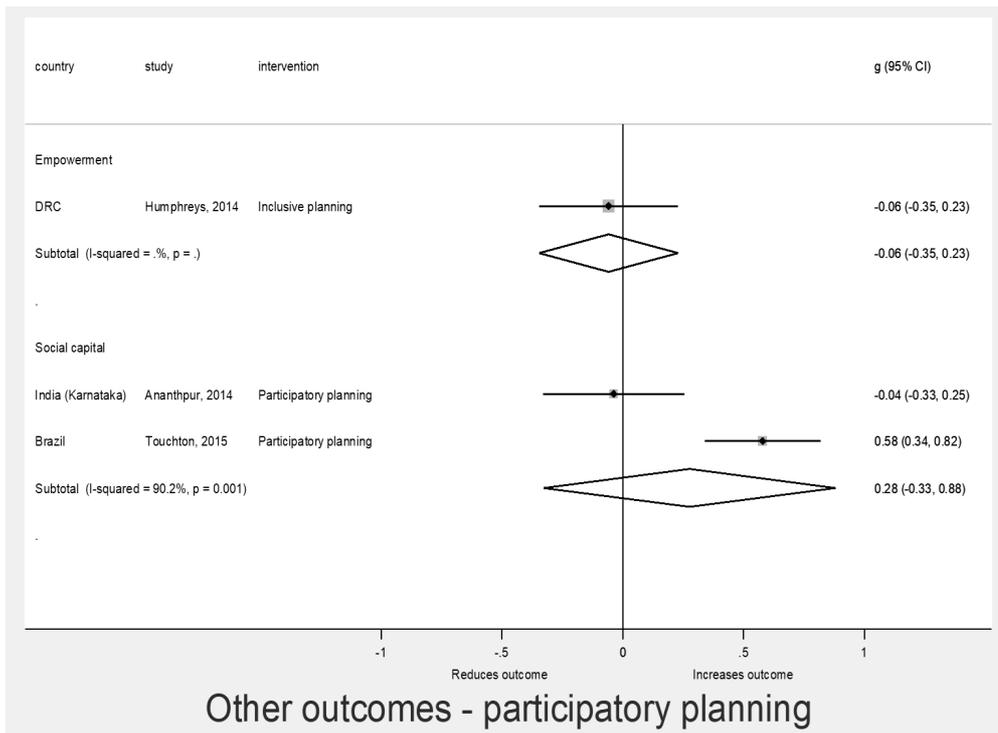
## Service access - participatory planning



Note: effect sizes for negative outcomes are inverted for comparability.

**Figure 20: Forest plots showing final outcomes for participatory planning**





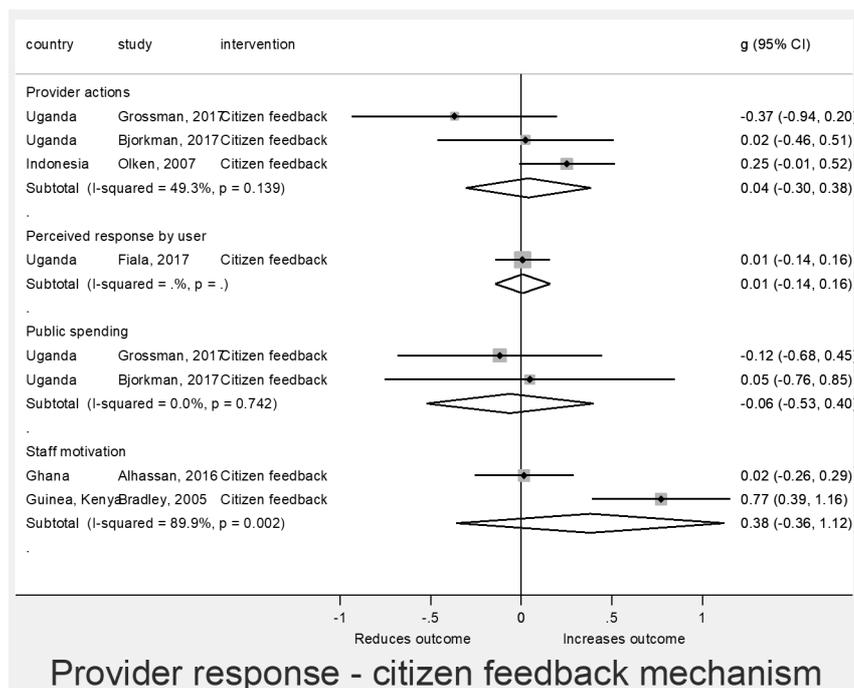
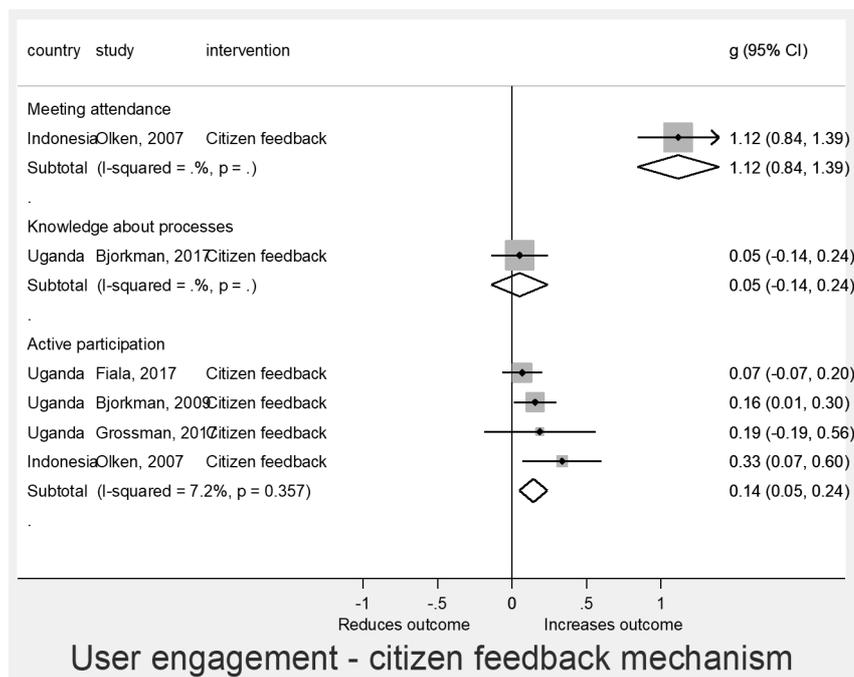
Note: effect sizes for negative outcomes are inverted for comparability.

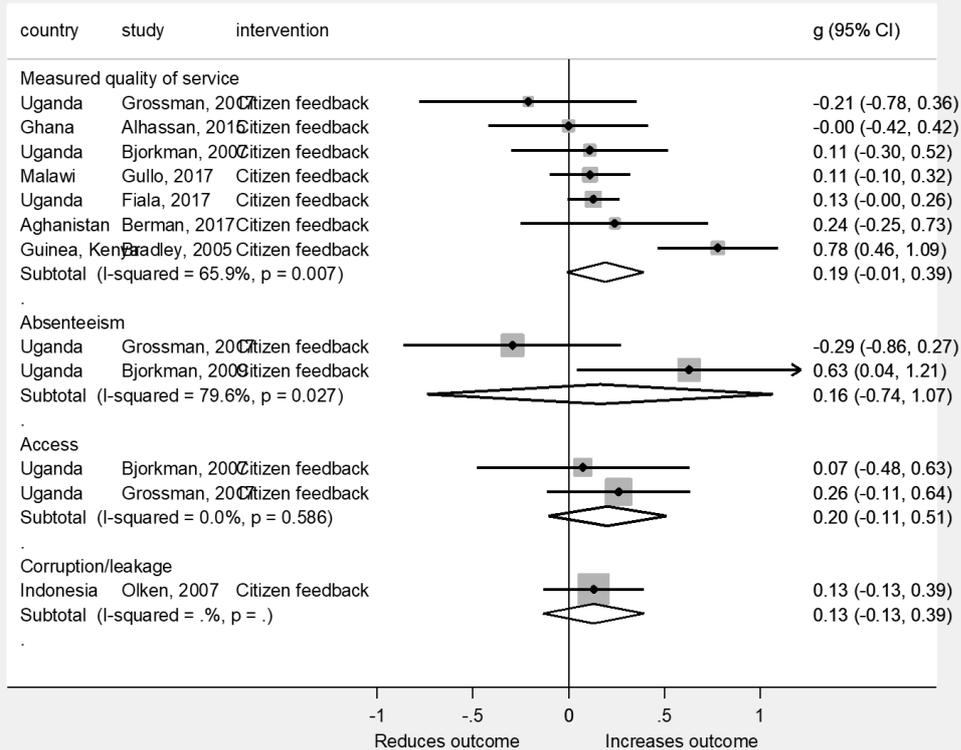
#### 4.3.4 Citizen feedback mechanisms

The story for citizen feedback mechanisms is more positive, although there is significant heterogeneity in the findings. For evaluations that also measure primary outcomes, citizen engagement improves for active participation (SMD=0.14, 95%CI=0.05, 0.24; four studies) and in one study that measured meeting attendance (Olken, 2007). The meta-analyses also did not suggest positive improvements in provider responsiveness on average, although some individual studies reported positive effects for provider actions (Olken, 2007) and staff motivation (Bradley et al.,

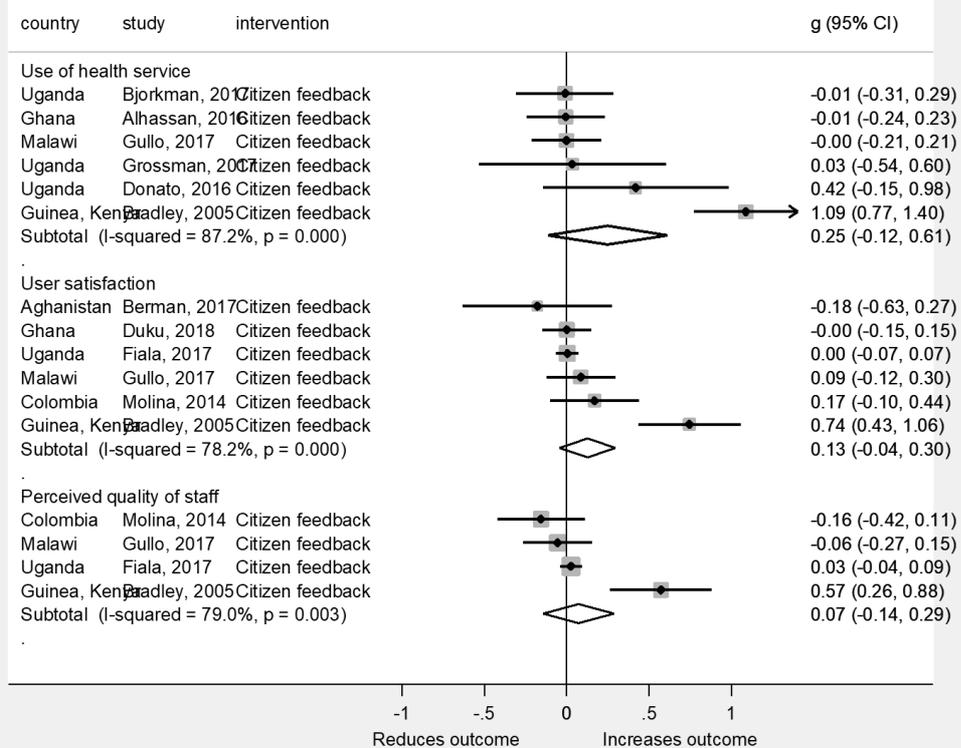
2005) (Figure 21). Several service access and use outcomes were assessed as having increased on average but not statistically significantly, including service quality (SMD=0.19, 95%CI=-0.01, 0.39; 7 studies) and user satisfaction (SMD=0.13, 95%CI=-0.04, 0.30; six studies). Finally, a few single studies reported positive wellbeing outcomes for reducing illness (Duku et al., 2018) and crime (Palladium, 2015), and improving empowerment and assets (Fiala et al., 2017) (Figure 22). Only one study (Fiala et al., 2017) measured state-society relations outcomes and was not able to detect significant changes due to citizen feedback mechanisms.

**Figure 21: Forest plots showing immediate and intermediate outcomes for citizen feedback mechanisms**





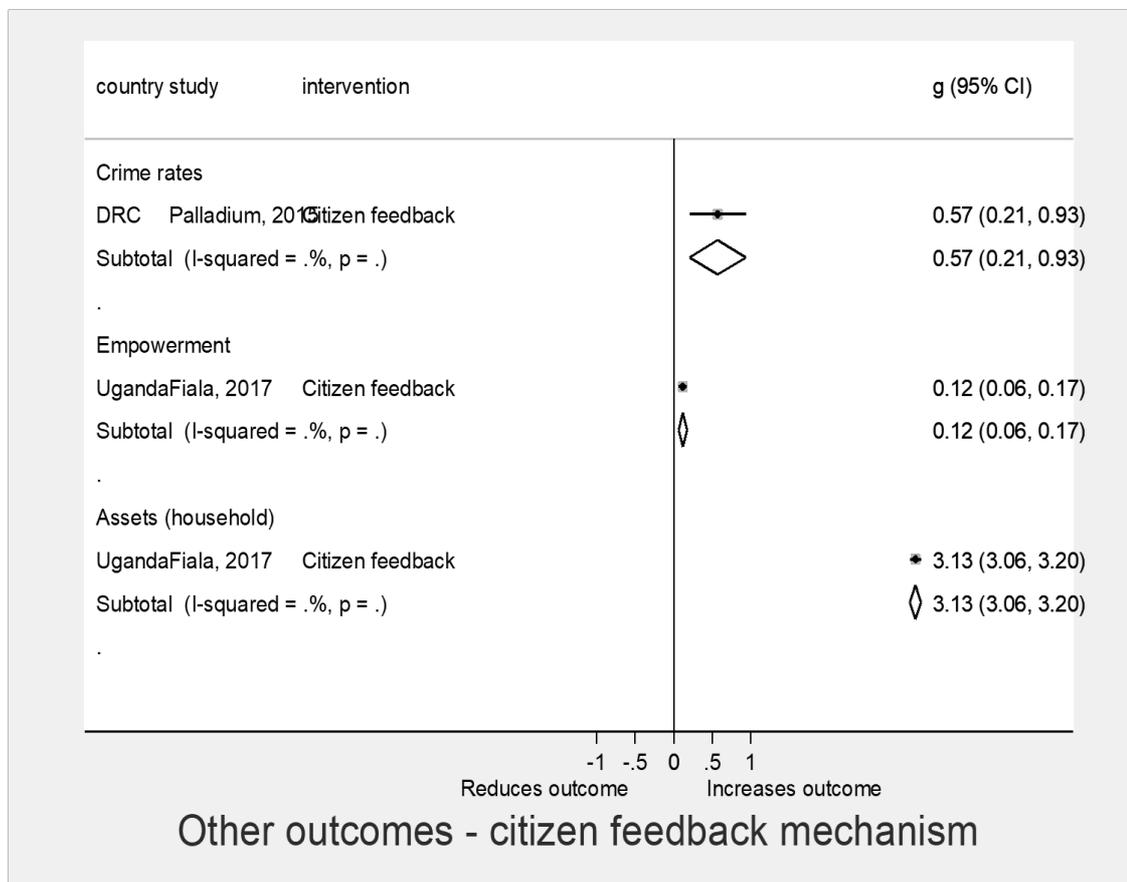
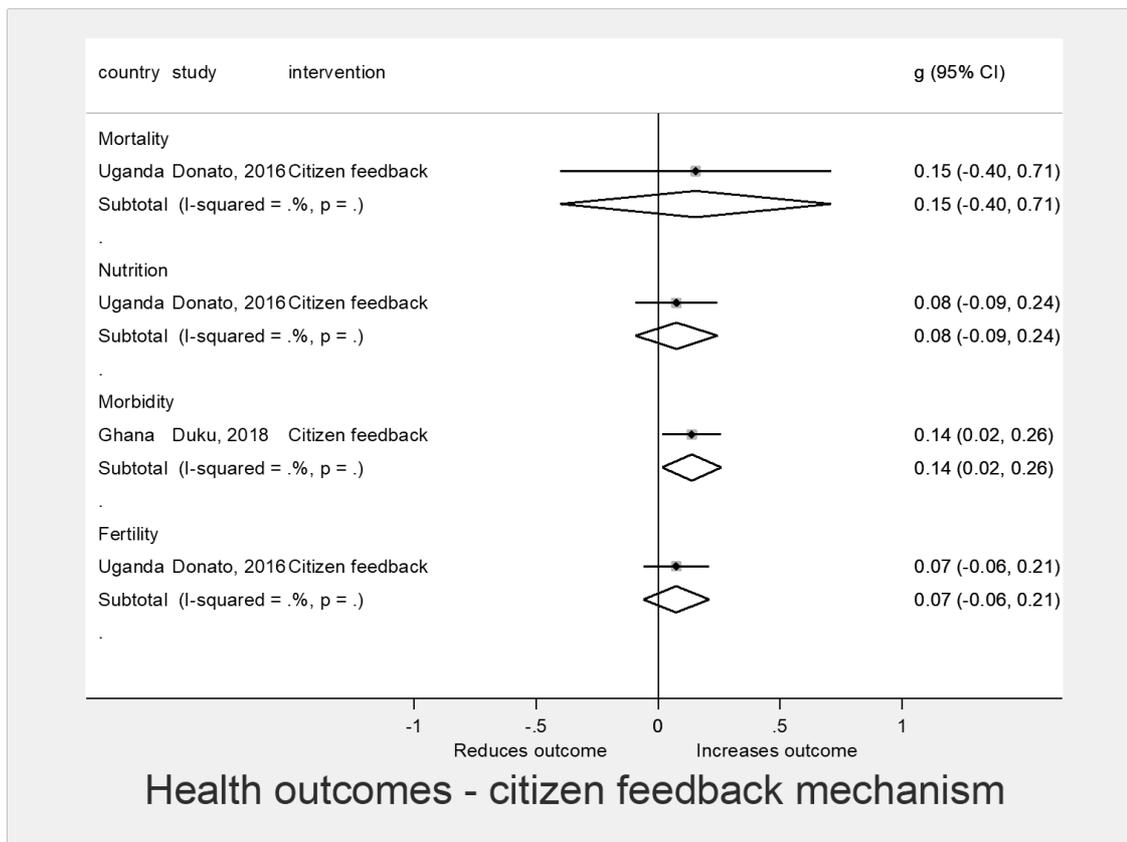
### Service access - citizen feedback mechanism

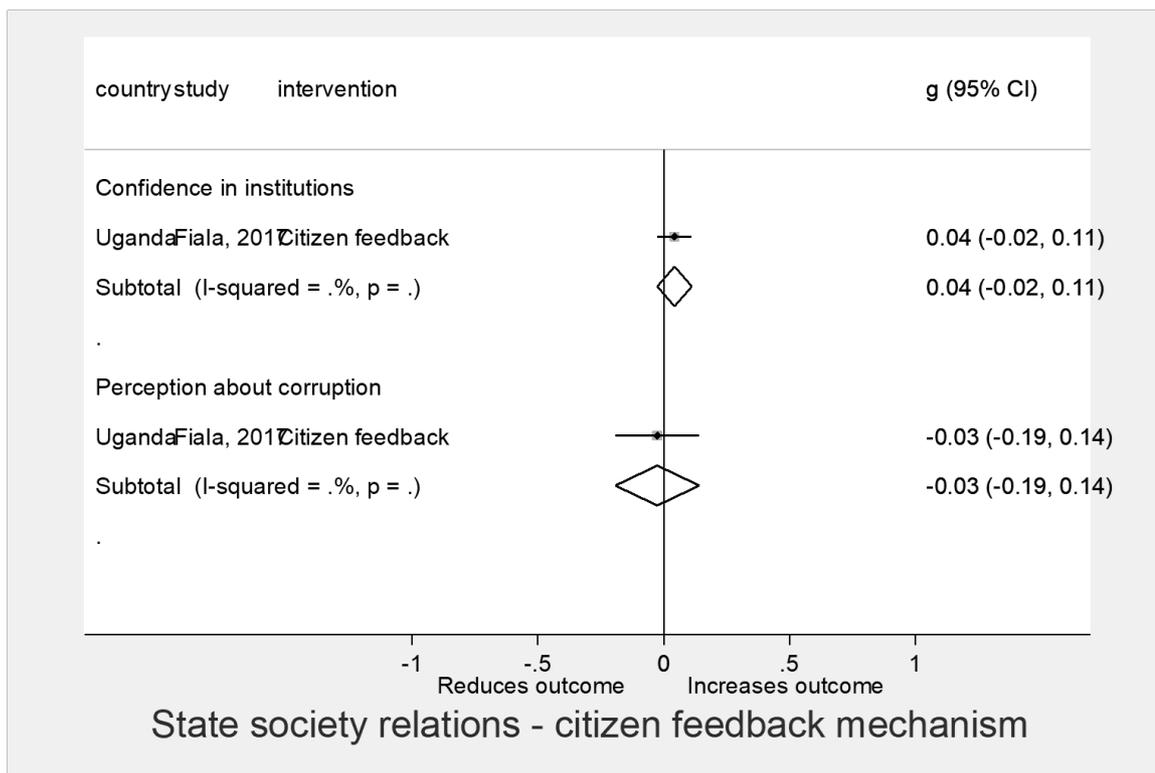


### Service use - citizen feedback mechanism

Note: effect sizes for negative outcomes are inverted for comparability.

**Figure 22: Forest plots showing final outcomes for citizen feedback mechanisms**



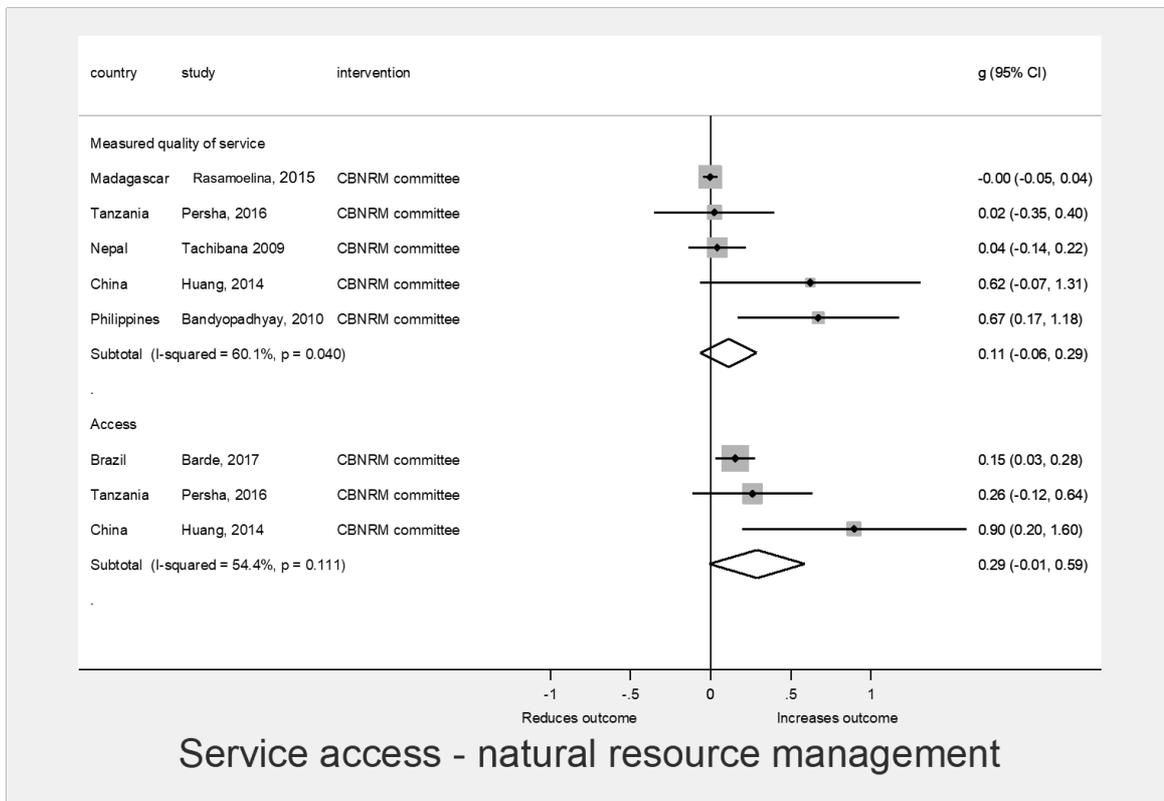
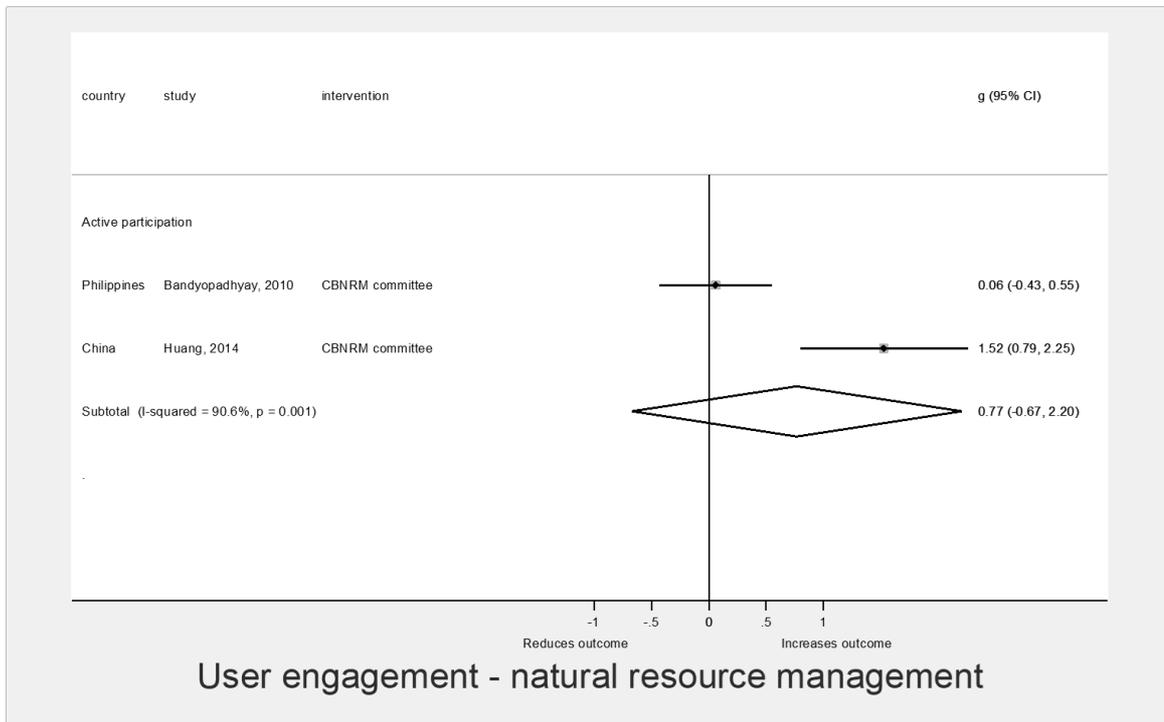


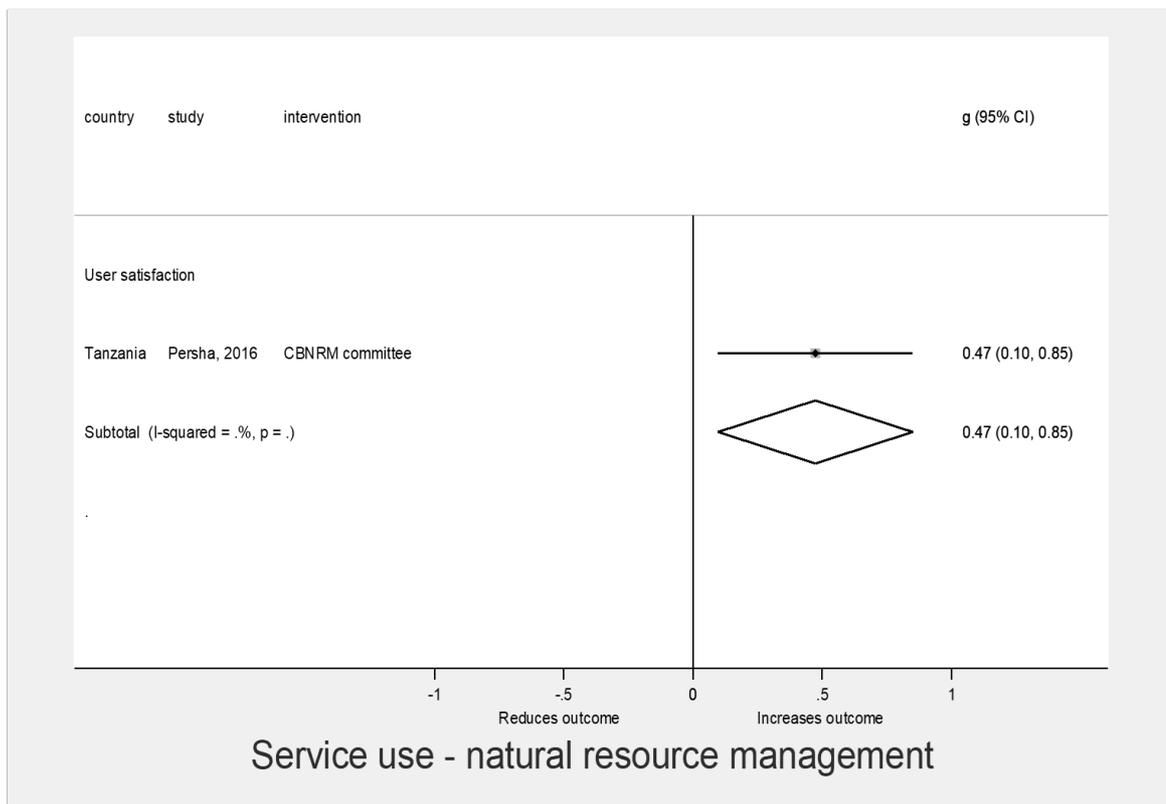
Note: effect sizes for negative outcomes are inverted for comparability.

#### 4.3.5 Community-based natural resources management committees

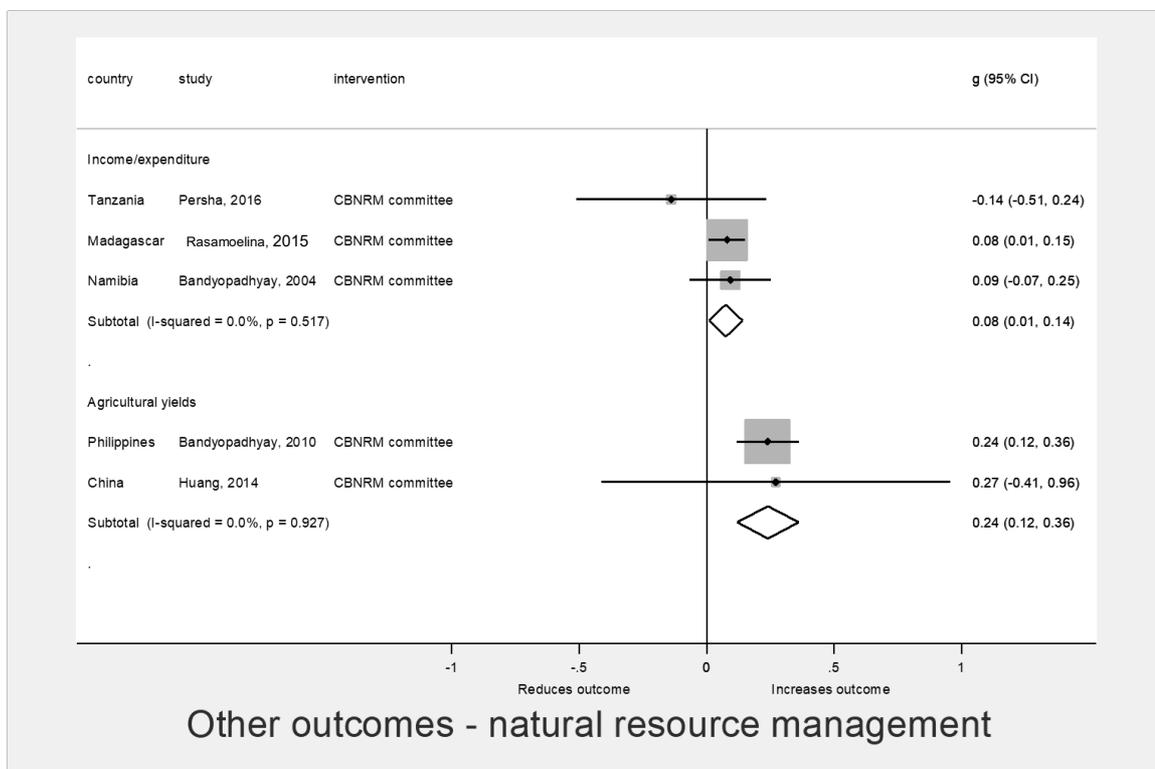
To some extent the findings for CBNRM are less convincing than other interventions, because, in the main, the included studies were assessed as being of risk of bias largely on design grounds (the exception is for the RCT by Barde et al., 2017). With this caveat in mind, the findings from meta-analysis suggested that final outcomes may improve for income/expenditure (SMD=0.08, 95%CI=0.01, 0.14; 3 studies), yield (SMD=0.24, 95%CI=0.12, 0.36; 2 studies) and tax payments (contribution to natural resource management) (SMD=0.46, 95%CI=0.06, 0.86; 2 studies) (**Figure 23**).

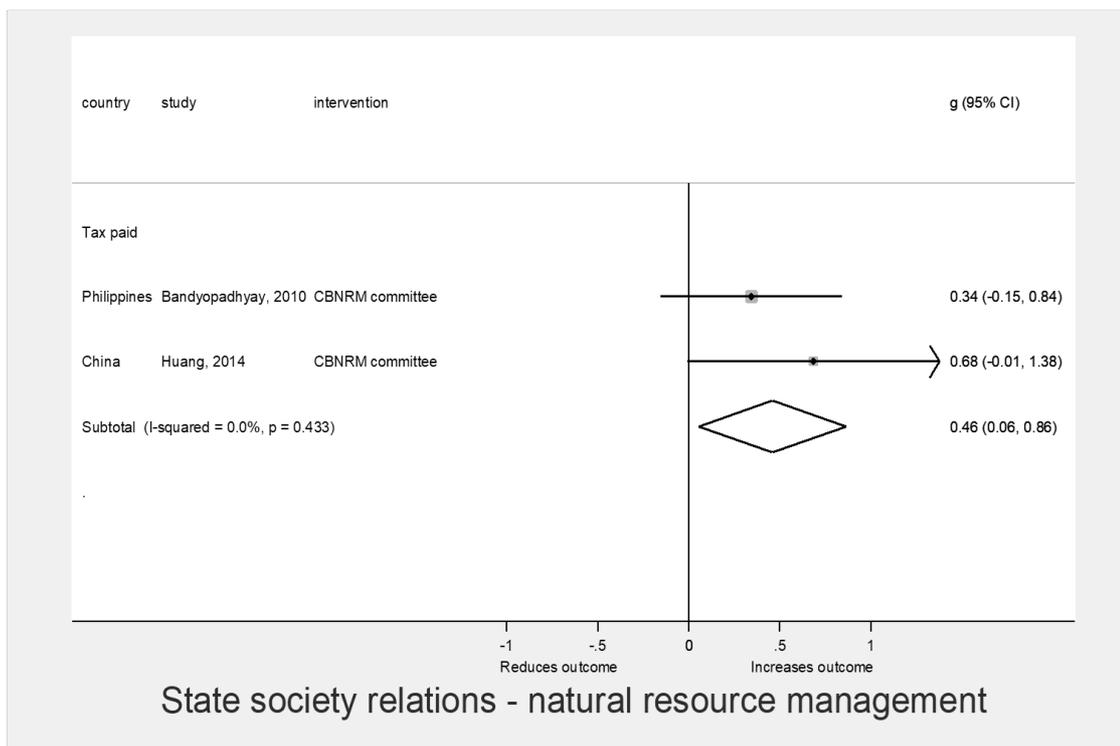
**Figure 23: Forest plots showing immediate and intermediate outcomes for CBNRM**





**Figure 24: Forest plots showing final outcomes for CBNRM**

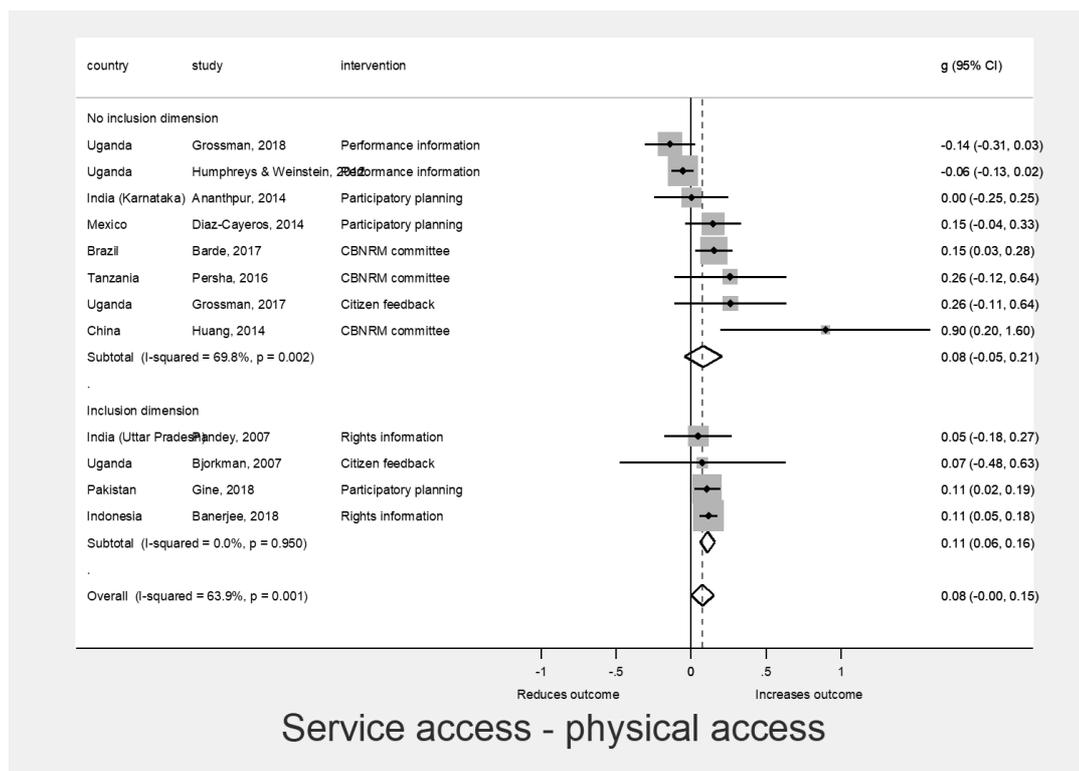


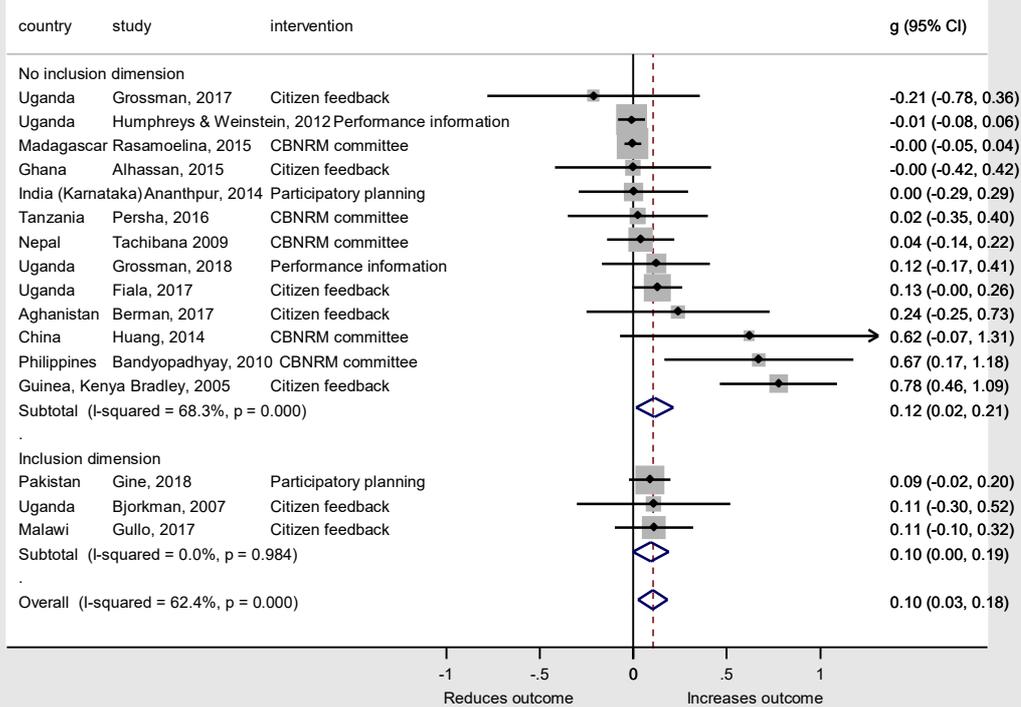


#### 4.3.6 Inclusion dimension

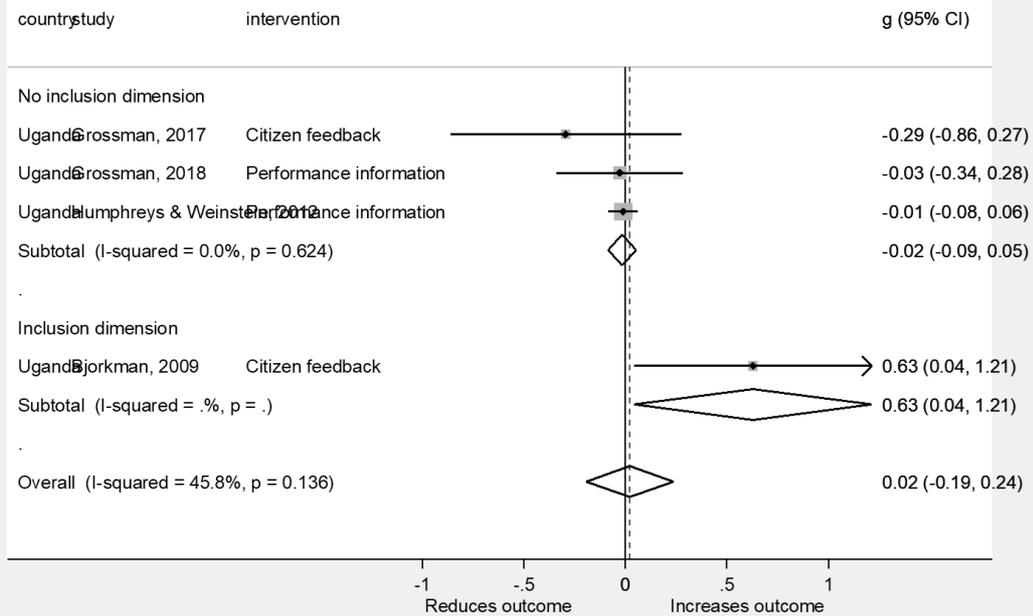
Where interventions had an inclusion dimension, the interventions tended to be at least as effective in improving outcomes, and more effective for service access outcomes (Figure 25 and Figure 26).

Figure 25: Intermediate outcomes by inclusion dimension of intervention

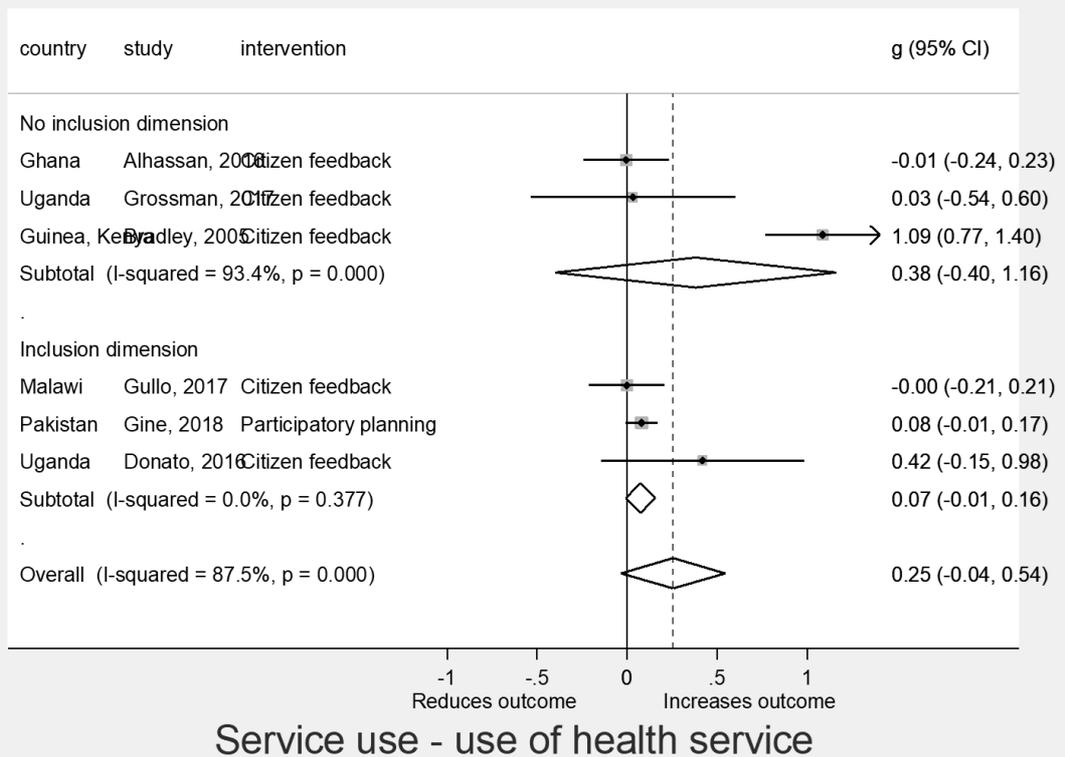
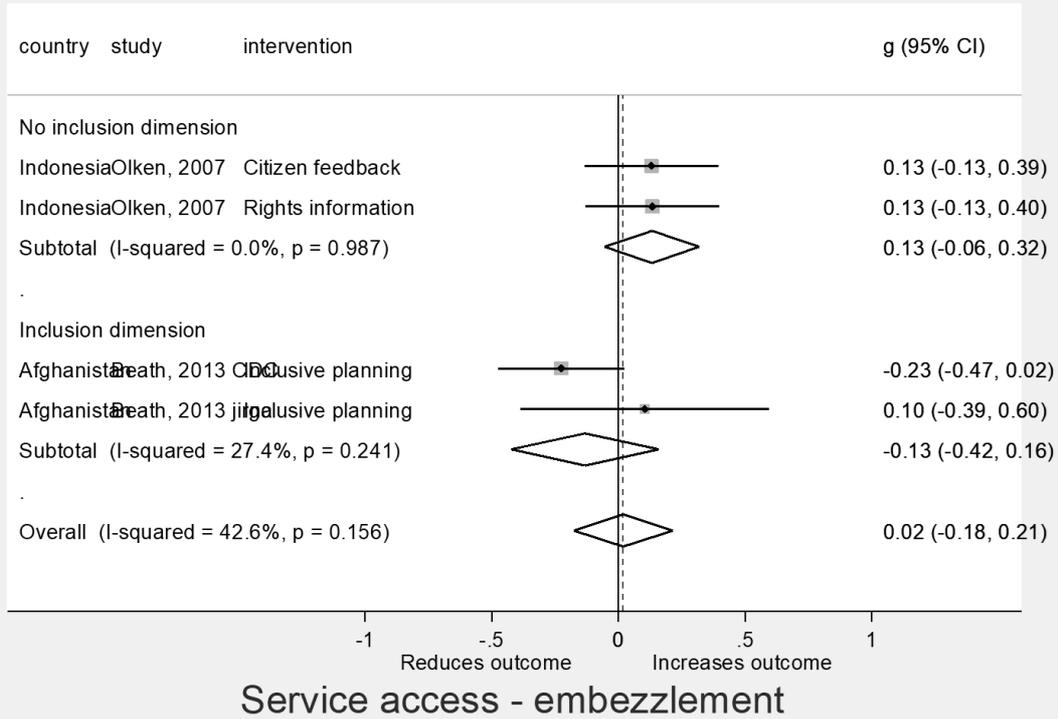


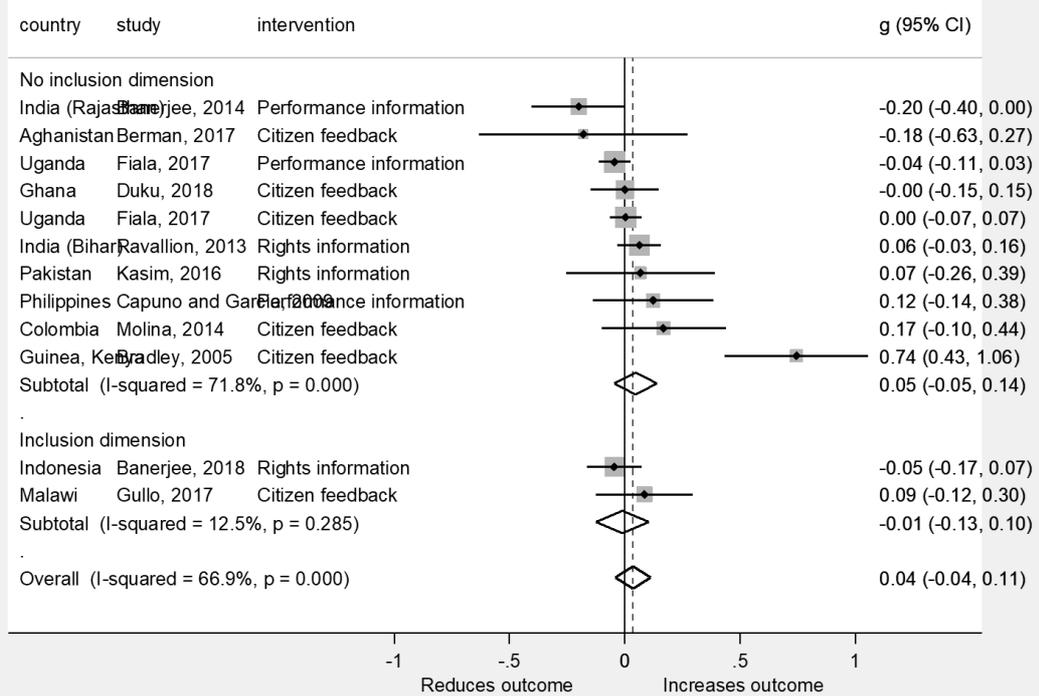


Service access - measured quality of service

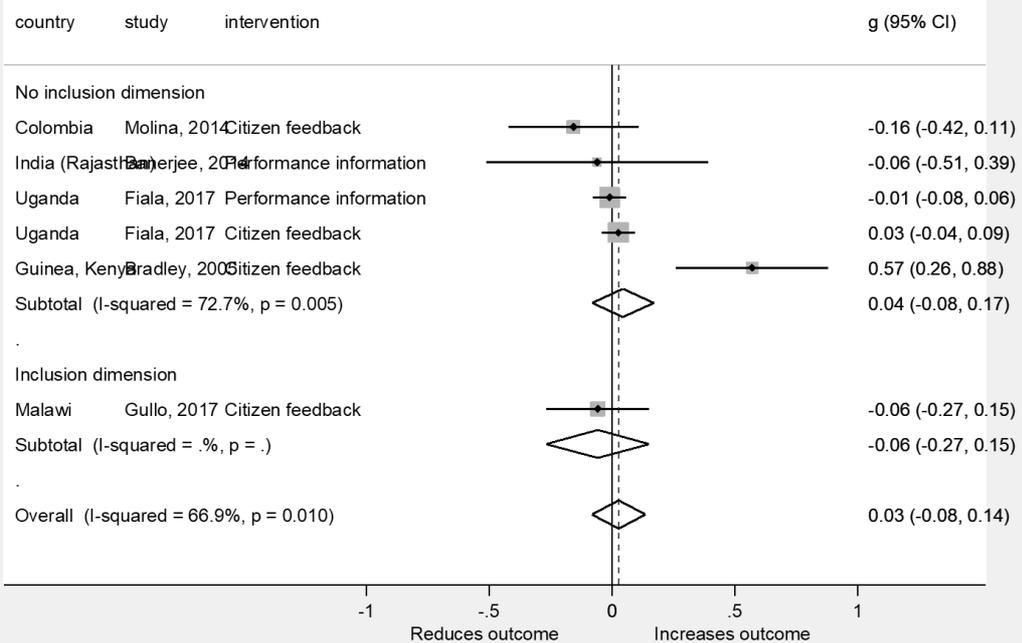


Service access - absenteeism

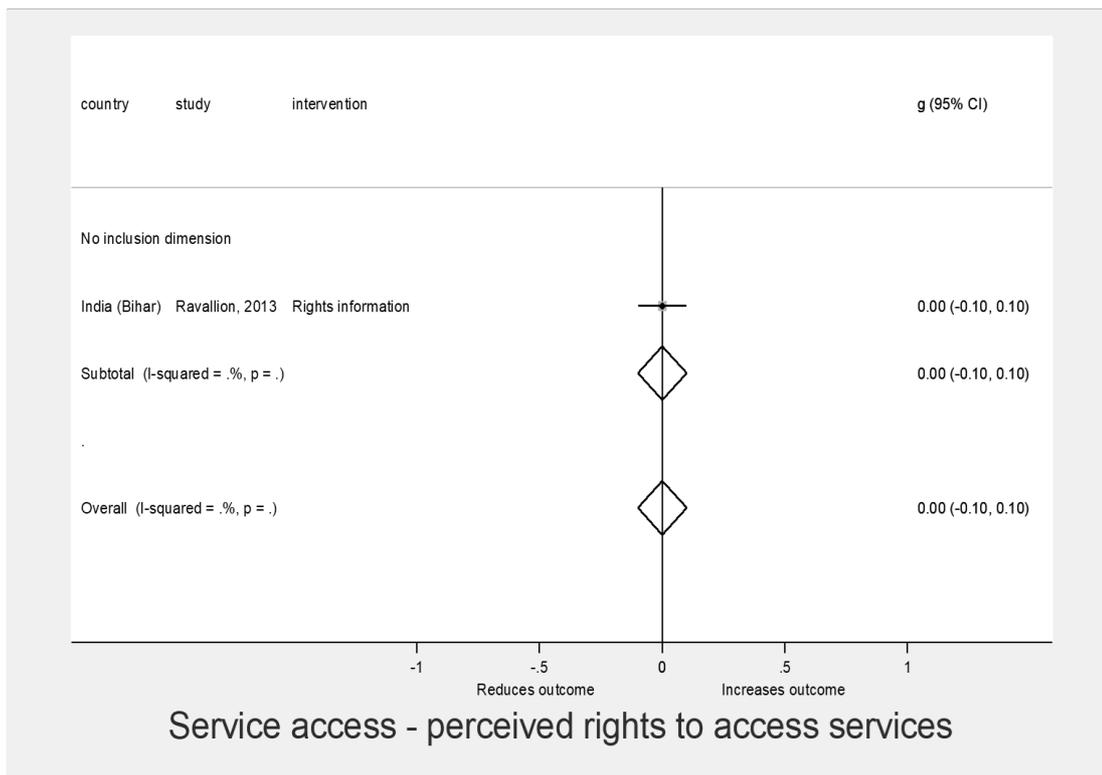




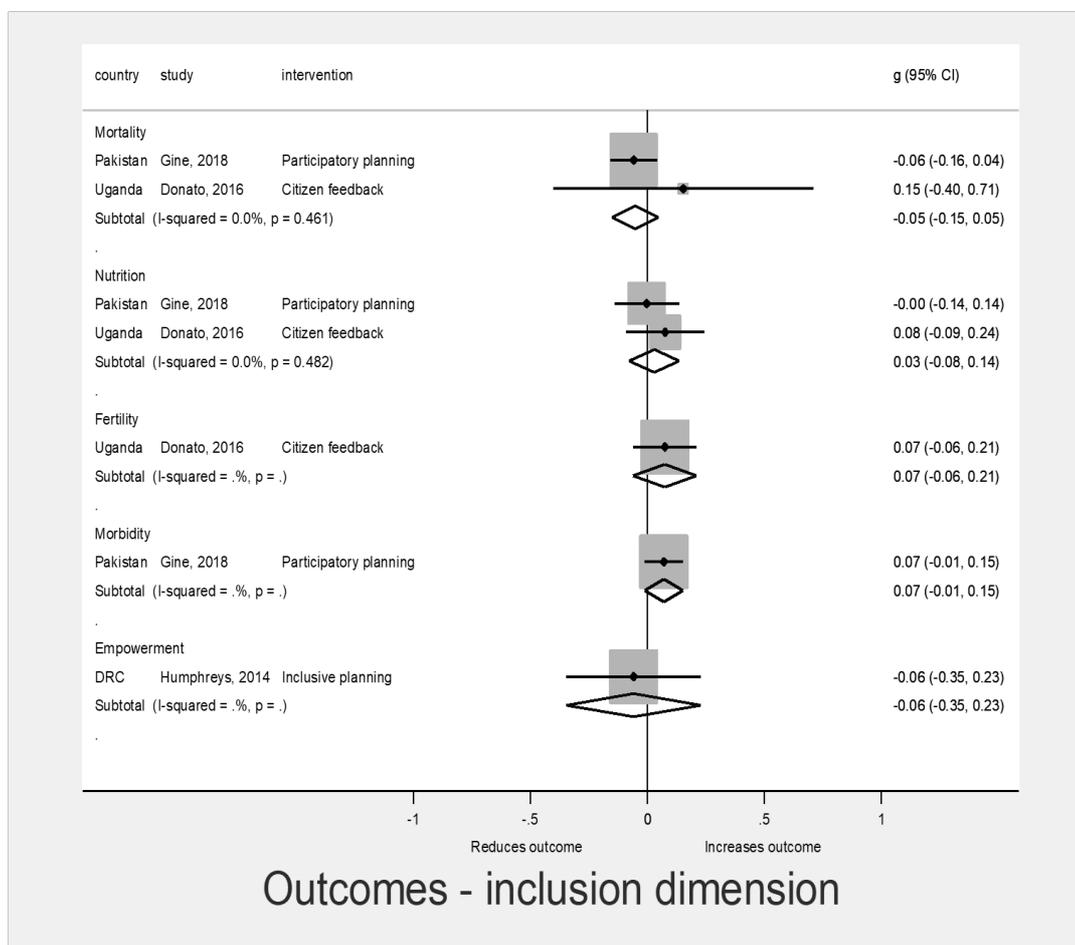
Attitudes to services - user satisfaction

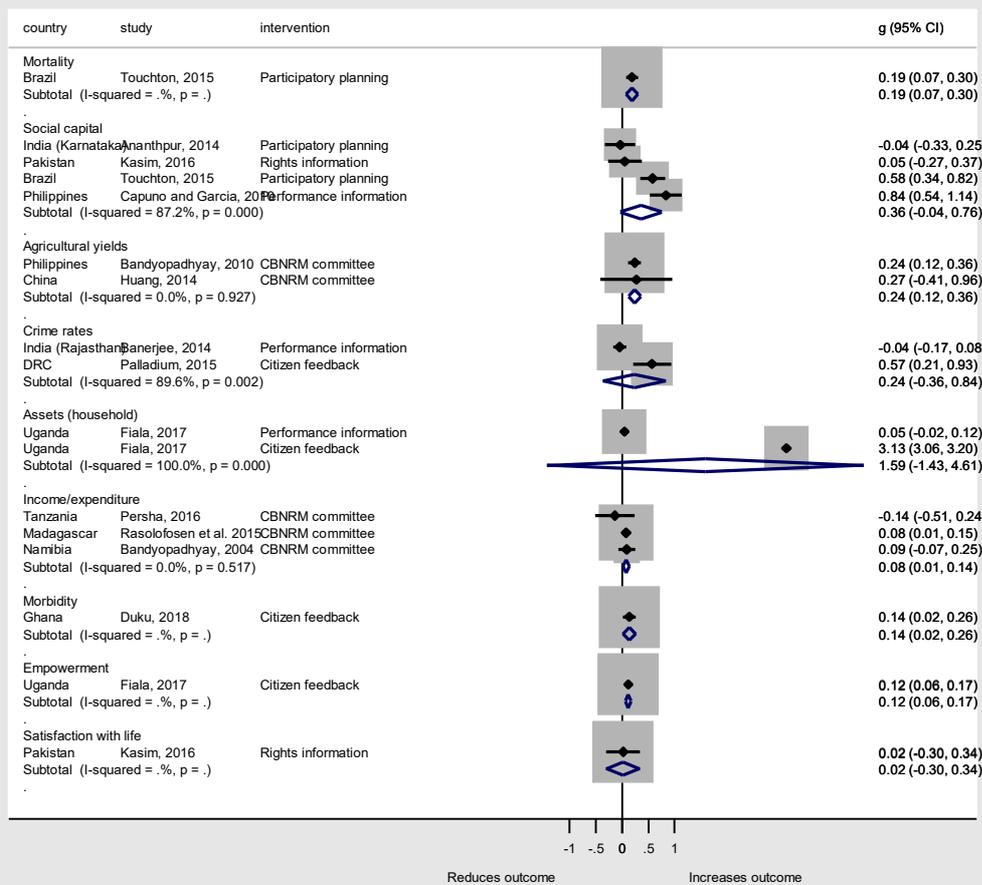


Attitudes to services - perceived quality



**Figure 26: Final outcomes by inclusion dimension of intervention**





## Outcomes - no inclusion dimension

### 4.4 Impacts by population group (Review question 3)

This section presents results of sub-group analysis for studies that report outcomes measured among different groups, including men, women and the poor. In addition, it presents further moderator analysis for whether interventions had an inclusiveness component by design and reporting outcomes by global region.

Three studies collected outcomes data measured separately among women and men (Ananthpur et al., 2014; Palladium, 2015; Ravallion et al., 2013) and a further five studies reported sub-group outcomes solely for women (Beath et al., 2013; Diaz-Cayeros et al., 2014; Fiala et al., 2017; Humphreys et al., 2014). The results, presented in **Table 13**, do not suggest there are differences in outcomes by sex, where outcomes for both men and women are reported in the same studies. There are differences in magnitude in a few cases, such as the two studies of employment (Ravallion et al, 2013) and local governance (Ananthpur et al., 2014) in India. Indeed, Ananthpur et al. (2014) suggests that the positive wellbeing outcomes measured among men are not seen among women. However, there are very few observations where studies report sex disaggregated effects, and when they do the confidence intervals overlap, so any differences can be interpreted as statistically insignificant.

**Table 13: Outcomes by sex sub-group**

<i>Outcome (study)</i>	<i>Sub-group</i>	<i>g</i>	<i>95%CI</i>		<i>I-sq</i>	<i>Tau-sq</i>	<i>Q</i>	<i>P-value</i>	<i>N obs</i>
Knowledge about services (Ravallion, 2013)	Male	0.090	-0.019	0.198	-	-	-	-	1
	Female	0.094	-0.010	0.198	-	-	-	-	1
Meeting attendance (Ravallion, 2013)	Male	0.110	0.000	0.220	-	-	-	-	1
	Female	0.128	0.030	0.227	-	-	-	-	1
Provider actions (Beath, 2013 CDC, <i>jirga</i> )	Male	-	-	-	-	-	-	-	0
	Female	0.106	-0.070	0.281	0.0%	0.0000	0.04	0.836	2
Politician performance (Diaz-Cayeros, 2014)	Male	-	-	-	-	-	-	-	0
	Female	-0.198	-0.360	-0.036	-	-	-	-	1
Use employment service (Ravallion, 2013)	Male	-0.017	-0.156	0.122	-	-	-	-	1
	Female	-0.042	-0.192	0.108	-	-	-	-	1
User satisfaction (Ravallion, 2013)	Male	0.070	-0.043	0.183	-	-	-	-	1
	Female	0.039	-0.070	0.148	-	-	-	-	1
Perceived right to access service (Ravallion, 2013)	Male	-0.013	-0.133	0.107	-	-	-	-	1
	Female	0.005	-0.105	0.114	-	-	-	-	1
Assets (household) (Fiala, 2017)	Male	-	-	-	-	-	-	-	0
	Female	0.009	-0.052	0.071	-	-	-	-	1
Income/expenditure (Ananthpur, 2014)	Male	0.285	-0.008	0.577	-	-	-	-	1
	Female	0.095	-0.196	0.387	-	-	-	-	1
Crime rates (Palladium, 2015)	Male	0.374	0.012	0.735	-	-	-	-	1
	Female	0.350	-0.012	0.712	-	-	-	-	1
Empowerment (Palladium, 2015)	Male	-	-	-	-	-	-	-	0
	Female	-0.146	-0.434	0.142	-	-	-	-	1

Note: effect sizes for negative outcomes are inverted for comparability.

Three studies reported outcomes for poor households (Banerjee et al., 2018; Pandey et al., 2007; Persha et al., 2016) (**Table 14**). In the case of Banerjee et al. (2018), the intervention targeted the poorest docile. In the case of Pandey et al. (2007) and Persha and Meshack (2017), outcomes are presented separately for lower-caste communities and poor households. The findings suggest that outcomes for the poor are usually positive and statistically significant (or marginally insignificant).

However, there are too few observations to draw conclusions, other than that studies must more consistently present results of sub-group analysis. Even where significant effects are not reported due to underpowered analyses, statistical synthesis (meta-analysis) can be undertaken to detect possible effects across studies.

**Table 14: Outcomes by poor sub-group**

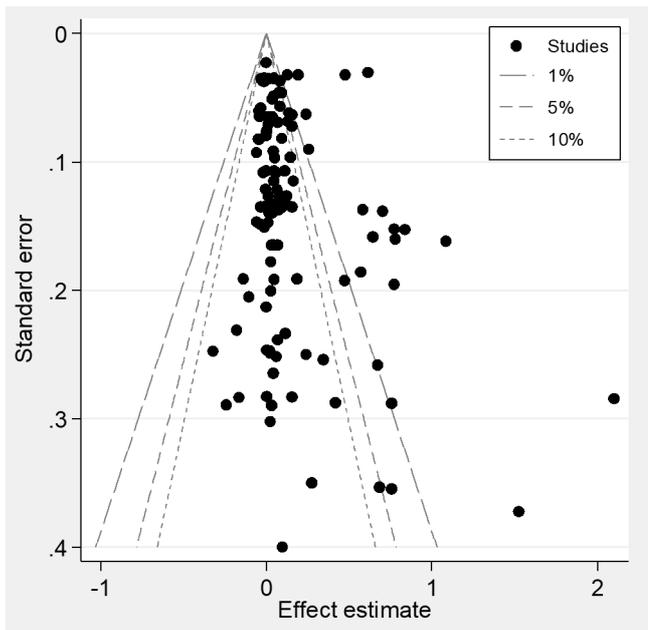
<i>Outcome (study)</i>	<i>g</i>	<i>95%CI</i>		<i>I-sq</i>	<i>Tau-sq</i>	<i>Q</i>	<i>P-value</i>	<i>N obs</i>
Physical access (Banerjee, 2018; Persha, 2017)	0.066	-0.006	0.137	0.0%	0.0000	0.18	0.672	2
Measured quality of service (Pandey, 2007)	0.221	-0.005	0.446	-	-	-	-	1
Cost of service (Banerjee, 2018)	0.084	0.009	0.159	-	-	-	-	1
User satisfaction (Persha, 2017)	0.449	0.073	0.826	-	-	-	-	1
Income/expenditure (Persha, 2017)	0.054	-0.319	0.428	-	-	-	-	1

Finally, we conducted analysis by global region. Bearing in mind that the analyses are likely to be confounded by other characteristics such as intervention type, we note simply that the analysis suggests intervention conducted in East Asia and Pacific and South Asia are more likely to have significant effects than studies conducted elsewhere.

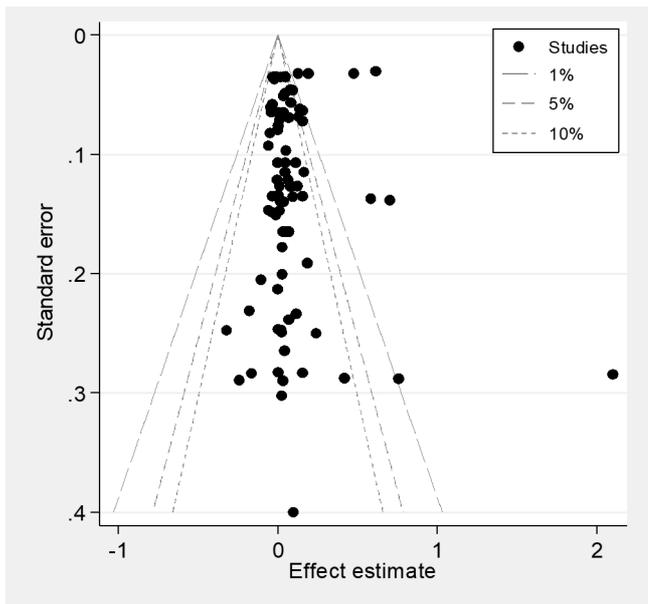
#### **4.5 Publication bias analysis**

This section presents results of the analysis of small study effects. **Figure 27** presents contour enhanced funnel graphs for all study designs (part a) and for RCTs only (part b). There does appear to be asymmetry in the plot, which is markedly less for RCTs than all study designs. This may support Peters et al. (2008) contention that bias may confound attribution of small study effects to publication bias. Eggers et al. (1997) test also did not find significant evidence for publication bias (**Table 15**).

**Figure 27: Funnel graphs**



a) All study designs



b) RCTs only

**Table 15: Results of Eggers tests**

<i>Sample</i>	<i>Coeff</i>	<i>95%CI</i>		<i>p-value</i>	<i>N obs</i>
All study designs	0.397	-0.417	1.212	0.336	113
RCTs	-0.644	-1.653	0.365	0.208	82

## 5. Results of framework synthesis (review question 4)

The following section presents the analysis of context and mechanisms that may contribute to findings along the causal chain (*review question 4*). We present the findings of a qualitative, realist-informed framework synthesis that moves toward “best fit” framework synthesis, focusing on the key mechanisms and moderators along the casual chain for each broad intervention group. These findings are drawn from a mixture of first, second and third order constructs.

This analysis is broken down across the five broad intervention groups: rights information provision; performance information provision; citizen feedback and monitoring; participatory planning; and community-based natural resource management (CBNRM). For each intervention group, the analysis identifies the key moderators (barriers and enablers) that explain the mechanisms triggered by the interventions along their causal chains. Each sub-section first presents an overview of the included primary studies and corresponding additional literature that were used for the analysis, then iterates a series of case comparisons that highlight the key explanatory factors identified through the synthesis process. Finally, the revised framework for each broad intervention group is presented as a refined theory of change articulating the primary mechanisms connecting the intervention to outcomes along the causal chain. Note that certain factors are important to all included intervention types; to avoid repetition, each factor is only discussed in-depth through case comparisons once, though included in all refined frameworks as relevant. The extent to which certain factors are generalizable across all intervention types and those unique to specific contexts are discussed in section 5. This section concludes with a section that integrates the framework synthesis with the meta-analysis, empirically testing the strongest moderating variables that emerged from the qualitative synthesis.

### 5.1 Rights information provision

Five studies comprised or included study arms of interventions that aimed to improve citizens’ access to information about their rights to services (**Table 16**).

**Table 16: Included studies of rights information provision**

First author	Year	Country	Sector and specific intervention	Additional literature included
Banerjee	2018	Indonesia	Information cards with rice subsidy rights and prices	2 (previous evaluation versions)
Kassim	2016	Pakistan	Information on government reforms	N/A
Olken	2007	Indonesia	Invitations to public construction monitoring meetings (“invitations” study arm)	1 (implementation report)
Pandey	2007	India	Health services presentation	N/A
Ravallion	2013	India	Video campaign of rights to guaranteed labor scheme	2 (qualitative and quantitative studies)

These studies look at the provision of information on rights to services that cover both merit goods (such as rice subsidies) and public goods (such as construction monitoring). Through providing citizens with information on their rights to services, including both entitlements to both quality and quantity, these interventions aim to increase their realization of their rights. The data extracted in the qualitative synthesis for these studies were reviewed to identify patterns of movements along the causal chain. Within this intervention group, three key factors emerged that helped explain the heterogeneity of results: whether the bottleneck to service access was correctly identified as demand-driven lack of information; whether the intervention targeted a collective or individual good; and whether the bottleneck was due to demand-driven lack of information about existing services or supply-driven rationing of service allocation or corruption. Case comparisons using the included studies are provided to illustrate the importance of these factors.

The first stage in the causal chain thus assumes that the underlying bottleneck to citizens' access to services is a lack of information about their rights. However, few studies provided *ex-ante* evidence that the key barrier to service access was lack of information. Olken (2007) is an exception; in explaining the design of the intervention, the researchers provided qualitative evidence that suggested that the barrier to citizen participation in construction monitoring meetings was due to the lack of written invitations. In the Indonesian cultural context, it was viewed as inappropriate to attend an event to which one had not been invited, and thus the public meetings were primarily attended by a few elite villagers. During the evaluation, this assumption was tested, and the researchers found some evidence that supported their identification of the barrier: following the intervention disseminating invitation cards, the number of non-elite villagers present at the meetings increased by 75 per cent (Olken, 2007).

In comparison, in Ravallion et al. (2013), though the researchers conducted qualitative research during the design phase to ensure their video would be salient to the rural, poor population targeted, and identified low levels of knowledge of their rights to the labor subsidy service, the intervention ultimately had limited impacts on use of the rural guaranteed labor scheme amongst the targeted population. Subsequent research of the jobs programme suggests that the key barrier to citizens' access to the labor programme was actually rationing of access to jobs by administrators, triggering discouragement amongst potential workers (Narayanan et al., 2017).

A key theme throughout the transparency and accountability-related studies is the difference in mechanisms triggered by interventions depending on the nature of the service they were targeting, which related to how citizens accessed the service. Broadly, the services could be split into two groups: "direct delivery" services and "indirect delivery" services. The first, "direct delivery," refers to those services that citizens access from individual service providers, such as the healthcare one receives from a clinician or the food subsidies one collects from the distributor. In these cases, citizens engage with the service provider staff on a regular basis as part of their normal service use. The second, "indirect delivery," refers to services that citizens access independently of the providers, such as public infrastructure that one uses without engaging with the contractors who built it. In this latter group, citizen engagement in service delivery tends to be limited to transparency/accountability interactions; in the

absence of such processes, citizens may not otherwise interact with the providers at all.

Where the intervention targets a directly delivered service, such as the provision of rice subsidies, and the bottleneck is correctly identified as pertaining to lack of information on the demand-side, then the provision of information may suffice to improve the delivery of services to citizens. In Indonesia, Banerjee et al. present evidence suggesting that disseminating cards with information on citizens' rights to rice subsidies and standard costs was sufficient to change citizens' bargaining power with the service provider to increase the amount of subsidized rice they received (2018). The authors highlight facilitating factors that triggered a significant change in response to a relatively small intervention, including:

- The *salience of the information* provided: rice is a staple of the Indonesian government, and the subsidized rice is significantly cheaper than the market rate yet doesn't cover their full monthly consumption; thus, citizens are highly motivated to attempt to access as much as possible;
- The *creation of perceptions of common knowledge* of eligibility to and costs of the subsidized rice, through the public campaigns in a sub-set of the treatment;
- The *appropriateness of the strength of the social sanctions* risk: The provision of information regarding rights to services is a relatively weak instrument for changing the balance of power between service providers and service users. However, Banerjee et al. argue that it was effective in the case of the rice subsidies because it created a small shift in citizens' bargaining power without eradicating the service providers' control completely over allocation of resources. In their context, this was important because the central government relied on the cooperation of the local village officials for the dissemination of the service; without their cooperation, it would be difficult to implement the project in their villages, and the authors present qualitative evidence suggesting that government officials were cautious of sanctioning incomplete compliance too forcefully (Banerjee et al., 2018).

Conversely, in the case of indirectly delivered services, the ability of citizens to influence service providers appears much weaker. In Olken (2007), though the bottleneck was likely correctly identified as described above, and an increase in participation suggested that communities were motivated to monitor the projects and did not suffer from the free rider problem, the analysis found statistically insignificant results of the intervention on decreasing corruption within the community construction projects. However, he provides evidence that supports the identification of the direct versus indirect delivery mechanism: in the treatment villages, the invitations to participate in monitoring did have an effect on lowering corruption as regards labor costs in construction projects, but not for materials costs. As materials costs comprise the majority of construction budgets, the overall results were insignificant. Yet the community construction projects required voluntary, unpaid labor contributions by community members in addition to providing paid labor opportunities; individual villagers were thus interacting with the contractors to access labor and wages, in addition to participating in the accountability meetings. They were thus highly aware of the real wages and amount of paid labor provided. Conversely, materials were sourced directly amongst contractors with community engagement only through accountability

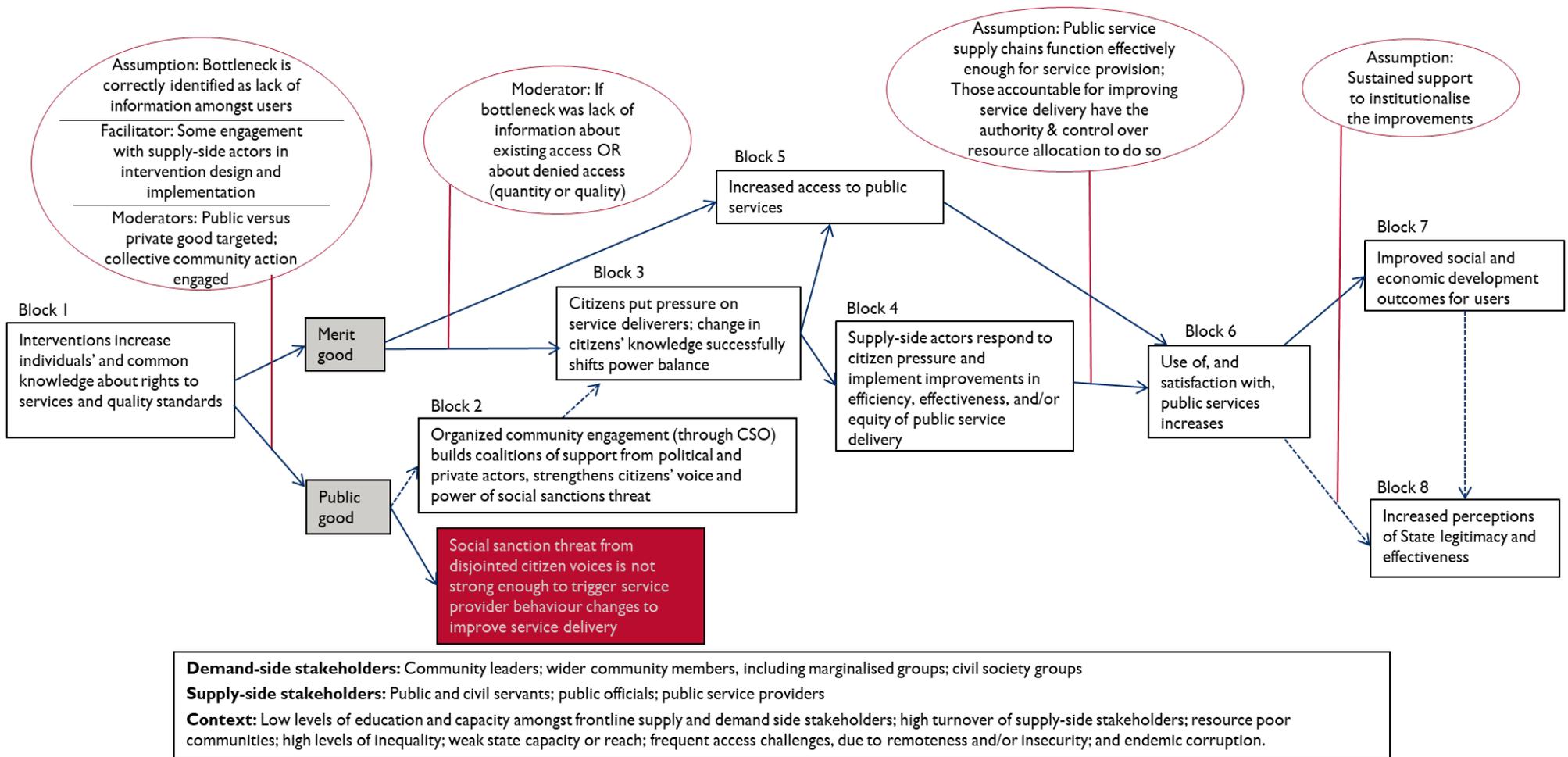
processes, and Olken notes that villagers likely had incomplete information about real costs.

A common element of rights-information provision interventions is a focus on engaging primarily or solely with demand-side actors. This thus triggers demand-driven responses, and may explain the lack of evidence regarding service provider response that led to breaks in the causal chain. However, in cases where service use has a direct effect on wellbeing outcomes, the provision of rights-information may be able to achieve results further along the causal chain directly through inspiring changes in citizen use of services, despite failing to influence the quality of service provision. For example, in India, Pandey et al. (2007) find that an information campaign on access to health services was successful in increasing citizens' knowledge of existing services that they could choose to access; unlike the video campaign for the guaranteed labor scheme, service allocation rationing was not an issue. However, though the campaign informed citizens on their rights and how to complain when service delivery didn't meet quality standards, the authors present qualitative evidence that suggested that the lack of engagement with the supply-side actors throughout the intervention may have triggered a break in the causal chain for service provider response and service quality improvements (Pandey et al., 2007).

Following the synthesis process, the original framework was adapted to create a "best fit" framework that highlights the abovementioned key mechanisms and moderating factors (**Figure 28**). Though the included studies within this intervention group did not include any instances in which an intervention targeting an indirectly delivered service was able to have an effect on service quality through the dissemination of information, the synthesis across the entire sample of included studies in this review identified the strong facilitating capabilities of building social capital and capacity for collective action amongst citizens, such as through working with organized community groups (e.g. local civil society organizations (CSOs) or interest groups) in addressing this bottleneck. Indeed, a subsequent intervention document related to the Olken (2007) experiment noted that a key project lesson had been the success of shifting from implementer-facilitated monitoring to forming and training groups of community monitors for the construction projects (World Bank, 2011). In the refined theory of change for this intervention group, we thus include the potential of CSO engagement to overcome the indirect delivery bottleneck.

In the diagram, the dotted lines denote the lack of evidence in the included studies. Grey boxes denote key moderators that trigger different mechanisms, leading to slightly different causal change pathways.

**Figure 28: Theory of change for interventions providing information on rights to public service quantity and quality**



## 5.2 Performance information provision

Six studies comprised or included study arms of interventions that improved citizens' access to information about the performance of public service providers (**Table 17**).

**Table 17: Included studies of performance information provision**

First author	Year	Country	Sector and specific intervention	Additional literature included
Banerjee	2014	India	Police community observers	N/A
Capuno	2010	Philippines	Dissemination of municipal scorecards	N/A
Fiala	2017	Uganda	Dissemination of scorecards of CDD projects ("scorecard" study arm)	2 (implementation reports)
Grossman	2018	Uganda	Intensive dissemination of district councilor scorecards	2 (implementation reports)
Humphreys	2012	Uganda	Intensive dissemination of scorecards of Members of Parliament (MP) performance	1 (previous evaluation version)
Timmons	2015	Brazil	Publication of municipal audit reports	N/A

These studies include interventions that provided performance information about both individual service providers in the form of elected politicians (Humphreys and Weinstein, 2012; Grossman & Michelitch, 2018; Capuno & Garcia, 2010) and service provider institutions (Timmons & Garfias, 2015; Banerjee et al., 2014; Fiala and Premand, 2017). Through providing citizens with performance information, these interventions aim to trigger mechanisms in which service providers respond to a change in motivated citizens' efforts to hold them accountable to performance improvements.

The data extracted in the qualitative synthesis for these studies were reviewed to identify patterns of movements along the causal chain. Within this intervention group, four key factors emerged that helped explain the heterogeneity of results: for interventions targeting elected politicians, the relative competitiveness of their constituency and the timing of the intervention in relation to the next election; for all types, the extent to which targeted supply-side actors accept the intervention (buy-in); and whether the information provided changes citizens' priors. Case comparisons using the included studies are provided to illustrate the influences of these factors.

As noted above, this sub-sample of studies includes interventions that disseminate performance information about individual elected politicians and about service provider institutions. Within the first group, Humphreys & Weinstein (2012) and Grossman & Michelitch (2018) measure the impact of intensive dissemination of performance information against a comparatively weak dissemination, whereas Capuno & Garcia (2010) measure the impact of providing performance information versus its absence. In the second group, Timmons & Garfias (2015) measures the impact of providing performance information in the form of audits related to municipal governments, and thus is still impacted by the electoral factors. Fiala and Premand (2017) include a study arm that provides scorecards to communities with the overall and relative performance of their local community-driven development (CDD) council regarding the community's chosen project. Banerjee et al. (2014) is the only included study which attempts to evaluate performance information regarding non-elected service provider performance, specifically the police.

The studies that evaluate the provision of performance information of elected politicians are included in this review because they attempt to make an explicit link between politician performance and service delivery and report the results on service delivery quality accordingly. As noted in the background section, the different spheres of governance interact, and in the case of these studies, the underlying theory is that changes to politician performance can be realized via informal processes of vertical accountability through a "shortened long route" of direct citizen pressures on politicians *outside of* the electoral cycle, which relies on the threat of immediate social sanctions and future sanctions at the ballot box. While there are many reasons for desiring strong politician performance and accountability to constituents, in this review we focus on the effects of these interventions on service delivery.

The first key moderator identified through the synthesis along the causal chain for politician performance interventions is the influence of competition within an electoral constituency on politicians' behaviors. This mechanism is specifically tested in Grossman & Michelitch (2018), wherein they find that the intense dissemination of scorecards for politician performance only triggered an improvement in politician performance in electorally competitive constituencies. Grossman & Michelitch (2018) provide contextual information suggesting that in Uganda, while the national-level politics are dominated by a single party, locally there is variation in relative competition for elected seats, which enabled them to test this mechanism. The findings in Humphreys & Weinstein (2012) support this theory; they find that while voters were strongly receptive to the disseminated performance information, it did not trigger improved performance amongst national-level MPs, who face minimal electoral competition.

This leads to the next key assumption: that the information provided is salient to citizens' decision-making. As noted, Humphreys & Weinstein (2012) found that while the information was salient to citizens' interests, it did not translate into changes in politicians' chances for re-election, thus suggesting that citizens' electoral decisions were based on factors other than politician performance. Grossman and Michelitch (2018) suggest that the salience of performance information to voters' decision-making depends on the political culture; in a context where voting is primarily along party, ethnic or religious lines, politician performance is unlikely to have a large impact on voters'

actions. Given the Ugandan context of limited national-level electoral competition, this factor could also help explain the null results.

In determining whether the performance information provided is likely to be salient to constituents, the extent to which it changes their priors appears to be influential. This mechanism is tested by Timmons & Garfias (2015), who find that the publication of the results of a municipal government audit influenced the willingness to pay taxes for those constituents whose priors were changed by the audit results. This mechanism may also help explain the dissipation in results over time that Capuno & Garcia observe; in their intervention, performance information was regularly disseminated to constituents over two years, and while the intervention started off by often triggering strong results, by the end of the project the results had weakened or even disappeared in some cases (2010). Drawing on the insights from Timmons & Garfias (2015), this dissipation could potentially be explained as the result of a decrease in the strength of the “shock” provided by the transparency initiative, as citizens and government developed expectations of the results.

Another potential explanatory factor between these two studies is the relative power difference between targeted supply-side actors (i.e. the politicians) and demand-side (constituents). It is reasonable to expect that there is a larger power difference between national-level MPs and their primarily rural constituents, compared to rural constituents and district-level councilors. Thus, in the absence of the potential for electoral sanctions, politicians who enjoy a greater level of power difference compared to their constituents are more able to ignore increased transparency without fear of credible social sanctions.

Timmons & Garfias (2015) present some evidence that suggests that while elections are not the only mechanism at play in determining whether performance information dissemination triggers improvements in performance, the timing of information dissemination relative to elections does have some effect. The authors of all included studies evaluating elected politician performance note that the reactions to the dissemination of performance information for elected politicians are likely to be affected by whether they are up for re-election and the time until the next election. Grossman & Michelitch (2018) argue that performance information should be disseminated at such a time that the politicians have the scope to improve their performance before the next election, yet not so close to the election that a negative response (e.g. vote buying or intimidation) is potentially triggered.

Even where the information provided is salient to constituents’ decision-making, the politicians may still manage to subvert the efforts to hold them accountable, either through preventing the dissemination of information or discrediting the messenger and/or the message. Across the included studies, whether this disruption occurred tended to depend on the extent to which the targeted supply-side actors were engaged in the intervention design; their support or “buy in” for the intervention; and the relative local credibility of the messenger of the performance information compared to the targeted actor or institution.

In Banerjee et al. (2014), the only included study which looked at non-elected service providers, the break in the causal chain occurred extremely early on, as the actors charged with implementing the intervention were the very ones whose performance was

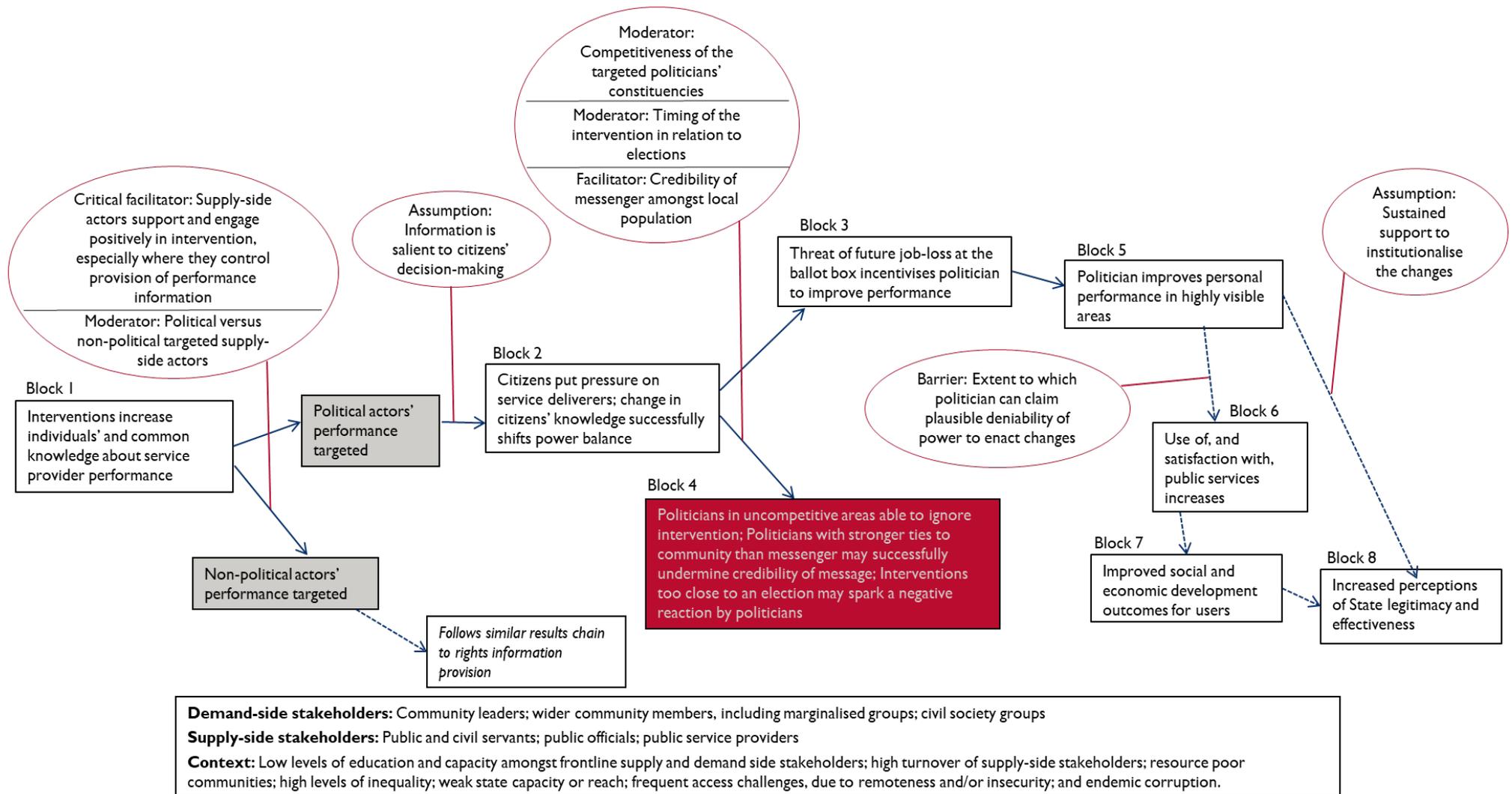
being measured, and they were able to successfully prevent effective implementation. The purpose of the community observer intervention was to increase citizens' understanding of the police performance and improve their perceptions, and it had been designed at national level, with the engagement of the national police leadership, yet it sought to change behaviors amongst local police chiefs. Without their buy-in, the implementation of the intervention was extremely poor, as they falsified records or simply ignored the directives (Banerjee et al., 2014). Humphreys & Weinstein (2012) noted cases in which the MPs forcefully blocked the dissemination of performance information within their constituencies. These cases evidence the importance of ensuring buy-in amongst the supply-side actors whose behaviors are targeted by the intervention.

In contrast, the intervention evaluated by Capuno & Garcia (2010) actively engaged the local government units (LGUs) in the implementation process, including at times selecting the LGU as the presenter of the performance information to the communities. Similarly, Grossman and Michelitch (2018) present qualitative evidence suggesting that many district councilors supported the scorecard initiative, as it increased competition.

The importance of the local credibility of the messenger can be understood by comparing the results of Capuno & Garcia (2010) with Humphreys & Weinstein (2012). In the latter, the information was developed and disseminated by a national-level NGO that did not necessarily have strong ties across all of the treatment constituencies. The authors present qualitative evidence from town hall meetings where the MP was effectively able to discredit the information presented by the NGO staff and undermine the message to such an extent that participants in the meetings had a *worse* estimation of their MP's performance compared to comparison groups (Humphreys and Weinstein, 2012). Conversely, in Capuno & Garcia (2010), the information was disseminated through local partners in each municipality, who were engaged in the process of gathering and analyzing the performance data as well. In some cases, the researchers actually worked through the LGUs to present the data, yet even in those where the local partner presented the results, the local partners' strong ties to the community reduced the politicians' ability to "shoot the messenger" (Capuno & Garcia, 2010).

Incorporating these insights into the framework, the following refined theory of change (**Figure 29**) presents an improved "fit" framework for performance information interventions. While the only included study to investigate performance information dissemination on service delivery through non-elected actors failed at the first stage of the causal chain, as described above, we nonetheless suspect that should the support of targeted service providers be secured for an intervention, the causal chain for these interventions would likely mimic that of rights information provision. Note that the results chain from interventions targeting elected politicians through to service delivery is quite long. The final barrier to move from changes in politician performance to improvements in service delivery was not reached in any of the included studies. Grossman and Michelitch (2018) suggest that this may be because improvements in service delivery cannot be the result of changes to a single actor (the politician); rather, they rely on multiple actors who may have limited to no direct accountability to the targeted politician (2018). This suggests the relative weakness of interventions that aim to affect service delivery through changes to politician performance.

**Figure 29: Theory of change for interventions providing information on individual and institutional service provider performance**



### 5.3 Citizen feedback and monitoring

Ten studies covered interventions that created or strengthened citizens' access to feedback and monitoring processes for public services (**Table 18**).

**Table 18: Studies included in analysis of citizen feedback and monitoring**

First author	Year	Country	Sector and specific intervention	Additional literature included
Alhassan	2016	Ghana	Collaborative community-based monitoring (CBM) + community assessment of health service performance	2 (qualitative studies)
Berman	2017	Afghanistan	Technical training for community monitors + facilitated accountability meetings for infrastructure projects (roads)	1 (qualitative case studies)
Björkman Nyqvist	2017	Uganda	Collaborative CBM of health services (two arms: (1) CBM only; (2) CBM + externally-generated performance information)	N/A
Bradley	2005	Kenya and Guinea	Healthcare services feedback loops	1 (working paper)
Fiala	2017	Uganda	Technical training for community monitors (two arms: (1) CBM only; (2) CBM + externally-generated performance information)	2 (implementation and completion reports)
Grossman	2017	Uganda	SMS-based anonymous feedback on public services	N/A
Gullo	2017	Malawi	Collaborative CBM of health services + participatory performance measurement	2 (implementation report + synthesis document)
Molina	2014	Colombia	Public construction monitoring meetings ("citizen audits")	N/A
Olken	2007	Indonesia	Anonymous feedback and invitations to public construction monitoring meetings (invites + feedback group)	1 (implementation report)
Palladium	2015	DRC	Community forums, scorecards and other engagement with security services	1 (implementation report)

This intervention group included the largest sample of included studies, though there were key differences in the intervention components that influenced the causal chains, particularly related to the nature of the public service that was targeted. Of the included interventions, four targeted healthcare, a directly delivered service, three targeted infrastructure, an indirectly delivered service, one targeted the security services, and two targeted a mixture of services. Regarding the nature of the intervention approach, two studies offered only community feedback opportunities: Grossman et al. (2017) and Bradley and Igras (2005).

The rest comprised a version of community-based monitoring, yet differed as to whether the monitoring comprised a collaborative process engaging both citizens and service providers or provided support only to citizens; whether the accountability or “interface” meetings between providers and citizens were facilitated; whether performance information was provided, and if so, if it was generated by the community or provided by external researchers; and whether technical training on monitoring for the particular service was provided to communities. The ramifications of these differences are discussed in depth below.

The framework synthesis identified two key moderating factors that influenced the causal chain and five common facilitators. Moderating factors included: 1) the type of service targeted, as above, and whether for indirectly delivered services, some additional support was provided to shift the power difference between service providers and citizens, either through well-respected civil society or government engagement; and 2) collaborative versus confrontational approaches. The common facilitators included the provision of technical monitoring skills; access to contracts and other key information; the inclusion of provider performance information; the incorporation of a dedicated community monitoring group; and the creation of common knowledge of provider performance.

As with the other accountability and transparency-for-accountability interventions, the nature of the service being targeted appeared to be a key moderating factor within the causal chains. Alongside the indirectly delivered services, the intervention evaluated by Grossman et al. (2017) followed a similar causal chain, as the SMS-based anonymous feedback intervention aimed to encourage citizens to complain to government officials regarding public services, and thus, the indirect accountability relationship between citizen and frontline service provider was mirrored. Conversely, the other study comprising a mixture of service types, Fiala and Premand (2017), was implemented in the context of a national CDD programme; in each community, only a single project prioritized and implemented through the CDD programme was targeted, such that while the nature of the services varied across communities, it was constant within each community.

The studies of indirectly delivered infrastructure projects demonstrate the key role external support to the community can play in overcoming the comparatively weaker social sanctions that are posed by communities monitoring indirectly delivered services. Similarly to Olken (2007), the interventions evaluated in Molina (2014) and Grossman (2017), both of which rely on engagement with unorganized citizens, were unable to realize significant improvements in public service delivery, despite achievements in triggering citizen engagement with the respective platforms. Conversely, even in a

challenging context such as the DRC, in Palladium (2015), the implementer's work with local civil society led to greater-than-expected project success in organizing and hosting well-attended community fora to encourage citizen engagement with the security sector. The evaluation presented qualitative evidence that suggested that participation in these fora had positively impacted people's perceptions of security and the security sector (Palladium, 2015). The role of civil society support to communities may be critical not only for encouraging engagement in monitoring and accountability processes, but also for shifting the balance of power between citizens and public service providers of indirectly delivered services. In Berman et al. (2017), the authors present evidence from qualitative research to test the underlying mechanisms, which found that the active engagement of the large, well-respected national-level NGO Integrity Watch Afghanistan (IWA) in the construction monitoring intervention was critical to the project's success. The social capital provided by IWA enabled the community monitors to access the critical information they needed to monitor the road construction, such as contracts; brought key stakeholders to the table to discuss issues in Provincial Monitoring Board meetings, including local leaders, government officials, contractors and community monitors; and thus increased the bargaining power of community monitors, enabling them to often enforce improvements before escalating the situation by complaining to the government. This theory is supported by the quantitative evidence, which showed the dissipation of the positive effects of the project after IWA ended its direct engagement in the intervention.

The creation of common knowledge amongst the community of the monitoring results further emerged as a strong facilitating factor. Two interventions incorporated the provision of anonymous feedback: Olken (2007), which consisted of invitations to monitoring meetings + anonymous feedback cards; and Grossman et al. (2017), the uBridge SMS programme to increase engagement between constituents and local government. In the former, consolidated anonymous feedback forms were read out at the open meetings, which the author argues created a common knowledge amongst participants as to the common nature of people's complaints, which had a small positive impact on their ability to trigger sanction measures (Olken, 2007). Conversely, in Grossman et al., 2017, though many messages were sent by constituents commenting on the quality of service delivery, common knowledge was not created, as the content of the messages was not public. This prevented the citizens from using the intervention to identify like-minded compatriots, build social capital and undertake collective action that might have increased the relative strength of their pressure on service delivery. This suggests a potential explanation for the break in the causal chain for this intervention.

Similarly, in analyzing citizen audits of construction projects in Colombia, Molina presents evidence that suggests that low participation in monitoring opportunities prevented the creation of common knowledge about the projects, which in turn discouraged politicians and service providers from adhering to quality standards, which he refers to as the "self-fulfilling prophecy" phenomenon (2014). However, in Fiala and Premand (2017), the authors report no significant change in numbers of community members engaged in monitoring following the intervention, despite seeing positive results; what changed was the capacity of the group monitoring the projects to carry out their mandate, and the creation of common knowledge of the monitoring results through intervention-led activities such as the scorecard presentation. Berman et al. (2017)

present similar findings, including qualitative evidence of “social shaming” initiatives undertaken by the monitors, such as partnering with the local mullah to announce the monitoring findings (good and bad) during sermons. The qualitative evidence further stresses the importance of the technical training to enable the monitors to effectively identify whether the construction was of sufficient quality or not (Berman et al., 2017); such technical training was absent from the intervention studied in Molina (2014). Thus, it may be that a dedicated monitoring group, with a mandate from the community and technical training in monitoring the service targeted, could have a greater impact than an open-forum type of intervention as in Molina (2014) and Olken (2007), and as noted above, the intervention studied in Olken (2007) ultimately adopted the approach of establishing and training a dedicated group of community monitors (World Bank, 2011).

Amongst the sample of community feedback and monitoring interventions, a unique feature of those targeting healthcare services was a focus on a collaborative process that engaged both supply and demand-side actors, i.e. both community members and frontline health center staff. This set the group apart from the other interventions, which focused on training and/or creating opportunities for citizens to hold providers accountable through dedicated accountability meetings. This included both public Town-Hall style meetings, as in Molina (2014), Olken (2007) and Palladium (2015), and higher-level fora such as the Provincial Monitoring Board meetings in Berman et al. (2017). These meetings are often more confrontational than in the phased, collaborative approach, wherein the implementers guide communities and service providers through a series of three types of meetings: citizen meetings, to build capacity for monitoring and ensure understanding of rights; service provider meetings, to present the emerging findings of the citizen meeting and begin planning for ways to address the highlighted issues; and an interface meeting, during which the community’s priorities and ideas for improvements are incorporated into the relevant service delivery plan, with a focus on assigning responsibilities amongst both community members and service provider staff to address areas in need of improvement. These interventions can be adjusted to include an explicit inclusivity component to improve the engagement of vulnerable groups along the causal chain. In the evaluation of CARE’s Community Scorecards by Gullo et al. (2017) and in Björkman Nyqvist, De Walque & Svensson (2017), a series of community meetings were held with different interest groups, including women, youth, the disabled, and the elderly. This ensured that views from across the community are fully captured. However, the approach relies in significant extent on the capacity of implementer staff and their facilitation skills.

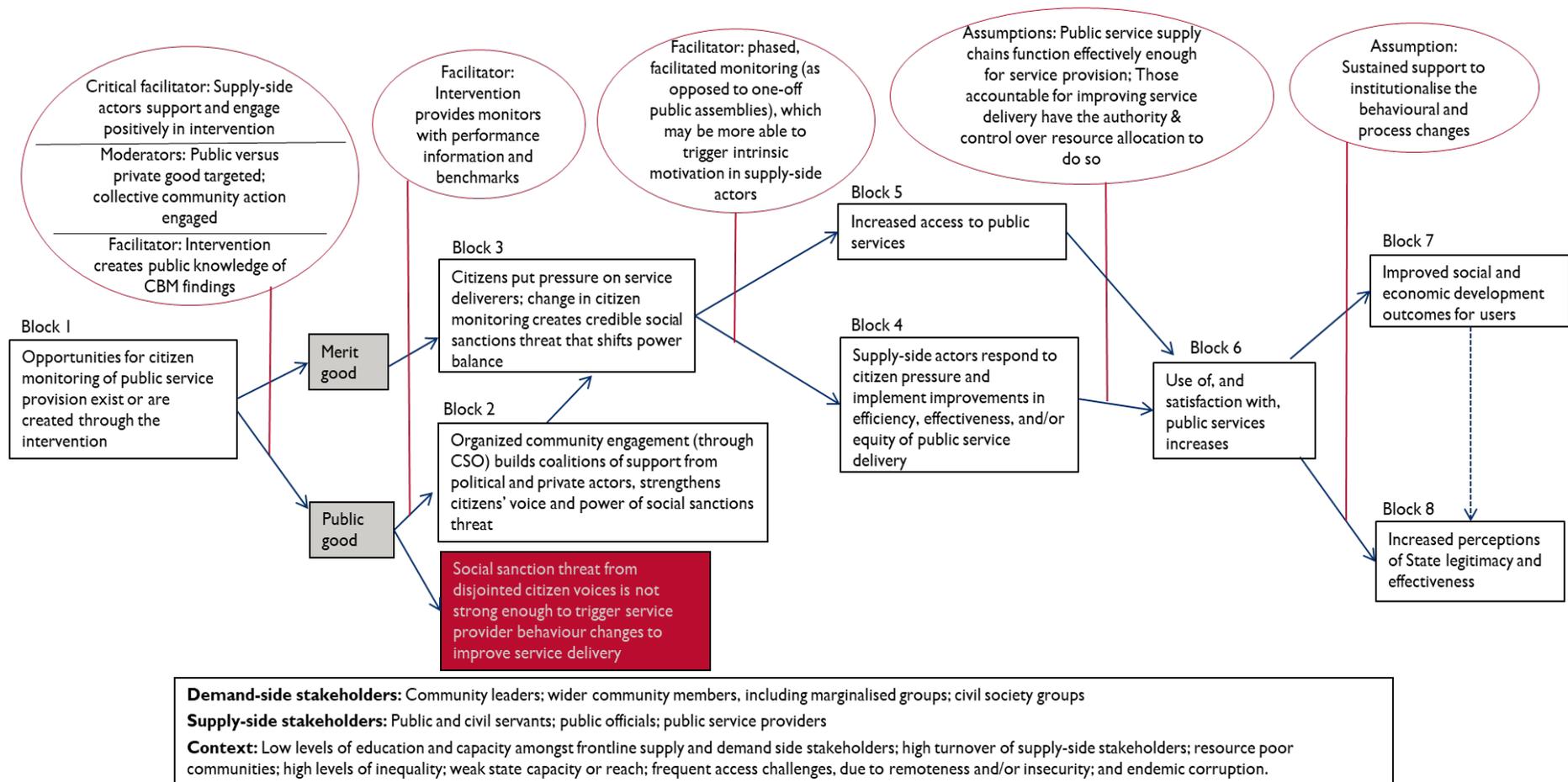
To attempt to explain the black box of intervention and outcome, Alhassan et al. tested the underlying mechanisms for service provider motivation, and found that the service providers working in rural health clinics were highly intrinsically motivated, and through the collaborative engagement with the community, increased their intrinsic motivation (2016). This suggests that monitoring interventions that rely on the “soft” power of social sanctions may be more effective when they focus on identifying mutually empowering “win-win” opportunities and ways for citizens and service providers to work together. This theory is also supported by qualitative evidence presented in Bradley and Igras (2005), wherein healthcare staff reported that the empowering process of local problem identification and solving had a strong impact on their attitudes, and led to changes in the way they engaged with each other and with community members. The increased sense

of self-efficacy built through this type of approach may extend to the community members, who see the responses to their efforts enacted by service providers, as suggested by Gullo et al. (2017).

The relationship between service providers and users may also be strengthened through the facilitated, collaborative approach because while learning about their service entitlements and identifying opportunities for improvement, citizens also learn more of the intricacies and challenges in service delivery, which may enable them to mitigate their expectations and be more understanding of the frontline staff. Gullo et al. (2017) suggest that the more realistic expectations held by households in treatment communities may account for their increased satisfaction with the health services, despite the context in which there were serious issues in health service supply chains due to a national-level scandal, which led to decreasing satisfaction with health services in control communities.

A final key facilitator in community monitoring interventions is the benefits wrought by including performance measurement information into the intervention. In Björkman Nyqvist, De Walque & Svensson (2017) this was done by external researchers and research assistants, who gathered the data and presented it to communities in a digestible and locally appropriate way. This was a very thorough approach, but it has made replication challenging, an issue the authors identify (Björkman Nyqvist, De Walque & Svensson, 2017). In Alhassan et al. (2016), the implementers worked with the community groups to support them to undertake the performance assessment, which they then used to identify the key opportunities for improvement. CARE's Community Scorecard methodology takes this further, working with communities to create a localized scorecard in which communities develop their own list of priorities and indicators (Gullo et al., 2017). In comparing their two treatment arms, wherein the difference was access to performance information, Björkman Nyqvist, De Walque & Svensson (2017) present evidence suggesting that having information on performance and benchmarks was critical for enabling communities to identify realistic opportunities for service improvements. Conversely, in Palladium (2015), which didn't include any performance information, though perceptions of security rose amongst participants, the study did not find evidence of improved service delivery outcomes, and conclude that changes in perceptions may occur more quickly than changes in service delivery (2015). Fiala and Premand, in a study arm comprising only interventions in livestock provision, also find that the inclusion of both community monitoring support and performance information is critical to achieving positive impacts on household assets (2017). Through the framework synthesis, the key mechanisms, barriers and facilitators were collected and used to refine the theory of change for this group of interventions (**Figure 30**).

**Figure 30: Theory of change for citizen monitoring and feedback interventions**



## 5.4 Participatory planning

Eight studies evaluated seven interventions or policies that created or strengthened citizens' access to participatory planning processes (**Table 19**) – note that while Touchton & Wampler, 2014 and Gonçalves, 2013 are separate studies, they are of the same countrywide policy.

**Table 19: Studies included in analysis of citizen engagement in planning**

First author	Year	Country	Sector and specific intervention (* if inclusive planning)	Additional literature included
Ananthpur	2014	India	Support to engage in participatory development planning	N/A
Beath	2013	Afghanistan	Mandated women's inclusion in participatory development planning*	2 (qualitative studies)
Beuermann	2014	Russia	Increased facilitation of participatory budgeting	N/A
Diaz-Cayeros	2014	Mexico	Municipal indigenous participatory governance*	1 (qualitative study)
Giné	2018	Pakistan	Community mobilization for participatory development planning*	N/A
Gonçalves	2013	Brazil	Municipal participatory budgeting*	5 (qualitative and quantitative studies)
Touchton	2014			
Humphreys	2014	DRC	Mandated women's inclusion in participatory development planning*	4 (implementation reports and qualitative study)

Within this sample, three studies measure the effect of participatory processes against the status quo (Touchton & Wampler, 2014; Gonçalves, 2013; and Diaz-Cayeros et al., 2014); two studies measure the effect of external support to participatory planning processes (Beuermann & Amelina, 2014; Ananthpur et al., 2014); two studies measure the effect of mandating women's inclusion in participatory planning (Humphreys et al., 2014; Beath et al., 2013); and one study measures the effect of participatory planning training on citizens' empowerment to demand services (Giné et al., 2018). Grouped differently, five of the studies look at interventions wherein citizens engage in government planning processes (Touchton & Wampler, 2014; Gonçalves, 2013; Beuermann & Amelina, 2014; Ananthpur et al., 2014; and Diaz-Cayeros et al., 2014), and three of them pertain to interventions wherein citizens are engaged in community-driven development (CDD) types of deliberations (Humphreys et al., 2014; Beath et al., 2013; and Giné et al., 2018). Through engaging citizens in the identification of priorities

and allocation of resources, these interventions aim to improve the responsiveness of service delivery to citizens' prioritized needs, particularly for vulnerable groups.

The data extracted in the qualitative synthesis for these studies were reviewed to identify patterns of movements along the causal chain. Within this intervention group, four key factors emerged that helped explain the heterogeneity of results: the extent to which the intervention correctly identified and adequately addressed barriers to participation for vulnerable groups; the extent to which the intervention process was designed to encourage the growth of local social capital and capacity for collective action; the extent to which the local government or decision-making body supported the process and had the capacity to implement it; and the incorporation of explicit measures to facilitate the inclusion of vulnerable groups. Case comparisons using the included studies are provided to illustrate the importance of these factors.

As noted above, a key goal of participatory planning processes is frequently to ensure the priorities of vulnerable and marginalized members of society are incorporated into decision-making. As described above in the equity discussion, however, only a minority of the included interventions were described as incorporating specific components to improve the inclusion of vulnerable groups in the activities. The majority of these were incorporated into participatory planning interventions; of the seven interventions in this set, five incorporated specific inclusion components. Barriers and facilitators to inclusive planning is thus a key focus of the framework synthesis. Again as noted previously, however, studies that incorporated inclusion components generally only focused either on inclusion for the poorest or women's inclusion. Thus, the dataset is limited in its capacity to provide insights into the barriers for vulnerable groups in general, and particularly weak to the barriers and facilitators of including other types of vulnerable groups, such as people with disabilities, refugees or internally displaced persons.

In order to support vulnerable groups to participate, the barriers they face at baseline must be adequately assessed (bottleneck identification) and the intervention designed to address the specific barriers in a culturally appropriate and locally relevant way. The different mechanisms triggered in four of our included studies can help illustrate the trickiness of doing so.

Two of the included studies, Beath et al. (2013) and Humphreys et al. (2014), demonstrate these challenges regarding including women in decision-making. Humphreys et al. (2012) evaluated the effects of mandating women's participation in the village development councils in the Democratic Republic of Congo, and found no effects; where women's participation was not mandatory, they nonetheless participated in roughly equal numbers. This suggests that the barrier to women's voices being heard in the local context was not the result of them being denied a seat at the table, an example of bottleneck misidentification. Meanwhile, Beath et al. (2013) studied the effect of mandating women's inclusion in food distribution planning. While in the Afghan context, women are frequently denied a seat at the table, the intervention design comprised an externally-imposed participation requirement that was not adapted to the local context, leading to unintended effects. The authors found that mandating women's participation alongside traditional *jirga* leaders led to an increase in leakages of food aid (Beath et al., 2013). Qualitative evidence in the evaluation suggested that the *jirga* elders were retaining some of the food aid for themselves as compensation for their services in the

distribution, and that when women were required to participate, they were generally the wives or relatives of the *jirga* members (*ibid.*). This suggests the possibility that mandating women's participation may have triggered elite families to "double dip" into the food aid as compensation for the services of both their male and female representatives. This demonstrates how nuanced an understanding of local practices is required in selecting an appropriate intervention to address an identified barrier.

Understanding and adequately addressing the power gap between "status quo" participants in decision-making processes and those excluded may be key to addressing participation barriers. In Giné et al. (2018), communities that received community-driven development training were evaluated to ascertain the effects of this sector-non-specific training on citizens' capacity to demand public service provision. The training covered elements of participatory development planning, and communities were organized and mobilized to prepare for project implementation. They found that the intervention had a significant effect on the provision of health services by the local "Lady Health Workers" (LHWs), which they attribute to the growth in collective action capabilities amongst women participants, who had indicated at baseline that healthcare was a priority concern (Giné et al., 2018). However, LHWs are local women from the village in a conservative area wherein women are frequently disempowered; the relative difference in power, therefore, between the LHWs and the other villagers is extremely small. Thus, in this context, an intervention that was designed to be empowering but did not specifically address people's capacity to demand health services nonetheless had an effect, given that the women had indicated that health was their priority area of focus and the relative power difference between village women and LHWs was minimal. It is telling that the study found limited to no effects on health services at the health center level (*ibid.*). This is in stark contrast to the experiences documented through qualitative research in Ananthpur et al. (2014), in which the members of the local elite at times actively attempted to dissuade or prevent villagers from participating in the decision-making processes. The ethnographic component of the study identified remnants of a feudal relationship between villagers and local elites; elites thus capitalized on this larger and entrenched power difference to stifle participation.

Incorporating into intervention design flexibility to enable communities to adapt the activities to their local context may be key to avoiding such shortcomings. In Brazil, participatory budgeting was designed as a pro-poor intervention at the national level, yet the specifics for how municipalities went about ensuring participation was left to them to decide. Thus, the extent to which measures were put in place to actively include vulnerable populations varied by municipality. While all incorporated pro-poor measures, in at least one case, specific mechanisms were created to facilitate the participation of historically marginalized groups such as LGBT citizens (Hernandez-Medina, 2010). Though the included impact evaluations of this policy do not present outcomes data disaggregated by vulnerable groups, evidence from participant interviews in a qualitative study of the policy suggested that the explicit measures adopted by some municipalities were critical to opening up the process to diverse disadvantaged groups (*ibid.*).

In Diaz-Cayeros et al. (2014), the authors note mixed effects of the intervention on women's participation in local governance. On the one hand, quantitative evidence suggested that the switch from political-party based to traditional governance systems led to a decrease in the number of women in senior municipal government positions, yet

the authors also found qualitative evidence that women's participation in traditional governance processes was slowly increasing (Diaz-Cayeros et al., 2014). In this last case, the intervention (the shift to traditional governance) was not imposed by an external party but rather chosen by the community. While the externally-imposed processes evaluated in Humphreys et al. (2014) and Beath et al. (2013) misidentified the local barrier and appropriate response, respectively, to ensuring women's inclusion, and thus do not enable a comparison of the value of incorporating explicit measures to address inclusion barriers, the qualitative evidence noted above from Brazil suggests that explicit measures may be required to support the engagement of vulnerable groups in processes in which they have been historically excluded. Though the intervention in Mexico increased participation across the community as a whole (by making it mandatory), the lack of complementary measures to support women's and other groups' empowered participation may have led to the initial declines in women's leadership evidenced in the evaluation.

The framework synthesis of the data suggests that the capacity of these interventions to empower communities to participate in local planning processes (i.e. to reach the first block of the causal chain) could be strongly facilitated through designs that encouraged the growth of local social capital and capacity for collective action. This theme emerges as a key mechanism for changing the balance of power between targeted actors on the supply and demand sides. In Brazil, the design of the participatory planning policy explicitly sought to incentivize collective action through engagement with the planning process, by encouraging citizens to create coalitions in support of their favored priorities, which stimulated the growth of local civil society (Touchton & Wampler, 2014). This success is also due to the Brazilian context, characterized by lower initial barriers to participation for marginalized citizens and historically strong civil society, and the long timeframe of the intervention and evaluation follow-up, uniquely long amongst this group of interventions.

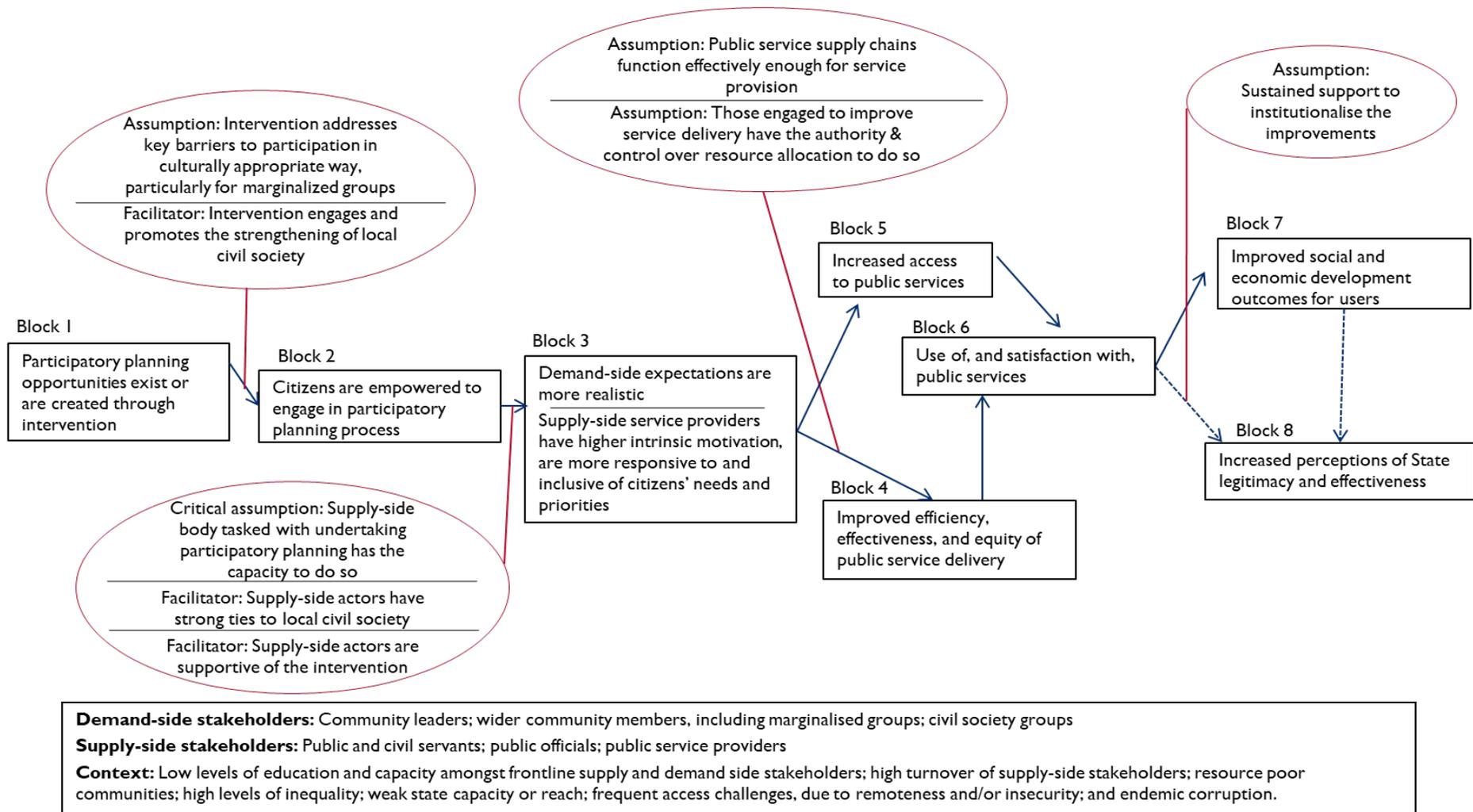
In comparison, the experience in India studied by Ananthpur et al. (2014) was very different: in this intervention, pairs of facilitators were trained and dispatched to the intervention areas to attempt to support the implementation of the community meetings and engagement with the Gram Panchayat (local village council). By relying on the individual capacity of two consultants in each area, this intervention failed to generate social capital and capacity for collective action amongst the targeted communities, and the balance of power between villagers and local elites was not challenged.

Ensuring buy-in from the government or community decision-making body for implementing participatory planning processes may be critical to their success, and opt-in style policies may strongly facilitate such buy-in. In Brazil, municipal governments choose whether or not to adopt participatory budgeting, ensuring strong government support for the process. Conversely, in Russia, the reforms were passed at national level and implemented across the country, without the flexibility for "settlements" to choose whether or not to adopt the policy (Beuermann & Amelina, 2014). Similarly, in India, Ananthpur et al. find qualitative evidence that suggests that local elites worked hard to inhibit the participatory nature of the intervention, as it jeopardized their control over development resources (2014).

The final critical barrier to successful implementation of participatory planning processes identified through the synthesis was the importance of ensuring that the government or community decision-making body had the capacity to implement the participatory planning process. In the case of Mexico, Diaz-Cayeros et al. documented the return to “traditional” governance for indigenous communities in an impoverished state (2014). Thus, the intervention was implemented in a context in which there were strong local capacities and traditions of engaging in such processes. In contrast, Beuermann & Amelina found that newly established “settlement”-level governments tasked with implementing participatory budgeting were saturated with attempting to establish and learn how to run their governments in general (2014); alongside everything else they were trying to learn, participatory budgeting fell by the wayside. This bottleneck further highlights the importance of timing in an intervention.

Incorporating these insights into the framework, the following refined theory of change presents an improved “fit” framework for performance information interventions (**Figure 31**).

**Figure 31: Theory of change for participatory planning and priority setting interventions**



## 5.5 Community-based natural resource management

Seven studies covered interventions that created or strengthened citizens' capacity to manage full or close-to-full decentralization of service delivery (Table 20).

**Table 20: Studies examining CBNRM**

First author	Year	Country	Sector and specific intervention	Additional literature included
Bandyopadhyay	2004	Namibia	Community wildlife conservancies	3 (qualitative studies and policy paper)
Bandyopadhyay	2010	Philippines	Irrigation management transfer to Irrigation Associations	1 (qualitative study)
Barde	2017	Brazil	Water User Associations	N/A
Huang	2014	China	Water User Associations	2 (qualitative studies)
Persha	2016	Tanzania	Joint forestry management	2 (policy document and implementation report)
Rasamoelina	2015	Madagascar	Community-based forestry management	2 (previous evaluation versions)
Tachibana	2009	Nepal	Community-based forestry management	5 (qualitative and quantitative studies)

The included studies in this intervention are quite different from those in the previous groups, as the service provision has been decentralized to such an extent that communities themselves are both the user and the provider. This fundamentally shifts the power dynamics at play, complicating the delineation between supply-side and demand-side actors. Community-based natural resource management (CBNRM) interventions aim to improve communities' sustainable access to resources through increasing their control over resource management and maintenance. The complexities and tensions involved in marrying the dual goals of resource use and preservation are evident throughout the interventions, which cover wildlife conservancy (Bandyopadhyay et al. 2004); participatory forestry management (Persha & Meshack 2016; Rasamoelina et al. 2015; and Tachibana & Adhikari 2009); and irrigation or water use (Bandyopadhyay et al. 2010; Barde 2017; and Huang 2014). Each of these studies evaluates the implementation of a national-level policy, which tend to have smaller results than pilots or experiments wherein the quality and uniformity of implementation is more easily managed.

A key moderator identified early in the causal chain for these interventions is the extent to which the policy constitutes a relinquishment of government control over the productive resource. For example, in Nepal, the community forestry project studied by Tachibana & Adhikari primarily represents a formalization and standardization of existing practices; the government remained only lightly involved in forestry management (2009). Conversely, in Tanzania, the Joint Forestry Management (JFM) intervention requires a

more engaged and active partnership between government forestry officials and communities, which has proven more challenging to implement (Persha & Meshack, 2016).

Building on this moderator, where the government is required to give up some of its control over the benefits from the productive resource through the CBNRM intervention, there is often a barrier wherein local officials choose not to fully implement the requirements of the policy or seek to undermine its promise of transferring resource benefits to communities. This tends to happen after the devolution of resource management responsibilities to the community, but before communities' rights to benefits are formalized, as in Persha & Meshack's study, wherein they note that only seven per cent of targeted communities had signed joint forestry agreements with the government, and present evidence to suggest that this barrier led to a break in the causal chain that inhibited communities' ability to realize the economic benefits of JFM (2016). In a second example, evaluating the implementation of irrigation management transfer (IMT) in the Philippines, Bandyopadhyay et al. present qualitative evidence that suggested the government water agency was withholding fees from the community associations; this risk was further evidenced in a qualitative study whose findings suggested that the government water agency only agreed to IMT in order to reduce its operating costs (Bedore 2011). This is a serious risk of CBNRM projects, as it may leave communities shouldering more of the burden of resource management without enjoying the benefits; in contexts where most communities are resource- and time-poor, this cost can be substantial.

The likelihood of incomplete implementation for national-level policies is compounded when the policies are not clearly specified, aligned with other key laws and regulations, or especially when contradictory to them. This was found to be the case in Rasamoelina et al. (2015), wherein the researchers conducted in-depth analysis of the myriad national policies, laws and regulations pertaining to natural resource management, and identified a number of inconsistencies and contradictions that helped explain the lack of impact on outcomes found in the statistical analysis. These inconsistencies and contradictions are vulnerable to exploitation by supply-side actors intent on retaining access to their benefits; Rasamoelina et al. present qualitative data suggesting that local officials selected a mixture of the policies that best suited their interests, rather than the interests of communities (2015). This sensitivity to capture by government officials substantially decreases the potential benefits communities may realize through CBNRM.

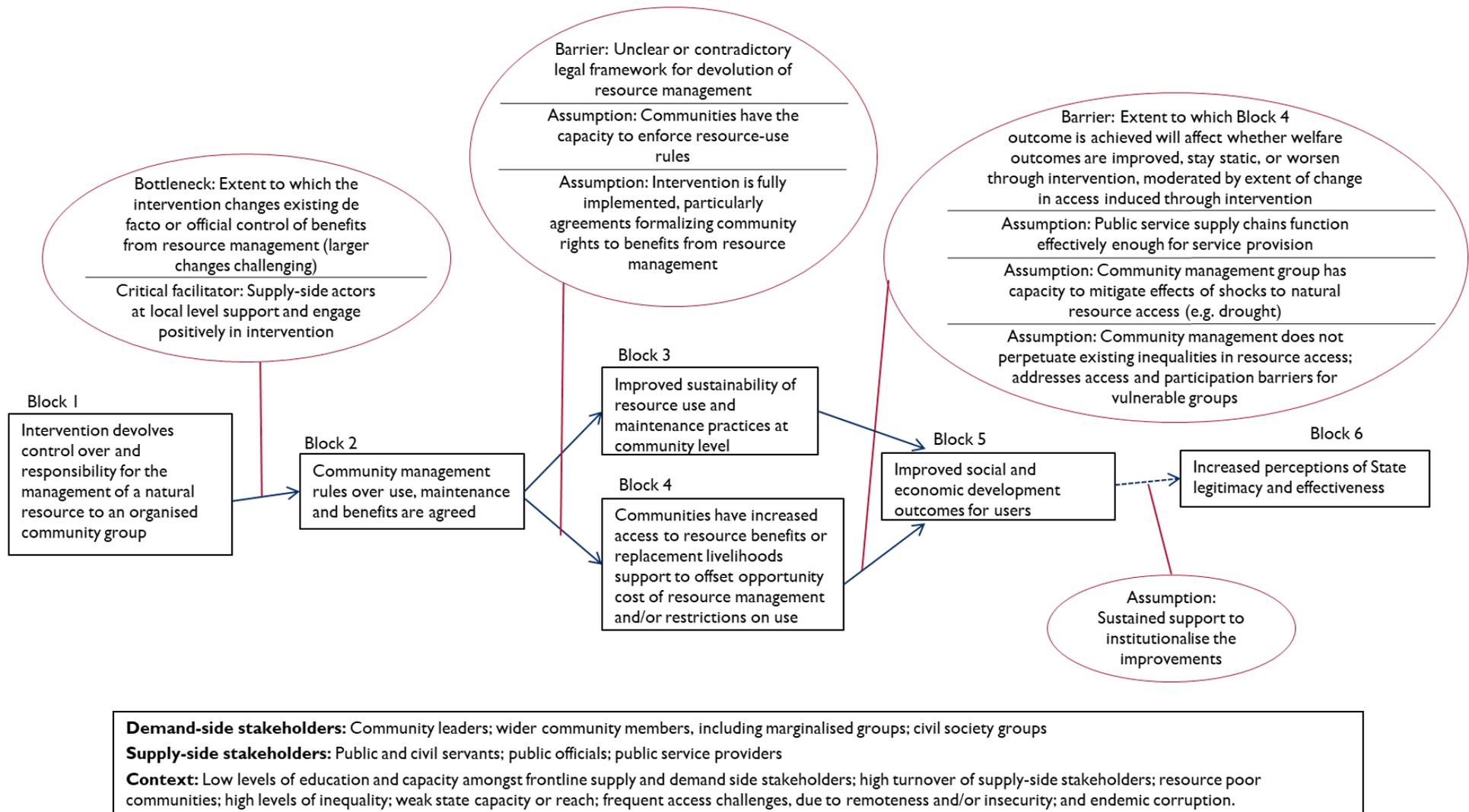
The success of CBNRM further depends on the type of resource use in which communities engage, and their capacity to enforce the rules. In a qualitative study of the community conservancies evaluated by Bandyopadhyay et al. (2004), participants highlighted the challenge of preventing poaching in areas frequented by migrants (Jones, 1999a). Such high-stakes monitoring may be beyond the capacity of communities to enforce, particularly without resorting to violence. Conversely, Tachibana & Adhikari suggest that the primarily light resource use in the Middle Hills of Nepal (collecting leaves and sticks for kindling) was more conducive to CBNRM; the authors interpret their findings to suggest that forests where logging is common may be more of a challenge for the CBNRM model (2015).

The provision of alternative livelihoods support is vital in areas where communities' traditional access to the resource is restricted as a result of the implementation of the conservation component of CBNRM. While this speaks to the tension between human quality of life outcomes versus environmental outcomes, various studies identified the potential to overcome this barrier through support for alternative livelihood means and practices. Further, analysis by Barde of community-based water management in Brazil suggested that CBNRM groups were effective at improving outcomes for communities because they had a higher level of downwards accountability to their communities (2017).

The synthesis of included studies and additional texts suggests that key factors for success in CBNRM interventions may rest on full legalization of the communities' ownership of resource benefits (Persha & Meshack, 2016); the injection of donor funds to catalyze the change in resource use (Barnes et al., 2002); sustained external support to enable the community groups to institutionalize slowly over years (Jones, 1999b); and the presence of tourism opportunities for communities to undertake alternative livelihoods (Barnes et al., 2002; Persha & Meshack, 2016).

As a result of the synthesis process, the theory of change was refined for CBNRM interventions. While the causal chain appears relatively linear, the large number of moderators, assumptions and identified barriers and bottlenecks, combined with the often weak results from the evaluations, suggests that these interventions are extremely tricky to carry out at national scale (**Figure 32**).

**Figure 32: Theory of change for community-based natural resource management interventions**



## 5.6 Common cross-cutting factors and integrated synthesis

Many interventions experienced challenges stemming from a lack of positive engagement with supply-side actors at the intervention target level, whose relative power the interventions often sought to diminish. Interventions implemented within the good governance domain of external engagement generally operate within a context of an imbalance of power in favor of the service provider, who controls the quality of and access to resources and services. Interventions that seek to change this balance of power without engagement with and buy-in from these actors may trigger response mechanisms in which the service providers attempt to block, discredit or co-opt the intervention to maintain their relative power. For example, Humphreys and Weinstein report evidence that some politicians whose performance scorecards were due to be disseminated successfully blocked implementation of the intervention in their constituencies, threatening violence (2012). Banerjee et al. (2014) identify this triggering of a negative response by the service providers at the targeted level (police station chiefs, in this case, who successfully prevented the implementation of community observers in most areas) as the key mechanism leading to a break in the causal chain. Similarly, Persha and Meshak (2016) and Rasamoelina et al. (2015) present evidence that government forestry staff members are able to exploit lack of clarity in national-level policies or top-down enforcement of complete implementation such that the officials are able to maintain their control over the resource benefits despite having devolved the responsibilities of management to the communities. Conversely, interventions that were designed and implemented with the support of key power brokers at the level of the intervention, as in the case of municipal governments that chose to implement participatory budgeting in Brazil (Touchton and Wampler, 2014; Gonçalves, 2013) or structured community engagement in the health sector that aimed to strengthen service providers' intrinsic motivation (Alhassan et al. 2016), were able to realize positive impacts across the causal chain.

It is important to note that while in the majority of included broad intervention groups, a break in the causal chain at this stage may at best prevent outcomes tied to service provider response or lead to null effects, in the case of community-based natural resource management there is a risk of causing negative effects on well-being outcomes. As noted in the Persha and Meshak (2016) and Rasamoelina et al. (2015) cases, this may happen where a lack of full intervention implementation leads to a context in which resource- and time-poor communities increase their burden of natural resource management, have less access to the resource due to sustainability restrictions, and are not afforded adequate compensation in the form of resource benefits ownership or alternative livelihoods support. The risk that an intervention may do harm to a community should be seriously considered during project design, and locally appropriate mitigation measures should be developed to lessen the likelihood of negative impacts.

Building on the above, the findings of this review lend some support to the theory that citizens' attempts to increase their relative power through means seen as confrontational by service providers often disincentivize the service provider from participating (World Bank 2004). The findings of this review suggest that approaches to citizen-service provider engagement in the realm of accountability, including transparency for

accountability, appear to work more effectively when implemented through phased, facilitated processes that are framed as collaborative, as opposed to one-off accountability meetings that tend to be interpreted as confrontational. Interventions that promote transparency with the aim of triggering mechanisms that motivate citizens to demand greater accountability often fall closer to the confrontational spectrum, and their limited success on realizing outcomes along the causal chain is evident throughout the included studies. Those that promote an explicitly collaborative process may be more effective, particularly when they incorporate measures to improve citizens' understanding of performance benchmarks, such as in Bjorkman and Svensson (2009) and Alhassan et al. (2016). In these two programmes, though citizens were provided or supported to gather information on service provider performance quality, respectively, the process of applying that knowledge to service improvements was done in a collaborative way that was mutually empowering, in line with the theory suggested by Fox (2014).

We note, however, a difference between interventions targeting individuals versus service provider institutions, and caution that it may be more difficult to engage in collaborative approaches to performance improvements with individuals, such as politicians, who are more likely to feel personally targeted. In these situations, the synthesis suggests that ensuring the engagement of a locally credible messenger to disseminate performance information reduces the ability of the targeted individual to undermine, co-opt or discredit the information.

One potential limitation of interventions relying on accountability and transparency through community engagement, however, is that while such interventions often met with some success in realizing improvements at a local level regarding service delivery quality, there are many service delivery bottlenecks that cannot be dealt with through community engagement. This was a barrier highlighted in Bradley and Igras (2005) and Gullo et al. (2017): in both these evaluations, the authors identified improvements only among indicators that could be addressed without changes in resources or support. This provides some support to an assumption identified in the initial theory of change, which identified a risk that improvements would be limited to those that were within the purview of the service providers targeted for support. Bottlenecks such as issues in service supply chains or those requiring the approval and engagement of more senior management, particularly at provincial level and above, are unlikely to be successfully addressed through community engagement efforts. This reinforces the need for proper bottleneck identification during project design, to ensure the proper tools are applied.

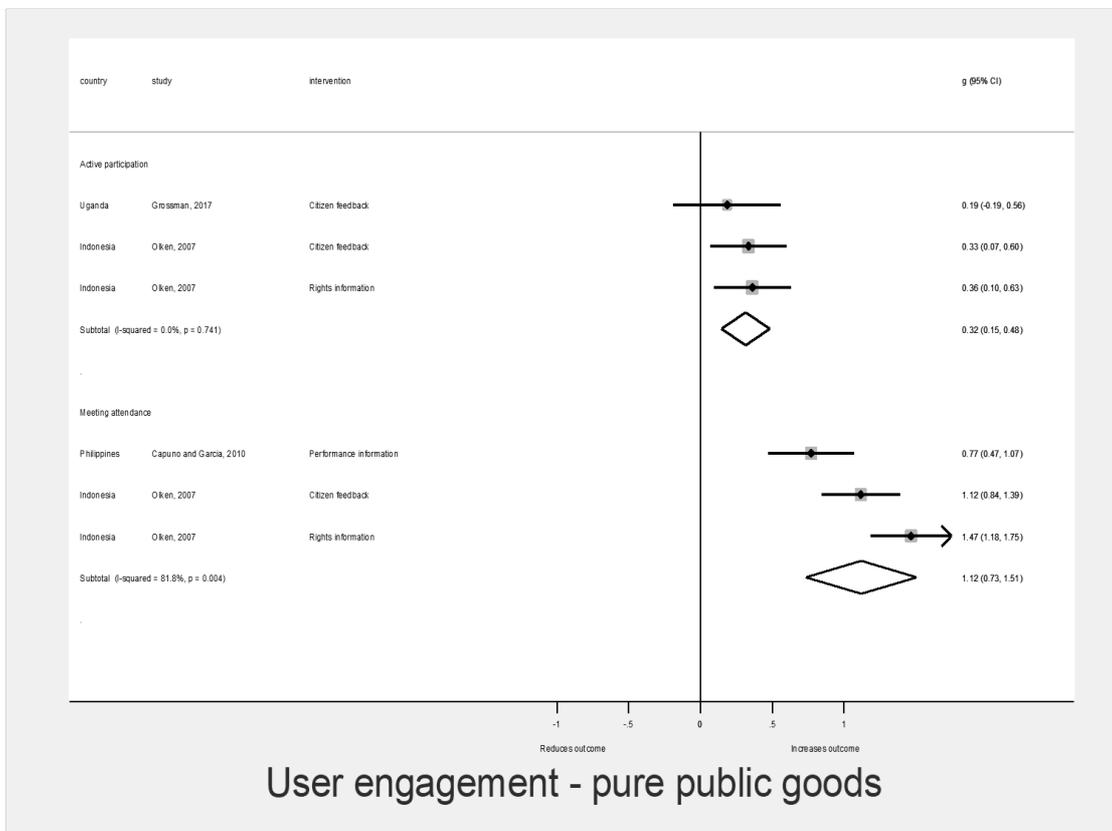
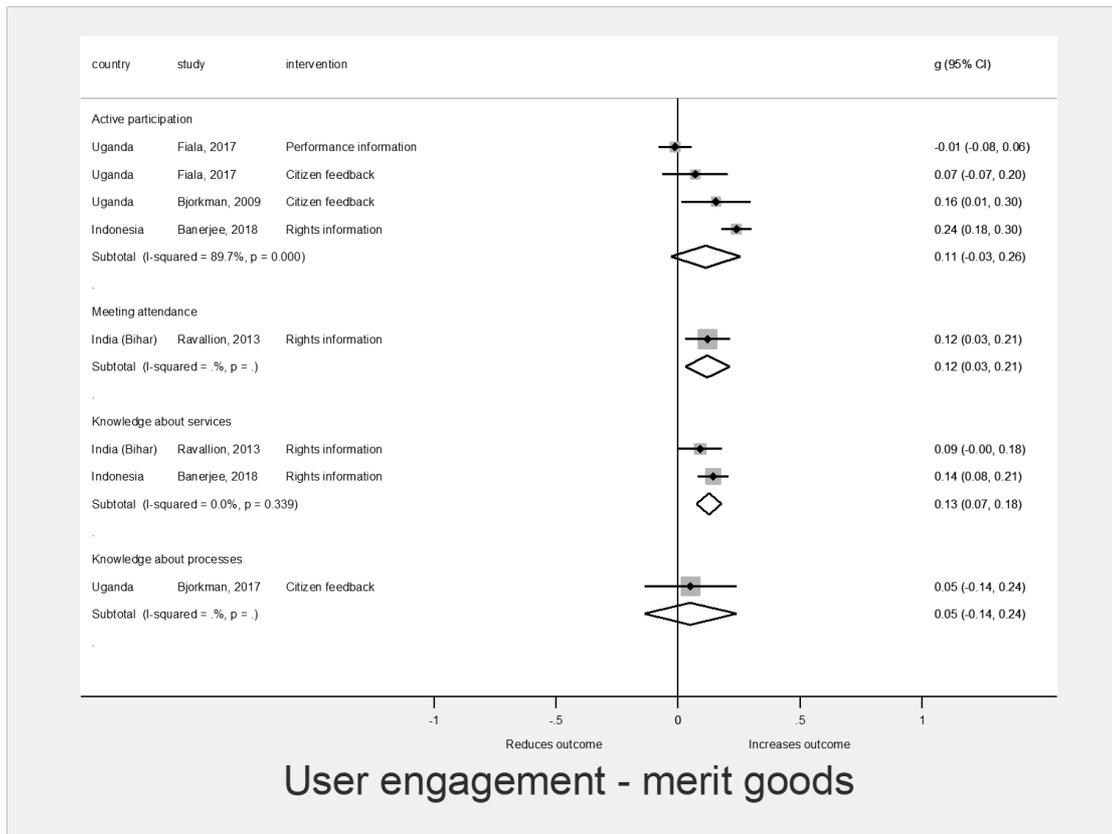
The findings of the framework synthesis suggest a key facilitator for interventions across the external engagement sphere of good governance was the incorporation of active engagement with local organized community groups, such as CSOs or interest groups, or the inclusion of measures that explicitly sought to build local social capital and capacity for collective action. This facilitator was present in each intervention that succeeded in addressing the bottleneck caused by a lack of service provider response in indirectly delivered service provision. For example, in their replication of Bjorkman and Svensson (2009), Donato and Mosqueira demonstrate the significant contribution of a strong presence of the local CSO partner in the targeted community on achieving positive results (2016). Similarly, in their in-depth ethnography of a "failed" intervention, Ananthpur et al. (2014) present qualitative evidence that suggests that positive results were achieved where the facilitators tasked with supporting the implementation of

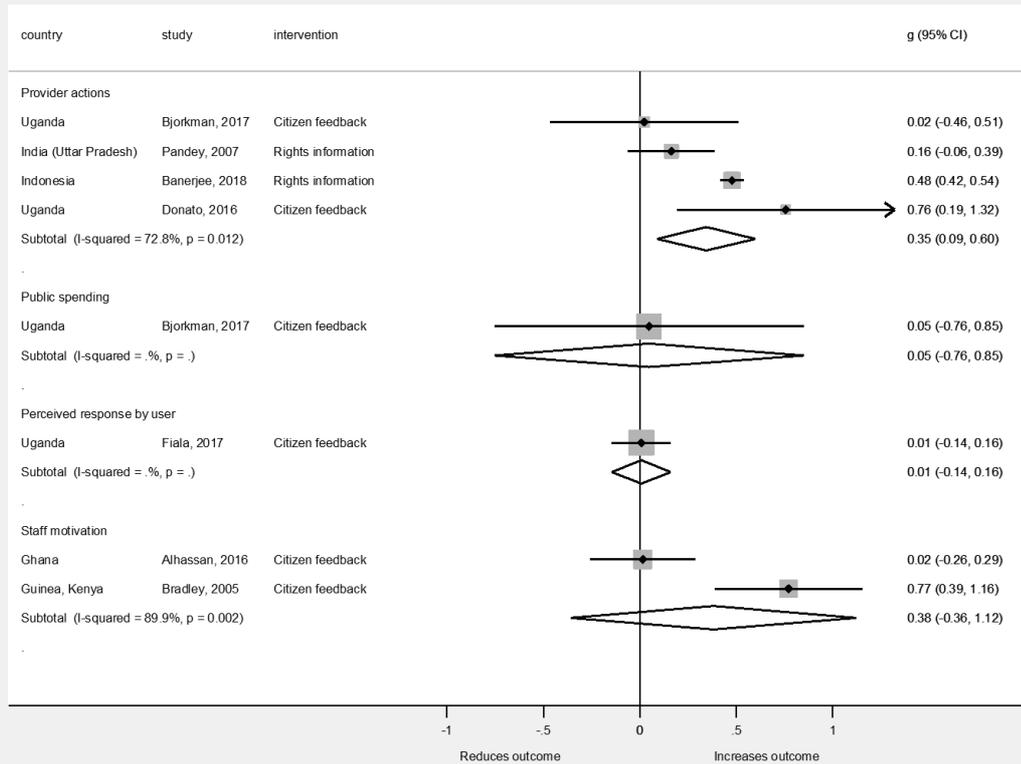
participatory planning processes were able to build relationships with local citizen groups, particularly women's groups, and work with them to address key issues.

Following the completion of the initial framework synthesis, we added codes to the meta-analysis data to test the strength of some of the mechanisms identified. We first tested the strength of the influence from the different types of service delivery. Initially, the distinction was theorized to be between pure public goods - services provided by the state which are non-rival and non-excludable, e.g. public roads - and merit goods - public services which are rival and excludable, usually because they are provided by front-line public servants, e.g. health services, or are subject to rationing, e.g. food subsidies. We expected to see stronger results around citizen engagement in merit goods provision, in which accountability to service users is more direct, leading to differential effects on access and possibly use and wellbeing further along the causal chain. Note that this distinction relates only to the three accountability and transparency interventions (rights information, performance information, and community feedback and monitoring); it did not emerge as a strong explanatory factor in participation interventions (participatory planning and CBNRM).

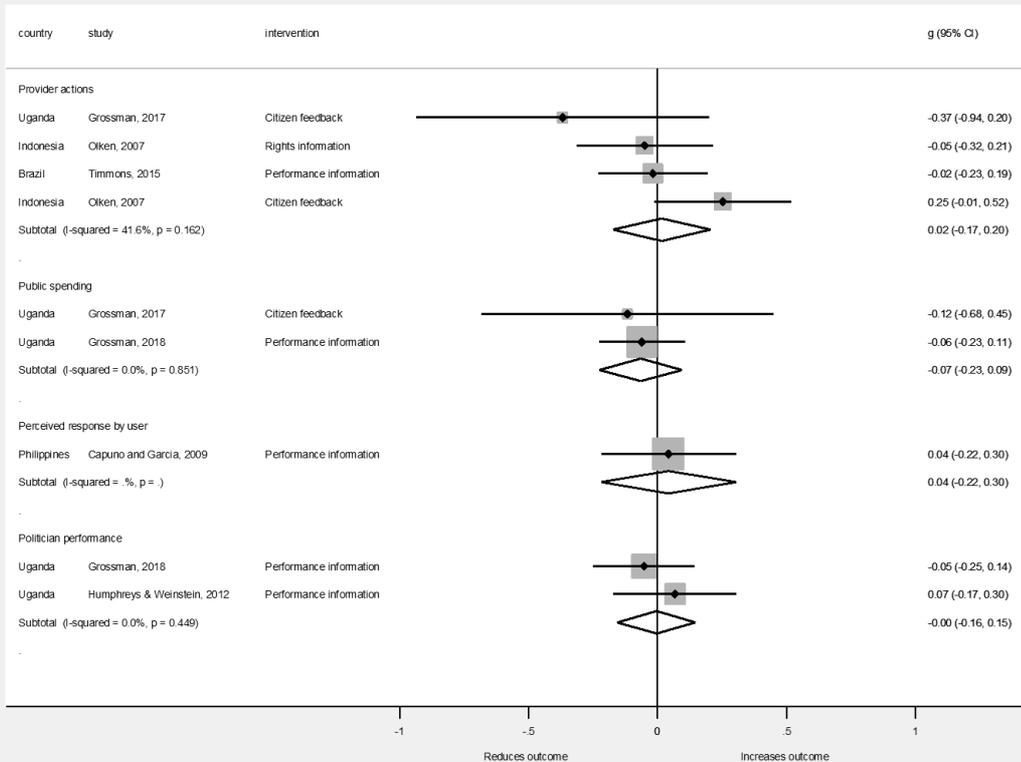
The results of meta-analysis showing immediate, intermediate and final outcomes are presented below. As **Figure 33** demonstrates, the expected difference in citizen engagement for merit versus pure public goods was not identified. This suggests that these interventions do not necessarily suffer from a free-rider or collective action bottleneck; the interventions were successful in stimulating citizen engagement in feedback and monitoring opportunities whether they are for pure public goods or merit goods. However, the distinction between the two groups of services becomes starker when looking at provider response (**Figure 31**), where the only outcome that suggests a significance increase is for provider actions (SMD=0.35, 95%CI=0.09, 0.60) and subsequently on changes in service access.

**Figure 33: Immediate outcomes: pure public and merit goods**





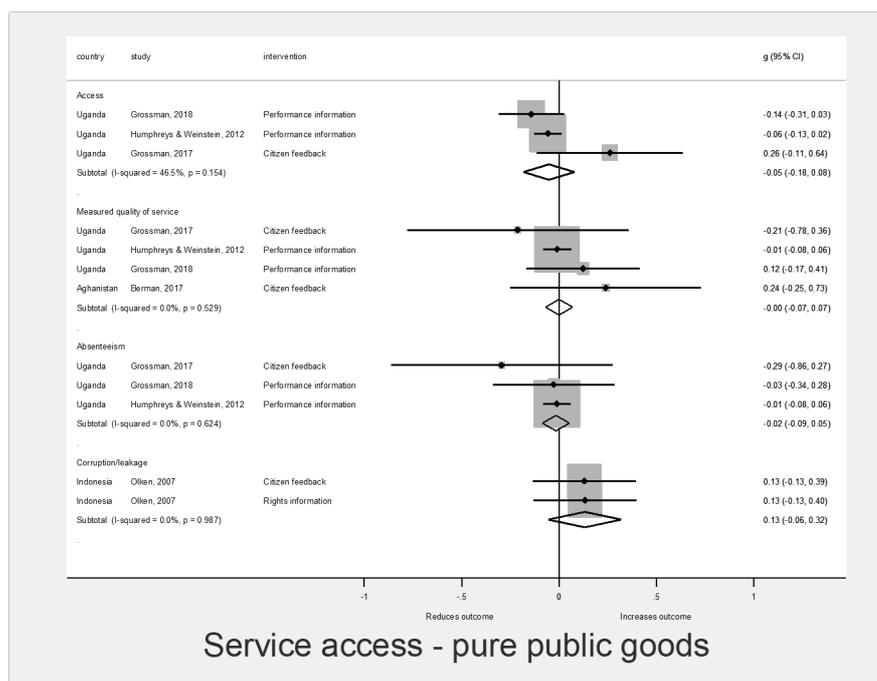
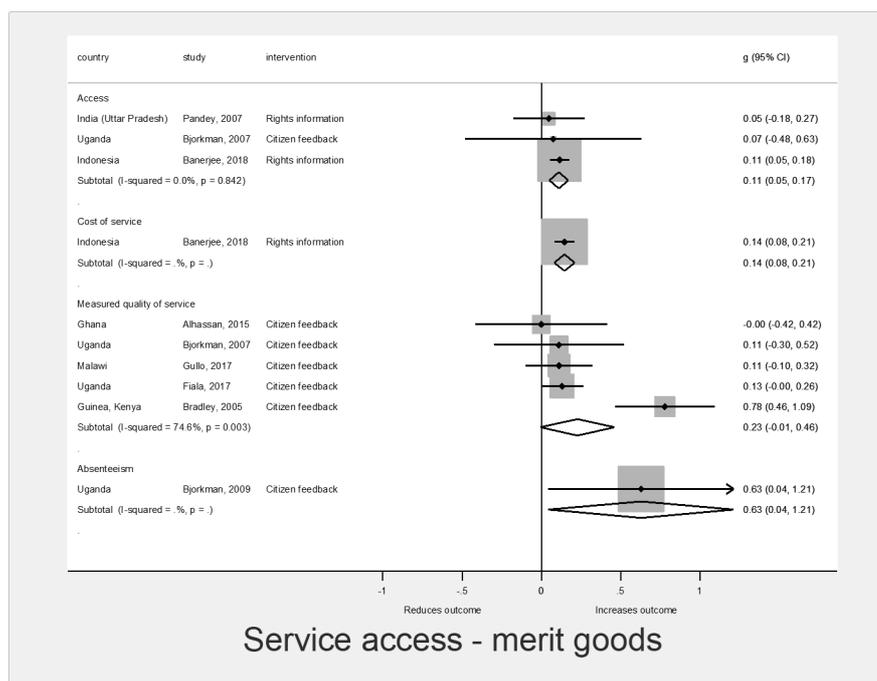
## Provider response - merit goods

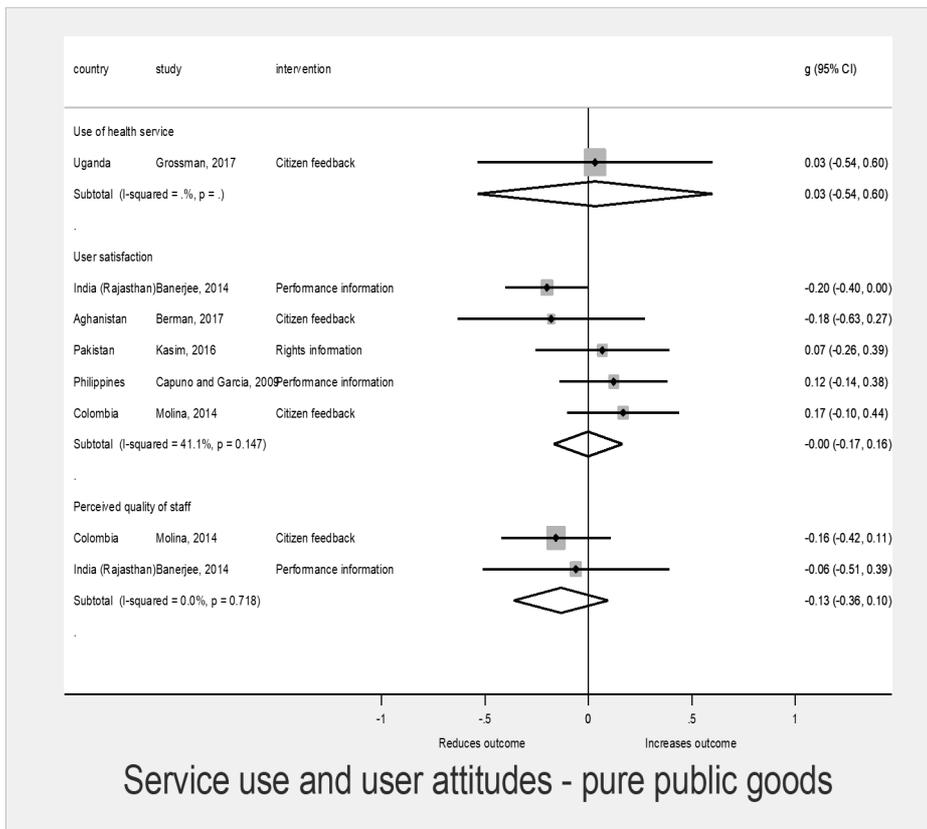
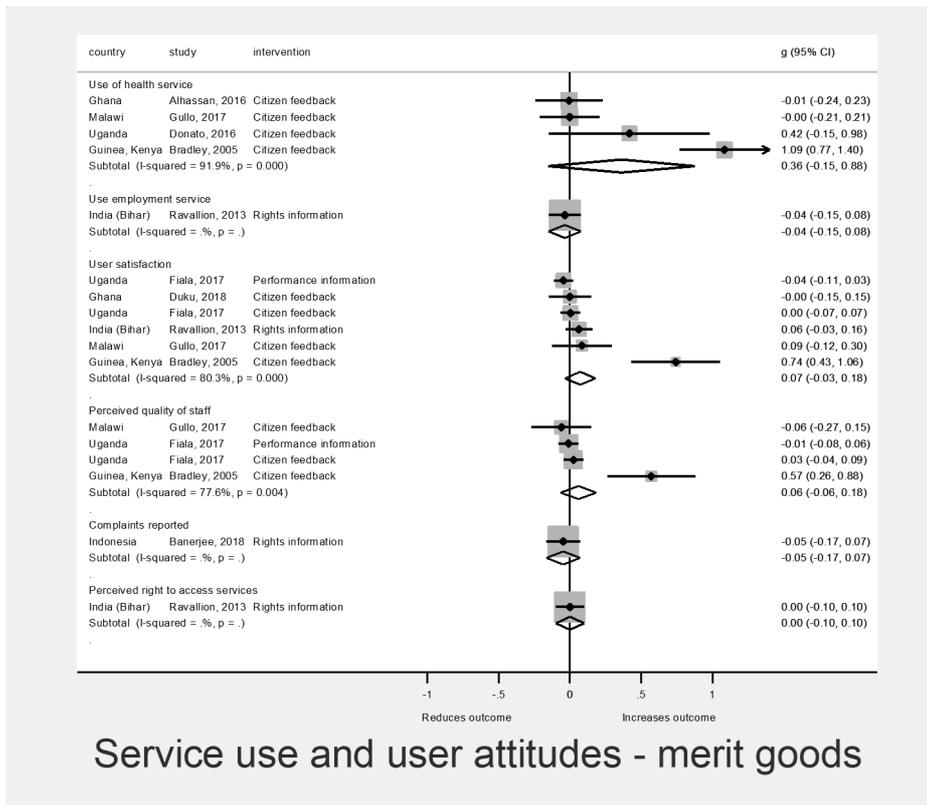


## Provider response - pure public goods

**Figure 34** shows findings for intermediate outcomes, indicating consistent differences between merit goods and pure public goods for service access outcome categories. The findings show positive effects for all outcome sub-categories (physical access, service cost, quality of service, absenteeism) for merit goods, but insignificant findings for pure public goods outcomes. There are no significant effects for service use variables; pooled effects for merit goods were positive in several cases, including health service use (SMD=0.36, 95%CI=-0.15, 0.88), user satisfaction (SMD=0.07, 95%CI=-0.03, 0.18) and perceived quality of staff (SMD=0.06, 95%CI=-0.06, 0.18), where they were null or negative for health service use, user satisfaction and quality of staff.

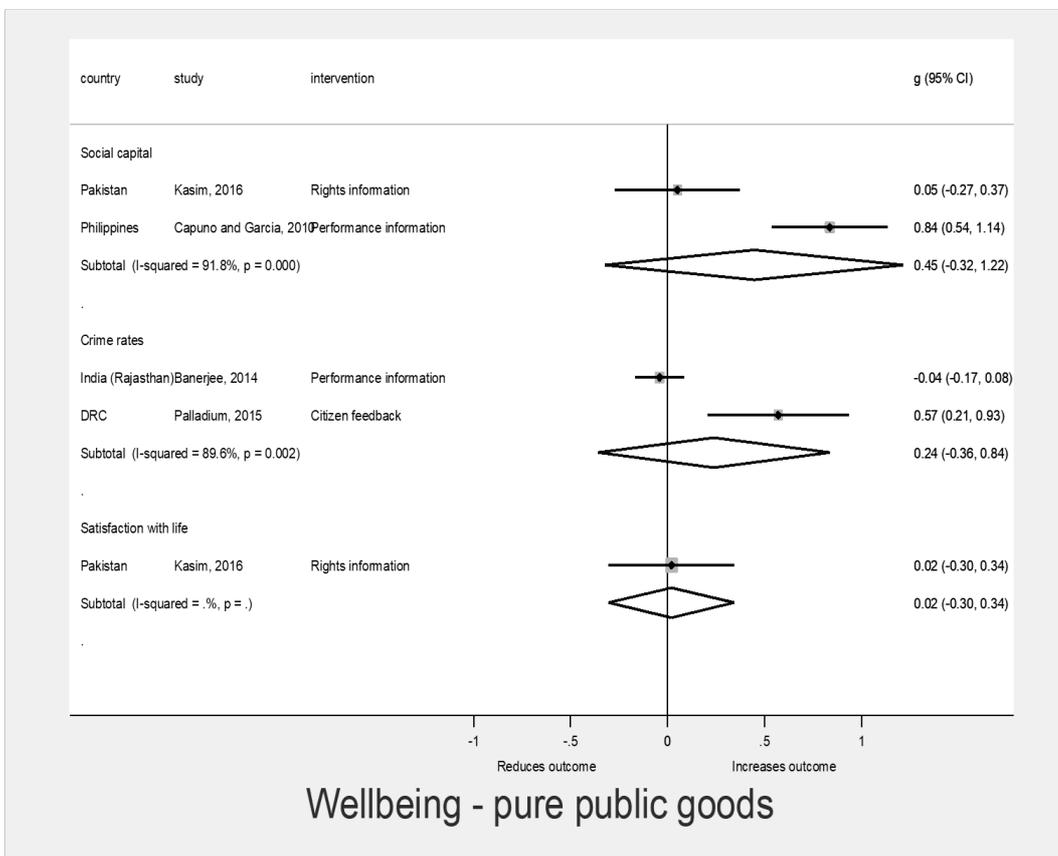
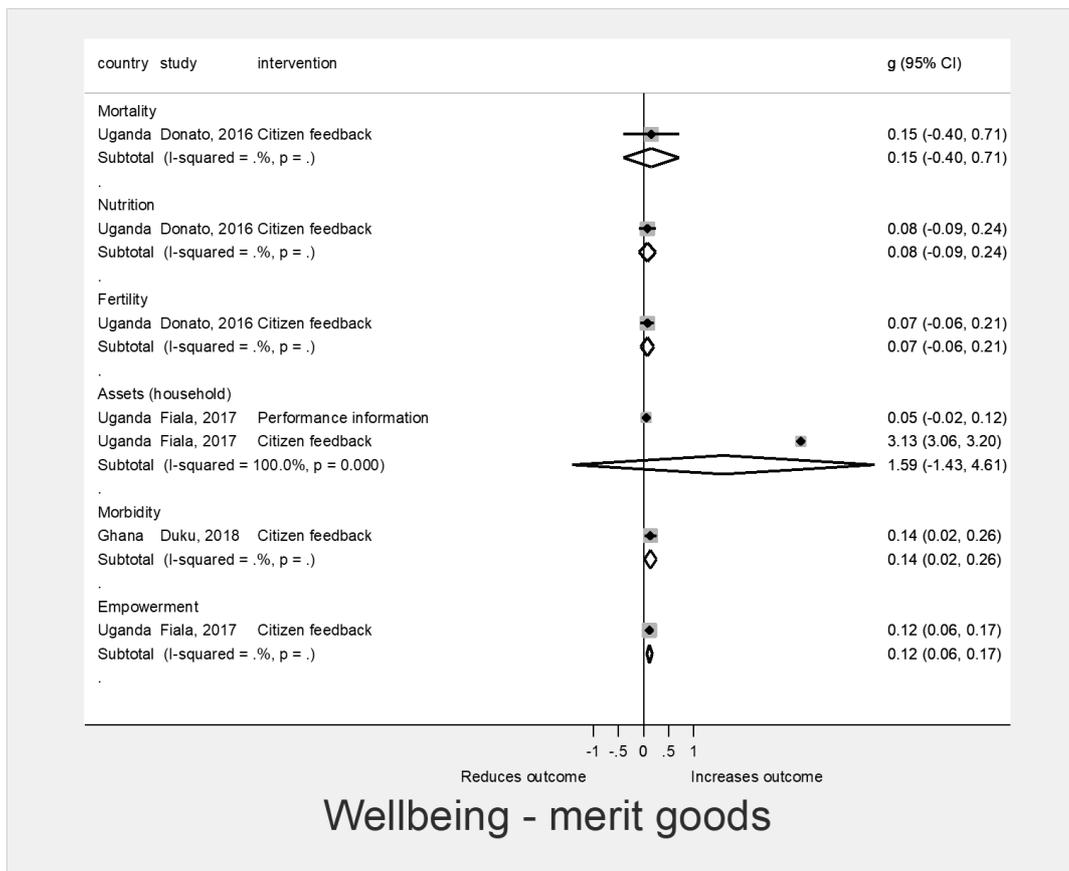
**Figure 34: Intermediate outcomes: pure public and merit goods**

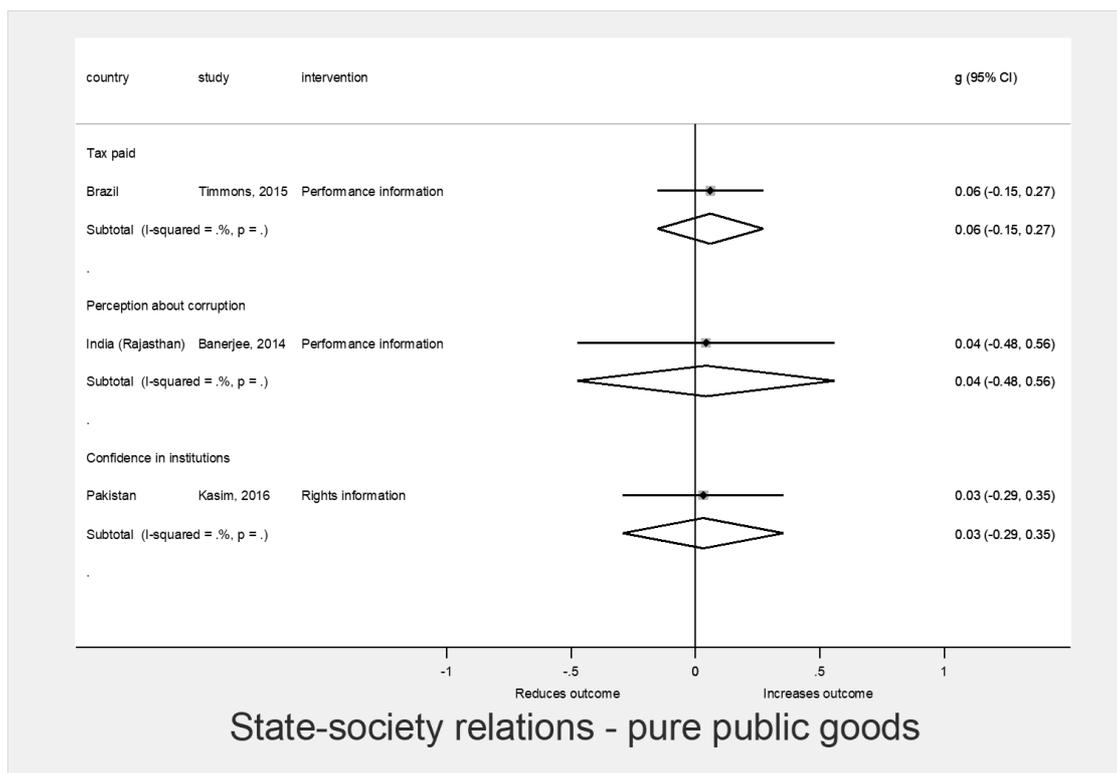
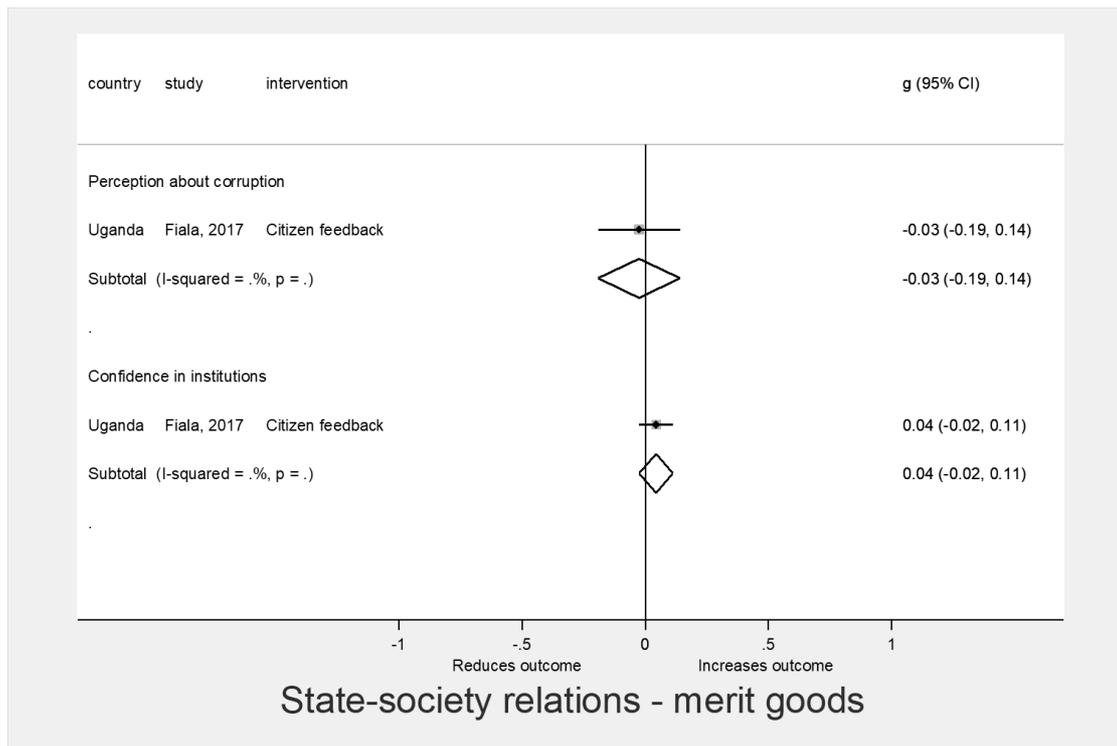




**Figure 35** presents findings for wellbeing and state-society relations outcomes. No more than a single study measured most outcomes, and the results do not suggest any differences between wellbeing and state-society relations for merit versus pure public goods.

**Figure 35: Final outcomes: pure public and merit goods**





Based on the results of the integration with the meta-analysis, we revised the theory, including the theory of change best-fit frameworks, to hypothesize that the break in the causal chain at provider response for services such as infrastructure or municipal government is more likely to be due to the nature of the interaction between citizens and those they are attempting to hold accountable. In what we initially conceptualized as merit good services, such as food subsidies, citizens collect the subsidies directly from the service provider staff member; thus, the citizens and providers interact in the

provision of services, and thereby have a relationship that extends beyond the accountability measures. This is in contrast to a service such as a road, which is built by service providers but accessed by citizens independently of the providers; once the road is built, the providers are no longer engaged in its day to day management and use. As a result, the relationship between the citizens and service providers is constrained to the accountability initiatives. Upon revisiting the framework synthesis, we extracted further evidence in support of this theory, which is described above.

In addition to the moderating variable regarding the nature of service provision, we further attempted to test the strength of the facilitator identified around service provider engagement by coding interventions according to whether they engaged with service providers in the design and/or implementation of the intervention a) at the point targeted by the intervention; b) with different public service officials whose behavior wasn't targeted; or c) no engagement with the supply side. However, the results were inconclusive, which was likely due to the small sample of studies within each group and additional key factors that made it difficult to statistically isolate the potential impact of service provider engagement.

## 6. Cost evidence (Review question 5)

Cost effectiveness is a key question for decision makers, and one that is rarely incorporated into systematic reviews.<sup>3</sup> Unfortunately, few included studies included cost information and no studies included cost information systematically. We present the data here drawn directly from the study reports (answering review question 5). **Table 21** presents the types of programme costs analyzed and key findings.

Two studies (Björkman et al. 2017; Pandey et al. 2007) presented some description of cost per outcome.<sup>4</sup> The measures used to define costs and expenditures varied across these studies. None of the studies presented tables with detailed breakdown of costs by any kind of category or intervention. This limited the potential for any kind of comparisons across programme settings and intervention designs.

Programme costs were reported in four studies (Ananthpur et al. 2014; Alhassan et al. 2015; Björkman et al. 2017; Pandey et al. 2007). Only total costs were presented across these studies, and the costing methodology used in arriving at these cost values were described as 'back of the envelope' and were not detailed. Björkman et al. (2017) presented approximate total intervention costs (cost for collecting data for the report cards which were the main cost item) over a four-year period for 13 treatment facilities at USD10,000 per facility.

Ananthpur et al. (2014) reported implementation costs of citizenship training and facilitation programme in rural India from 100 treatment villages. However, the attrition

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<sup>3</sup> For a good example, see Doocy and Tappis (2017).

<sup>4</sup> Bjorkman et al. (2017) only reported results of the combined package of facilitated meetings to enhance participation with the dissemination of report cards on the facility's performance. Hence the comparison of costs with the facilitated meetings without report cards was not possible based on published data.

rate of household respondents was relatively high (attrition rate=39.91%) as 3,545 households were visited on both rounds of the panel compared to 4,000 households as per sample size calculations at the start of the study. The total cost reported at US\$200,000 (2009 reference year) might have resulted in censoring<sup>5</sup> of cost data calculations as missing not at random (Glick et al., 2015). Since the implementation involved citizen training and facilitation programme, the implementation costs are correlated to the cost of participants who were censored might differ from the cost of those without censored data.

Pandey et al. (2007) presented intervention costs of US\$4,000 across 55 village clusters receiving the information campaign. There is very low attrition (1.91%), hence limited censoring of cost data. The authors also report costs of US\$0.22 per household, presumably based on numbers of households with women reached by the intervention (data not reported). We also used information reported in the papers to standardize cost estimates wherever possible. For example, Alhassan (2015) reported costs across 32 health facilities (private: 21 intervention, 16 controls; public: 11 intervention, 15 controls) which represent about 10 per cent of the total number of accredited clinics/health centers in each of the two study regions. The costs reported at US\$380 per intervention design would mean the overall cost of intervention to be US\$ 12,160 across the 32 intervention health facilities.

**Table 21: Studies reporting implementation costs**

<i>Study</i>	<i>Programme costs reported</i>	<i>Total cost data</i>	<i>Unit cost</i>	<i>Cost-effectiveness</i>
Ghana: Alhassan et al. 2015	Community engagement implementation costs per cycle per year as part of the intervention design	US\$ 12,160 total intervention cost*	US\$ 380 per year per facility	-
Karnataka: Ananthpur et al. 2014	Intervention costs	US\$ 200,000 total intervention cost across 100 villages over four years	US\$ 250 per village per year*	-
Uganda: Björkman et al. 2017	Costs for collecting data for the report cards excluding the costs of collecting data for the evaluation or researcher time	USD\$130,000 over 13 treatment facilities over a four-year period*)	US\$ 2,500 per facility/ community per year*	US\$ 278 per death averted of a child aged under five
Uttar Pradesh: Pandey et al. 2007	Total costs of intervention (information campaign)	US\$ 4,000 total costs of information campaign	US\$ 72 per village per year*; US\$ 0.22 per household in a village cluster	-

Notes: - not reported. \* as estimated by authors based on reported data.

<sup>5</sup> Cost data may be considered as incomplete due to loss of follow-up, and such data is called as 'censored'. MNAR or nonignorably missing censoring occurs when the mechanism that generates the censored observations is correlated with the mechanism that generates cost (Glick, et. al. 2015)

We adjusted the cost estimates across the studies to specific target currency (US\$) and the latest price year at which exchange rate conversion data are available (2016). The revised costs across the interventions identified for the calculations are reported in **Table 22**.

**Table 22: Converted cost calculations to target currency (US\$) and price year (2016)**

Study	Assessment Period	Total cost data	Unit cost per year	Cost-effectiveness
Ghana: Alhassan et al. 2015	Baseline: June 2013 Follow-up: March 2014	US\$ 12,417	US\$ 388 per facility	-
Karnataka: Ananthpur et al. 2014	Baseline: Oct-Nov 2007 Follow-up: Oct-Dec 2009	US\$ 221,700	US\$ 277 per village	-
Uganda: Björkman et al. 2017	Long-term evaluation: 2005-2009 Short-run evaluation: 2005, 2007-09	USD\$144,105	US\$ 2,771 per facility/ community	US\$ 308 per death averted of a child aged under five
Uttar Pradesh: Pandey et al. 2007	Baseline: 2004 Follow-up: 2005 (after 12 months)	US\$ 4,820	US\$ 87 per village per year (US\$ 0.27 per household in a village cluster)	-

Note: \* reference price year reported in the study used as base year for the cost calculation.

Three studies reported factors influencing implementation costs. Alhassan et al. (2015) suggested that factors such as champions being community members and resources being mobilized from within the community, influenced in keeping the implementation costs low. Bjorkman et al. (2017) highlighted the cost of data collection for the report card to be the main cost item influencing implementation costs. Pandey et al. (2007) suggested that if the government or local organizations could disseminate the information campaign, such as radio or newspapers, it could result in even lower intervention costs.

## 7. Summary of main findings

This systematic review synthesized both quantitative and qualitative evidence from 35 studies of 41 unique policies or trial arms in 20 low- and middle-income countries. Evidence was found spanning five global regions on programmes that incorporated the principles of participation, accountability, transparency and inclusion (PITA) to increase citizen engagement in public service delivery. This included programmes promoting participation (participatory priority setting); inclusion of marginalized groups; transparency (information on rights and public service performance), and/or citizen efforts to ensure public service accountability (citizen feedback and monitoring). The primary goal was to determine the programmes' impact on the quality of and access to public services, including health care, social protection, justice and physical infrastructure, and social and economic wellbeing of citizens (review question 1). We also considered the impact on intermediate outcomes in the causal chain, including citizen engagement and provider response (review question 2), and how results vary by participants and location (review question 3). In addition, we aimed to understand the mechanisms and processes through which change happens, by identifying programme design, implementation, context, and mechanism factors associated with programme effectiveness along the causal chain (review question 4). Due to insufficient cost data, we were unable to address review question 5 on the cost-effectiveness of interventions incorporating PITA characteristics.

We used quantitative meta-analysis to combine the results of the impact evaluations, including sub-group analysis to explore heterogeneity by intervention, study location and other moderators. We conducted a detailed critical appraisal of the included impact evaluations to assess the credibility of the results. From the included programmes, we identified 36 associated qualitative and programmatic documents that we used to address review question 4. We used framework synthesis to synthesize the data.

We reported quantitative results along the causal chain to address review questions 1-3, supported by the results from the qualitative framework synthesis to address review question 4. We start by presenting the results of the overall synthesis, followed by the individual results for the five intervention areas.

### 7.1 Effectiveness of citizen engagement interventions

An analysis found that citizen engagement interventions are usually *effective in increasing the engagement of service users*, for example improving meeting attendance, contributing to community funds, and general knowledge about services. The average pooled effect on user engagement was an increase of 0.23 standard deviations (95%CI=0.12, 0.34) in the typical outcome measure across all interventions. However, the *effects of interventions promoting citizen engagement on provider actions were very limited*: the pooled effect on provider responsiveness was not significant across all PITA mechanisms and interventions.

We considered diversity and equity of impacts across different population groups in three ways. Overall, few of the studies reported disaggregated intervention approaches and/or analysis of results for different population groups. We identified five studies that incorporated specific measures within the intervention to extend the engagement to

vulnerable groups, which comprised three participatory planning interventions and one each of rights information provision and citizen feedback or monitoring. These programmes tended to have smaller effects on citizen engagement and access to services than other programmes, but it is unclear whether this was due to many of the programmes being implemented in challenging contexts (e.g. Afghanistan, Pakistan and DRC) rather than problems inherent in targeting vulnerable community members. Further, we identified nine studies that conducted sub-group analysis to differentiate impacts for different population groups, most commonly by socio-economic status and by gender, yet these were spread widely across intervention type and geography. Finally, we looked for studies that conducted equity-oriented causal chain analysis, and identified only one study that conducted a detailed qualitative assessment that incorporated consideration of differentiated impacts for women. We also examined overall differences by global region, but were not able to find consistent differences by intervention or outcomes along the results chain. Ultimately, due to the small sample of studies across a wide range of interventions and outcomes, it is difficult to conclude anything systematically for different population or geographic groups.

### ***7.1.1 Performance information provision***

We identified six evaluations of public official or service provider performance information interventions, such as the dissemination of municipal government performance scorecards in Afghanistan, Brazil, the Philippines and Uganda, and monitoring information provided in police stations in India. The framework synthesis identified that amongst performance information interventions, a key facilitating factor was the extent to which implementers secured the support of and buy-in from the actors whose performance was being analyzed and disseminated. Without such support, the findings suggest that the targeted actors may be able to avoid accountability by either preventing full implementation of the intervention, or by successfully undermining the credibility of the performance information disseminated. Most of these interventions targeted political actors' performance (as opposed to specific public services), in attempt to "shorten the long route" of citizen-state accountability by increasing citizen engagement with politicians outside of elections. While interventions were at times successful in eliciting some improvements in politician performance, the findings suggest that, ultimately, this route remains too long to identify short-term effects on service delivery. Politicians may claim plausible deniability of their individual capacity to influence service delivery change, and such interventions do not engage many key actors involved along the public service delivery supply chain.

### ***7.1.2 Citizen feedback mechanisms***

We identified 10 evaluations of accountability interventions, which specifically comprised citizen feedback or monitoring mechanism interventions, that is, those that solicited feedback regarding and/or actively engaged citizens in the monitoring of service delivery, to hold public service providers and institutions responsible for executing their powers and mandates according to appropriate standards. These include community report cards in infrastructure (Afghanistan, Indonesia and Colombia), health (Ghana, Malawi and Uganda), agriculture (Uganda) and the security sector (DRC), and individual citizen 'feedback loops' in Guinea, Kenya and Uganda. The framework synthesis suggested that citizen feedback and monitoring interventions were more successful at achieving results where some or all of the following factors were present:

- Interventions targeted a service that citizens accessed through interactions with front-line providers;
- A phased, facilitated approach jointly engaged citizens and service providers in monitoring
- Performance benchmarks;
- Creation of common knowledge of feedback or monitoring results; and
- Working through local community organizations to strengthen community members' voices.

### **7.1.3 Rights information provision**

We identified five evaluations of *rights information* interventions, which enable users to demand minimum standards for access to services, such as for social protection services in Indonesia (food subsidies) and India (public works), maternal and child health care in India and freedom of information in Pakistan.

The results from the framework synthesis suggested that interventions informing citizens of their rights were more likely to succeed where they targeted the provision of a service citizens access directly from front-line providers; created a sense of common knowledge about people's rights to the service among citizens and providers; and built an appropriate level of social sanction risk for providers.

### **7.1.4 Participatory planning interventions**

We identified nine participatory priority setting, planning or budgeting interventions, wherein citizens participated in setting the priorities for and/or planning of local services. These include support for participatory budgeting in municipal governments in Brazil, Mexico and Russia, and support for participatory planning in India, Pakistan, Guinea and Kenya. It also included requirements for inclusive participation in two fragile contexts, Afghanistan and DRC.

The framework synthesis suggested three factors improved the likelihood of achieving results along the causal chain:

- Strong local buy-in from front-line service providers for the intervention;
- Incorporating specific, culturally appropriate measures that address local barriers to the participation of vulnerable groups; and
- Interventions designed to spur the growth of local civil society and capacity for collective action.

### **7.1.5 Community-based natural resource management**

We identified seven community-based natural resource management (CBNRM) interventions, wherein citizens form local collectives and take over the management of a shared resource, for forest management in Nepal, Madagascar and Tanzania, and water user associations in Brazil, China and the Philippines, and Namibia.

We identified four key contextual factors that mediated results chains amongst community-based natural resource management (CBNRM) interventions. Where interventions required large shifts in control over the resource, representing a relinquishment of power from local officials to community groups, we identified a lack of engagement and buy-in from local officials as a frequent barrier to the full implementation of the CBNRM policy. Critically, this barrier often resulted in situations in

which community groups took on additional responsibilities for resource management, but did not gain access to the corresponding promised benefits. A related factor is the clarity of the national CBNRM policy context; where there were multiple vague and overlapping policies governing natural resource use, officials were more able to adjust or block full implementation of CBNRM in a way that preserved their power and control over resource benefit access. We identified external support to change resource use as a key facilitating factor: even in the absence of full policy implementation, access to alternative livelihoods such as tourism may still enable communities to realize the joint socio-economic and environmental objectives of CBNRM. Finally, we identified the type and intensity of local resource use as a key moderating factor influencing the effectiveness of CBNRM; community management may not be appropriate in contexts prone to illegal logging or poaching, where attempts to enforce regulations may endanger community members.

## **7.2 Overall completeness and applicability of evidence**

We identified 50 papers associated with 35 studies in low-and middle-income countries. While this is a growing evidence base, with 60 per cent of the included papers published within the last five years and 11 ongoing studies identified, this still represents a limited evidence base from which to make conclusions. The largest number of studies or trial arms testing a particular mechanism was 16, for studies testing policies to encourage or mandate participation, and these studies reported on a diverse range of outcomes. Geographically, the evidence base is skewed towards Sub-Saharan Africa and India, representing half of the evidence base. We identified no studies from North Africa or the Middle East and limited evidence from Latin America and the Caribbean and East Asia and the Pacific region.

While we identified seven studies of community-based natural resource management committees, these were all rated as having a high risk of bias or having some concerns, with the exception of Barde's (2017) evaluation of water user associations in Brazil.

We also undertook a formal assessment of the external validity of the included studies. A number of studies still do not report their sampling strategy clearly, and a surprisingly small share of studies specifically discuss the generalizability of their findings to other contexts. Only 11 studies explicitly discussed external validity. Among those studies, five acknowledged the limits to the generalizability of their findings, due to the small scale of the study or the sampling strategy. Four studies claimed generalizability of their findings, either to the level of an Indian state (Banerjee et al. 2014; Ravallion et al., 2013), or to other areas of the country under similar conditions, such as density of population or distance to a health facility (Touchton 2015; Björkman et al. 2017). Finally, two studies claimed generalizability of their findings to other contexts, and potentially other countries (Fiala & Premand, 2017; Timmons & Garfias, 2015).

## **7.3 Quality of the evidence**

Overall, the quality of evidence from randomized studies is relatively high, with studies for the most part ensuring comparability of intervention and control groups and protecting them from selection bias. The risk of bias assessment is therefore more relevant at the outcome level. We identified concerns related to the way some outcomes are measured

in the majority of studies. This is due to the use of self-report measures that are often biased by the intervention itself. A majority of the non-randomized studies are natural experiments, which in most cases did not provide enough information on the selection process into the programme to reject the risk of selection bias, or failed to overcome the selection bias and confounding that was identified. Transparency in reporting is an issue for randomized and non-randomized studies alike given the few pre-registrations of trial, outcomes or analysis plan. The use of methods such as placebo outcomes or groups, and blinding for outcome assessors or data analysts, is not common, though it seems relatively easy to implement and could reduce risks of biases.

#### **7.4 Limitations and potential biases in the review process**

There are several limitations of this review related to both the existing evidence base in this area and the synthesis approach.

#### **7.5 Limitations of the existing evidence base**

1. Statistical power for the meta-analyses and heterogeneity analysis: Our ability to make strong conclusions on the effectiveness of the PITA mechanisms and interventions were limited by the number of studies looking at each intervention and outcome area. This was despite using a fairly high level of aggregation for mechanisms, intervention areas and outcomes. In addition, we were unable to undertake the full moderator analyses that we specified in the protocol to explore heterogeneity quantitatively that due to a limited number of included studies in each mechanism and intervention category.
2. Reporting in primary studies: We were limited in our ability to test key mechanisms quantitatively that we identified through the framework synthesis due to limited reporting of design and contextual characteristics in the impact evaluations. For example, our framework synthesis and previous reviews have suggested that the extent to which interventions engaged with or were strongly supported by national or local governments would be an important determining factor for effectiveness. However, primary studies rarely reported on this in detail.
3. Cost-effectiveness analysis: We aimed to undertake an analysis of the cost-effectiveness of the included set of interventions (review question 5), however we were limited by the available cost data.

#### **7.6 Limitations of the review scope and synthesis process**

4. The focus of our review questions were on the value added of incorporating PITA characteristics into existing service delivery, and therefore we did not include studies that studied the impact of combining PITA-based interventions with co-interventions to improve resources or capacity for service delivery. One of the tentative conclusions of our review is that citizen engagement interventions that do not incorporate complementary interventions along the service provider supply chain may be insufficient to improve key wellbeing outcomes for target communities. However, we are unable to say this conclusively without comparing to the results of interventions that do combine PITA and supply side interventions. We believe that this would be a valuable subject for future synthesis.

5. We did not include studies of education related to PITA mechanisms in our review due to overlap with existing systematic reviews and time and resource limitations. However, the inclusion of this evidence base may have increased the power of our quantitative analysis and the generalizability of our results to this sector.
6. Due to time and resource limitations, we did not undertake independent double coding of effect size information or the qualitative data extraction. In addition, we only undertook double coding for the risk of bias assessments for a sample of 20 per cent of studies rather than the full set. However, the results of the independent double coding of risk of bias demonstrated a high level of agreement between the two authors.

## **7.7 Deviations from the protocol**

This review largely followed the approach described in the associated protocol published in the Campbell Library (Waddington et al., 2018), however there are several deviations that should be noted.

1. Upon identifying the included studies, we mapped the characteristics of each intervention and produced a framework of five sub-interventions that shared similar design characteristics. These categories were not pre-specified in the protocol as we defined our intervention inclusion criteria using PITA design characteristics and were unsure what the final set of included interventions would look like. We used these categories to undertake sub-group analysis by intervention area.
2. As noted in the previous section, we did not undertake full independent double coding of effect size information or the qualitative data extraction although categorization of all effect sizes into outcome groups for every study was done by two authors.
3. We discussed exploring the possibility of applying alternate methods to link the meta-analysis with context and mechanism information, such as QCA (Befani, 2016). QCA articulates the associations between empirical effects and context and mechanism conditions drawing on “truth-tables” which articulate all possible instances of conditions and show which cases share the same combination of conditions. We noted that the application of QCA is limited by the number of included studies, their comparability and the completeness of reporting within them, hence the application of QCA was not feasible in this review. We were unable to apply QCA to our review due to number of included studies, their comparability and the completeness of reporting within them. Instead we used realist-informed framework synthesis that moved towards “best fit” framework synthesis to explore context and mechanism information. In addition, we identified some potential programme mechanisms through the qualitative framework synthesis that we subsequently tested in the meta-analysis through sub-group analysis that were not described in the protocol.

## **7.8 Agreements and disagreements with other studies or reviews**

This systematic review is the first that we are aware of to consider the effects of a range of interventions with PITA characteristics across a range of sectors. The findings from

the review are broadly consistent with reviews that have examined governance interventions and/or have examined demand and supply in service delivery. For example, the recent review of community driven development programmes by White et al. (2018) found that effects tended to diminish further along the causal chain, such as programmes were often ineffective in improving wellbeing outcomes, apart from in the special case of water and sanitation.

Several high quality systematic reviews exist focusing specifically on the impact of community-based monitoring and information interventions (Molina et al. 2016; Snilstveit et al. 2015). In 2016, Molina et al. published a review of the effects of 15 community monitoring studies in the health and education sectors. Snilstveit et al.'s (2015) mixed method systematic review examines the effects of education interventions including community-based monitoring of schools and education systems.

Hanna et al.'s (2011) systematic review of anti-corruption interventions found that monitoring interventions have been effective in cases where they were implemented and monitored by a party desiring to lower corruption, and where they have been combined with either nonfinancial or financial incentives. They also suggested community-level monitoring works but only "*when the community can punish corruption*" (Hanna et al. 2011: 49).

USAID's (2015) Practitioner's Guide for Anticorruption Programming Guide aggregates lessons from more than 300 USAID programmes between 2007 and 2013 which included anticorruption design elements. They suggest that public awareness campaigns or citizen monitoring groups have little impact without willing coordination with governments.

## **8. Conclusions and implications**

### **8.1 Implications for policy and programming**

This section presents the main conclusions for policy and programmes from the synthesis of impact evidence on interventions promoting external participation and accountability in low- and middle-income countries. As might be expected for a review of broad interventions and even broader scope of outcomes, there is significant heterogeneity in findings. In order to manage the anticipated heterogeneity, we developed a framework which enabled sensible grouping of interventions and outcomes. The results from analysis according to this grouping suggested significant heterogeneity in findings across intervention groupings and outcomes.

The first conclusion is that, regardless of intervention type, interventions are usually effective in improving engagement of citizens in service delivery and improving access to services and quality of service provision. However, external participation and accountability interventions are not often able to elicit strong responses from public services.

Secondly, evidence suggests some interventions may be more effective in improving service delivery outcomes, including those with stronger accountability components and which provide rights information. These findings about relative effectiveness across interventions are tentative in light of the heterogeneity in evidence included in the review.

The third main conclusion is that outcomes tend to get smaller along the causal chain, to the extent that we do not expect participation and accountability interventions of themselves to improve wellbeing. This finding should not be surprising, partly because the deteriorating causal chain is a common occurrence, called elsewhere the ‘funnel of attrition’ (see White, 2014). The other reason is that the systematic review inclusion criteria were limited to studies examining the marginal effect of a participation or accountability intervention on top of standard public service delivery. Hence, any study (or trial arm) that incorporated any co-interventions, including increased resource delivery, was excluded. It is highly possible that participation and accountability interventions when provided alongside other services that can relieve important bottlenecks, can act to improve behavioral responses and wellbeing.

The results suggest it is important to pay particular attention when designing and implementing interventions in the following areas:

- **Ensuring positive engagement with supply-side actors at the intervention target level**

Many interventions experienced challenges stemming from a lack of positive engagement with supply-side actors at the intervention target level, whose relative power the interventions often sought to diminish. Interventions seeking to change this balance of power with engagement and buy-in from these actors are likely to be more effective in improving service delivery outcomes and state-society relations. Interventions implemented with the strong support of the targeted supply-side actors, such as the case of municipal governments that chose to implement participatory budgeting in Brazil or structured community engagement in the health sector have been able to realize positive impacts across the causal chain.

- **Particular consideration for natural resource management committees**

In the majority of included broad intervention groups, a limited response on behalf of the service provider may at worst prevent outcomes tied to service provider response or lead to null effects. In the case of CBNRM, however, there is a risk of causing negative effects on well-being outcomes, where a lack of full intervention implementation leads to a context in which resource- and time-poor communities increase their burden of natural resource management, have less access to the resource due to sustainability restrictions, and are not afforded adequate compensation in the form of resource benefits ownership or alternative livelihoods support.

- **Collaborative versus confrontational approaches to service provider engagement**

The findings of this review lend some support to the theory that citizens’ attempts to increase their relative power through means seen as confrontational by service providers often disincentivize service provider participation (World Bank 2004). The findings of this review suggest that approaches to citizen-service provider engagement in the realm of accountability, including transparency for accountability, appear to work more effectively when implemented through phased, facilitated processes that are framed as collaborative, as opposed to one-off accountability meetings that tend to be interpreted as confrontational. Interventions that promote transparency with the aim of triggering mechanisms that motivate citizens to demand greater accountability often fall closer to the

confrontational spectrum, and their limited success on realizing outcomes along the causal chain is evident throughout the included studies. Those that promote an explicitly collaborative process may be more effective, particularly when they incorporate measures to improve citizens' understanding of performance benchmarks. We note, however, a difference between interventions targeting individuals versus service provider institutions, and caution that it may be more difficult to engage in collaborative approaches to performance improvements with individuals, who are understandably more likely to feel personally targeted. In these situations, the synthesis suggests that ensuring the engagement of a locally credible messenger to disseminate performance information reduces the ability of the targeted individual to undermine, co-opt or discredit the information.

- **Facilitating engagement by building local social capital and capacity for collective action**

Across included interventions, a key facilitator identified in the framework synthesis was the value-add of incorporating into intervention design active engagement with local organized community groups, such as CSOs or interest groups, or the inclusion of measures that explicitly sought to build local social capital and capacity for collective action. The role of civil society support to communities may be critical not only for encouraging engagement in monitoring and accountability processes, but also for shifting the balance of power between citizens and public service providers of indirectly delivered services. There is some evidence that CSO engagement is particularly critical for interventions targeting indirectly-delivered, pure public goods. Engaging CSOs in the intervention may strengthen the social capital of individual citizens: the stronger voice may increase citizens' ability to access the information needed to hold service providers accountable; help bring key stakeholders together in interface meetings; and increase citizens' bargaining power with service providers, thus strengthening their capacity to realize improvements in service delivery quality.

## **8.2 Implications for research**

The results suggested significant heterogeneity according to study design and implementation characteristics. Thus, RCTs tended to have smaller effects than non-randomized studies. Although this finding is consistent across different literatures, and is indicative of the types of effect estimand that RCTs produce, it is important to note that well-conducted RCTs are considered to provide the most reliable estimates of outcome changes, and as a study design is highly amenable to the types of interventions contained in this review. The result of the risk of bias analysis has shown that the overall quality of evidence from the randomized studies is relatively high: risks of confounding and selection bias are low, however researchers should rely less on self-reported outcome measures, which are more susceptible to biases. A majority of non-randomized studies were at high risk of selection bias and confounding, due to the unclear or self-selection of communities into the programme and the lack of baseline data. When baseline data is available and the appropriate analysis method is used, authors overcome these biases. There are therefore opportunities to conduct more natural experiments evaluating national policy or reform in this sector. There are concerns related to reporting, in particular there is a lack of transparency with regards to how

analyses were conducted, how authors responded to implementation problems (e.g. attrition), and approaches to selecting groups for inclusion in the study (external validity).

Researchers should consider the following when undertaking impact evaluations in this area:

1. **Reporting of intervention and comparison group conditions:** in many cases, we had difficulties in identifying precisely what the impact evaluation was evaluating; either due to limited reporting of the intervention characteristics or because the status of the citizens in the comparison group was unclear. As noted in the search results section, we decided to exclude two studies after identifying additional documents that alerted us to the presence of significant co-interventions not reported on in the impact evaluations. This limits the amount of learning that can take place from the studies, for implementers who may wish to take the intervention to a new setting or for synthesis work. Authors should consider drawing on tools such as the TIDieR intervention reporting guidelines for health (Hoffman et al. 2014).
2. **Consideration of equity:** there is a lack of research on how citizen engagement interventions affect women, ethnic groups or other vulnerable groups. For example, few impact evaluations undertook sub-group analysis for these groups or undertook parallel qualitative research to understand how these groups are able to participate in this type of programme or their perspectives. For example, we only identified two studies that assessed how mandating the participation of women into PITA processes affects services and wellbeing. Given that the majority of the interventions covered by our review rely extensively on participation of the community and frequently do not, at least explicitly, make efforts to incorporate vulnerable groups, it is important to understand how vulnerable groups are able to participate.
3. **Prioritization of mixed-methods impact evaluations:** few studies incorporated qualitative research that would allow them to uncover the mechanisms that lead to the success or failure of the intervention. Ananthpur et al. (2014) was one notable exception that included a four-year ethnography of the intervention to understand the mechanisms that led to the lack of impact in the programme.
4. **Greater standardization of outcomes collected in studies of PITA mechanisms:** in many sectors, there are common wellbeing outcome indicators which facilitates cross-study learning (e.g. child diarrheal morbidity in studies of water, sanitation and hygiene interventions). There does seem to have been some standardization already done for some governance interventions, for example, reporting of quality of participation in community-driven development programmes. However, there is far greater scope for standardization of outcomes for commonly used constructs for citizen engagement interventions, as shown in the great diversity of outcomes collected.

We have attempted in this review to demonstrate that it is possible to undertake higher-level synthesis work to articulate broader mechanisms at play which aimed to inform centralized strategic planning. However, we note that systematic reviews are usually most effective – especially in communicating findings to programmes – when they examine a particular intervention, such as “community-driven development”. Hence our attempt in this study to provide both broader-level analysis of empirical results across

studies and within-study findings for particular interventions. In addition, our study identified several potential areas for future synthesis work:

5. We focused in this review on interventions that isolated the PITA component, and therefore did not **incorporate co-interventions to target the resource base or capacity of the public service providers**. It would be useful for a future systematic review to compare the findings of interventions that introduce only PITA mechanisms alongside PITA mechanisms combined with co-interventions. Any synthesis work would likely need to focus on particular aspects of participation and accountability, or intervention groups, in order to be both manageable and policy-relevant.
6. We excluded studies of interventions from the education sector, as they have been synthesized by several previous reviews. However, we note that a similar **mechanisms synthesis could be undertaken of studies in the education sector, which constitute a substantial body of research in this area**.
7. **Fully mixed-methods systematic reviews examining the effectiveness of particular intervention types** (e.g. participatory budgeting, community-driven development) would also be valuable.

## Appendix A: Detailed methodology

### Criteria for considering studies for this review

The main criteria determining eligibility of studies in the review are grouped by population, intervention, comparison, outcome and study design.

#### *Types of studies*

To answer research questions 1, 2 and 3 we included counterfactual studies that used an experimental or quasi-experimental design and/or analysis method to measure the net change in outcomes that were attributed to an intervention or policy. We included randomized and non-randomized studies that were able to take into account confounding (Reeves et al., 2017; Waddington et al., 2017). Specifically, we included the following study types:

- Randomized controlled trials (RCTs), with assignment at individual, household, community or other cluster level, and quasi-RCTs using prospective methods of assignment such as alternation.
- Non-randomized studies with selection on unobservables:
  - Regression discontinuity designs, where assignment was done on a threshold measured at pre-test, and the study used prospective or retrospective approaches of analysis to control for unobservable confounding.
  - Studies using design or methods to control for unobservable confounding, such as natural experiments with clearly defined intervention and comparison groups, which exploit natural randomness in implementation assignment by decision makers (e.g. public lottery) or random errors in implementation, and instrumental variables estimation.
- Non-randomized studies with pre-intervention and post-intervention outcomes data in intervention and comparisons groups, where data were individual level panel or pseudo-panels (repeated cross-sections), which used the following methods to control for confounding:
  - Studies controlling for time-invariant unobservable confounding, including difference-in-differences, or fixed- or random-effects models with an interaction term between time and intervention for pre-intervention and post-intervention observations;
  - Studies assessing changes in trends in outcomes over a series of time points (interrupted time series, ITS), with or without contemporaneous comparison (controlled ITS), with sufficient observations to establish a trend and control for effects on outcomes due to factors other than the intervention (e.g. seasonality).
- Non-randomized studies with control for observable confounding, including non-parametric approaches (e.g. statistical matching, covariate matching, coarsened-exact matching, propensity score matching) and parametric approaches (e.g. propensity-weighted multiple regression analysis).

Analysis under research question 4 addressed programme design, implementation, context and mechanism in greater detail. We incorporated descriptive information about each programme evaluated in each included counterfactual studies, as well as from

additional programme and project design and implementation documents relating to each of these. Information on underlying context and behavioral mechanisms drew on information contained anywhere in included study reports, whereas evidence on outcomes drew on effects data from relevant study arms in quantitative counterfactual estimation only.

Analysis under research question 5 aimed to address unit cost, cost-efficiency, cost-effectiveness or benefit-cost evidence on interventions in particular contexts. We aimed to incorporate economic evaluations of included programmes drawing on standard approaches to synthesis of economic appraisal evidence (Shemilt et al., 2011). However, we only identified four studies that reported any cost information. They are reported descriptively in the results (Section 5).

Eligible comparators for research questions 1-3 included groups that received normal service delivery ('business as usual') without improved PITA characteristics, or groups that received an intervention testing the inclusion of different PITA design characteristics or weaker or less intensive implementation of PITA design characteristics.

#### *Types of participants*

We included any participants from low-and middle-income countries (L&MICs), including participants from the general population and those from specific population sub-groups. We collected data on differential effects and experiences for sub-populations available and coded information according to the PROGRESS-plus criteria, where progress stands for place of residence, race/ethnicity, occupation, gender, religion, education, socioeconomic status, and social capital, and 'plus' represents additional categories such as age, disability, and sexual orientation (O'Neil et al. 2014).

#### *Types of interventions*

We included interventions that aimed to increase the external engagement by public institutions and services with citizens and service users. We defined interventions as either stand-alone interventions or interventions that formed part of a larger programme that inherently or by definition sought to improve the PITA-characteristics of engagement between public services and institutions and citizens. They could be implemented either on the supply or demand side of service delivery, or target both simultaneously, for example through the introduction of public-service audits that worked with both the community and civil servants.

To be included in the review, the intervention needed to improve the effectiveness and responsiveness of institutions' engagement with constituents. We grouped eligible interventions as follows:

- *Participation*: The intervention promoted or formalized continuous citizen input in the design and implementation of public services, processes or policies. Eligible interventions were:
  - **Participatory priority setting**, planning or budgeting, including participatory budgeting and healthcare committees, where a specific group of citizens participates in the health priority setting, planning and management of local health services.

- **Community-based natural resource management (CBNRM)** committees such as forest user groups (FUGs), participatory forest management (PFM), water user associations (WUAs).
- **Transparency:** The intervention involved the disclosure and/or dissemination of information (rules, plans, processes, prices and actions) regarding the governance of public services or institutions, with the aim of changing power relations between service providers and users. Included interventions were:
  - **Rights information**, where information provided about service user rights that allows users to demand better quality or minimum quality services.
  - **Performance information**, including score cards, in which information is disseminated about the quality of services, and public audits, in which a government line department presents their budget and achievements to their constituents.
- **Accountability:** The intervention encompassed monitoring to encourage or actively hold individuals, public service providers and institutions responsible for executing their powers and mandates according to a certain standard. Included interventions were:
  - **Citizen feedback mechanisms**, which allow citizens to feedback concerns or priorities around service delivery to providers, and / or to monitor the delivery of public service delivery. This category also includes social audits, whereby public forums bring together a service provider with local authorities, neighbors, and representatives, to monitor the delivery of a specific project.
- **Inclusion:** This covers the promotion of participation, transparency and accountability for marginalized and vulnerable groups such as women, ethnic minorities or lesbian, gay bisexual, transgender and intersex (LGBTI) people. Eligible interventions are:
  - **Quotas** for women or minority group representation in participatory budgeting (participation) or community development committee (accountability), or information provided about service user rights of women or minority groups (transparency).

#### *Types of outcome measures*

We included studies that reported outcomes measuring improvement in access to services, service behaviors, attitudes towards services, including user satisfaction, social and economic quality of life improvements for the proposed intervention, and 'state legitimacy' (state-society relations). Our inclusion criteria for outcomes were broad in order to be able to provide a full picture of the effects of the included interventions along the causal chain, described in **Table 23**.

*Primary outcomes:* intermediate outcomes were eligible that measured service access or quality (block 5 in the theory of change), use or user satisfaction (block 6) and endpoint outcomes measuring social or economic wellbeing for individuals in the relevant sector (block 7) or state legitimacy (block 8). Examples of wellbeing outcomes include: morbidity or mortality; income, wealth or poverty status; nutritional status or food security; resilience to shocks; crime rates. Studies needed to report primary outcomes relating to service delivery, wellbeing or state-society relations to be included in the review.

*Secondary outcomes:* 'immediate outcomes' measuring citizen engagement with public institutions and services, such as participation in decision-making, inclusion, transparency and accountability, and responsiveness of public services and public service delivery agents, such as public spending, leakages and corruption.

**Table 23: Types of outcomes along the causal chain**

<b>Outcome type</b>	<b>Secondary outcomes</b>		<b>Primary outcomes</b>				
<b>Causal chain area</b>	Service user engagement	Service provider response	Service access and quality	Service use	Attitudes to services	Wellbeing outcomes	State-society relations
<b>Outcomes measured in included studies</b>	Knowledge about services	Public spending	Facilities construction	Use of services: vaccination, antenatal/postnatal care, family planning	User satisfaction	Health outcomes: morbidity, mortality, fertility	Satisfaction with government
	Participation in meetings	Perceived response by users	Reliability of services	Quantity of service used (e.g. irrigation water)	Complaints reported	Nutrition	Payment of tax
	Freedom of participation	Project staff motivation	Measured quality of services available	Staff absenteeism	Perceived quality of care provided	Agricultural yields	Confidence in institutions
			Embezzlement/leakages			Income and expenditure	Perceptions about corruption
			Access to forestry or natural resources			Assets	
						Crime rates	
						Feelings of security	
						Satisfaction with life	

#### *Duration of follow-up*

We will include any follow-up duration, coding multiple outcomes where studies report multiple follow-ups. Several studies presented multiple follow-ups, which are reported in the descriptive results section.

#### *Types of settings*

Interventions could be implemented in any low- or middle-income country, as defined by the World Bank at the time the intervention was implemented.

#### *Other inclusion criteria*

We included both completed and ongoing studies, including protocols of ongoing studies that met all other inclusion criteria or studies listed in registries of ongoing impact evaluations.

We included studies published in any language, although all included studies were in English. We included studies published in 2000 or after, following Phillips et al. (2017).

Reasons for inclusion and exclusion for similar programmes based on these decision rules are given in **Table 24**.

**Table 24: Reasons for including and excluding similar interventions**

Include	Exclude	Rationale
<p>Intervention: <i>Tuungane</i> (Humphreys et al., 2012)</p> <p>Country: Democratic Republic of Congo (DRC)</p> <p>PITA: P, I</p> <p>Summary: The <i>Tuungane</i> evaluation measures the impact of the social mobilization interventions of this CDR project through an experiment in which both treatment and control communities receive a small grant, and their inclusive decision-making capacities are evaluated (P). Further, intervention communities were randomly assigned to require gender parity in decision-making groups or not, and thus the value-add of quotas for women’s participation can be isolated (I). In this case, the quotas ensure women citizens are able to contribute to community decision-making, on par with male citizens.</p>	<p>Intervention: Mandated political representation for women (Iyer et al., 2011)</p> <p>Country: India</p> <p>PITA: I</p> <p>Summary: This paper looks at the impact of introducing quotas for women’s participation in local government councils (I). However, these are elected positions wherein the incumbents are formal government employees. Thus, while such a change may impact women citizen’s access to public officials, it does not create specific opportunities for private citizens to engage with public officials.</p>	<p>Both these interventions incorporate quotas to ensure women’s participation. However, in Humphreys et al. 2012 the intervention creates quotas for women’s participation <i>in an external citizen engagement intervention</i>, whereas the Iyer et al. 2011 study targets the “I” characteristics of the formal political system, which is not the governance domain of focus for this review.</p>
<p>Intervention: Joint Forestry Management (Persha &amp; Meshack, 2016)</p> <p>Country: Tanzania</p> <p>PITA: P</p>	<p>Intervention: Decentralization of Water Supply (Asthana, 2012)</p> <p>Country: India</p> <p>PITA: T</p>	<p>Though both cases focus on the management of common-good natural resources, and both look at the impact of decentralization, the Asthana 2012 study only devolves power from one level of government to a lower level, and thus resides within the sphere of internal systems</p>

Include	Exclude	Rationale
<p>Summary: This intervention devolves control over common resource management completely, from the government to communities (P). Thus, communities are empowered to create their own rules for natural resource use, and they share accountability with the government for the enforcement of those rules.</p>	<p>Summary: This study evaluates the impact of decentralization from state-level government to local government. Thus, though the intervention was designed to reduce corruption, it does not engage citizens in the process or create specific opportunities for them to engage.</p>	<p>management, as citizens are not engaged in the process. The Persha and Meshak 2016 study, in contrast, empowers communities to create their own rules for managing natural resources, which may differ from state-level rules.</p>
<p>Intervention: Citizen Report Cards (Björkman et al., 2006)</p> <p>Country: Uganda</p> <p>PITA: A</p> <p>Summary: This study looks at the impacts of an intervention in which “report cards” of health service provision were disseminated amongst communities (T), and a series of interface meetings between service providers and citizens were organized to review the reports and identify an action plan for improvements (A).</p>	<p>Intervention: MIRA Makwanpur (Manandhar et al., 2004)</p> <p>Country: Nepal</p> <p>PITA: P</p> <p>Summary: This intervention formed community-based, participatory women’s health groups with the aim of identifying key local challenges and potential solutions (P), with the ultimate goal of improving birth outcomes.</p>	<p>Though both of these health-sector interventions work to identify challenges and develop action plans to improve outcomes, the Björkman et al. 2006 study enables citizens to hold public health providers accountable for delivering services, and jointly develops strategies for improvement to which the health providers are accountable. In Manandhar et al., 2004, the women’s groups are empowered to take responsibility for their own healthy practices; there are no requirements on the health service providers to take responsibility for addressing challenges the women identify. The intervention aims to change health outcomes <i>outside</i> the sphere of public service delivery.</p>

Include	Exclude	Rationale
<p>Intervention: Raskin subsidy identification cards (Banerjee et al., 2018)</p> <p>Country: Indonesia</p> <p>PITA: T</p> <p>Summary: This study presents the results of an experiment in which recipients of the Raskin food subsidy were sent cards confirming their right to the subsidy; an alternative intervention in which lists of eligible households in communities were publicly displayed; and a control set where there were no changes in publication of eligibility for the subsidy. The aim was to test the effect of these different transparency initiatives on reducing corruption in subsidy provision.</p>	<p>Intervention: Ciudad Mujer (Women’s City) (Bustelo et al., 2016)</p> <p>Country: El Salvador</p> <p>PITA: T</p> <p>Summary: This intervention created “one stop shops” for a variety of public services targeted to women, under the auspices of a health facility. When women arrived, they would take part in an orientation that explained all of the different services they could access at the facility, improving their knowledge of their rights to services (T).</p>	<p>Both of these interventions aim to increase citizens’ knowledge of their rights to access services (or public subsidies). However, the intervention in Bustelo et al. 2016 was purely about access to services; it did not aim to change the way that women engaged with public service providers, except to encourage them to take advantage of the services. In contrast, the experiment in Banerjee et al. 2018 had the explicit aim of attempting to reduce corruption in the subsidy programme by limiting service providers’ ability to direct who received the subsidy and who didn’t. Thus, in this latter case, the change in knowledge changes the power relations between service provider and user.</p>
<p>Intervention: random federal government audits of transfers to sub-national government and publication of results to citizens (Timmons &amp; Garfias, 2015)</p> <p>Country: Brazil</p> <p>PITA: T</p>	<p>Intervention: increase in the number of government audits (Olken 2007, audit arm)</p> <p>Country: Indonesia</p> <p>PITA: A</p>	<p>Both interventions use a ‘top-down’ audit to improve accountability. In the case of Olken 2007, the audit is undertaken by the government auditor (which constitutes an ‘internal accountability’ intervention by our definitions) and is presented to communities (which constitutes a transparency intervention for ‘external accountability’). The probability of being audited is known to be</p>

Include	Exclude	Rationale
		<p>very low in control arms, whereas it is known to be 100 per cent in treatment arms. Hence the study is not able to disentangle the effect of the internal and external accountability interventions and is therefore excluded from the review.</p>
		<p>In contrast, the probability of audit in Timmons &amp; Garfias 2015 is randomly determined; the threat is equal in all municipalities. We therefore consider that the main mechanism being evaluated is the publication of the results of the audit to citizens. The study thus evaluates the effect of providing performance information to enable citizens to hold public officials accountable, with the aim of changing power relations between public officials and citizens.</p>

## Search methods for identification of studies

We developed the systematic search strategy in consultation with an information specialist (John Eyers) to cover comprehensively the published and unpublished literature, following systematic search guidelines in Kugley et al. (2017). We also drew upon, and expanded, the search terms used in the evidence map by Philips et al. (2017) and harvested terms from the papers included in that map that were eligible for inclusion in our review. To reduce the potential for publication bias, the search included both academic databases as well specialist organizational websites, websites of bilateral and multilateral agencies and repositories of impact evaluations in international development. The full list of databases searched is below. The substantive scope of this review is cross-sectoral and therefore in addition to general sources of social science research, we searched several sector specific databases, for example databases of health, governance and public management. We searched for studies published in 2000 or after up until 2018.

Search terms for the academic databases can be found in **Appendix C**. Separate search strings were developed for the two academic health databases to capitalize on MeSH terms, to remove non-health related terms and add some specific health-related intervention terms (Medline and Global Health). The search strings combine specific intervention terms, study design terms and terms for low-and middle-income countries.

A simplified series of search strings was developed for searching the grey literature, wherein the search engines are not as sophisticated as the academic databases and cannot handle the same detailed strategy. Due to the broad scope of the review, and in order to ensure the grey literature search was exhaustive, a series of PITA search strings were developed. These focused on PITA terms such as participatory or participation. An intervention-based strategy, more similar to the academic database strategy, was piloted, but discarded due to the number of individual searches per site that were required for an exhaustive search, rendering it inefficient. Population and study type terms were not included, because the advanced search options within the grey literature search engines were not sophisticated enough to allow for an “or” limiter for each L&MIC and methodology. The broad study type term “impact evaluation” was added alongside each search to improve the relevance of results.

### *Electronic searches*

We searched the following academic databases:

- CAB Global Health (Ovid): <http://www.ovid.com/site/catalog/databases/30.jsp>
- Econlit (Ovid): <http://www.ovid.com/site/catalog/databases/52.jsp>
- Medline (Ovid): <http://www.ovid.com/site/catalog/databases/901.jsp>
- Scopus: <https://www.scopus.com/>
- Social Sciences Citation Index (SSCI) (via Web of Science): <https://webofknowledge.com/>.

We searched the following specialist organizational databases:

- CARE International: <http://www.careevaluations.org/>
- Catholic Relief Services: <https://www.crs.org/our-work-overseas/research-publications>
- Centre for Public Impact: <https://www.centreforpublicimpact.org/observatory/>

- Chemonics International: <https://www.chemonics.com/technical-areas/democracy-and-governance/>
- EGAP (Evidence in Governance and Politics): <http://www.egap.org/>
- International Growth Centre (IGC) at LSE: <https://www.theigc.org/publications/>
- International Rescue Committee (IRC): <https://www.rescue.org/reports-and-resources>
- Mercy Corps: <https://www.mercycorps.org/research>
- Oxfam International: <https://policy-practice.oxfam.org.uk/publications>
- RTI International: <https://www.rti.org/publications>
- Samuel Hall (evaluations): <http://samuelhall.org/category/publications/>
- Transparency International (TI): <https://www.transparency.org/>
- U4 Anti-Corruption Resource Centre: <http://www.u4.no/publications/>.

Bilateral and multilateral agencies and general repositories of impact evaluations in international development to be searched include:

- 3ie Repository of Impact Evaluations  
<http://www.3ieimpact.org/en/evidence/impact-evaluations/>
- 3ie RIDIE (Registry for International Development Impact Evaluations):  
<http://ridie.3ieimpact.org/>
- African Development Bank (AfDB):  
<https://www.afdb.org/en/documents/publications/>
- Asian Development Bank (ADB): <https://www.adb.org/publications>
- BREAD: <http://ibread.org/bread/papers>
- Center for Effective Global Action (CEGA): <http://cega.berkeley.edu/evidence/>
- Design, Monitoring and Evaluation for Peace:  
[www.dme4peace.org/learn/resources/](http://www.dme4peace.org/learn/resources/)
- DFID Research for Development (R4D): <http://r4d.dfid.gov.uk/>
- GEF (Global Environmental Facility) evaluation database:  
[http://www.gef.io/evaluations/all?f\[0\]=field\\_jeo\\_grouping%3A312](http://www.gef.io/evaluations/all?f[0]=field_jeo_grouping%3A312)
- Global Facility for Disaster Reduction and Recovery:  
<https://www.gfdr.org/en/publication>
- Innovations for Poverty Action (IPA): <http://www.poverty-action.org/projectevaluations>
- Inter-American Development Bank Publications:  
[https://publications.iadb.org/facet-view?locale-attribute=en&field=type\\_view](https://publications.iadb.org/facet-view?locale-attribute=en&field=type_view)
- J-Poverty Action Lab (J-PAL): <https://www.povertyactionlab.org/evaluations>
- Global Facility for Disaster Reduction and Recovery:  
<https://www.gfdr.org/en/publications>
- Locus (International Development Coalition): <https://locus.ngo/resources>
- Prevention Web (UNIDSR): <https://www.preventionweb.net/english/professional/>
- RePEc (via EBSCO Discovery): <https://www.ebscohost.com/discovery>
- World Bank E-Library (via EBSCO Discovery):  
<https://www.ebscohost.com/discovery>
- United Nations Evaluation Group: <http://www.uneval.org/evaluation/reports>
- USAID Development Clearing House:  
<https://dec.usaid.gov/dec/home/Default.aspx>.

### *Other searches*

We used the evidence gap map of state-society relations as a primary source of potential studies (Phillips et al., 2017). In addition, we screened the bibliography of existing systematic reviews and literature reviews, including Molina et al., (2016), Lynch et al. (2013) and Hanna et al. (2011). We also screened the reference lists of included studies and undertook forward citation-tracking for those studies using Google Scholar.

### *Targeted searches for studies to address review question 4*

In order to answer question 4 relating to programme design, implementation, mechanisms and context, we attempted to identify programme and project documents associated with the programmes in the impact studies identified in the first stage of the search. We did this by undertaking a targeted search for programme names and authors using Google and Google Scholar. We also screened the reference lists of included studies for programme and project documents. Evidence on context and mechanisms were collected from any studies eligible for research questions 1-4. Programme mechanisms may have been suggested by study authors or identified by the review team. In addition, we imputed contextual information not provided in included studies using international data, for example the World Development Indicators (World Bank) or the “Polity IV” governance index (Marshall et al. 2011; as also used in Lawry et al., 2014).

### *Studies to address review question 5*

We aimed to incorporate and synthesize economic evaluations and cost data that were presented in the included studies. However, only four presented any cost data. These are presented in the results section.

## **Selection of studies**

All search results were imported into EPPI-Reviewer 4 and duplicates removed. All studies were double screened against the review inclusion criteria by two independent reviewers using information available in the title and abstract, drawing on a third reviewer to resolve disagreements. If a title and abstract did not present enough information to definitively include or exclude a study, it was included for full-text screening.

At the title and abstract stage, we used innovative text mining technologies to reduce the initial screening workload (O’Mara-Eves et al., 2015). We used two functions in EPPI Reviewer 4 to do this: the priority-screening function and inclusion/ exclusion classifier (Thomas et al., 2011; O’Mara-Eves et al., *ibid*). The priority screening function can be used at the title and abstract screening stage to prioritize the items most likely to be ‘includes’ based on previously included documents. This involved double screening a random test set of citations to train the priority screening function, which learned to identify relevant records based on key-words in the title and abstract of the included and excluded studies. All team members were involved at this stage of screening. The function continues to learn as screening progresses. Using priority screening in this way allows for the identification of includable records at an earlier stage in the review process so that work can begin earlier on full-text screening and data extraction. We also used the priority screening function to classify studies into groups based on their probability of inclusion in the review. We conducted piloting and verification and excluded studies with a low probability of inclusion (<20% probability of inclusion) automatically from the

review. We screened a random 10 per cent sample of the automatically excluded studies as a check on accuracy of the function. We present the results of this process in the search results section.

Studies included for full-text screening were double screened by two independent reviewers. Disagreements on inclusion or exclusion were resolved by discussion and the input of a third reviewer if necessary.

Screening of studies intended to address research question 4 took place in a second stage of screening. Studies were assessed for relevance, that is, whether they covered one of the programmes included to answer research questions 1-3.

## **Data extraction and management**

We extracted the following descriptive, methodological, qualitative and quantitative data from each included study using a standardized data extraction form (data extraction form provided in **Appendix D**):

- Descriptive data including authors, publication date and status as well as other information to characterize the study including country, type of intervention and outcome, population, context, type of intervention.
- Methodological information on study design, analysis method, type of comparison (if relevant) and external validity.
- Quantitative data for outcome measures, including outcome descriptive information, sample size in each intervention group, outcomes means and standard deviations, test statistics (e.g. t-test, F-test, p-values, 95% confidence intervals), cost data, and so on.
- Information on intervention design, including how the intervention incorporates participation, inclusion, transparency and accountability characteristics, participant adherence, contextual factors and programme mechanisms.

We extracted quantitative data for outcomes analysis using Excel. We extracted descriptive, methodological and qualitative data using KoBo Toolbox. Descriptive and qualitative data were single coded by one reviewer and checked by a second reviewer. One reviewer also checked the coding of intervention characteristics and mechanisms coded by others.

## **Criteria for determination of independent findings**

We report data according to the intervention that the evidence was based on. We avoided double-counting of evidence and synthesis of dependent findings from multiple studies in any single analysis by linking papers prior to analysis. Where information was collected on the same programme for different outcomes at the same or different periods of time, we extracted information on the full range of outcomes over time. Where multiple outcomes were reported from different specifications, we selected the specification according to likely lowest risk of bias in attributing impact, for example the most appropriately specified outcomes equation. Where studies reported multiple outcome sub-groups for the same outcome construct (e.g. studies reporting simple, intermediate and complex knowledge), we calculated “synthetic effects” (sample weighted averages) prior to synthesis. Where studies reported multiple outcomes or evidence according to

sub-groups of participants, we reported data on relevant sub-groups separately. Further information on criteria for determining independent effect sizes is presented below.

## **Assessment of risk of bias in included studies**

We report the critical appraisal results for each included study (results and **Appendix F**).

### *Assessment of risk of bias in experimental and quasi-experimental studies (Review Questions 1-3)*

We assessed the risk of bias in the included quantitative counterfactual studies (impact evaluations) drawing on the signaling questions in the 3ie risk of bias tool which covers both internal validity and statistical conclusion validity of experimental and quasi-experimental designs (Hombrados and Waddington, 2012) and the bias domains and extensions to Cochrane's ROBINS-I tool and RoB2.0 (Sterne et al., 2016; Higgins et al., 2016). One reviewer undertook the risk of bias assessment and discussed uncertain cases with a second or third reviewer as necessary<sup>6</sup>. The risk of bias tool can be found in **Appendix D**. We did the risk of bias at the paper level, noting any potential differences in methods and risk of bias for different outcomes reported in each paper.

We assessed risk of bias based on the following criteria, coding each paper as 'Yes', 'Probably Yes', 'Probably No', 'No' and 'No Information' according to sub-questions relating to the following bias domains:

- Causal inference: factors relating to baseline confounding and biases arising from differential selection into and out of the study (attrition);
- Deviation from intended intervention: factors relating to biases due to performance bias (e.g. cross-overs, contamination, survey effects) and motivation bias (Hawthorne effects);
- Outcomes data collection: factors relating to biases in outcomes data collection (e.g. social desirability or courtesy bias, recall bias);
- Analysis reporting: factors relating to biases in methods of analysis and reporting.

We used the following decision rule to assign a risk of bias rating for each domain:

- "High risk of bias": if any of the criterion within that domain were assessed as "No" or "Probably No".
- "Some concerns": if one or several criterion within that domain were "Unclear" and none were "No" or "Probably No".
- "Low risk of bias": if all of the criterion within that domain were "Yes" or "Probably Yes".

Finally, we used the decision rule of RoB2.0 (Higgins et al., 2016) to reach an overall risk of bias judgment:

- "High risk of bias": if any of the bias domains were assessed as being "high risk".
- "Some concerns": if any of the bias domains were "some concerns" and none were "high risk".
- "Low risk of bias": if all of the bias domains were assessed as "low risk".

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<sup>6</sup> The risk of bias of each study will be independently assessed by two reviewers for the final version of the report.

### *Critical appraisal of project design and implementation (Review Question 4) and cost evidence (Review Question 5)*

It was not necessary to critically appraise the information that we extracted on programme design, implementation and context from the project documents as this information is descriptive. We aimed to assess the quality of the cost evidence, specifically cost effectiveness studies, cost-benefit or cost-efficiency studies, drawing on the approach to the appraisal of cost evidence taken in Doocy and Tappis (2016). They adapted two guides to the use and appraisal of cost evidence; the German Federal Ministry for Economic Cooperation and Development's Tools and Methods for Evaluating the Efficiency of Development Interventions (BMZ, 2011) and the Campbell Collaboration Economic Methods Policy Brief (Shemilt, 2008). However, we only identified cost data in four studies, most of which was unit cost data, and therefore we did not undertake this appraisal.

### **Measures of treatment effect**

An effect size expresses the magnitude or strength of the relationship of interest (Borenstein et al., 2009). To address questions 1, 2 and 3, we extracted data from each individual study to calculate standardized effect sizes for cross-study comparison. To ensure comparability across outcomes, we transformed each measure so that an increase indicates an improvement (hence we reversed the sign for any variables measuring negative outcomes like mortality and absenteeism).

For continuous outcomes comparing group means in a treatment and control group, we calculated the standardized mean difference (SMDs), measuring the mean difference in standardized units of the variance of the outcome. We calculated SMD as Cohen's  $d$  along with standard error using formulae provided in Borenstein et al. (2009), which we adjusted to account for small sample bias using Hedges'  $g$  method (Ellis, 2010):

$$g \cong d \left(1 - \frac{3}{4(n_1 + n_2) - 9}\right)$$

Formulae for effect size calculations were used depending on data provided in included studies. For example, for studies reporting means ( $X$ ) and pooled standard deviation (SD) for treatment (T) and control or comparison (C) at follow up (p+1) only:

$$d = \frac{x_{Tp+1} - x_{Cp+1}}{SD}$$

If the study did not report the pooled standard deviation, but reported the standard deviations of outcome in each group, we calculated SD as follows:

$$SD_{p+1} = \sqrt{\frac{(n_{Tp+1} - 1)SD_{Tp+1}^2 + (n_{Cp+1} - 1)SD_{Cp+1}^2}{n_{Tp+1} + n_{Cp+1} - 2}}$$

For studies reporting means ( $\underline{X}$ ) and standard deviations (SD) for treatment and control or comparison groups at baseline (p) and follow up (p+1):

$$d = \frac{\Delta X_{p+1} - \Delta X_p}{SD_{p+1}}$$

For studies reporting mean differences ( $\Delta X$ ) between treatment and control and standard deviation (SD) at follow up (p+1):

$$d = \frac{\Delta X_{p+1}}{SD_{p+1}} = \frac{X_{Tp+1} - X_{Cp+1}}{SD_{p+1}}$$

For studies reporting mean differences between treatment and control, standard error (SE) and sample size (n):

$$d = \frac{\Delta X_{p+1}}{SE\sqrt{n}}$$

For studies reporting regression results, we intended to follow the approach suggested by Keef & Roberts (2004) and used the regression coefficient and the pooled standard deviation of the outcome. However, in most cases, the pooled standard deviation of the outcome was unavailable, and so we used regression coefficients and standard errors or t-statistics to do the following, where sample size information was available in each group:

$$d = t \sqrt{\frac{1}{n_T} + \frac{1}{n_C}}$$

where  $n$  denotes the sample size of treatment group and control. We used the following where total sample size information ( $N$ ) was available only (as suggested in Polanin, 2016):

$$d = \frac{2t}{\sqrt{N}} \quad Var_d = \frac{4}{N} + \frac{d^2}{4N}$$

We calculated the t-statistic ( $t$ ) by dividing the regression coefficient by the standard error. If the authors only reported confidence intervals and no standard error we calculated the standard error from the confidence intervals. If the study did not report the standard error, but reported  $t$  we extracted and use this as reported by the authors. In cases in which 1 percent, 5 percent and 10 percent significance levels were reported rather than  $t$  or  $se(b)$ , then  $t$  was imputed approximately, using information about sample size, as follows:

$$Prob > 0.1: t=0.5$$

$$0.1 \geq Prob > 0.05: t = 1.58$$

$$0.05 \geq Prob > 0.01: t = 1.96$$

$$0.01 \geq Prob: t = 3.2.$$

#### *Dependent effect sizes*

Estimation of a standard meta-analytic effect size relies on the statistical assumption of independence of each included estimation of effect (Gleser & Olkin, 2007). Dependent effect sizes arise when one study provides multiple results for the same outcome of

interest, when a study has multiple treatment arms compared to the same comparison group or multiple studies use the same dataset and report on the same outcome. We therefore used rules to ensure that only statistically independent effect sizes were included in any one meta-analysis. In general, we only included one effect estimate per sample in a single meta-analysis. Where we identified several papers that reported on the same study we extracted effect size data from the most recent publication. Where studies collected multiple outcomes measuring the same underlying constructs, rather than choosing a particular outcome, we felt a more objective decision rule was to calculate the average which we then used in meta-analysis. Where different studies reported on the same programme, but used different samples (for example from different regions, or different treatment arms) we included both estimates, treating them as independent samples, provided effect sizes were measured relative to separate control or comparison groups. Where a study reported multiple effect size estimates using different specifications for the same outcome, we chose the one with the lowest risk of bias. Where studies reported multiple effect sizes according to different follow-up periods, we calculated an average effect size for any overarching analysis.

#### *Unit of analysis issues*

We assessed studies for unit of analysis errors (The Campbell Collaboration, 2014), arising when the unit of allocation of a study or treatment unit is different to the unit of analysis of outcomes data collection. If unit of analysis errors exist, we corrected for this by calculating the effective sample size ( $N_e$ ) using the following adjustment (Higgins and Green, 2011, Waddington et al., 2012):

$$N_e = \frac{N}{1 + (m - 1)c}$$

where  $N$  is the total sample size,  $m$  is the average number of observations per cluster and  $c$  is the intra-cluster correlation coefficient, assumed equal to 0.05. Where included studies used robust Huber-White standard errors to correct for clustering, we calculated the standard error of  $d$  by dividing  $d$  by the t-statistic on the coefficient of interest.

We suspected several studies to have unit of analysis errors which we corrected in effect size calculation. These studies were Capuno & Garcia (2010), and certain outcomes within Alhassan et al. (2016), Kasim (2016), Pandey et al. (2007), Palladium (2015), Touchton & Wampler, (2014), Bandyopadhyay et al. (2010), Rasamoelina et al. (2015), Persha & Meshack (2016) and Bradley & Igras (2005).

#### *Dealing with missing data*

In cases of missing or incomplete data, we reported the characteristics of the study but stated that it could not be included in the analysis due to missing data.

#### *Assessment of heterogeneity*

We assessed heterogeneity by calculating the Q-statistic,  $I^2$ , and  $\text{Tau}^2$  to provide an estimate of the amount of variability in the distribution of the true effect sizes (Borenstein et al., 2009). We complemented this with assessment of heterogeneity of effect sizes graphically using forest plots. We explore heterogeneity using moderator analysis to correlate intervention characteristics with outcomes.

### *Assessment of reporting biases*

We attempted to reduce publication bias by searching for and including unpublished studies in the review. We will also undertake exploratory tests for the presence of publication bias through the use of contour-enhanced funnel graphs (Peters et al., 2008) and statistical tests (Egger et al. 1997) for the final version of the report.

## **Data synthesis**

### *Methods of synthesis: Review questions 1-3*

Once we identified all included studies, we conducted a mapping exercise, which grouped studies under intervention, main PITA mechanism, sector and outcome measure. The inclusion criteria for the review were broad and so we used the mapping to determine appropriate categories to synthesize across. The minimum criteria for meta-analysis is usually to combine studies using meta-analysis when we identify two or more effect sizes using a similar outcome construct and where the comparison group state is judged to be similar across the two, similar to the approach taken by Wilson et al. (2011).

We conducted separate analyses by primary outcome (*review question 1*):

- service delivery and access (quantity and quality)
- service use
- attitudes to services
- wellbeing outcomes
- state-society relations.

We also analyzed the intervention mechanisms by analyzing secondary outcomes by intervention type (*review question 2*):

- service user and citizen engagement (demand-side behaviors)
- service provider and public servant response (supply-side behaviors).

Finally, we explored heterogeneity in effects by intervention type, region and effects for particular sub-groups of participants (*review question 3*).

As heterogeneity exists in theory due to the variety of interventions and contexts included, we used inverse-variance weighted, random effects meta-analytic models (Higgins & Green, 2011). We used Stata's *metan* command (Sterne et al., 2008) to generate the meta-analyses and forest plots.

### *Methods of synthesis: Review question 4*

In the context of 'real world' programmes, we are often concerned about project design and implementation quality as the principal reasons why programme evaluations show limited impacts, which is partly why advocates of mixed-methods evaluation approaches recommend collecting implementation process data (e.g. Bamberger et al., 2010). We used a realist-informed framework synthesis approach to extract information from project design and implementation documents and included impact studies on context, implementation and mechanisms.

Framework synthesis starts with the identification or development of a framework to guide the analysis that highlights key factors that help understand or predict heterogeneity across results, which is built out through in-depth reading of included studies to include additional relevant themes against which studies are coded and

reviewed to identify patterns (Snilstveit et al., 2012). Framework synthesis is well-placed to handle complexity across interventions and contexts and is amenable to the use of a wide range of potential sources of data, including ‘thin’ evidence (evidence based on surveys and quantitative data, as compared to ‘thick’ qualitative data), policies and implementation documents (such as proposals or monitoring reports) (*ibid.*).

Realist synthesis highlights variation in programme design in explaining differences in outcomes across contexts (Pawson, 2006). Realists argue that the effectiveness of a programme depends on the combined action of the behavioral mechanisms underlying it and the context in which it takes place. Behavioral mechanisms operate through the values, beliefs and past experiences of individuals in the social system. Thus, factors such as interpersonal networks and individual agency are important in the adoption and rejection of an intervention. The action of mechanisms depends in part on the context in which they are used. Behavior change is achieved via the entire system of social relationships (the context) and, therefore, an intervention geared towards the achievement of behavior change must be aligned with the context in which it is used (Waddington et al., 2009). The approach that draws these concepts together is called context-mechanism-outcome (CMO) synthesis. There are different ways of conducting CMO synthesis including iterations of a causal model (e.g. theory of change diagram) (Waddington et al., 2014), CMO tables (Petrosino et al., 2012) and qualitative comparative analysis (QCA) (Ton et al., 2017).

Van der Knapp et al. (2006) is possibly the first example of a systematic review that explicitly incorporates context-mechanism-outcome synthesis. These authors indicate that the CMO synthesis is undertaken after the systematic review and meta-analysis. The broad approach is as follows:

- Information on possible programme mechanisms was collected from studies during the coding phase. We searched included studies for information about how or why the intervention is supposed to work, following Van der Knapp et al., who state that “The focus in such a classification can be on behavioral and social ‘cogs and wheels’ of the intervention... but could also include administrative or legal mechanisms.” (p.6). As noted in more detail below, we then identified and coded mechanisms associated with particular broad intervention groups and PITA elements.
- Information on contextual factors was collected during the coding phase. This was partly contained in the detailed information about the comparison condition, co-interventions and background information about participants collected from included studies and project and programme design and implementation documents, and key contextual information collected from international datasets.

CMO is largely an iterative process, and thus the full list of CMO codes for analysis was developed as part of the synthesis. Initially, we drew on potential codes identified in the protocol, including contextual conditions and enabling conditions, including: systemic and social levels targeted by the intervention; whether the intervention is designed to build off of and work within local systems of power relations and social norms that uphold the social contract between the State and society (as in Halloran’s “accountability ecosystem”, 2015; the political salience of the public service targeted (Mcloughlin and Batley, 2012); or the relative power of proponents versus opponents in the adoption

phase of the policy cycle (Resnick et al, 2015). Where key enabling conditions are already in place, an intervention effectively designed may be successfully implemented in isolation; where key conditions are missing, the intervention design may need to be adjusted or expanded to include complementary interventions that seek to strengthen the enabling environment. For example, an intervention seeking to build transparency and accountability through open data interventions may need to build a coalition of support that engages people at the point in the system targeted for data release, upstream, downstream, and externally to create an environment in which data is provided, demanded, and used (Hogge, 2010). These enabling conditions may change depending on context factors such as the target level of the intervention- whether it targets service delivery at community, sub-national, or national level (E-Pact Consortium, 2016) or whether the external stakeholders it seeks to engage are organized civil society or interest groups, marginalized or vulnerable groups, or citizens and service users more broadly (McGee and Gaventa, 2010). We further conducted more detailed analysis of whether the bottleneck for good governance is likely to be properly identified as resting with citizens (e.g. lack of organization, lack of knowledge/capacity), with the system (e.g. lack of opportunities for citizens to engage), or with individual service providers (e.g. power relations, corruption).

The combination of realist-informed framework synthesis that moved towards “best fit” framework synthesis was selected as the most appropriate method to link the meta-analysis with context and mechanism information given the complexity and heterogeneity of included interventions.

In our analysis, we began with the theory of change developed during the protocol as the overarching framework, which we built out into a template to include the series of additional potential explanatory factors identified in the protocol regarding the enabling conditions that allow for project success, and systemic and social levels targeted by the intervention. Data from the studies was then extracted along the framework, including coding that identified the source of the data to maintain clarity between first, second and third order constructs. Each extracted data was coded as being sourced from: observations from implementers; insight reported by participants (i.e. quotes, first order constructs); survey by researcher; commentary by researcher (i.e. researcher interpretation of results, second order constructs); or commentary by reviewer (i.e. interpretation based on insights from synthesis, third order constructs). The goal of framework synthesis is to draw conclusions that explain relationships between study findings, with a focus on explaining heterogeneity of results due to variations in context, intervention design and implementation quality. We focused on extracting data that enabled the identification of mechanisms, moderators, and other explanatory factors along the causal chain.

Following the extraction and analysis of data across the framework, interventions were organized according to broad intervention group and key PITA mechanism. Critical case comparisons were identified to evidence the role of moderators in triggering different mechanisms under different contexts. Moving towards “best fit” framework synthesis, which is more iterative and focused on building programme theories (Carroll et al., 2013), we analyzed the emerging patterns of moderators and mechanisms within each set of interventions to identify those that most frequently or persuasively facilitated sense-making of the results of each study. These insights were used to create composite

frameworks for each group of interventions that refine the initial framework based on the findings from the qualitative synthesis. Thus, we more precisely highlight intervention-specific mechanisms and moderators influencing movement along the causal chain.

#### *Methods of synthesis: Review question 5*

We aimed to draw on standard approaches to synthesize economic appraisal evidence (Shemilt et al., 2011; Shemilt et al., 2008). However, we only identified four studies reporting cost data and therefore we simply report the cost data that we identified in a table in the results section.

#### *Investigation of heterogeneity*

The following moderator variables were collected, as indicated in the protocol:

- Methodology: study design, risk of bias status, timing of evaluation (follow-up length).
- Intervention characteristics: intervention, PITA characteristic, sector, co-interventions (whether an intervention is implemented in isolation or as part of an integrated programme)
- Context variables: region, country income level, democracy policy index score.
- Participant characteristics: e.g. sex, socio-economic status.

#### *Deviations from protocol*

We discussed exploring the possibility of applying alternate methods to link the meta-analysis with context and mechanism information, such as QCA (Befani, 2016). QCA articulates the associations between empirical effects and context and mechanism conditions drawing on “truth-tables” which articulate all possible instances of conditions and show which cases share the same combination of conditions. We noted that the application of QCA is limited by the number of included studies, their comparability and the completeness of reporting within them, hence the application of QCA was not feasible in this review. We were unable to apply QCA to our review due to number of included studies, their comparability and the completeness of reporting within them. Instead we used realist-informed framework synthesis that moved towards “best fit” framework synthesis to explore context and mechanism information.

## Appendix B: Authors and sources of support

### Review authors

**Lead review author:** The lead author is the person who develops and co-ordinates the review team, discusses and assigns roles for individual members of the review team, liaises with the editorial base and takes responsibility for the on-going updates of the review.

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## Roles and responsibilities

- **Content:** The substantive component of the analysis was undertaken by Ada Sonnenfeld (AS), Jennifer Stevenson (JS) and Hugh Waddington (HW), who provided additional inputs on intervention design and outcomes. The team were supported by an advisory group of academics and policy makers with specific expertise in governance.
- **Information retrieval:** AS and JS designed the electronic search terms, which were developed in platform search protocols by John Eyers. AS and JS undertook the screening of titles and abstracts and online sources. AS, JS and HJW screened studies at full text.
- **Data collection:** AS, JS and HW collected descriptive data from included studies. JS and HW extracted effect size data. Juliette Finetti, JS and HW did the risk of bias assessment. Denny John from the Campbell Collaboration extracted information on unit costs.
- **Statistical analysis and framework synthesis:** HW conducted the meta-analysis. AS did the framework synthesis. All authors contributed to the discussion and implications.

## Sources of support

We are grateful for financial support from the United States Agency for International Development (USAID) via NORC project number 7554.070.01.

We thank Daniel Phillips (NatGen) for coordinating the peer review. Helpful inputs were given at various stages of the review process by the Campbell Collaboration Methods Group, three anonymous referees, USAID and the following stakeholder advisory group members:

- Andrew Greer, USAID
- Annette Brown, FHI360
- Courtney Tolmey, Results for Development
- Erik Wibbels, USAID
- Guy Grossman, University of Pennsylvania
- Joanne Trotter, Aga Khan Foundation
- Laura Adams, USAID
- Morgan Holmes, USAID.

Finally, we are also grateful to Rohini Pande for helpful advice at the scoping stage of the review.

## Declarations of interest

None of the team members have any financial interests in the review or have worked on primary research covering the interventions covered by the review.

## Plans for updating the review

The authors will undertake, or contribute to, updates once resources are identified and relevant studies become available.

## Appendix C: Detailed search strategy

### Example search strategy for social science database

#### Web of Science (Social Sciences Citation Index):

#26 AND #11 AND #5

# 28

#27 AND #26 AND #5

# 27

TS=("random\* control\* trial\*" or "random\* trial\*" or RCT or "propensity score matching" or PSM or "regression discontinuity design" or RDD or "difference in difference\*" or DID or difference-in-difference or evaluat\* or matching or "interrupted time series" or (random\* NEAR/3 allocat\*) or "instrumental variable\*" or IV or ((quantitative or "comparison group" or counterfactual or "counter factual" or counter-factual or experiment\* or quasi-experimental or "quasi experimental" ) NEAR/3 (design or study or analysis)) or QED or "field experiment" or "field trial")

# 26

#25 OR #24 OR #23 OR #22 OR #21 OR #20 OR #19 OR #18 OR #17 OR #16 OR #15 OR #14 OR #13 OR #12

# 25

TS=(((sms OR "short message\*" OR "text message\*" OR bulk-messag\* OR "bulk messag\*" OR mass-messag\* OR "mass messag\*" OR "public awareness" OR engagement OR information) NEAR/3 (campaign\* OR strategy OR strategies)) OR "information dissemination")

# 24

TS=("standard service\*" OR standard-service\* OR standardized-service\* OR standardized-service\* OR "standardized service\*" OR "standardized service\*")

# 23

TS=((service\* OR one-stop OR "one stop") NEAR/1 (center\* OR center\* OR shop\*)) OR TS=((communit\* OR community-based) NEAR/3 monitor\*)

# 22

TS=(("social\* accountab\*") NEAR/2 (mechanism\* OR system\* OR arrange\* OR organi\* OR regulat\*)) OR TS=((social OR public) NEAR/1 audit)

# 21

TS=("report card\*" OR reportcard\* OR report-card\* OR "score card\*" OR scorecard\* OR score-card\*) OR TS=("political reserv\*" OR "reserved place\*" OR "reserved position\*" OR "reserved seat\*")

# 20

TS=("e governance" OR e-governance OR egovernance OR "electronic governance") OR TS=((politic\* NEAR/3 (inclus\* OR participat\* OR quota OR quotas)) OR (quota\* NEAR/3 participat\*))

# 19

TS((((disaster\* OR disaster-risk\*) NEAR/6 (respond\* OR response\* OR management OR reduc\* OR preparedness)) OR DRR) NEAR/3 (committee\* OR council\* OR association\* OR shura))

# 18

TS=((communit\* OR district\* OR cluster OR cluster-level) NEAR/6 development NEAR/3 (committee\* OR council\* OR association\* OR shura))

# 17

TS(("natural resource\*" OR natural-resource\* OR NRM OR "common property" OR common-property OR "common resource\*" OR common-resource\* OR water-use\* OR "water use\*" OR "water management" OR water-management OR land-use\* OR "land use\*" OR land-management OR "land management" OR irrigat\*) NEAR/6 (participat\* OR transparen\* OR inclus\* OR represent\* OR consult\* OR community\* OR committee\* OR council\* OR association\* OR group\* OR shura))

# 16

TS=((health OR healthcare OR hospital\*) NEAR/3 (committee\* OR "action group\*" OR council\* OR association\* OR shura))

# 15

TS=((inclus\* OR particip\* ) NEAR/6 (strateg\* OR action\* OR budget\* OR development OR plan\*))

# 14

TS=("community engagement" OR "community consultation\*" OR (civic NEAR/3 education))

# 13

TS=((communit\* OR inclus\* OR particip\*) NEAR/6 (((climate-change OR "climate change") NEAR/2 (adapt\* OR mitigat\* OR vulnerab\*)) or resilien\*))

# 12

TS=(((disaster\* NEAR/2 reduc\* NEAR/2 risk\*) OR (disaster\* NEAR/2 (respond\* OR response\* OR manag\*)) OR ((hazard\* OR risk\* OR vulnerab\*) NEAR/2 (map\* OR assess\*)) OR HVA OR HVRA OR DRR) NEAR/6 (participat\* OR inclus\* OR consult\* OR communit\*))

# 11

#10 OR #9 OR #8 OR #7 OR #6

# 10

TS=(economic NEAR/2 model\*)

# 9

TS=("cost minimi\*" OR "cost-utilit\*" OR "health utilit\*" OR "economic evaluation\*" OR "economic review\*" OR "cost outcome" OR "cost analys\*" OR "economic analys\*" OR "budget\* impact analys\*")

# 8

TS=(cost-effective\* OR cost-benefit OR costs)

# 7

TS=("life year" OR "life years" OR qaly\* OR daly\*)

# 6

TS=((cost OR economic\*) AND (costs OR cost-effectiveness OR markov))

# 5

#4 OR #3 OR #2 OR #1

# 4

TS=((Imic or Imics or "third world" or "lami countr\*")) OR TS=("transitional countr\*")

# 3

TS=(((developing or "less\* developed" or "under developed" or underdeveloped or "middle income" or "low\* income") NEAR/1 (economy or economies))) OR TS=((low\* NEAR/1 (gdp or gnp or "gross domestic" or "gross national"))) OR TS=((low NEAR/3 middle NEAR/3 countr\*))

# 2

TS=("Developing Countries") OR TS=(Africa or Asia or Caribbean or "West Indies" or "South America" or "Latin America" or "Central America") OR TS=(((developing or "less\* developed" or "under developed" or underdeveloped or "middle income" or "low\* income" or underserved or "under served" or deprived or poor\*) NEAR/1 (countr\* or nation\* or population\* or world)))

# 1

TS=((Afghanistan or Albania or Algeria or Angola or Argentina or Armenia or Armenian or Aruba or Azerbaijan or Bangladesh or Benin or Byelarus or Byelorussian or Belarus or Belorussian or Belorussia or Belize or Bhutan or Bolivia or Bosnia or Herzegovina or Hercegovina or Botswana or Brasil or Brazil or Bulgaria or "Burkina Faso" or "Burkina Fasso" or "Upper Volta" or Burundi or Urundi or Cambodia or "Khmer Republic" or Kampuchea or Cameroon or Cameroons or Cameron or Camerons or "Cape Verde" or "Central African Republic" or Chad or China or Colombia or Comoros or "Comoro Islands" or Comores or Mayotte or Congo or Zaire or "Costa Rica\*" or "Cote d'Ivoire" or "Ivory Coast" or Cuba or Djibouti or "French Somaliland" or Dominica or "Dominican Republic" or "East Timor" or "East Timur" or "Timor Leste" or Ecuador or Egypt or "United Arab Republic" or "El Salvador" or Eritrea or Ethiopia or Fiji or Gabon or "Gabonese Republic" or Gambia or Gaza or "Georgia Republic" or "Georgian Republic" or Ghana or Grenada or Guatemala or Guinea or Guiana or Guyana or Haiti or Hungary or Honduras or India or Maldives or Indonesia or Iran or Iraq or Jamaica or Jordan or Kazakhstan or Kazakh or Kenya or Kiribati or Korea or Kosovo or Kyrgyzstan or Kirghizia or "Kyrgyz Republic" or Kirghiz or Kirgizstan or "Lao PDR" or Laos or Lebanon or Lesotho or Basutoland or Liberia or Libya or Macedonia or Madagascar or "Malagasy Republic" or Malaysia or Malaya or Malay or Sabah or Sarawak or Malawi or Mali or "Marshall Islands" or Mauritania or Mauritius or "Agalega Islands" or Mexico or Micronesia or "Middle East" or Moldova or Moldovia or Moldovian or Mongolia or Montenegro or Morocco or Ifni or Mozambique or Myanmar or Myanma or Burma or Namibia or Nepal or "Netherlands Antilles" or "New Caledonia" or Nicaragua or Niger or Nigeria or Pakistan or Palau or Palestine or Panama or Paraguay or Peru or Philippines or Philipines or Phillipines or Phillippines or "Puerto Ric\*" or Romania or Rumania or Roumania or Rwanda or Ruanda or "Saint Lucia" or "St Lucia" or "Saint Vincent" or "St Vincent" or Grenadines or Samoa or "Samoan Islands" or "Navigator Island" or "Navigator Islands" or "Sao Tome" or Senegal or Serbia or Montenegro or Seychelles or "Sierra Leone" or "Sri Lanka" or "Solomon Islands" or Somalia or "South Africa" or Sudan or Suriname or Surinam or Swaziland or Syria or Tajikistan or Tadzhiestan or Tadjikistan or Tadzhiik or Tanzania or Thailand or Togo or Togolese Republic or Tonga or Tunisia or Turkey or Turkmenistan or Turkmen or Uganda or Ukraine or Uzbekistan or Uzbek or Vanuatu or "New Hebrides" or Venezuela or Vietnam or "Viet Nam" or "West Bank" or Yemen or Yugoslavia or Zambia or Zimbabwe) NOT ("African-American\*" OR "African-American\*" OR "Mexican American\*" OR "American Indian\*" OR "Asian American\*" OR "native american\*"))

### **Example search strategy for health databases**

#### **Ovid MEDLINE:**

1 ((Afghanistan or Albania or Algeria or Angola or Argentina or Armenia or Armenian or Aruba or Azerbaijan or Bangladesh or Benin or Byelarus or Byelorussian or Belarus or Belorussian or Belorussia or Belize or Bhutan or Bolivia or Bosnia or Herzegovina or Hercegovina or Botswana or Brasil or Brazil or Bulgaria or "Burkina Faso" or "Burkina Fasso" or "Upper Volta" or Burundi or Urundi or Cambodia or "Khmer Republic" or Kampuchea or Cameroon or Cameroons or Cameron or Camerons or "Cape Verde" or "Central African Republic" or Chad or China or Colombia or Comoros or "Comoro

Islands" or Comores or Mayotte or Congo or Zaire or "Costa Rica\*" or "Cote d'Ivoire" or "Ivory Coast" or Cuba or Djibouti or "French Somaliland" or Dominica or "Dominican Republic" or "East Timor" or "East Timur" or "Timor Leste" or Ecuador or Egypt or "United Arab Republic" or "El Salvador" or Eritrea or Ethiopia or Fiji or Gabon or "Gabonese Republic" or Gambia or Gaza or "Georgia Republic" or "Georgian Republic" or Ghana or Grenada or Guatemala or Guinea or Guiana or Guyana or Haiti or Hungary or Honduras or India or Maldives or Indonesia or Iran or Iraq or Jamaica or Jordan or Kazakhstan or Kazakh or Kenya or Kiribati or Korea or Kosovo or Kyrgyzstan or Kirghizia or "Kyrgyz Republic" or Kirghiz or Kirgizstan or "Lao PDR" or Laos or Lebanon or Lesotho or Basutoland or Liberia or Libya or Macedonia or Madagascar or "Malagasy Republic" or Malaysia or Malaya or Malay or Sabah or Sarawak or Malawi or Mali or "Marshall Islands" or Mauritania or Mauritius or "Agalega Islands" or Mexico or Micronesia or "Middle East" or Moldova or Moldovia or Moldovian or Mongolia or Montenegro or Morocco or Ifni or Mozambique or Myanmar or Myanma or Burma or Namibia or Nepal or "Netherlands Antilles" or "New Caledonia" or Nicaragua or Niger or Nigeria or Pakistan or Palau or Palestine or Panama or Paraguay or Peru or Philippines or Philipines or Phillipines or Phillippines or "Puerto Ric\*" or Romania or Rumania or Roumania or Rwanda or Ruanda or "Saint Lucia" or "St Lucia" or "Saint Vincent" or "St Vincent" or Grenadines or Samoa or "Samoan Islands" or "Navigator Island" or "Navigator Islands" or "Sao Tome" or Senegal or Serbia or Montenegro or Seychelles or "Sierra Leone" or "Sri Lanka" or "Solomon Islands" or Somalia or "South Africa" or Sudan or Suriname or Surinam or Swaziland or Syria or Tajikistan or TadzhiKistan or Tadjikistan or TadzhiK or Tanzania or Thailand or Togo or Togolese Republic or Tonga or Tunisia or Turkey or Turkmenistan or Turkmen or Uganda or Ukraine or Uzbekistan or Uzbek or Vanuatu or "New Hebrides" or Venezuela or Vietnam or "Viet Nam" or "West Bank" or Yemen or Yugoslavia or Zambia or Zimbabwe) not ("African-American\*" or "African-American\*" or "Mexican American\*" or "American Indian\*" or "Asian American\*" or "native american\*")).ti,ab,hw.

2 ("Developing Countries" or Africa or Asia or Caribbean or "West Indies" or "South America" or "Latin America" or "Central America" or ((developing or "less\* developed" or "under developed" or underdeveloped or "middle income" or "low\* income" or underserved or "under served" or deprived or poor\*) adj1 (countr\* or nation\* or population\* or world))).ti,ab,hw,kw.

3 (((developing or "less\* developed" or "under developed" or underdeveloped or "middle income" or "low\* income") adj1 (economy or economies)) or (low\* adj1 (gdp or gnp or "gross domestic" or "gross national"))) or (low adj3 middle adj3 countr\*).ti,ab,hw,kw. (9725)

4 (Imic or Imics or "third world" or "lami countr\*" or "transitional countr\*").ti,ab,hw,kw. (5281)

5 or/1-4

6 ("random\* control\* trial\*" or "random\* trial\*" or RCT or "propensity score matching" or PSM or "regression discontinuity design" or RDD or "difference in difference\*" or DID or difference-in-difference or evaluat\* or matching or "interrupted time series" or (random\* adj3 allocat\*) or "instrumental variable\*" or IV or ((quantitative or "comparison

group" or counterfactual or "counter factual" or counter-factual or experiment\* or quasi-experimental or "quasi experimental") adj3 (design or study or analysis)) or QED or "field experiment" or "field trial").ti,ab,hw,kw.

7 exp Randomized Controlled Trial/ or Randomized Controlled Trials as Topic/ or random allocation/ or Propensity Score/ or Quasi-Experimental Studies/ or Controlled Before-After Studies/ or Interrupted Time Series Analysis/

8 6 or 7

9 (((communit\* or village\* or stakeholder\*) adj3 (engag\* or consult\* or meeting\* or outreach\* or represent\* or participat\* or network)) or (civic adj3 education) or audit or "social responsibility" or (moral\* adj2 obligat\*)).ti,ab,hw,kw.

10 Community Participation/ or Community Networks/ or Stakeholder Participation/ or Social responsibility/ or Moral Obligations/ or Management Audit/

11 ((inclus\* or participat\*) adj6 (strateg\* or action\* or budget\* or plan\*)).ti,ab,hw,kw.

12 ((health or healthcare or hospital\* or women\* or communit\*) adj3 (committee\* or "action group\*" or council\* or association\* or shura)).ti,ab,hw,kw.

13 (((disaster\* or disaster-risk\*) adj6 (respond\* or response\* or management or reduc\* or preparedness)) or DRR) adj3 (committee\* or council\* or association\* or shura)).ti,ab,hw,kw.

14 ("e governance" or e-governance or egovernance or "electronic governance").ti,ab,hw,kw.

15 ("report card\*" or reportcard\* or report-card\* or "score card\*" or scorecard\* or score-card\*).ti,ab,hw,kw.

16 ((accountab\* adj2 (mechanism\* or system\* or arrange\* or organi\* or regulat\*)) or ((social or public) adj1 audit) or ((communit\* or community-based) adj3 monitor\*)).ti,ab,hw,kw.

17 ((service\* or one-stop or "one stop") adj1 (centre\* or center\* or shop\*)).ti,ab,hw,kw.

18 ("standard service\*" or standard-service\* or standardized-service\* or standardised-service\* or "standardized service\*" or "standardised service\*").ti,ab,hw,kw.

19 Mass Media/ or Electronic Mail/ or Internet/ or Text Messaging/ or Communication/ or Health promotion/ or Consumer Health Information/ or Information Dissemination/

20 (((sms or "short message\*" or "text message\*" or bulk-messag\* or "bulk messag\*" or mass-messag\* or "mass messag\*" or "public awareness" or engagement or information or "mass media" or email or e-mail or "electronic mail" or internet or communicat\*) adj3 (campaign\* or strategy or strategies)) or "health promot\*" or "consumer health information" or (information\* adj2 disseminat\*)) and (entitle\* or rights or (health adj1 (service\* or provider\*) adj3 performance\*) or "service provision").ti,ab,hw,kw

- 21 or/9-20
- 22 5 and 8 and 21
- 23 limit 22 to yr="2000 -Current\*
- 24 exp health facilities/ or Delivery of Health Care/ or Regional Health Planning/
- 25 (hospital or hospitals or infirmary or infirmaries or clinic or clinics or ((health or medical) adj (centre\* or center\* or facilit\*)) or (deliver\* adj2 ("health care" or healthcare or "health service\*")) or (plan\* adj2 region\* adj2 health)).ti,ab,hw,kw.
- 26 24 or 25
- 27 23 and 26

**Table 25: Search record for online repositories**

ID	Site name	URL	Search start	Search end	Num. hits	Num. studies included in in-depth assessment
1	EGAP (Evidence in Governance and Politics)	<a href="http://egap.org/biblio">http://egap.org/biblio</a>	05/03/18	05/03/18	233	3
2	World Bank Open Knowledge Repository	<a href="https://openknowledge.worldbank.org/">https://openknowledge.worldbank.org/</a>	06/03/18	08/03/18	2106	11
3	3ie Repository of Impact Evaluations	<a href="http://www.3ieimpact.org/en/evidence/impact-evaluations/">http://www.3ieimpact.org/en/evidence/impact-evaluations/</a>	08/03/18	12/03/18	566	17
4	Innovations for Poverty Action (IPA)	<a href="http://www.poverty-action.org/search-studies">http://www.poverty-action.org/search-studies</a>	13/03/18	13/03/18	47	6
5	J-Poverty Action Lab (J-PAL)	<a href="https://www.povertyactionlab.org/evaluations">https://www.povertyactionlab.org/evaluations</a>	13/03/18	13/03/18	147	11
6	Design, Monitoring and Evaluation for Peace	<a href="http://www.dmeforpeace.org/learn/resources/">www.dmeforpeace.org/learn/resources/</a>	13/03/18	13/03/18	35	0
7	United Nations Evaluation Group	<a href="http://www.uneval.org/evaluation/reports">http://www.uneval.org/evaluation/reports</a>	13/03/18	13/03/18	0	0
8	Oxfam International	<a href="https://policy-practice.oxfam.org.uk/publications">https://policy-practice.oxfam.org.uk/publications</a>	19/03/18	19/03/18	19	2
9	CARE International	<a href="http://www.careevaluations.org/">http://www.careevaluations.org/</a>	19/03/18	19/03/18	7	0
10	Mercy Corps	<a href="https://www.mercycorps.org/research">https://www.mercycorps.org/research</a>	19/03/18	19/03/18	5	0
11	Catholic Relief Services	<a href="https://www.crs.org/our-work-overseas/research-publications">https://www.crs.org/our-work-overseas/research-publications</a>	20/03/18	20/03/18	1	0
12	DFID Research for Development (R4D)	<a href="http://r4d.dfid.gov.uk/">http://r4d.dfid.gov.uk/</a>	20/03/18	20/03/18	79	1

ID	Site name	URL	Search start	Search end	Num. hits	Num. studies included in in-depth assessment
13	IDEAS / REPEC	<a href="https://ideas.repec.org/">https://ideas.repec.org/</a>	20/03/18	21/03/18	476	2
14	BREAD	<a href="http://ibread.org/bread/papers">http://ibread.org/bread/papers</a>	21/03/18	21/03/18	16	0
15	Locus (International Development Coalition)	<a href="https://locus.ngo/resources">https://locus.ngo/resources</a>	21/03/18	21/03/18	1	0
16	GEF (Global Environmental Facility) evaluation database	<a href="http://www.gefio.org/evaluations/all?f[0]=field_ieo_grouping%3A312">http://www.gefio.org/evaluations/all?f[0]=field_ieo_grouping%3A312</a>	27/03/18	27/03/18	34	0
17	Global Facility for Disaster Reduction and Recovery	<a href="https://www.gfdr.org/en/publications">https://www.gfdr.org/en/publications</a>	28/03/18	28/03/18	0	0
18	Samuel Hall (evaluations)	<a href="http://samuelhall.org/category/publications/">http://samuelhall.org/category/publications/</a>	28/03/18	28/03/18	0	0
19	IFPRI	<a href="http://www.ifpri.org/publications">http://www.ifpri.org/publications</a>	28/03/18	28/03/18	6	0
20	LSE ICG	<a href="https://www.theigc.org/search/?select-post_type%5B%5D=publication">https://www.theigc.org/search/?select-post_type%5B%5D=publication</a>	28/03/18	28/03/18	0	0
21	3ie RIDIE (Registry for International Development Impact Evaluations)	<a href="http://ridie.3ieimpact.org/">http://ridie.3ieimpact.org/</a>	28/03/18	28/03/18	8	1
22	Open Governance Partnership	<a href="https://www.opengovpartnership.org/resources/all-resources">https://www.opengovpartnership.org/resources/all-resources</a>	28/03/18	28/03/18	0	0
23	CGIAR: Consultative Group on	<a href="https://cgspace.cgiar.org/handle/10568/83389">https://cgspace.cgiar.org/handle/10568/83389</a>	28/03/18	28/03/18	299	0

ID	Site name	URL	Search start	Search end	Num. hits	Num. studies included in in-depth assessment
	International Agricultural Research					
24	Asian Development Bank (ADB)	<a href="https://www.adb.org/publications">https://www.adb.org/publications</a>	28/03/18	28/03/18	31	0
25	Center for Effective Global Action (CEGA)	<a href="http://cega.berkeley.edu/evidence/">http://cega.berkeley.edu/evidence/</a>	28/03/18	28/03/18	34	1
26	ICNL Research Centre	<a href="http://www.icnl.org/research/library/ol/">http://www.icnl.org/research/library/ol/</a>	28/03/18	28/03/18	0	0
27	RTI International	<a href="https://www.rti.org/publications">https://www.rti.org/publications</a>	28/03/18	28/03/18	15	0
28	Chemonics International	<a href="https://www.chemonics.com/technical-areas/democracy-and-governance/">https://www.chemonics.com/technical-areas/democracy-and-governance/</a>	28/03/18	28/03/18	3	0
29	USAID Development Clearing House	<a href="https://dec.usaid.gov/dec/home/Default.aspx">https://dec.usaid.gov/dec/home/Default.aspx</a>	28/03/18	28/03/18	36	0
30	Inter-American Development Bank Publications	<a href="https://publications.iadb.org/facet-view?locale-attribute=en&amp;field=type_view">https://publications.iadb.org/facet-view?locale-attribute=en&amp;field=type_view</a>	29/03/18	29/03/18	63	1
31	African Development Bank (AfDB)	<a href="https://www.afdb.org/en/documents/publications/">https://www.afdb.org/en/documents/publications/</a>	29/03/18	29/03/18	23	0
32	AgEcon	<a href="https://ageconsearch.umn.edu/?ln=en">https://ageconsearch.umn.edu/?ln=en</a>	29/03/18	29/03/18	79	0
33	Prevention Web (UNIDSR)	<a href="https://www.preventionweb.net/english/professional/">https://www.preventionweb.net/english/professional/</a>	29/03/18	29/03/18	111	1
34	AGRIS	<a href="http://agris.fao.org/agris-search/index.do">http://agris.fao.org/agris-search/index.do</a>	29/03/18	29/03/18	220	1
35	Transparency International (TI)	<a href="https://www.transparency.org/">https://www.transparency.org/</a>	29/03/18	29/03/18	0	0

<b>ID</b>	<b>Site name</b>	<b>URL</b>	<b>Search start</b>	<b>Search end</b>	<b>Num. hits</b>	<b>Num. studies included in in-depth assessment</b>
36	U4 Anti-Corruption Resource Centre	<a href="http://www.u4.no/publications/">http://www.u4.no/publications/</a>	29/03/18	29/03/18	0	0
37	Centre for Public Impact	<a href="https://www.centreforpublicimpact.org/observatory/">https://www.centreforpublicimpact.org/observatory/</a>	29/03/18	29/03/18	11	0
38	World Vision	<a href="http://www.wvi.org/resources">http://www.wvi.org/resources</a>	29/03/18	29/03/18	123	0
39	IRC	<a href="https://www.rescue.org/reports-and-resources">https://www.rescue.org/reports-and-resources</a>	29/03/18	29/03/18	0	0
40	Independent Development Evaluation, AfDB	<a href="http://idev.afdb.org/en/page/evaluations">http://idev.afdb.org/en/page/evaluations</a>	29/03/18	29/03/18	2	1

## Appendix D: Data extraction forms

### Study characteristics coding tool

The study descriptive characteristics were extracted using the survey tool KoBo Toolbox. The full survey tool will be available in the online Annexes. The question headings are presented here:

#### 1: Report Identification

- Unique study ID
- First author and short title
- Other papers used for coding
- Study publication date
- Publication type
- Funding agency type(s)
- Funding agency name(s)
- Independence of the evaluation
- Independent data collection
- Conflict of interest
- Comments on conflict of interest
- Ethical clearance
- Name of Ethics Board reviewing and clearance number
- Language of publication
- Other methods
- Any other relevant information you'd like to add for this section?

#### 2: Context

- Country
- Detailed location
- World Bank region
- WB income category
- Country performance - governance indicators
- Any other relevant information you'd like to add for this section?

#### 3: Intervention Descriptives

- Programme or project name
- Intervention type
- PITA type(s)
- Intervention sector
- Intervention description
- Objectives of the intervention
- Intervention scale
- Intervention development
- Intervention implementing agency
- Intervention funding agency type
- Intervention funding agency name
- Intervention target group
- Targeting methods
- Intervention start date
- Intervention end date
- Any other relevant information you'd like to add for this section?

#### 4: Equity

Consideration of equity

Equity methods

Equity dimensions

Any other relevant information you'd like to add for this section?

#### 5: Process and Implementation

Information about programme take-up (among participants)

Methods of assessing take-up

Results of the assessment of take-up

Information about programme adherence (among participants)

Methods of assessing adherence

Results of the assessment of adherence

Information about implementation fidelity / intervention delivery quality

Methods of assessing implementation fidelity

Results of the assessment of intervention fidelity

Other description of process / implementation factors

#### 6: Contextual Barriers /Facilitators

Causal mechanisms / barriers and facilitators

Methods of identifying causal mechanisms / barriers and facilitators

Results of identifying causal mechanisms / barriers and facilitators

Any other relevant information you'd like to add for this section?

#### 7: Cost

Are any unit cost data / cost-effectiveness estimates provided?

If yes, please list the page numbers where this is reported

Any other relevant information you'd like to add for this section?

#### 8: External Validity

Study length

Efficacy or effectiveness trial

Personnel implementing the programme

Sampling frame for the study

Author discussion of external validity

If yes, please summarize the external validity discussion

Programme theory discussed?

Report any description/statement of programme theory as stated by author(s).

Is the study using theory to inform the evaluation design and/or analysis?

Any other relevant information you'd like to add for this section?

#### 9: Study Design

Does the study include multiple study arms?

If so, do the study arms involve different study designs?

Please create a unique identifier for each study arm

Primary study design

Corresponding study arm(s)

Additional study design

Corresponding study arm(s)

Further study designs

Methods used for analysis

Methods used in each study arm

Design and analysis method description

Unit of analysis (UoA)

Method used to address differences between UoA and unit of data collection

Type of comparison group

Comparison group description

Any other relevant information

#### 10: Blinding

Blinded participants

Blinded observers

Blinded analysts

Method used to blind

Any other relevant information

#### 11: Outcomes

For this section, answer all questions (as relevant) for each outcome reported

Outcome

Corresponding study arm(s)

Definition of outcome

Follow up period

Sub-group analysis

Sub-group analysis description

Location of effect size data

### **Mechanisms and thematic information**

To synthesize the mechanisms, moderators, and other explanatory factors, data including first, second and third order constructs were extracted from included studies and corresponding additional documents using the following prompts:

Study ID, identifier // Region // Country // Country income level // Democracy policy index score

Intervention designer // Study frame // Level of society at which change targeted // Sector

Demand-side type of participants targeted // Supply-side type of participants targeted

Demand-side participants actively engaged // Supply-side participants actively engaged

Underlying bottleneck or barrier project aims to address

Bottleneck identification - how was the bottleneck/problem identified?

What evidence is presented for the existence of the bottleneck locally?

What evidence is presented that the problem identified is the key problem for addressing the overarching issue?

Actors targeted by intervention // Initial power difference // Onus for change // Type of change

Do targeted supply-side actors have the authority or capacity to influence outcomes desired?

Intervention Type // Intervention Description // PITA characteristic(s) // Intensity of PITA change

Strategic (complex) or tactical (tool based) - degree of flexibility/adaptability of intervention

Implemented in isolation or as integrated programme // Institutionalized or one-off intervention

Support provided by implementer to actors whose behaviors are targeted for change

Information on take-up (did targeted people actually participate?) // Implementation fidelity

Evidence on buy-in from above, at, and below targeted actors // Implementation quality

Barriers/Facilitators assessed by the authors

Moderators (barriers/facilitators) and mechanisms identified through synthesis, to outcomes of:

- Citizen engagement
- Provider response
- Provision and quality of services
- Use of services
- Attitudes about services
- Sustainability
- Income / poverty status
- Health
- Nutritional status / food security
- Human resilience
- Environmental
- Social / psychological
- State - society relations

**Table 26: Risk of bias coding tool**

<b>Description</b>	<b>Question</b>	<b>Coding</b>	<b>Decisions rules</b>
<b>Unique study identification #</b>	Study	For example, PITA001	
<b>Paper</b>	Surname / year of first author of paper for effect size data extraction	Open answer	
<b>Outcome</b>			
<b>Outcome description</b>	Write more information on the outcome and how it was measured.		
<b>Design type</b>	What type of study design is used?	1= Randomized controlled trial (RCT) (random assignment to households/individuals) or quasi-RCT 2= Cluster-RCT (quasi-RCT) 3= Natural experiment: randomized or as-if randomized 4= Natural experiment: regression discontinuity (RD) 5 = CBA (non-randomized assignment with treatment and contemporaneous comparison group, baseline and endline data collection) – individual repeated measurement 6= CBA pseudo panel (repeated measurement for groups but different individuals)	

		7= Interrupted time series (with or without contemporaneous control group) 8= Panel data, but no baseline (pre-test) 9 = Comparison group with endline data only	
<b>Methods used for analysis</b>	Which methods are used to control for selection bias and confounding?	1= Statistical matching (PSM, CEM, covariate matching) 2= Difference in differences (DID) estimation methods 3= IV-regression (2-stage least squares or bivariate probit) 4=Heckman selection model 5= Fixed effects regression 6= Covariate adjusted estimation 7= Propensity weighted regression 8= Comparison of means 9 = Other	
<b>Design and analysis method description</b>	Briefly describe the study design and analysis method undertaken by the authors	Open answer	
<b>Unit of analysis</b>	Is unit of analysis in cluster allocation addressed in standard error calculation (RCT and NRS)?	1=Yes 2=No 3=Not reported/unclear 4=Not applicable	<b>Definitions</b> -Unit of analysis (UoA) = unit of observation or unit of data collection -Unit of treatment = unit of implementation of the intervention -Unit of randomization (UoR)= unit of assignment to control or treatment groups

<b>Method used to address differences between UoA and unit of data collection</b>	Briefly describe methods used to adjust standard errors to account for correlation of observations within clusters (e.g. cluster-robust standard errors reported)	Open answer	<b>Rules:</b> -If UoA = UoR, code YES -If UoA != UoR, standard errors are clustered at the UoR level or data is collapsed to the UoR level, code YES. Otherwise code NO
<b>Type of comparison group</b>	Indicate type of comparison group	1=No intervention (service delivery as usual) 2=Other intervention comprising PITA mechanism 3=Pipeline (wait-list) control (still service delivery as usual) 8=Other	
	Type of comparison group (if other)	Open answer	
<b>Multiple interventions</b>	Are different treatment arms treated differently in the analysis?	1=yes 2=no 9=NA	Some studies don't differentiate different treatment arms in their analysis. This is more likely to happen when there are small variations to the main interventions.
<b>Assignment mechanism</b>	Mechanism of assignment: was the allocation or identification mechanism random or as good as random?	1= Yes, 2 = Probably Yes, 3 = Probably No, 4 = No, 8 = Unclear	
<b>Assignment justification</b>	Justification for coding decision (Include a brief summary of justification for rating, mentioning your response to all	Open answer	<b>Definitions:</b> -randomization method: computer, public lottery -randomization procedure: stratification, pairwise matching, multiple draws

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sub questions, cite relevant pages).

For RCTs, the authors describe a random component in sequence generation (e.g. lottery, coin toss, random number generator) and assignment is performed for all units at the start of the study centrally or using a method concealed from participants and intervention delivery. For NRS, the authors convincingly argue why the assignment is as good as prospective randomization.

**Rules:**

- If information on method and procedure is provided, and balance table suggests that allocation was random, code YES
  - If there is not enough information but a balance table shows that the groups are probably randomly allocated, PROBABLY YES
  - If there is not enough information and there is no balance table, UNCLEAR
  - If the method of randomization was a public lottery for instance, more info needs to be provided on the setting of the process and the participants. If it's too vague it should be a PROBABLY YES
  - If there are sub treatment groups, how were these assigned? If not clear whether they were randomized and are a large part of the analysis, code PROBABLY NO.
  - Is there imbalance that suggests a problem in the randomization?
  - What is the magnitude of the imbalance, the number of variable affected, the significance of difference between groups?
  - Was the randomization procedure adapted to the sample size (in all the strata there should be at least one of each group, better if there are 2)?
-

<b>Confounding</b>	Group equivalence: was the method of analysis executed adequately to ensure comparability of groups throughout the study and prevent confounding	1= Yes, 2 = Probably Yes, 3 = Probably No, 4 = No, 8 = Unclear	
<b>Confounding justification</b>	<p>Justification for coding decision (Include a brief summary of justification for rating, mentioning your response to all sub questions, cite relevant pages).</p> <p>Baseline characteristics should be similar in magnitude for RCTs and statistically insignificant for NRS; unbalanced covariates should usually be controlled in adjusted analysis.</p>	Open answer	<p><b>Rules:</b></p> <ul style="list-style-type: none"> <li>- For the outcomes which have more than one analysis, assess confounding on the most rigorous method (the one on which effect sizes are extracted).</li> <li>- If different methods are used for some outcomes and not others, how sensitive are the results from different approaches?</li> <li>- If there were imbalances at baseline and they were not controlled for in the analysis, select PROBABLY NO or NO depending on the magnitude of the imbalances and relevance of the variables.</li> <li>- If there are imbalances and they are controlled for, select PROBABLY YES</li> <li>- If there are no imbalances and relevant covariates are added, code YES</li> <li>- If there is no balance table code UNCLEAR</li> <li>- Were the adjustments to randomization taken into account in the analysis (stratum fixed effects, pairwise matching variables)? (Bruhn and McKenzie 2009)-</li> </ul>

<b>Selection bias</b>	Was any differential selection into or out of the study (attrition bias) adequately resolved?	1= Yes, 2 = Probably Yes, 3 = Probably No, 4 = No, 8 = Unclear	
<b>Selection bias justification</b>	Justification for coding decision (Include a brief summary of justification for rating, mentioning your response to all sub questions, cite relevant pages).  For attrition, overall should be <20% and similar across intervention groups, or the study establishes that attrition is randomly distributed (e.g. by presenting balance by key characteristics across groups).	Open answer	<p><b>Attrition:</b></p> <p>-If there is an attrition problem but no information provided on the relationship between attrition and treatment status, UNCLEAR</p> <p>-If there is an attrition problem but it is proven that it is not differential and it is not a large %: YES</p> <p>-If there is differential attrition, code PROBABLY NO or NO, depending on % affected.</p> <p><b>Sampling of survey respondents;</b></p> <p>-Sometimes the sample of the study is larger than the sample of survey respondents: how were these sampled? were these similarly sampled across treatment groups? If not enough information and sub sample is very small, code UNCLEAR.</p>
<b>Deviations from intended interventions</b>	2: Spill-overs, cross-overs and contamination: was the study adequately protected against spill-overs, cross-overs and contamination?	1= Yes, 2 = Probably Yes, 3 = Probably No, 4 = No, 8 = Unclear	
<b>Deviations justification</b>	Justification for coding decision (Include a brief summary of justification for rating,	Open answer	<b>Implementation issues</b> -Has there been any problem in the implementation that might have led the control

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mentioning your response to all sub questions, cite relevant pages).

For example, intervention groups are geographically separated, authors use intention to treat estimation or instrumental variables to account for non-adherence, and survey questions are not likely to expose individuals in the control group to information about desirable behaviors ('survey effects').

participants to receive the treatment (implementer's mistake)?

**Spillovers from the treatment participants**

-Does the intervention have by nature risks of spillovers if control and treatment participants are in contact?

-If yes, does the random assignment prevent or limit the risk of contact between the two group? if yes, select YES or PROBABLY YES

-If not, was there anything in place in the design to measure the potential effect of the spillover (e.g. variation in the % of unit within a cluster receiving the treatment)

-If not, is there any assessment of whether this problem has occurred through survey data or qualitative interview?

**Information exposure through surveys:**

-Is there anything in the survey that might have given the control participants an idea of what the other group might receive?

-If yes, is there a risk that this has changed their behaviors? (John Henry effect). If yes, code PROBABLY NO

-Is there anything in place in the design of the study that allows to control for that survey effect? (e.g. a pure control with no monitoring except baseline endline)

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<b>Performance bias</b>	Was the process of monitoring individuals unlikely to introduce motivation bias among participants?	1= Yes, 2 = Probably Yes, 3 = Probably No, 4 = No, 8 = Unclear	
<b>Performance justification</b>	Justification for coding decision (Include a brief summary of justification for rating, mentioning your response to all sub questions, cite relevant pages).  For example, the authors blind participants to intervention status, conduct infrequent monitoring visits, or data are from a survey or administrative record data not associated with a particular intervention	Open answer	<ul style="list-style-type: none"> <li>- Was there more monitoring visits/ events/ follow up with the treatment group?</li> <li>- Was a placebo control used to measure monitoring effects?</li> <li>-Were survey respondents aware that they were going to be surveyed and when?</li> </ul>
<b>Outcome measurement bias</b>	Outcome measurement: was the study free from biases in outcome measurement?	1= Yes, 2 = Probably Yes, 3 = Probably No, 4 = No, 8 = Unclear	
<b>Outcome justification</b>	Justification for coding decision (Include a brief summary of justification for rating, mentioning your response to all sub questions, cite relevant pages).	Open answer	<b>Outcome assessors' bias:</b> <ul style="list-style-type: none"> <li>-Are outcome assessors blinded?</li> <li>-If not, are the outcome measures likely to be biased by their judgement? If yes, code PROBABLY YES (we can't assume people were subjective it will be hard to find evidence that this is the case)</li> </ul>

For example, participants or outcome assessors are blinded to intervention status, or 'hard' outcomes data are collected using non-blinded participant or observer reporting, and data (e.g. for pre-intervention outcomes) are not collected retrospectively over long recall periods.

**Respondents reporting bias:**

- Are participants in the treatment group likely to have more accurate answers because of recall bias?
- Do the respondents have incentives to over/under report something related to their performance, actions? Do researchers put in place mechanisms to reduce the risk of reporting bias?
- Are the researchers or outcome assessors strongly involved with the implementation of the programme?
- Do the respondents have incentives to exaggerate their satisfaction (they received an intervention clearly meant to improve a service)?
- Are they doing falsification tests or measuring the effect on placebo outcomes?

**Timing issue:**

- Is the baseline survey conducted before the start of the intervention implementation?
- If not, is this delay likely to affect baseline data?
- If yes, what is the % of the baseline data affected by this (all treatment respondents or just a fraction)? Vary from PROBABLY YES to NO.

**Analysis reporting**

4: Analysis reporting: was the study free from selective analysis reporting?

1= Yes, 2 = Probably Yes, 3 = Probably No, 4 = No, 8 = Unclear

<b>Analysis reporting</b>	<p>Justification for coding decision Open answer (Include a brief summary of justification for rating, mentioning your response to all sub questions, cite relevant pages).</p>	<ul style="list-style-type: none"> <li>- If no pre analysis plan should never be more certain than PROBABLY YES</li> <li>- If there are different treatment considered the same in the analysis, code NO</li> <li>- Is there any key element that they didn't analyses in the paper that could have helped understand the results?</li> <li>- Do they mention that they have unreported analysis and why? Were these analyses important in understanding the results?</li> <li>- If ITT estimation are not reported alongside treatment-on-the-treated analysis, code PROBABLY NO or NO.</li> </ul>
	<p>For example, a trial protocol or pre-analysis plan is published and referred to, or results for relevant outcomes in the methods section are reported in the results section. For RCTs, authors report results of unadjusted analysis and intention to treat (ITT) estimation, alongside any adjusted and treatment-on-the-treated/complier-average-causal-effects analysis.)</p>	
<b>Other bias</b>	<p>6: Other risks of bias: Is the study free from other sources of bias?</p>	<p>1= Yes, 2 = Probably Yes, 3 = Probably No, 4 = No, 8 = Unclear</p>
<b>Other bias</b>	<p>Justification for coding decision Open answer (Include a brief summary of justification for rating, mentioning your response to all sub questions, cite relevant</p>	

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pages).

For example, information is collected using a different survey instrument in different intervention groups; measurement of the intervention received is unclear.

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<b>Blinded observers</b>	Blinding of outcome assessors?	1=Yes 2=No 8=unclear 9= N/A	If there is no information, code NO. If there is information but it is ambiguous, code UNCLEAR.
<b>Blinded analysts</b>	Blinding of data analysts?	1=Yes 2=No 8=unclear 9= N/A	If there is no information, code NO. If there is information but it is ambiguous, code UNCLEAR.
<b>Method used to blind</b>	Describe method(s) used to blind	Open answer (including describe method of placebo control) 9= N/A	

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## Appendix E: Characteristics of included studies

Table 27: Table of characteristics of included studies: citizen feedback and monitoring interventions

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
Alhassan et al. 2016 (Duku et al., 2018; Alhassan et al. 2015)  <b>Ghana</b> - Greater Accra and Western (predominantly rural) regions of Ghana	Accountability	Health	WOTRO-COHEiSION Ghana project: This intervention used existing community groups or associations to identify gaps in service delivery in healthcare facilities, using a tool known as MyCare. Focus groups were held by a facilitator identify these gaps. The issues were then communicated to all intervention health facilities by the facilitator and a community liaison	No explanation of how the intervention was developed. Field trial of community engagement activities, designed to improve a national policy but not implemented by the Ghanaian government.	Evaluation design: consider gender dynamics of focus groups	24 - 48	Cluster RCT  Statistical matching (PSM), Different-in-difference (DID) estimation methods	No PITA mechanism (service delivery as usual)	Attitudes to services  Service access / quality  Service use  Well-being  Provider Response

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			person and the facilities were encouraged to initiate changes through the development of an improvement plan. A small token prize was offered to the best performing health facilities.						
Berman et al. 2017  <b>Afghanistan</b>	Accountability	Local infrastructure	Integrity Watch Afghanistan (IWA)'s infrastructure monitoring programme: Works with community volunteers to train them in a combination of engineering and accounting skills in order to monitor	Appears locally developed through the implementing NGO, IWA. This study tests their existing programme through a field experiment.	Not explicit	Two follow ups: 24, 48	Cluster RCT  Fixed effects regression	No PITA mechanism (service delivery as usual)	Service access / quality

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			<p>local road construction quality, as well as how to monitor financials of providers. The implementer, IWA, provides ongoing support for monitoring. In addition to training, they also establish semi-formal accountability mechanisms called Provincial Monitoring Boards, which include representatives from the Ministry of Rural Rehabilitation and Development (MRRD), Provincial Councils, IWA-trained community</p>						

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			monitors, construction contractors, and sometimes aid agencies. At these meetings, they discuss construction quality, contractor performance, and potential misappropriation of funds. Finally, IWA encourages informal accountability through monitor-led community mobilization.						
Björkman et al. 2017 (Björkman et al. 2014;	Accountability Inclusion	Health	Community Scorecard and Monitoring: Two citizen feedback	Designed by staff from Stockholm University and	Intervention design: Participants divided into	Two follow ups: 12, 48	Cluster RCT DID estimation	No PITA mechanism (service	Wellbeing Service use

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
Björkman & Svensson 2009; Björkman & Svensson 2010; Björkman & Svensson 2007; Björkman et al. 2006; Donato & Garcia, 2016)			interventions tested in this RCT: - Researchers created a scorecard of health facilities based on two surveys of health facility data and user data, and presented the results through a series of meetings with (a) community members (through PRA-informed techniques), (b) service providers, and (c) a mixed interface meeting with both groups (five days). This was followed by a one-day midterm review at six	the World Bank, implemented in cooperation with a number of Ugandan practitioners and community organizations.	key social groups such as women, men, youths, disabled, elderly to get perspectives over service delivery and determine preferences for change.		methods, Fixed effects regression, covariate-adjusted estimation	delivery as usual)	Provider response  Citizen engagement  Service access / quality  Other

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			<p>months, data collection after at one year, repeat engagement at two years mark, one day review at three years mark, and final follow-up and data collection at four years mark.</p> <p>- In the second intervention, a similar process was followed without the initial scorecard development, presentation and dissemination.</p>						
Fiala & Premand, 2017  <b>Afghanistan</b>	Accountability	Social protection; Local infrastructure	Community monitoring training for NUSAF2: Communities selected to receive	Not clear - NUSAF2 was a large-scale CDD programme	Not explicit	Two follow ups: 19, 24	Cluster RCT  Covariate-adjusted estimation	Other PITA mechanism	Wellbeing  Provider response

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			a local development project through a community-based development programme called the Second Northern Uganda Social Action Fund (NUSAF2). Three treatment arms, including the two below (the other is under performance information provision): - A randomly selected sub-set of the NUSAF2 communities received intensive, six-day training on how to monitor community	implemented by the Office of the Prime Minister, in coordination with local district and sub-county with funding from the World Bank and DFID. This particular RCT worked with the Inspectorate of Government, the main oversight arm of the government of Uganda.					Citizen engagement Other State-society relations Service access / quality

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			<p>projects, as well as identify and make complaints about corruption and mismanagement to implementing partners, local, sub-national or national leaders. The trainings were implemented in partnership with local civil society organizations.</p> <p>- Within these communities, a randomly selected sub-set were presented researcher generated scorecards - a community facilitator, trained</p>						

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			by the research team went to communities to present these scores. The information presented included a ranking of communities relative to other NUSAF2 communities.						
Grossman et al. (2017)  <b>Uganda - Arua</b>	Accountability	Health	U-Bridge: U-Bridge is an SMS-based service system that allows citizens and local government officials to submit, monitor and respond to requests around public service delivery. It is an open-source	U-Bridge was designed by UNICEF Uganda and RTI International. It is not stated to what extent, if any, local stakeholders were engaged	Not explicit	14 [intervention]	Cluster RCT  Covariate-adjusted estimation	No PITA mechanism (service delivery as usual)	Provider response  Service access / quality  Service use  Citizen engagement

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			software that runs on mobile devices, including tablets and smartphones. Citizens can choose to register to participate in the sending and receiving of messages. The implementing team registered mobile phone numbers at community meetings, and the team undertaking the research also did door-to-door registration.	in the design process.					

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
Gullo et al. 2017  <b>Malawi -</b> Ntcheu district	Accountability  Inclusion	Health	CARE Malawi Community Score Card (CSC) around health (6-month cycles, after which all phases repeated): - 1st phase: relevant stakeholders identify the sectoral and geographic scope of the initiative, and facilitators trained. 2nd phase: CSC is conducted with the community via focus group discussions to identify and prioritize issues they are facing in accessing services. Groups are	The Community Score Card was developed by CARE Malawi in 2002.	Intervention design: Participants were divided into key social groups such as women, men, youths in order to get their perspectives over issues concerning service delivery and determine their preferences for change.	24	Cluster RCT  DID estimation methods	No PITA mechanism (service delivery as usual)	Attitudes to services  Service access / quality  Service use

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			<p>separated by men, women, youth, etc. A measurable indicator is developed for each theme. The indicators are then verified and scored by the community, generating a Score Card. They also give suggestions for improvement.</p> <p>3rd phase: The same process is conducted with service providers.</p> <p>4th phase: interface meeting between community members and service providers, as well as local government</p>						

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			officials and other power holders to share and discuss their respective Score Cards, issues and priorities. Community-wide action plan for service improvement is agreed. 5th phase: action plan implementation, monitoring.						
Molina, 2014 <b>Colombia</b> - Nationwide projects	Accountability	Local infrastructure	Citizen Visible Audit (CVA) programme: for funds allocated to infrastructure projects to facilitate provision of public goods for people who live in the	N/A	Not explicit	Unclear	Comparison group with baseline data only (NRS)  Statistical matching, Covariate-	No PITA mechanism (service delivery as usual)	Attitudes to services  Provider response

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			<p>nearby community. Selection of projects to be audited was determined by the size of royalties received, the number of previous irregularities in the management of royalties, and the expected social impact of the project. Initially, information disseminated about the programme in the relevant community via radio, newspapers, invitations and television. During the first public forum the</p>				adjusted estimation, Comparison of means		Service access / quality

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			<p>infrastructure project was introduced to the community, citizens were told about their rights and entitlements. Periodic public forums held, bringing together local authorities, neighbors, and representatives from the implementing firm, where the project progress was explained in detail. Commitments monitored by the community, facilitators from the central government (DNP) and the</p>						

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			<p>project supervisor. If a commitment was not honored, facilitators and supervisors intervene to let the local government know about this. If the problem persists, administrative complaints submitted to the Supreme Audit Body. Before making the final payment to the executing firm, the finalized project is presented to the community.</p>						

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
Olken, 2007  <b>Indonesia -</b> Java (East Java and Central Java)	Accountability	Local infrastructure	Kecamatan Development Project (KDP) - invitation to accountability meetings + scorecards treatment arm: In the context of a CDD project in which communities apply for block grants to fund development projects, one treatment arm included invitations plus anonymous comments forms asking for villagers' opinions of project. The distribution was the same as the invitations	The programme that this intervention is part of is a World Bank-funded and government implemented CDD programme. The intervention PITA mechanism itself seems to be created by donors or the researchers.	Not explicit	7	Cluster RCT  Covariate adjusted regression		Service access / quality  Citizen engagement  Provider response

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			<p>treatment.</p> <p>Comments forms contained three closed-response questions (good, satisfactory, poor) about aspects of the projects and two free response questions asking about job performance of implementers and project-related issues. These were to be returned to sealed drop box before the meeting, placed either at a village school or at a store in the village. Comments forms were collected from drop</p>						

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			boxes two days before the meeting and summarized by an enumerator, who read the summary at the meeting.						
Palladium, 2015  <b>DRC</b> - Bukavu, Kananga, and Mutavi cities	Accountability	Justice and security	Security Sector Accountability and Police Reform (SSAPR) Programme: Various citizen engagement components to encourage policy accountability: - Journalists trained with the aim of bringing security issues into public debates and better informing citizens,	The design of the theory of change involved extensive consultative process between the DFID Stabilization Unit and the SSAPR design and implementation team. It was based on	Evaluation design: They do sub-group analysis by women and men.	48 [intervention]	CBA - pseudo-panel (repeated measurement for groups but different individuals) (NRS)  Statistical matching, Different-in-difference (DID) estimation methods	No PITA mechanism (service delivery as usual)	Provider response  State-society relations  Attitudes to services  Well-being

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			<p>raising awareness on security issues and reporting on the implementation of police reform.</p> <ul style="list-style-type: none"> <li>- Individuals trained from more than 150 CSOs to increase their knowledge of local security issues and specific tools designed to assist local community members to hold the police to account. These include scorecards, suggestion boxes and various forms of action research.</li> <li>- A number of community forums designed to support</li> </ul>	<p>SSAPR's implementation experience and the personal knowledge of the programme team.</p> <p>Beneficiaries not included in this process</p>					

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			<p>collaboration between police, the community and administrative officials.</p> <p>- Worked with local government assemblies to link them more closely to the police reform process. Parliament members in all pilot cities participated in security control activities as well as security monitoring missions.</p>						

**Table 28: Table of characteristics of included studies: participatory planning interventions**

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
Ananthpur et al. 2014  <b>India</b> - Karnataka state - Gulbarga, Raichur, Bidar, Davengere and Chitradurga districts	Participation	Local government / Sub-national government - no specific sector	“People’s Campaign” Karnataka - RCT: An information campaign intervention that had three stages: - citizenship engagement programme which lasted one week where facilitators visited each village neighborhood to encourage them to attend neighborhood	Intervention format itself was developed in another state Kerala - locally driven campaign by the communist (CPI-M) led government. Bureaucrats and activists from the Karnataka State Institute Development (KSIRD) designed the intervention for Karnataka	Evaluation design: in their qualitative analysis, they consider the participation of marginalized groups and how women have been mobilized by the intervention. Also gender sub-group analysis	24	Cluster RCT  DID estimation methods; Fixed effects regression	No PITA mechanism (service delivery as usual)	Citizen engagement  Provider response  Service access / quality  State-society relations  Wellbeing

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			meetings (ward sabhas). Citizens were informed about training that would instruct them in processes of participatory planning, and disseminated information about the budgets. They explained the purpose and value of the gram sabha, rights of citizens, and information on how to examine panchayat	- contextualized to the low literacy, high inequality, and semi-arid context of north Karnataka.					

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			<p>records such as budgets, and minutes of meetings. At the end of the week, a special meeting was held where priorities were finalized and listed in a Village Action Plan. Straight after the Village Action Plan, a meeting was held with local bureaucrats to reach an agreement on the plan implementation, bureaucrats</p>						

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			committed to provide funding and technical support for projects over the course of the year. Over the next 2 years, the progress of the implementation was monitored roughly every month, citizen initiatives were tracked.						
Beath et al. 2013 <b>Afghanistan</b>	Participation Inclusion	Social protection	The programme considers the provision of wheat / food aid through the National Solidarity	World Bank programme, including the mandated interventions	Intervention design: considers the mandating of women into	48	Cluster RCT	Other PITA mechanism	Provider response  Citizen engagement

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			<p>Programme (NSP) CDD programme in Afghanistan. The intervention that we include aims to test whether mandating (women's) participation in elected councils (traditional unelected councils) overseeing food aid distribution leads to better targeting and less leakage. We do not include the results that</p>		elected councils				Service access / quality

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			focused only on the impacts of the NSP programme itself.						
Bradley & Igras, 2005  <b>Guinea / Kenya</b>	Participation	Health	COPE (Client-Oriented, Provider-Efficient services): intervention implemented COPE in health facilities: COPE is a tool to help health providers identify service delivery issues, and develop plans to deal with them. Includes client exit interview	Seems not to be locally driven: COPE was pioneered by Engender Health in the early 1990s and has been adapted by a variety of agencies since.	Not explicit	15	CBA (non-randomized study (NRS) with comparison group with pre-test and post-test) - individual repeated measurement  Statistical matching; Comparison of means	No PITA mechanism (service delivery as usual)	Service access / quality  Service use  Attitudes to services  Provider response

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			<p>too, which encourages staff to talk with and listen to their clients about the quality of the services offered. At the beginning, external facilitators oriented district supervisors and intervention site managers to the method in a one-day workshop. After the orientation, COPE was introduced in four sites in</p>						

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			<p>each country. District supervisors were encouraged to attend (and mostly they did attend), the first and subsequent COPE exercises, to help site staff address some of the more difficult issues. As per the usual COPE process, external resources were used to conduct short, on-site training in all intervention</p>						

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			sites on topics identified as priorities by facility staff.						
Beuermann & Amelina, 2014  <b>Russia</b> - Adygea, Penza, and Perm.	Participation	Local government / Sub-national government - no specific sector	Participatory Budgeting Training Russia - RCT: In 2006, all rural settlements in Russia were required by law to hold public hearings before approving newly legislated formal settlement budgets - participatory budgeting. This trial supported this process,	Not clear - this is an RCT that introduces training to implement a government law - so the RCT interventions probably not driven at the local settlement level but funded by World Bank + government of Russia so	Not explicit	22	Cluster RCT  Fixed effects regression	Weaker PITA mechanism (same PITA type)	Provider response  Citizen engagement  State-society relations  Attitudes to services

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			<p>tested through 2 treatment groups:</p> <ul style="list-style-type: none"> <li>- The first group provided six training sessions covering the whole cycle of participatory budgeting (training treatment).</li> <li>- The second provided the same training sessions plus two full-time consultants for 1 year to each settlement. The consultants were local</li> </ul>	<p>potentially nationally driven.</p>					

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			<p>residents trained in the fundamentals of fiscal planning, participatory budgeting and in the creation of the necessary local legal documents. They ensured the realization of six community meetings for budgetary priorities.</p>						

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
Diaz-Cayeros et al., 2014  <b>Mexico - Oaxaca</b>	Participation  Inclusion	Local government / Sub-national government - no specific sector	Usos y costumbres, Oaxaca: A 1995 constitutional government amendment in Oaxaca gave municipalities the choice to change to a traditional system of local governance (indigenous areas). It is a varying set of rules and practices to select leaders and solve collective-choice dilemmas at a	Constitutional change was a formalization of informal, traditional means of local government that already existed in most indigenous areas. The authors hint at one of the drivers of the law change - however, there is no information presented on why the change in	Intervention design: formalizes participation of traditional forms of governance, specifically indigenous groups in municipality level government decision-making. Evaluation design: measures women participation	120 / 240	CBA (non-randomized study (NRS) with comparison group with pre-test and post-test) - individual repeated measurement  Statistical matching; DID estimation methods	Weaker PITA mechanism (same PITA type)	Service access / quality

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			<p>local level - varies by municipality. Based on community assemblies where discussion over public priorities shapes the decision about budget spending. Engaging most of the community in the process of deliberation. Once collective decisions are taken according to these informal rules,</p>	<p>constitutional government amendment came about.</p>					

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			<p>they are taken to the formal municipal government institutions. Other differences between the usos and other system include the way in which political leaders are chosen, how collective decisions are made, the way in which tax rates and bases are decided upon and employment in public services</p>						

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			and how monitoring and sanctions are decided for public employees.						
Giné et al. 2018	Participation Inclusion	Health	Social Mobilization for Empowerment (MORE) programme: The MORE programme is a CDD programme, however, in the first 3 years of the programme, treatment villages were only provided support for social	CDD programme with local NGO designed community mobilization intervention	Intervention design: the inclusion of women and poor households in the mobilization and CO formation process was actively encouraged	36	Cluster RCT Fixed effects regression	Pipeline (wait-list) control (still service delivery as usual)	Service access / quality Wellbeing Attitudes to services Service use

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			<p>mobilization. They assess the impact of this intervention before the resource inputs came. Representatives from the NGO helped organize villagers into grass-roots organizations of 15 to 20 members called Community Organizations (COs), which aimed to provide a platform for collective efforts and allow</p>						

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			<p>members to pool resources for common development goals. A social mobilization team (SMT) approached a few people in the village to help organize a meeting of the community with the social organizer (SO). COs hold regular meetings where members can discuss local issues, prioritize community needs, and</p>						

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			resolve any conflicts at the local level.						
Goncalves, 2013  <b>Brazil - Nationwide</b>	Participation  Inclusion	Infra-structure - roads electricity telecom water and sanitation	Participatory Budgeting Brazil - city council is in charge of organization and promotion of meetings, also providing technical information to participants. Participatory process formally begins with a set of parallel neighborhood assemblies, open to all	Locally developed - PB emerged from direct negotiations between government officials and civil society leaders, as they sought to produce practical solutions to pressing needs. Community participation promoted by the elected	Intervention design: some participatory budgeting areas adopt a "quality of life index," which allocates greater resources on a per capita basis to poorer neighborhoods.	168	CBA (non-randomized study (NRS) with comparison group with pre-test and post-test) - individual repeated measurement  Statistical matching; Fixed effects regression	No PITA mechanism (service delivery as usual)	Provider response  Wellbeing

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			<p>residents. An update of the previous years' approved works is given, local needs are discussed, desired investments are listed, and neighborhood representatives are elected by the attendants. Elected delegates take part in municipality-wide coordinating meetings, to draw up a final draft for the</p>	<p>mayors of the Worker's Party of Brazil.</p>					

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			<p>different area investment priorities, which is then passed to the executive and the participatory council. Budget is defined by them using the popular priority ranking together with a set of weights (such as the share of population affected by the project, the index of local poverty and measure of need/shortage of the good</p>						

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			demand for example) which are designed to promote equity in the distribution of resources as well as to take account of the project technical and financial feasibility.						
Touchton & Wampler, 2014  Brazil - Nationwide (municipalities with 100000+ people)	Participation	Local government / Sub-national government - no specific sector	Participatory Budgeting Brazil - city council is in charge of organization and promotion of meetings, also providing technical information to	Locally developed - PB emerged from direct negotiations between government officials and civil society leaders, as they sought to	Intervention design: some participatory budgeting areas adopt a "quality of life index," which allocates greater resources on a per capita	240	CBA (non-randomized study (NRS) with comparison group with pre-test and post-test) - individual repeated measurement	No PITA mechanism (service delivery as usual)	Provider response  State-society relations  Wellbeing

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			participants. Participatory process formally begins with a set of parallel neighborhood assemblies, open to all residents. An update of the previous years' approved works is given, local needs are discussed, desired investments are listed, and neighborhood representatives are elected by the attendants.	produce practical solutions to pressing needs. Community participation promoted by the elected mayors of the Worker's Party of Brazil.	basis to poorer neighborhoods.		Statistical matching		

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			<p>Elected delegates take part in municipality-wide coordinating meetings, to draw up a final draft for the different area investment priorities, which is then passed to the executive and the participatory council. Budget is defined by them using the popular priority ranking together with a set of weights (such</p>						

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			<p>as the share of population affected by the project, the index of local poverty and measure of need/shortage of the good demanded for example) which are designed to promote equity in the distribution of resources as well as to take account of the project technical and financial feasibility.</p>						

**Table 29: Table of characteristics of included studies: Community-based natural resource management committees**

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length -months	Primary study design and analysis method	Comparison group	Outcomes
Bandyopadhyay et al. 2004  <b>Namibia -</b> Kunene and Caprivi regions	Participation	Natural resource management	Policy on Wildlife Management, Utilization and Tourism in Communal Lands: In 1995, the post-independent government laid out a set of access rules for communal lands. It created communal conservancies or areas where communities could economically exploit and	The intervention is a consequence of a policy enacted by the post-independent government in 1995, the "Policy on Wildlife Management, Utilization and Tourism in Communal Lands"	Not explicit	12 - 48 [intervention]	Comparison group with endline data only (NRS)  IV-regression; Covariate-adjusted estimation; Comparison of means	Weaker PITA mechanism (same PITA type)	Wellbeing

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length -months	Primary study design and analysis method	Comparison group	Outcomes
			<p>gain from wildlife resource management. They give communities rights over wildlife resources if they are able to identify conservancy boundaries, have a well-defined membership, choose a representative committee to implement programmes and develop an acceptable</p>						

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length -months	Primary study design and analysis method	Comparison group	Outcomes
			constitution. The local villagers benefit by being able to negotiate contracts with tourism agencies, manage guards and game-hunting activities, and make decisions about revenue sources and uses.						
Bandyopadhyay et al. 2010	Participation	Natural resource management	Irrigation Management Transfer (IMT) Philippines: The intervention involves	Combination of local driver and donor funding - interest from international organizations, local forces	Evaluation design: sub-group analysis by asset rich or asset poor	48	Comparison group with baseline data only (NRS)  Statistical	Weaker PITA mechanism (same PITA type)	Provider response  Service access / quality

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length -months	Primary study design and analysis method	Comparison group	Outcomes
System (MRIIS) in Region-2, Luzon			Irrigation Management Transfer (IMT) contracts for Irrigation Associations (IAs) - transfer of more management responsibility to local farmer organizations. An IMT contract requires prior infrastructural improvements such as canal lining, modified pipes, improved gates and so on. A greater role for	toward decentralization and a natural evolution within the irrigation sector. Launched under a World Bank funded programme.			matching; IV-regression		Citizen engagement Wellbeing

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length -months	Primary study design and analysis method	Comparison group	Outcomes
			<p>IAs is expected to increase the responsiveness of water management to suit real-time needs. IMT IAs also collect irrigation service fees (ISF) from their members and remit these to NIA (the national irrigation organization), which is expected to return 50% of the fees.</p>						
			<p>Compared to</p>						

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length -months	Primary study design and analysis method	Comparison group	Outcomes
			IAs without the IMT contracts (less power devolved to them than the IMT IAs)						
Barde, 2017 <b>Brazil</b>	Participation	Natural resource management	Water User Associations Brazil - small-scale water supply systems implemented and operated by water user associations		Not explicit	120	CBA (non-randomized study (NRS) with comparison group with pre-test and post-test  Statistical matching; DID estimation methods	No PITA mechanism (service delivery as usual)	Service access / quality

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length -months	Primary study design and analysis method	Comparison group	Outcomes
Huang, 2014  <b>China</b> - Ningxia and Henan provinces from the Yellow River Basin (YRB) and Hebei province in the Hai River Basin	Participation	Natural resource management	Water User Associations (WUAs) China: WUA is a farmer-based, participatory organization in which farmers organize themselves to elect a board as their representative to manage the village's irrigation system. WUAs should be set up in a context-specific manner and contingent on the local history	Unclear whether locally driven or donor created - the first WUA was established in south China in 1995 with the assistance of the World Bank - not clear who drove the policy forward. Policy documents starting from 2002 made clear the government's intention to extend WUAs nationwide.	Not explicit	72	CBA (non-randomized study (NRS) with comparison group with pre-test and post-test) - individual repeated measurement  IV-regression; Fixed effects regression	Other PITA mechanism / no PITA mechanism (service delivery as usual)	Provider response  Service access / quality  Citizen engagement  Wellbeing  Service use

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length -months	Primary study design and analysis method	Comparison group	Outcomes
			of water management and specific problems needed to be resolved - so some heterogeneity in how they operate.						
Persha & Meshack, 2016  <b>Tanzania -</b> Kilimanjaro, Tanga, Pwani, Lindi, Morogoro, Iringa, and Mbeya regions	Participation	Natural resource management	Joint Forestry Management: Under JFM, the government and a village institution jointly manage a government forest reserve via a formal co-management agreement and decentralized	PFM was first introduced in 1998 and strengthened through the government's 2001 National Forest Programme, but the authors do not state to what extent the policies were	Evaluation design: assess the impact of the evaluation on women headed households	144 for forest outcomes	CBA - pseudo-panel (repeated measurement for groups but different individuals) (NRS)  Statistical matching; DID	No PITA mechanism (service delivery as usual)	State-society relations  Wellbeing  Service access / quality

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length -months	Primary study design and analysis method	Comparison group	Outcomes
			process. JFM creates forest management institutions in villages, with a formal decision-making role for villagers around the conservation and management of government forest reserves. It specifies a set of management activities that communities should engage in as part of JFM,	developed locally or with influence of donors. The programme is implemented from the top down.			estimation methods		

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length -months	Primary study design and analysis method	Comparison group	Outcomes
			implements a legal agreement on the allocation of rights and responsibilities around forest use and management on the part of the government and community signatories, and provides for revenue-sharing from forest management activities between government and						

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length -months	Primary study design and analysis method	Comparison group	Outcomes
			communities." (p.3)						
Rasamoelina et al. 2015  (Rasolofoson et al. 2015)  <b>Madagascar</b>	Participation	Natural resource management	Gestion Contractualisée des Forêts (GCF), CFM component: A law to pass responsibility over natural resources over to community groups. A local natural resources management group (in Malagasy Vondron'Olona Ifotony (VOI), or Grassroots Community) is created. The	The policy is presented as having been developed by the Madagascar government, but it is not clear the extent to which the World Bank may or may not have exerted influence over the policy development.	Not explicit	N/A	Comparison group with endline data only (NRS)  Statistical matching	No PITA mechanism (service delivery as usual)	State society relations  Wellbeing

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length -months	Primary study design and analysis method	Comparison group	Outcomes
			<p>VOI operates according to a set of rules. Once created, the VOI can request the transfer of management of a given resource from its legal owner, be it the State or the local authority. The contract is signed by three parties: (i) the VOI; (ii) the owner of the resources, be it the State or the Municipality (in the case of</p>						

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length -months	Primary study design and analysis method	Comparison group	Outcomes
			forests, typically the forest administration); and (iii) the Municipality (Commune), which is the most decentralized institution with elected leaders. The typical forest contract is often established with support from NGOs and requires the expertise of an						

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length -months	Primary study design and analysis method	Comparison group	Outcomes
			environmental mediator.						
Tachibana & Adhikari, 2009 (Tachibana & Adhikari, 2005)  <b>Nepal</b> - Middle Hills region	Participation	Natural resource management	Community Forestry Management Nepal: Co-management indicates management by user groups which are officially approved and registered at local forest offices. By complying with the management criteria set by the forest offices, the registered user	Mix - traditional approaches to CFM emerged spontaneously out of government failures to forest management. Also supported by international donors - several specific projects mentioned including Australian donors. Government began to support at the	Not explicit	216 months for forest condition, approximately 84 months for other outcomes	CBA (non-randomized study (NRS) with comparison group with pre-test and post-test) - individual repeated measurement  IV-regression; Covariate-adjusted estimation	No PITA mechanism (service delivery as usual)	State-society relations

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length -months	Primary study design and analysis method	Comparison group	Outcomes
			<p>groups receive various support from the government. 02). Upon satisfying several prerequisites, the district forest offices (DFOs) have provided legal status to well-functioning user groups by registering them. The DFOs must provide various supports, notably technical advice, to the</p>	<p>end of the 1980s.</p>					

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length -months	Primary study design and analysis method	Comparison group	Outcomes
			<p>registered user.  Groups need to:</p> <ul style="list-style-type: none"> <li>- establish an election system for the committee responsible for forest management.</li> <li>- prepare forest management plans</li> </ul>						

**Table 30: Table of characteristics of included studies: performance information**

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
Banerjee et al., 2014 (Benerjee et al. 2012)	Transparency	Justice and security	RCT - Community monitoring in police stations: Two volunteers from the local community were assigned to spend around three hours in the police station during peak operating hours. Their role was to watch the activities within the police station and become familiar with the duties, procedures and challenges faced by the police. The goals were to give a group of citizens firsthand experience with the police in a positive setting and encourage them to share their experience with others, and to provide	Developed collaboratively by researchers and the implementing agency, the Rajasthan police. The community monitoring intervention was developed in response to the Police Reform Commission report recommendations on community policing.	Not explicit	18	Cluster RCT (quasi-RCT)  Covariate-adjusted estimation	No PITA mechanism (service delivery as usual)	Attitudes to services  Wellbeing  State-society relations

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			<p>community oversight in the police station. In addition, within each police station, staff members were randomly selected for a training intervention. They were trained in either / or soft skills such as communication, mediation, stress management, motivation, team building, leadership, attitudinal, change or professional/Investigation skills.</p>						

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
Capuno & Garcia, 2010 (Capuno & Garcia, 2009)  <b>Philippines</b> - 12 local government units (LGUs) in Bulacan and Davao del Norte Provinces	Transparency	Local govern ment / Sub-national govern ment - no specific sector	Good Governance and Local Development (GGLD) project: The project developed and disseminated a set of indicators about good local governance on the responsiveness of local officials as assessed by their constituents and on citizens' civic participation and trust in local officials. In treatment areas, the intervention activities included the generation of governance index (GI) scores and their public dissemination. The GI assesses Local Government Units from zero to 100 (highest) from household surveys	The Philippine Center for Policy Studies, an NGO, developed the intervention. In 2000, the Governance for Local Development Index (Gofordev Index or GI) was formulated, which was subsequently piloted for two years (2001-2003) in this impact evaluation.	Not explicit	22	CBA - pseudo-panel (repeated measurement for groups but different individuals) (NRS)  DID estimation methods; Statistical matching	Weaker PITA mechanism (same PITA type)	Attitudes to services  Provider response  State-society relations  Citizen engagement

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			and official audited financial reports and meeting minutes of local consultative bodies, along three performance domains. In each province, local partners in each site were two Local Government Units (local planning and development office) and two CSOs. GI materials were distributed in transport terminals, municipal halls and marketplaces. Some also sent materials to households.						
Fiala & Premand, 2017	Transparency	Other	Community monitoring training for NUSAF2: Communities selected to receive a local development project	Not clear - NUSAF2 was implemented by the Office of the Prime Minister, in	Not explicit	Scorecard only int.: 4	Cluster RCT Covariate-	Other PITA mechanism	Provider response Wellbeing

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
<b>Afghanistan</b>			through a community-based development programme called the Second Northern Uganda Social Action Fund (NUSAF2). Three treatment arms, the one below is performance information provision: - A randomly selected sub-set of the NUSAF2 communities were presented researcher generated scorecards - a community facilitator, trained by the research team went to communities to present these scores. The information presented included a ranking of communities relative to other NUSAF2	coordination with local district and sub-county with funding from the World Bank and DFID. Community monitoring element worked with the Inspectorate of Government, the main oversight arm of the government of Uganda.			adjusted estimation		Citizen engagement  Service access / quality  State-society relations  Other

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			communities in their district.						
Grossman & Michelitch, 2018  <b>Uganda</b> - nationwide	Transparency	Local government / Sub-national government - no specific sector	ACODE Scorecard: outlined politician legally defined job duties and included scorecard dissemination to citizens. Politicians were informed and invited to meetings	It appears that the intervention was designed jointly by the research team and the local NGO	Not explicit	24	Cluster RCT (quasi-RCT)  Fixed effects regression	Weaker PITA mechanism (same PITA type)	Provider response  Service access / quality  Other
Humphreys & Weinstein, 2012  <b>Uganda</b> - nationwide	Transparency	Local government / Sub-national government - no	Policing Politicians: Using a scorecard, previously developed, containing "detailed information on the performance of Ugandan Members of Parliament (MPs), informed a randomly selected sample of MPs that the	Developed by the researchers in partnership with the implementing agency	Not explicit	48	Prospective randomized assignment (RCT) or quasi-randomized assignment (e.g. alternation) (quasi-RCT)	Weaker PITA mechanism (same PITA type)	Provider response  Services access / quality  Citizen engagement

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
		specific sector	information would be disseminated in their constituencies, and provided voters with information about their MP's performance through a variety of dissemination channels. While scorecards were produced and released publicly for all 319 elected MPs, the authors informed the MPs that a random sample of constituencies had been selected for robust dissemination campaigns prior to the 2011 elections. In the month before the 2011 election, a sample of constituencies also received dissemination				Covariate-adjusted estimation		

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			campaigns to distribute fliers with updated scorecard information. As part of the baseline survey and the endline survey, the researchers provided a random sample of voters from across all constituencies with their MP's scorecard.						
Timmons & Garfias, 2015  <b>Brazil - Nationwide</b>	Transparency	Local government / Sub-national government - no specific sector	Random Public Audit - Results Publication: The Brazilian federal government undertakes random audits of sub-national expenditures (coming from federal transfers). Audits contain detailed information about the manner in which funds were spent. They identify corruption,	No mention of donor support - seems to be locally driven.	Not explicit	48	Natural experiment: randomized or 'as-if' randomized assignment  Fixed effects regression	No PITA mechanism (service delivery as usual)	State-society relations  Other

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
			theft, and other improper expenditure; they also identify violations in the procedural rules governing expenditure and record-keeping. The results of the audits are then posted on the internet and distributed to journalists.						

**Table 31: Table of characteristics of included studies: rights information**

Papers and location	PITA mechanism	Sector	Intervention description	Intervention development	Equity considered?	Study length - months	Primary study design and analysis method	Comparison group	Outcomes
Banerjee et al., 2018 (Banerjee et al. 2016; Banerjee et al. 2015a; Banerjee et al. 2015b)	Transparency Inclusion	Social protection	Raskin programme (Rice for the Poor): Food subsidy giving poor households 15kg of rice (half a typical monthly rice consumption) at co-pay price one-fifth of market price. The evaluated intervention is information is given in three treatments: 1) Entitlements information (amount). The government prints the quantity of the entitlement per	Mixture of government and researchers	Intervention design: Raskin is targeted at poor households	18	Cluster RCT  Fixed effects regression	Weaker PITA mechanism (same PITA type)	Citizen engagement  Service access / quality  Service use  Attitudes to services

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household (15Kg):

1a) In half of the villages, all eligible households received cards.

1b) In the other half, only those in the lowest decile of predicted per capita household consumption received it.

2) Entitlements information (amount and price). The government printed the copay price on the card.

3) Entitlements information + public information with beneficiary lists. A community facilitator hung up posters announcing cards and beneficiary lists and also

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			played prerecorded announcement about the cards in the local language over the village mosque loudspeaker.						
Kasim, 2016	Transparency	Local government / Sub-national government - no specific sector	Information Campaign on RTI Law - Khyber Pakhtunkhwa (KPK) Pakistan: Multiple (7) treatment groups testing variations of an intervention that delivered messaging campaign on three recent reforms implemented by the provincial government: (i) the Right to Information (RTI) Act; (ii) the Right to Services (RTS)	It seems researcher driven, although messages were designed in association with the support of the provincial government in Khyber Pakhtunkhwa (KPK).	Not explicit	6	Cluster RCT  DID estimation methods; Covariate-adjusted estimation	Weaker PITA mechanism (same PITA type)	Wellbeing  State-society relations  Attitudes to services

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Act; and (iii) an e-Grievance Redressal System established as part of the Peshawar High Court. Messages on each act were disseminated via robot-calls to randomly selected cellular phone users in the province, which was followed by an SMS message. The messaging campaign for the e-Grievance System followed a procedure, but at the end of the call, the recipient was asked about violation of their rights and interest in using the new service.

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Olken, 2007	Transparency	Infrastructure - roads, electricity, telecom	Kecamatan Development Project (KDP) - RCT of invitations to participate in accountability meetings. In the context of a CDD project in which communities apply for block grants to fund development projects (mainly road surfacing to ensure year-round use), the specific treatment arm for this intervention area is the following: invitations to participate in village accountability meetings. Either 300 or 500 invitations were distributed throughout the	The programme that this intervention is part of is a World Bank-funded and government implemented CDD programme. The PITA intervention itself seems to be created by donors or the researchers.	7	Cluster RCT  Fixed effects regression	Weaker PITA mechanism (same PITA type)	Citizen engagement  Provider response  Service access / quality
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			village several days prior to each of the three accountability meetings. Invitations were distributed either by sending them home with school children or asking heads of hamlets and neighborhood associations to distribute throughout their areas of the village.						
Pandey et al. 2007	Transparency Inclusion	Health	Rights information campaign: The information campaign was conducted in two rounds in each village cluster, separated by a period of 2 weeks. Each round consisted of 2-3	Local NGO Sahbagi Shikshan Kendra and researcher team	Evaluation design: sub-group analysis by lower and mid-high caste.	12	Cluster RCT (quasi-RCT)  DID estimation methods	No PITA mechanism (service delivery as usual)	Service access / quality  Provider response

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districts (out of 70 districts in total in the state).

meetings (4-6 meetings in total) as well as distribution of posters and leaflets. Residents were informed in advance about the dates and locations of meetings, and separate meetings were held in low and mid to high caste neighborhoods. Each meeting lasted an hour and consisted of a 15-minute audiotaped presentation that was played twice, opportunities to ask questions, and distribution of leaflets. Research assistants read a scripted introduction and

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were allowed to answer questions only to which the answers were already written on the leaflets. Health services information included information about the services available and where to complain about quality of quantity of health services.

Ravallion et al. 2013  (Ravallion et al. 2015)  <b>India - Bihar</b>	Transparency	Social protection	NREGA (National Rural Employment Guarantee Act) information campaign: NREGA is a public works scheme promising 100 days' work per year to rural households. The information	Developed following an in-depth needs assessment, which suggested that knowledge was low on NREGA entitlements	Evaluation design: sub-group analysis for men and women.	12	Cluster RCT  DID estimation methods; Comparison of means	No PITA mechanism (service delivery as usual)	Citizen engagement  Attitudes to services  Service use  Service access / quality  Other
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<p>campaign consists of a video providing information on NREGA services and entitlements. The 25-minute video involved professional actors performing in an entertaining and emotionally engaging story-based plot. The main story line centered on a temporary migrant worker returning to his village from the city to see his wife and daughter, learning there is NREGA work even in the lean season so he can stay with family. The film was shown in common areas such as open</p>	<p>and that an information campaign would need to engage viewers emotionally, should influence public knowledge not just that of participants, and should be relatively easy to scale up if proved effective in a trial.</p>	<p>Provider response Wellbeing</p>
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ground, school building or community hall. The showings were followed by question and answer sessions and distribution of one-page flyers that pictorially illustrated the main entitlements and processes under the scheme. Efforts were made by facilitators to announce and advertise the upcoming screenings in advance. Local officials including community leaders were invited to attend.

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## Appendix F: Results of critical appraisal

Table 32: Risk of bias assessment for RCTs: whether the study is likely to be free from these sources of bias

<i>Study and Outcome</i>	<i>Random assignment mechanism</i>	<i>Confounding</i>	<i>Selection bias</i>	<i>Deviations from intended interventions</i>	<i>Performance bias</i>	<i>Outcome measurement bias</i>	<i>Analysis reporting bias</i>
<b>Alhassan et al. (2016)</b>							
1-Staff experiences with clients	Yes	Probably No	Probably No	Probably Yes	Yes	Probably Yes	No
<b>Alhassan et al. (2016)</b>							
2-Staff motivation levels	Yes	Probably No	Probably No	Yes	Yes	Probably No	No
<b>Alhassan et al. (2015)</b>							
3-Patient safety & risk status	Yes	Probably Yes	Yes	Probably Yes	Yes	Probably Yes	No
<b>Ananthpur et al. (2014)</b>							
1-Information availability & participation	Probably Yes	Probably No	Probably Yes	Probably Yes	Yes	Probably No	Probably No
<b>Ananthpur et al. (2014)</b>							
2-Public goods	Probably Yes	Probably Yes	Probably Yes	Probably Yes	Yes	Probably Yes	Probably No
<b>Banerjee et al. (2014)</b>							
1-Police behavior (Decoy survey outcomes)	Yes	Probably Yes	Yes	Probably Yes	Yes	Yes	Probably Yes
<b>Banerjee et al. (2014)</b>							
2-Crime victim satisfaction (Victimization survey)	Yes	Probably Yes	Unclear	Probably Yes	Yes	Yes	Probably Yes
<b>Banerjee et al. (2014)</b>							
3-Public perception of police (household survey)	Yes	Probably Yes	Unclear	Yes	Probably Yes	Yes	Probably Yes

<i>Study and Outcome</i>	<i>Random assignment mechanism</i>	<i>Confounding</i>	<i>Selection bias</i>	<i>Deviations from intended interventions</i>	<i>Performance bias</i>	<i>Outcome measurement bias</i>	<i>Analysis reporting bias</i>
<b>Banerjee et al. (2018)</b> 1-Card receipt, belief about their eligibility & card use	Yes	Yes	Yes	Probably Yes	Probably Yes	Yes	Yes
<b>Banerjee et al. (2018)</b> 2-Quantity purchased & price paid	Yes	Yes	Yes	Probably Yes	Yes	Yes	Yes
<b>Beath et al. (2013)</b> 1-Targeting	Probably Yes	Unclear	Yes	Probably Yes	Yes	Probably No	Yes
<b>Beath et al. (2013)</b> 2-Corruption & nepotism	Probably Yes	Unclear	Yes	Probably Yes	Yes	Yes	Yes
<b>Beath et al. (2013)</b> 3-Participation	Probably Yes	Unclear	Yes	Probably Yes	Yes	Yes	Yes
<b>Berman et al. (2017)</b> Road quality (technical assessment)	Probably Yes	Yes	Unclear	Probably No	Yes	Probably No	Probably Yes
<b>Beurman &amp; Maria (2014)</b> 1-Participation, alignment of priorities & satisfaction (mostly household data)	Probably Yes	Yes	Probably Yes	Yes	Yes	Yes	Probably Yes
<b>Beurman &amp; Maria (2014)</b> 2-Tax collection & budget allocation (administrative data)	Probably Yes	Yes	Yes	Yes	Yes	Yes	Probably Yes
<b>Björkman &amp; Svensson (2009)</b>	Yes	Yes	Probably Yes	Yes	Yes	Yes	Probably Yes

<i>Study and Outcome</i>	<i>Random assignment mechanism</i>	<i>Confounding</i>	<i>Selection bias</i>	<i>Deviations from intended interventions</i>	<i>Performance bias</i>	<i>Outcome measurement bias</i>	<i>Analysis reporting bias</i>
1-First stage outcome: community involvement in the monitoring							
<b>Björkman &amp; Svensson (2009)</b> 2-Impact on practices & management, Utilization & coverage	Yes	Probably Yes	Probably Yes	Yes	Yes	Probably No	Probably Yes
<b>Björkman &amp; Svensson (2009)</b> 3- Immunization & other health outcomes	Yes	Probably No	Probably Yes	Yes	Yes	Probably Yes	Probably Yes
<b>Björkman et al. (2017)</b> 1-Health outcomes	Yes	Probably Yes	Probably Yes	Probably Yes	Yes	Yes	Probably Yes
<b>Björkman et al. (2017)</b> 2-Utilization & coverage	Yes	Yes	Yes	Probably Yes	Yes	Probably No	Probably Yes
<b>Björkman et al. (2017)</b> 3-processes&health treatment practices	Yes	Yes	Yes	Probably Yes	Yes	Yes	Probably Yes
<b>Björkman et al. (2017)</b> 4-Health treatment practices from household survey	Yes	Probably Yes	Probably Yes	Probably Yes	Yes	Probably Yes	Probably Yes
<b>Björkman et al. (2017)</b> 5-Alternative mechanisms	Yes	Yes	Yes	Probably Yes	Yes	Yes	Probably Yes
<b>Fiala &amp; Premand (2017)</b> All outcomes	Yes	Probably Yes	Probably Yes	Yes	Probably Yes	Probably Yes	Yes

<i>Study and Outcome</i>	<i>Random assignment mechanism</i>	<i>Confounding</i>	<i>Selection bias</i>	<i>Deviations from intended interventions</i>	<i>Performance bias</i>	<i>Outcome measurement bias</i>	<i>Analysis reporting bias</i>
<b>Giné et al. (2018)</b> 1- Illness incidence, immunization, diarrhea & nutrition WASH outcomes	Probably Yes	Probably Yes	Unclear	Probably Yes	Yes	Yes	Probably Yes
<b>Giné et al. (2018)</b> 2- Utilization of basic health unit (BHU)	Probably Yes	Probably Yes	Probably Yes	No	Yes	No	Probably Yes
<b>Giné et al. (2018)</b> 3- Pregnancy & Lady Health Worker performance & satisfaction	Probably Yes	Probably Yes	Yes	Probably Yes	Yes	Probably No	Probably Yes
<b>Gullo et al. (2017)</b> 1-Maternal health service utilization	Yes	Probably Yes	Probably No	Unclear	Yes	Yes	Probably Yes
<b>Gullo et al. (2017)</b> 2-Perceived quality of services when last received	Yes	Probably Yes	Probably No	Unclear	Yes	Yes	Probably Yes
<b>Gullo et al. (2017)</b> 3- Supportive care	Yes	Probably Yes	Probably No	Unclear	Yes	Probably Yes	Probably Yes
<b>Kasim (2016)</b> 2-Phone survey outcomes	Unclear	Probably Yes	Unclear	Yes	Yes	Probably Yes	No
<b>Kasim (2016)</b> 1-In person survey outcomes	Unclear	Probably No	Unclear	Yes	Yes	Probably No	No

<i>Study and Outcome</i>	<i>Random assignment mechanism</i>	<i>Confounding</i>	<i>Selection bias</i>	<i>Deviations from intended interventions</i>	<i>Performance bias</i>	<i>Outcome measurement bias</i>	<i>Analysis reporting bias</i>
<b>Olken (2007)</b> 1-Corruption	Yes	Probably Yes	Probably Yes	Yes	Yes	Probably Yes	Probably Yes
<b>Olken (2007)</b> 2-Nepotism	Yes	Probably Yes	Yes	Yes	Yes	Yes	Probably Yes
<b>Olken (2007)</b> 3-Participation	Yes	Yes	Yes	Yes	Yes	Yes	Probably Yes
<b>Olken (2007)</b> 4-Impact on meetings	Yes	Yes	Yes	Yes	Probably Yes	Yes	Probably Yes
<b>Pandey et al. (2007)</b> 1- Outcomes which could be compared before & after	Yes	Probably Yes	Yes	Yes	Yes	Probably Yes	Yes
<b>Pandey et al. (2007)</b> 2- Outcomes which could not be compared before & after	Yes	Probably No	Yes	Yes	Yes	Probably Yes	Yes

**Table 33: Risk of bias assessment for non-randomised studies: whether the study is likely to be free from these sources of bias**

<i>Study and outcome</i>	<i>Group equivalence (confounding)</i>	<i>Selection bias</i>	<i>Deviations from intended interventions</i>	<i>Performance bias</i>	<i>Outcome measurement bias</i>	<i>Analysis reporting bias</i>	<i>Other bias</i>
<b>Bandyopadhyay, 2004</b> Household income	No	Probably no	Yes	Yes	Unclear	Probably no	Yes
<b>Bandyopadhyay, 2004</b> Household expenditure	No	Probably no	Yes	Yes	Probably yes	Probably no	Yes
<b>Bandyopadhyay, 2010</b> Irrigation level indicators	No	Unclear	Unclear	Yes	Unclear	Probably yes	Yes
<b>Bandyopadhyay, 2010</b> Farmers yields	No	Unclear	Unclear	Yes	Yes	Probably yes	Yes
<b>Barde, 2017</b> Access to piped water	Probably yes	Yes	Probably Yes	Yes	Yes	Probably Yes	Yes
<b>Bradley, 2005</b> All outcomes	Probably No	Unclear	Unclear	Yes	Probably no	No	Yes
<b>Capuno, 2010</b> Membership in local organization and participation in local projects	No	No	Yes	Yes	Probably no	Yes	Yes
<b>Capuno, 2010</b> Desired change in service delivery, responsiveness of leaders	No	Unclear	Unclear	Yes	Yes		Yes
<b>Diaz-Cayeros, 2014</b> All outcomes	Probably yes	Probably yes	Unclear	Yes	Yes	Unclear	Yes

<b>Goncalves, 2013</b>							
Expenditure share in different sectors	Probably No	Probably yes	Probably yes	Yes	Yes	Unclear	Yes
<b>Huang, 2014</b>							
All outcomes	Probably No	Unclear	Probably Yes	Yes	Yes	Unclear	Yes
<b>Molina, 2014</b>							
All outcomes	No	No	Unclear	Yes	Yes	No	No
<b>Palladium, 2015</b>							
All outcomes	Unclear	unclear	Yes	Yes	Unclear	No	Yes
<b>Persha, 2016</b>							
Forest conditions	Yes	Probably yes	Unclear	Yes	Unclear	Probably no	Yes
<b>Persha, 2016</b>							
Governance and livelihood	Probably yes	Probably yes	Probably yes	Yes	Unclear		Yes
<b>Rasamoelina, 2015</b>							
Deforestation	Unclear	Unclear	Unclear	Yes	Yes	No	Yes
<b>Rasamoelina, 2015</b>							
Household consumption expenditures	No	No	Probably yes	Yes	Yes	No	Yes
<b>Tachibana, 2009</b>							
All outcomes	Unclear	Unclear	Unclear	Yes	Yes	Yes	Yes
<b>Timmons, 2015</b>							
Log tax collection	Unclear	Unclear	Unclear	Yes	Yes	Probably Yes	Yes
<b>Touchton, 2015</b>							
Health care and sanitation spending, infant mortality	Probably No	Unclear	Probably yes	Yes	Yes	Unclear	Yes
<b>Touchton, 2015</b>							
Number of CSO per municipality	Probably No	No	Probably yes	Yes	Yes	Unclear	Yes

## Appendix G: Additional information for meta-analysis

**Table 34: Citizen engagement outcome variables**

<i>Outcome</i>	<i>Detailed variable</i>	<i>Study</i>
Knowledge about processes	Correctly names local leader	Ananthpur et al., 2014
	Aware of who monitored facility performance	Bjorkman et al., 2017
Knowledge about services	Had heard of programme	Ananthpur et al., 2014
	Knows about own service user rights	Banerjee et al., 2018
	Knows about facilities available	Ravallion et al., 2013
Participation	Attended any meeting in past year	Ananthpur et al., 2014
	Probability of participating in local government projects	Capuno and Garcia, 2010
	Attendance of non-elite at meetings	Olken, 2007
	Women participated in meeting	Ravallion et al., 2013
Active participation	Contribute to preparing maintenance plan	Bandyopadhyay et al., 2010
	User engagement - used Raskin card	Banerjee et al., 2018
	Expressed views at meeting	Bjorkman et al., 2009, 2017
	Intensity of community monitoring training	Fiala et al., 2017
	Village requests for services	Grossman et al., 2017
	Maintenance expenditure	Huang et al., 2007
	Number who talk at meetings	Olken, 2007

**Table 35: Provider response outcome variables**

<i>Outcome</i>	<i>Detailed variable</i>	<i>Study</i>
Public spending	Central transfers per capita, spending on cultural institutions, administration, housing and utilities*	Beuermann & Amelina, 2014
	Funds received at the health facility	Bjorkman et al., 2017
	Per capita expenditure on administration and planning, housing and urbanism*	Goncalves et al., 2013
	Health care and sanitation spending	Touchton & Wampler, 2015
	Total funds received by health center	Grossman et al., 2017
	Development projects spending	Grossman & Michelitch, 2018
Provider actions	Traditional <i>Panchayat</i> active, health, roads, electricity, sanitation transport, water, irrigation activity*	Ananthpur et al., 2014
	Provided subsidy card	Banerjee et al., 2018
	Participation - mean effects index	Beath et al., 2013
	Facility staff works closely with the community, visible staff duty roster, health facility receives monitoring visits from heads*	Bjorkman et al., 2017

<i>Outcome</i>	<i>Detailed variable</i>	<i>Study</i>
	Civic engagement - mayors carry out council meetings, council meetings are open to citizens*	Diaz-Cayeros et al., 2014
	Health monitoring index	Grossman et al., 2017
	Effect on project selection – agriculture, watsan, transport, health, other*	Humphreys et al., 2014
	Adoption of participatory budgeting	Timmons, 2015
	Provider action - serious response taken	Olken, 2007
	Village council meeting occurred in past six months	Pandey et al., 2007
Staff motivation	Overall staff motivation score	Alhassan et al., 2016
	Facility management: my opinion is valued by management, staff morale is high, management encourages training, supervisors help solve problems, supervisors help with training, feel part of a team, feel benefit from supervision*	Bradley et al., 2005
Politician performance	Current mayor of the municipality is a woman, share of the municipal council made up by women*	Diaz-Cayeros et al., 2014
	Politician performance index	Grossman & Michelitch, 2018
	MP performance according to the scorecards	Humphreys & Weinstein, 2012
Perceived response by user	Perceives President is responsive to needs	Ananthpur et al., 2014
	Perceived to have benefited vulnerable households, proportion of recipients reported ex-post to be vulnerable*	Beath et al., 2013
	Citizen satisfaction with public decision making in their settlement*	Beuermann & Amelina, 2014
	Perceives barangay councilors, captain, mayor respond to the needs of the barangay and attend to complaints*	Capuno and Garcia, 2009
	Perceived challenges in procurement process index, satisfaction with supplier index, satisfaction with district vet index*	Fiala et al., 2017

Note: \* synthetic effect calculated across individual outcomes reported.

**Table 36: Service access outcome variables**

<i>Outcome</i>	<i>Detailed variable</i>	<i>Study</i>
Physical access to services	Water sources, roads, <i>Anganwadis</i> , below poverty line (BPL) cards provided*	Ananthpur et al., 2014
	Use of food subsidy card in past two months and amount (kg)*	Banerjee et al., 2018
	New health units constructed and amenity renovations undertaken*	Bjorkman et al., 2007
	Municipal household access to water, sanitation and electricity services*	Diaz-Cayeros et al., 2014
	Lady health worker assigned to community	Gine et al., 2018

<i>Outcome</i>	<i>Detailed variable</i>	<i>Study</i>
	Water parts and services provided	Grossman et al., 2017
	Development projects provided	Grossman & Mitchelich, 2018
	Land irrigated	Huang et al., 2014
	Access to water	Humphreys & Weinstein, 2012
	Access to water	Barde et al., 2017
	Development work undertaken, visited by midwife*	Pandey et al., 2007
	Forest products harvested from reserve	Persha et al., 2016
Cost of service	Service access price, subsidy*	Banerjee et al., 2018
	Amount of consultation fee paid at BHU	Gine et al., 2018
Measured quality of service	Health facility performance index	Alhassan et al., 2015
	Employees in <i>Anganwadi</i> , Engineer visits, extension visits, roads with a drain, roads free of garbage*	Ananthpur et al., 2014
	Canal maintenance	Bandyopadhyay et al., 2010
	Condition of amenities at health centers, number of beds, drugs availability, weighing scale, bicycle equipment, use of equipment*	Bjorkman et al., 2017
	Index of quality of LHW services received, wait time at basic health unit*	Gine et al., 2018
	Num days facility is without ORS or antimalarials, outpatient referrals, frequency of events undertaken by clinic*	Grossman et al., 2017
	Outreach campaigns, new employees	Grossman & Mitchelich, 2018
	Timely water deliveries	Huang et al., 2014
	Respondent's average assessment of the quality of six government services	Humphreys & Weinstein, 2012
	Antenatal care, postnatal care by a community health worker*	Gullo et al., 2017
	Aggregate of three measures of road quality	Berman et al., 2017
	Forest cover, forest governance index	Persha et al., 2016
	Forest cover	Rasamoelina et al. 2015
	Interpersonal skills: politeness to client (offered a seat, maintained eye contact, greeted, explained well, records maintenance, gentle mannered, confirmed client understood, session uninterrupted)*	Bradley et al., 2005
	Forest cover (logging index of forest averaged over plots)	Tachibana & Adhikari, 2004

<i>Outcome</i>	<i>Detailed variable</i>	<i>Study</i>
	Overall score of indices measuring quality of training	Fiala et al., 2017
Absenteeism	Workers not physically present	Bjorkman et al., 2009
	Unauthorized absent, health center has attendance register book*	Grossman et al., 2017
	Absenteeism	Grossman & Mitchelich, 2018
	Doctor was present at medical clinic	Humphreys & Weinstein, 2012
Corruption/leakage	Embezzlement – food aid retained by leaders*	Beath et al., 2013
	Per cent missing roads, unskilled labor, materials*	Olken et al., 2007

Note: \* synthetic effect calculated across individual outcomes reported.

**Table 37: Service use and attitudes to services outcome variables**

<i>Outcome</i>	<i>Detailed variable</i>	<i>Study</i>
Use of health service	Health insurance enrolment	Duku et al., 2018
	Child received immunization	Donato & Mosqueira, 2016
	Service use – pre- and post-pregnancy indexes, child immunization*	Gine et al., 2018
	Antenatal care, admissions to maternity unit, attendance at clinic, pregnant women received free bed nets, mother given vitamin A, child given vitamin A, child dewormed*	Grossman et al., 2017
	Antenatal, postnatal care received, went for HIV testing with husband/partner*	Gullo et al., 2017
	Ever heard a health talk at the site	Bradley et al., 2005
Use employment service	Service use: participation, days, wages*	Ravallion et al., 2013
User satisfaction	Perception of overall healthcare quality, health insurance scheme*	Duku et al., 2018
	Victim reports being 'satisfied' or 'completely satisfied' with police response	Banerjee, 2014
	Average over family of outcomes on citizen satisfaction with services	Beuermann & Amelina, 2014
	Desired changes in the delivery of public services	Capuno and Garcia, 2009
	User satisfaction basic health unit	Gine et al., 2018
	Satisfaction with governmental services	Kasim, 2016
	Perceived quality of services when last received: delivery care, family planning*	Gullo et al., 2017
	Overall satisfaction reported by citizen	Molina, 2014
Villagers' assessment of road quality	Berman et al., 2017	

<i>Outcome</i>	<i>Detailed variable</i>	<i>Study</i>
	Household satisfaction with village natural resource committee, household ranking of trajectory of forest reserve condition*	Persha et al., 2016
	Attitudes - public infrastructure improved in last year, migration decreased in village, benefits to participation in planning ( <i>Gram Sabha</i> ), work increased in village, wage increased in village, project increased employment, can get work when demanded, work opportunities increased, women treated well at worksite, women of hh would like to work on project, assets created by project are useful to women*	Ravallion et al., 2013
	Clients agree with positive statements about services and facility in general	Bradley et al., 2005
	Overall performance of the community project management committee	Fiala et al., 2017
	Complaints reported - protests reported, complaints about distribution process, complaints about list of beneficiaries*	Banerjee et al., 2018
Perceived quality of staff	Public perception of police responsiveness to citizens, victim reports police became aware of victims' crimes, confidence in police*	Banerjee et al., 2014
	Able to convey concerns to service provider, treated well by the service provider, user satisfaction lady health worker*	Gine et al., 2018
	Perceived quality of family planning services	Gullo et al., 2017
	Citizen reported provider performance, politician performance*	Molina, 2014
	Positive views about staff performance*	Bradley et al., 2005
	Trust in leadership, management committee*	Fiala et al., 2017
Perceived right to access services	Attitudes - women of hh would be allowed to work on NREGA, distance women would be willing to go to work, women paid equal wages as men*	Ravallion et al., 2013

Note: \* synthetic effect calculated across individual outcomes reported.

**Table 38: Wellbeing outcome variables**

<i>Outcome</i>	<i>Detailed variable</i>	<i>Study</i>
Health: mortality	Under five-year-old deaths	Bjorkman et al., 2017 Donato & Mosqueira, 2016
	Neonatal mortality	Gine et al., 2018
	Infant Mortality	Touchton & Wampler, 2015
Health: morbidity	Frequency of Illness	Duku et al., 2018
	Child diarrhea incidence in the last six months, respondents who fell ill in past month*	Gine et al., 2018

<i>Outcome</i>	<i>Detailed variable</i>	<i>Study</i>
Health: fertility	Average number of pregnancies per year, births per year*	Bjorkman et al., 2017
	Number of pregnancies, births	Donato & Mosqueira, 2016
Nutrition	HAZ for children 0-12 months, WAZ for children 0-12 months*	Bjorkman et al., 2017
	Incidence of stunting	Gine et al., 2018
Agriculture	Rice production - yield per hectare	Bandyopadhyay et al., 2010
	Rice production, wheat production (yield per unit land and per unit water)*	Huang et al., 2014
	All assets, number of cattle*	Fiala et al., 2017
Crime	Household reports crime was committed	Banerjee et al., 2014
	Respondent reports crime committed	Palladium et al., 2015
Empowerment	Leadership, decision-making, equality of rights, right to complain*	Humphreys et al., 2014
	Perceived individual influence in community, perceived collective power of community*	Fiala et al., 2017
Social capital	NGO active in village	Ananthpur et al., 2014
	Member in local organization	Capuno and Garcia, 2010
	Number of CSOs per municipality	Touchton & Wampler, 2015
	General level of trust – fear of strangers, feel people are helpful, trust others*	Kasim et al., 2016
Satisfaction with life	Subjective wellbeing	Kasim et al., 2016

Note: \* synthetic effect calculated across individual outcomes reported.

**Table 39: State society relations outcome variables**

<i>Outcome</i>	<i>Detailed variable</i>	<i>Study</i>
Confidence in institutions	Trust in the federal government, civil service, district court, mosques*	Kasim et al., 2016
	Trust in leaders, local officials and politicians	Fiala et al., 2017
Perceptions about corruption	Public perception of reduction in police corruption	Banerjee et al., 2014
	Low perceived level of corruption, payment was made to district officer*	Fiala et al., 2017
Taxes paid	Paid tax last year, contributed last year*	Ananthpur et al., 2014
	Irrigation Service Fees (ISF) collection	Bandyopadhyay et al., 2010
	Local revenue per capita	Beuermann & Amelina, 2014
	Rate of water fee collected	Huang et al., 2014
	Property tax per capita	Timmons et al., 2015

Note: \* synthetic effect calculated across individual outcomes reported.

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