

Alissa Fishbane: Good afternoon, I'm Alissa Fishbane from ideas42 and I'll be moderating the panel today. I should say it was a little touch and go whether I would make it here since I've been recovering from a concussion, but once I saw the panelists, I couldn't miss the opportunity to join these women leaders, all of whose work I've really admired over the years and some I've had the fortune to work with. Before I introduce each of them and dive into questions and we'll also save some time at the end to ask questions, in fact, to have the audience ask some questions, just wanted to take a minute and frame up our conversation today.

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We'll be talking about how we use behavioral science to innovate for development outcomes. I think what's really important here is to think about the word innovate because how we often innovate in international development is very different than how we innovate in other sectors like technology. I'll give you an example. We use a cell phone, which is something we're all familiar with. If you think back to the first iPhone, in function, it was really similar to the Blackberry, but it completely changed our experience with using a phone. This is a really nice example to show how designing successful products often has to do as much with designing well for the human interaction with the product as it is the product or technology itself. We know in international development, so much of what we do has to do with human interaction.

If you take, we'll be talking about immunizations and vaccines later, I think this is one example, where the technology is a huge innovation for us, but until we also tackle how people get vaccinated, when they get vaccinated, we're not going to be realizing the full impact of these innovations.

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How do we typically innovate in international development or anywhere in the social sector for human interaction? I'd argue that sometimes we forget about it altogether and other times, when we do, it's often based on our intuition or judgment. We sit in a room, we brainstorm big ideas. Sometimes, it's based on a user experience, we pick the best one and we roll it out, but this is very different than how we innovate in technology.

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Another example we're all familiar with, the airplane. This, we think of as being invented by the Wright brothers in the early 1900s, but really the wing technology goes back a couple hundred years, the engine technology goes back a few decades and so really, these innovations are built on years and years of scientific insights. We have those insights for human interaction from the behavioral sciences, which gives us years and decades of empirical research to draw upon from all the disciplines that look at human decision making and behavior. I think what's really important about that piece is often when we use our intuition, we're not developing these programs fully because often as people, we act in ways that are counter-intuitive. For example, we achieve more if we have shorter deadlines than longer deadlines and we're more likely to commit to something farther away.

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The first point is it's really important to have these scientific insights. The second is we need to be constantly iterating and replicating on them. My final example here

is with the vacuum cleaner that Sir James Dyson created and famously, there's commercials about these 5,000 some-odd iterations that he went through to get to the wind-tunnel design he was happy with. We also have this methodology that we can be using in development, using randomized trials and other rigorous methods to be testing what's working, constantly iterating and getting to the impact we need to be seeing.

[00:04:00] That's what we'll be talking about today, combining behavioral science and testing to be able to improve outcomes. At ideas42, where I am, we have a specific methodology that's tailored specifically to work with partners and be able to innovate in this way and each of our panelists will be talking about how they approach this work. I'll do brief introductions and we'll kick off the questions.

[00:04:30] To the left of me is Elizabeth Fox, who's the Deputy Coordinator from Maternal and Child Survival and the Global Health Bureau at USAID. Next to her is Joanna Murray who's the Director of Research at Development Media International. Then, we have Shobhini Mukerji, who's the Executive Director of J-PAL South Asia and finally, Annie Duflo, Executive Director of Innovations for Poverty Action. I thought we could actually get it off with you, Annie. You guys have developed soapy water hand washing stations, using behavioral and other insights, if you could talk to us about how you've done that to achieve better outcomes.

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Annie Duflo: Great. Thank you and thank you so much for having me on this panel. Just a very quick background on Innovations for Poverty Action, we are an international, nonprofit research organization that works with academics from various academic institutions and practitioners to design, rigorously evaluate and then promote effective approaches to poverty problems. A lot of these approaches are based on behavioral insights.

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A lot of the interventions and research studies that you may have heard about today, we have been involved in some ways, which is really exciting to be here. Richard Thaler, who's one of the fathers of behavioral economics and its application to public policy said that one of its main mantras, number one mantras is "Make it easy." In other words, if you want people to do things that are better for them, make it easy for them. If you want people to be organ donors, make it a default options, so they don't have to think about it. If you want people to eat healthy food, put the healthy food at the forefront of the cafeteria.

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Hand washing, for us, hand washing is easy. We don't even have to think about it. It's a habit. It's almost ingrained, but in context, without piped water, it's not easy. The goal of this project that I'm going to talk about is to make hand washing as convenient as possible for people in that context. This is a project that was funded by DIV at USAID and led by researchers Clair Null and Amy Pickering Claire at Mathematica and Stanford University. They are at the conference today, if you want to talk to them and there's a little booth at the Innovations Marketplace that you can go and see.

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This is a really important problem. It has been estimated that if hand-washing was

[00:07:30] made universal, it could save up to one million lives annually. Yet, globally, only 19% of people wash their hands with soap after they have been in contact with fecal matters. There has been a lot of efforts to solve this problem, often using advocacy and education about hand-washing, but usually they have limited results.

[00:08:00] The researchers together with IPA and Catapult Design decided to develop a hand washing station that would be convenient for people to use and that would also conserve soap and water. Because usually in this context, when you see a hand washing station, it's really inconvenient for people to use. There is a bucket of water, you have to use one hand to pour water over the other, so it wastes a lot of water. The soap is also a problem. It's expensive, it breaks and it gets stolen easily. The team used a human centered design to address these issues and design a better hand washing station.

[00:08:30] Human centered design very much, like the behavioral economics insight, is that you need to design products based on your understanding of human behaviors. This requires a lot of observing people, how do people actually wash their hands. It requires a lot of rapid prototypes and testing and iteration. The researchers also played games with households to understand their preferences in ways that they

[00:09:00] couldn't necessarily express it. Through this iterative process, they designed what's now called Povu Poa, which means cool foam. The idea is that instead of soap, it uses a foam. It's a foam soap that uses laundry detergent that's widely available and that's pretty cheap. This is inside a dispenser and there is a tap. It solves a lot of issues. It's very convenient because of the tap. It is also adaptable to different contexts because there are two different versions of it. The usage of the foam solves the soap security issue and it also makes the model much more affordable than your traditional hand washing station. In fact, the price fell down threefold.

[00:09:30] There was a randomized pilot to test whether this new station would in fact lead to more hand washing. Hand washing in fact was multiplied by more than two in schools and in clinics, which was really effective at improving hand washing. I hope that you go and see it. It's really an exciting example of a great leverage that the kind of funding that DIV put into this can achieve.

[00:10:00] Alissa Fishbane: That's great. I'm going to jump from something that's an actual product to a very different type of way to use behavioral insights, which is developing communication campaigns and achieving behavior change through that and ask Joanna talk about your work in doing that.

[00:10:30] Joanna Murray: Sure, so at DMI, we're running randomized control trial in Burkina Faso in West Africa and that's being led in partnership with J-PAL and with IPA, who are running the independent evaluation. The intervention itself, which DMI are implementing is a radio campaign, which is being forecast over the course of two and a half years. It's being broadcast on seven randomized radio stations, targeting rural communities. The aim of the campaign is to increase uptake of modern contraception among women living in those communities.

The intervention itself, as I said is we're forecasting on the radio and there are

[00:11:30] different components to that radio intervention. It features really intensive broadcasting of radio spots. These include some short 60 second stories, some 30 second spots, which are more testimonials from individuals who are using particular contraceptive methods, talking about why they have chosen those particular methods and also an evening show, which features an interactive element, so people can call in. We've partnered with Marie Stopes International, MSI and they have health agents, who come into the radio shows and answer callers' questions about, particularly concerns about things like side effects.

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[00:12:30] In terms of how we incorporate behavioral insights into the design and the implementation of our campaigns, really the core aspect is ensuring good integration between our research and our creative processes. We have a team of local Burkinabe script writers and we also have a local Burkinabe research team. In designing the campaign and actually throughout the process of implementing the campaign, we use various approaches to conducting qualitative research to help inform the design of the campaign. This includes both carrying out focus group discussions among the target audience, individual interviews with key stake holders and influencers, so that might be health agents that might be religious leaders that might be village chiefs, but also a really crucial aspect that we've introduced into this family planning campaign is allowing our creative team themselves to go out and spend time in the communities that we're trying to target. We run these immersion trips, whereby our creative teams, who themselves may have grown up in some of the villages that we're targeting, but who still primarily now live in capital city, so we allow them to go and spend a week or two, immerse in the communities that they're targeting and directly observing those villagers and how people live in [inaudible 00:13:37] there.

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[00:14:00] Now, of course, the challenge with family planning is you can't really directly observe some of the behaviors that we're trying to target, but it does allow [inaudible 00:13:45] to get inspiration. It allows them to spend time, observing some of the social factors and some of the key influences of a woman's decision about whether or not she can use a contraceptive method. For example, mothers-in-law tend to have a [inaudible 00:14:01] on whether or not a couple have another child. There's often a strong desire from mothers-in-law to have a family. Also, it gives them a chance to just gain inspiration for stories that will really resonate and engage with the target community that we're working with.

[00:14:30] What we learn about behaviors through the immersion trips, the different approaches that we use to our formative research, we distill all of that information down into a message brief. That's really the core that our creative team then use to develop their stories. We include within that information about the barriers, the key obstacles to people changing their behaviors, but also some of the drivers and the levers that we can use to help change behaviors. It's really important that our research is then easily translated to that creative team, so that they understand, even if they haven't had ... You know, they're not like our research team, who are out in the field all the time, but they have a good understanding of what are the barriers, what are the factors we can use to facilitate behavior change and what are the key social factors and the key influences that affect whether or not someone

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adopts the use of contraception.

Alissa Fishbane: Thank You Joanna. It's a helpful example and starting to talk really around how to stimulate the [inaudible 00:15:31] and I wanted [inaudible 00:15:32] can continue that conversation with your work in coordination with DIV on the immunizations.
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Shobhini Mukerji: Sure, I shall do that. I'm actually speaking to a converted audience I'm sure, so I don't have to convince anyone about the importance of [inaudible 00:15:50] interventions. The example I'm going to talk about in particular is immunization. Immunization is a highly cost effective way of improving child survival, yet we see that if I look at WHO statistics, we find that about 23 million children, infants across the world are not fully immunized. In India, this figure from the latest household surveys that the government has carried out, the fourth round, it points to about 54% children in India are fully immunized. That's a low number if you look at it. If you compare this with countries like Nepal and Bangladesh, which are half of our per capita income, it's above 80% for immunization rates in Nepal and Bangladesh.
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[00:16:30] What is going on here? I think there is a real need to improve full immunization rates in India and the government of India is making huge investments in infrastructure, in improving the supply, improving access. There are health clinics. There are frontline workers. There are trained government officials. They've improved in the last decade. They have improved the cold chain supply of vaccines, yet we find that the demand for immunization rates is low.

[00:17:00] We were looking at some of the reasons why this demand could be low and some of them include, it's a very common, actually reason that we found is that the future benefits of immunization seem very low in comparison to the current the opportunity cost in the current trade off. It's a trip to the vaccination center in rural India for that mother, who will forego a day's wage. It's a child's discomfort to getting immunized, which we must not underestimate because in fact just before coming here, I had gone to see this evaluation that we're running on the ground and had 20 children in a camp, getting immunized, one after the other. They were crying and the mother was holding the children and looking away. It's like the mother was getting the shot, it seemed like that. Why would you want to come back over and over again to complete five shot?
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[00:18:00] Immunization interestingly is a classic example, where we see time inconsistent preferences. I think we're all, at least I am also guilty of that. Parents may be tempted to postpone, thinking that, "We'll always do it later." Then, the last thing I think we find is that caregivers fail to stick to the immunization schedule. I'll talk about the statistics in a bit, but we find that between the first and the fifth shot, there's a huge drop in the rates of immunization. There's something going on here and [inaudible 00:18:17] intervention in particular that we are testing, we are testing three demand-side strategies to increase immunization at large scale in India. Two of the interventions, we are actually averaging mobile technology. You talked about that right at the beginning. We're looking at mobile platforms as a form of incentive, so there are mobile top-ups that are given to families, who come to get the children immunized. There are various, I guess we are changing the rates
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of the mobile top-ups in terms of flat rate, increasing the rates by the end of the fifth shot. We are sending targeted reminders through SMS reminders for these mobile phones.

[00:19:00] The last one is actually looking at social networks and leveraging social networks in the village, where we have these influential nodes, who spread the communication and spread the message. This intervention is being carried out in a state in northern India with ... When I mean large-scale, it's 970 villages and about 15,000 families, it's being carried out, this intervention across five very large districts of a normal state. This is a large scale government replication in a way of an earlier smaller scale study. It was done by an NGO, where we saw six-fold increase in full

[00:19:30] immunization rates when we added the demand side incentives in addition to the supply. This is more of a larger scale evaluation of that study that we're running right now. The incentive there was different, it was in the form of lentils that we gave. I think that at the end of it, they gave a slightly bigger, they give a set of bowl or some thali. Interestingly, two of the researchers working on the study are in this room. There are nine researchers on the study, so if you have any specific questions, you can ... One of them was John Floretta and he was in the previous panel. We have Anna Schrimpf as well, so you should feel free to ask them about this.

[00:20:00] This is more of a larger scale evaluation of that study that we're running right now. The incentive there was different, it was in the form of lentils that we gave. I think that at the end of it, they gave a slightly bigger, they give a set of bowl or some thali. Interestingly, two of the researchers working on the study are in this room. There are nine researchers on the study, so if you have any specific questions, you can ... One of them was John Floretta and he was in the previous panel. We have Anna Schrimpf as well, so you should feel free to ask them about this.

Alissa Fishbane: Thanks Shobhini. We've now heard a few examples and I know Elizabeth, you're working on many studies-

Elizabeth Fox: That's right.

Alissa Fishbane: ... in the field right now with Office of Evaluation Services and I was hoping you could talk about how your work with them has made the global health programs more efficient.

Elizabeth Fox: Sure, I have to start with asking the audience a question though, how many of you caught the quick video that we had before this panel? Not very many. Some of you did because what that video does is it explains how the Office of Evaluation Services at GSA works and works with different organizations. What I'm going to talk about is a little bit different because this is more how the kinds of behavioral insights and rapid randomized control trials can be introduced into ongoing programs in order to apply behavioral nudges and make things work more efficiently. To do that, like the way the Office of Evaluation Services works across the US government, I mean the GSA is the US government. They work with agencies and with programs that have a lot of data. They collect data from the Veterans Administration or the Department of Education. This is routinely collected data that's available.

[00:21:00] Sure, I have to start with asking the audience a question though, how many of you caught the quick video that we had before this panel? Not very many. Some of you did because what that video does is it explains how the Office of Evaluation Services at GSA works and works with different organizations. What I'm going to talk about is a little bit different because this is more how the kinds of behavioral insights and rapid randomized control trials can be introduced into ongoing programs in order to apply behavioral nudges and make things work more efficiently. To do that, like the way the Office of Evaluation Services works across the US government, I mean the GSA is the US government. They work with agencies and with programs that have a lot of data. They collect data from the Veterans Administration or the Department of Education. This is routinely collected data that's available.

[00:21:30] As you can see from the panel and I see for most of you in the room, the work that we do in development is done in very different circumstances. The countries, where we work don't have good data systems in a lot of cases or the data systems are manual and they're not routinely collected and they're just not available. The challenge when OES came to us and said, "Let's do something," was to say let's find

[00:22:00] a place, where we have programs, where we have data that is collected with some routine nature or the data that's available through clinics or data on Immunization. We don't really have data on hand-washing because people don't check the box when they wash their hands, but as some place, where we can use that data, so we're not setting up a big new expensive study, but a place where we can say, "Let's work within your existing program and let's look within data that is routinely

[00:22:30] collected and see how by introducing a change, a nudge, a different incentive, a different way of making something easier for somebody, if that's going to work."

Then, once that happens, we can apply it more generally across a program. That's what the video does. It talks to you or tells you and shows you what those

[00:23:00] programs are where we've worked with OES. They're exciting programs. We work with them on malaria and family planning in some of the toughest places in Nigeria and we're working with them also in Ethiopia, looking at adherence on HIV, AIDS treatment. These interventions and working I think with an outside entity that's used to working in a developed country with big datasets and trying to say, "How

[00:23:30] does that work in a country, where your data is pretty lousy, how can you also apply those behavioral insights and do the RCTs in ways that will be efficient and that can be scalable," because that's the promise. When I go to my boss and say, "This is a good thing to do," I have to say, "it will be useful and it'll be useful in a lot of our programs."

Working with them has already changed the way we work internally at USAID in maternal and child health and in malaria and in family planning and in HIV, AIDS.

[00:24:00] It's worked in two ways and I'll talk about that. It's worked in one way because it made people nervous. It makes our partners nervous to say, "You can really do this." I mean we've been kind of doing this the same way for many years and we do an evaluation at the end of a project, but what happens if you've got more real-time data? You're sort of checking how things work right along the way and if we're paying a lot of money for a new approach and they print it all up or they write the

[00:24:30] stuff and then, you have to wait till the end of the project to see if it worked.

How about if we were able to do quick rapid RCTs on those and do adjustments or say "That worked, but it really wasn't worth the cost." I think in some way just the idea that they're there and that they're our partner has put our stakeholders and partner on notice that this is not business as usual, we're going to be looking at behavioral interventions in a different way and we're going to be holding the

[00:25:00] standard of measurement to a different standard. It doesn't always work, so just making people nervous is good, but we've got to deliver. That's what we're working on. It's what the video shows.

What we're finding are some issues and these are issues that I think any of you in the room that have worked in countries can readily identify. In some cases, we've said, there's routine data available for example on how often moms come to antenatal care. If somebody has great, big spreadsheet and they tally it up, but what we found when we started working when OES started working with antenatal care clinics is the data is very unreliable. You have to get a very, very big sample in order to say, "I really can tell when I use this reminder card versus that reminder

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[00:26:00] card if we're getting a change," because there's so much variance in the data and there's so much human error in the data that we've had to both augment our data sources and sort of the validity of the data alongside doing the RCT, which is a really interesting methodological question that I'd love to discuss with all of you, who know how to do this.

[00:26:30] In some cases, we had to put more people in, we had to make samples bigger. We've also had to tackle the problem in places, where these problems, they're very complex situations. I just got back from Liberia and I was looking at the kind of data available in the clinics in Liberia and we're just happy that those clinics are open.

[00:27:00] There's not a lot of routine health information data. It's how to do the kind of rapid data use on RCTs to do these more efficient nudges when your data sources are either not available or there's so much variability in your environment because of poverty and because of lack of services and access that everything else is moving around you. You can't really hold on a randomized control.

I'll get back to that a little later on some scale-up issues, but it's worked. It's working for both the nervousness motive, but also I think from the lessons we're learning, especially around data.

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Alissa Fishbane: That's great, it's perfect to talk about how the science and the data come together-

Elizabeth Fox: Oh, yes.

Alissa Fishbane: ... in the messy world of devolvement. I want to continue on measurement, before I do I've been asked to briefly talk about our program financial heuristics with DIV. I wanted to just use it to illustrate a quick point that I think has been really nicely said in different ways on this panel already, which is that we can't just rely on traditional methods, solutions for problems that are often ... We often say, "Well, if people just had more information, they know to do this," or "If we just educate them, it would solve the problem," but we see from all of these examples how it's the way we communicate, it's the strategies we have to do to supplement the communication that are going to make the difference between knowing what you have to do and actually doing it.

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[00:28:30] Financial heuristics is really a behaviorally formed approach to financial education and it's taking instead of going through the traditional classes, where you learn the theory, how can we provide simple rules of thumb that are actionable to live by? I'll

give you one just really quick example, instead of understanding all the accounting between separation of accounts and etc., we tell micro-entrepreneurs, "You have one drawer, where you put all the business money and you have one drawer, where you put all the personal money and you do not mix them. Pay yourself a salary every week." Working with DIV and IPA and others, we've actually taken the early trials that we've done, where we've gotten really great results in terms of increasing financial behaviors, like separating accounts and calculating revenues, but also outcomes in terms of improving business revenues, including down weeks, which are really important. We're trying to make it more scalable and in terms of

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[00:29:30] operational and cost-effectiveness and working in India and the Philippines, creating weekly messages, weekly phone calls to clients that are delivered through interactive voice recordings that are just a couple minutes long. They talk to the entrepreneurs and each week deliver a new rule of thumb.

[00:30:00] This is [inaudible 00:29:47] and I think most of what we've talked about today is in the innovation marketplace and around here, so if anyone wants to learn more, I'd encourage you to find these and others there. With that I want to jump back to the measurement piece. You talked a lot about how to take on some of the challenges of that and I think one of the other challenges is in measurement. Joanna, as often, how do we measure communication campaigns and that'll be helpful to hear a little bit more about that.

Joanna Murray: Yeah, so as I mentioned earlier, DMI, we're running a randomized control trial to measure the impact of a radio intervention and the mass media as a method of social behavior change communication is by its nature, operates best at scale and therefore is very difficult to randomize and evaluate rigorously. I guess the first point to make is that part of the challenge is trying to find funders, who are perhaps who are not risk-averse, who are willing to investing in expensive evaluations, which take a long time, which are challenging in many ways and hard work, but which ultimately test and measure important questions. The family planning randomized control trial that we're working on is funded by USAID DIV, the Global Innovation Fund and a philanthropist. A big hurdle to overcome initially was finding donors and funders who are willing to invest in potentially risky test, which might prove that actually this demand generation method doesn't work, but who are willing to invest in testing that in the first place.

[00:32:00] With mass media, as I said, it's very difficult to randomize as an intervention and particularly, in places where the national media is dominant and is strong. For example, in the US here, you could, in theory, run a cluster randomized control trial and you could broadcast on TV stations in local channels, so in Chicago, in New York etc. When really you're delivering an intervention that's not going to have much effect because you're not able to broadcast on the national stations, the ABC, NBC, Fox, all of those that actually the majority of the population are watching. We spent a lot of time, looking at different lower middle-income countries, where there might be a media landscape that was amenable to randomization.

[00:33:00] We identified Burkina Faso as a fairly unique country in terms of its media landscape, so it has a really weak national media. People tend not to listen to the national radio station because it broadcasts in French, whereas the local radio stations all broadcast in their local languages. Really what that facilitates is randomization, so we can identify radio stations, which still reach the majority of the population and don't overlap in terms of their transmitter each and then, randomize them. That's what we did. We did a first randomized control trial in partnership with the London School of Hygiene & Tropical Medicine, which was looking at child survival. The second one is focused on family planning. It's not to say that randomized control trials are easy to do anywhere else. We think there's one or two other countries, where it may be feasible, but it is a big challenge.

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[00:34:00] In places, where such rigorous evaluations are not possible, especially when you're wanting to operate at national scale, we've been looking at ways of implementing quasi experimental methods, so now that we've scaled up around child survival campaign in Burkina Faso for example, we're using an approach that's more similar to what Elizabeth was describing around as a time series data collection platform. We're collecting real-time data all the time, which helps both inform the campaign design and helps us to iterate and change the campaign design as we go along.

Alissa Fishbane: [00:34:30] We talked about how we get the data on how we get good reliable results and the next step often with this is how once we have something that's working, how do we talk to other service providers, other governments in scaling this? These behavioral approaches are often very different than traditional approaches to poverty alleviation, so I wanted ... Shobhini, you spend a lot of time speaking to policymakers and other folks. How do you have these conversations with them?

[00:35:00] Shobhini Mukerji: I think one of the main questions I'm actually asked is on the cost of on an intervention like this. For example, we were talking to the government the way we are implementing this program right now and the government is implementing the program, we're evaluating it, the key question they asked was it's going to be very expensive for us to give things like mobile top-ups and how much, how long do we do that for? It's important for me to and this is what I always do is to talk to them about the fixed cost that they're already incurring in setting up the camp, having the health care workers. There's a fixed cost that's associated with the supply side of the intervention. Now, if anything that the government is doing, so it's important for the government to understand and this is how explain to them is that for each child immunized, the cost will go down if there are more kids actually going to get immunized at the healthcare centers.

[00:36:00] I think this is in fact, no one thinks in terms of the benefits in the future and how things will get cheaper in the future if there's critical mass. Anyway, I think that's one of the main criteria. Then, again it's talking to them about ... The other issue that I find when governments are talking to me is to say there's an ideological issue maybe and there are state in particular, there are districts, where there are large Muslim families and the government says, "They are not going to get the kids immunized and they have an ideological issue." When we did the ... One, the key question was to understand through some baseline that we did is it really an issue? The results were startling. There was an issue with behavior, but it was not an ideological issue. We found that in these districts, 96% families came to get the kids immunized in the first shot. In the second shot, it was also similar rates, I think between [inaudible 00:36:46], but by the time you go to the fourth and the fifth last shot, it went down to as low as 40%.

[00:37:00] It's useful then and this is the statistic we give back to the government to say, it's useful to understand what the underlying issues are. I talked about the underlying issues in my previous discussion as well, but that's one of the ways that we are able to convince the government in terms of why it's a cost-effective way of achieving

the outcomes. I think that's [inaudible 00:37:13].

Alissa Fishbane: That's great. I was just actually ... Annie is right next to you, who also spends a lot of time speaking with governments and trying to convince them to use good evidence to adopt for policy and practice that we could build on Shobhini's comments and if you could talk a little bit about how has the US government helped and how can they further help in this effort?

Annie Duflo: Well, in fact the two other USAID funded initiatives that we have been involved with have been scaled or being scaled, so I'll talk very briefly about them. One was the chlorine dispensers, which you may have heard about from evidence section at another panel. Karen in the back can tell you more about it, so a study in Kenya showed that when you place chlorine dispensers next to a community water source, the use age of clean water increases six-fold. There is an important behavioral component to this intervention. It's the reminder because the chlorine dispensers is right next to the water source when you are getting the water, so it's not as having like chlorine in your tap water, but almost. This intervention is now being scaled by Evidence Action, which is a social enterprise that was created to scale evidence-based effective ideas. It has now reached four million people. Evidence Action works very closely with governments when necessary to scale this approach.

[00:39:00] Another intervention, you may have seen the movie before you came is the Community Health Workers. We partnered with the Ministry of Health in Zambia to figure out a more effective way to recruit the most productive community health workers and compared like two types of recruitment strategies, one that emphasized community service and the other that emphasized skills and career growth. The second strategy was much more effective. The community health workers were visiting households more often and this led to positive health impact. There is a common point to these two studies and to the hand-washing station, example I gave earlier, which is not yet at the stage of scale, but in the next phase, we are going to work on figuring out distribution channels and refining the design for mass production. The common factor here is cost-effectiveness and that sort of builds on what Shobhini said, these are low cost interventions.

[00:40:30] I mean if you think of the community health workers, it practically has no cost. This is just a tweak in the message and it's pretty easy to implement and that certainly plays a role in what can be scaled. Actually, want to make a little parenthesis here on cost, using this example and sort of going back to the whole of randomized control trials in evaluating the effectiveness of these types of interventions. There's often a temptation to compare the cost of the randomized control trial to the cost of the program that you're evaluating, but this is actually not the right comparison. In this case, the cost of the program was practically zero. This was a tweak in the message. The cost of the RCT was pretty high because we measured like behaviors, we measured health outcomes, so the right comparison is the cost of the RCT with the value of the benefit and not just during the time of the evaluation, but over time because this approach is now being used by the Ministry of Health to go through their next phase of community health workers. You can calculate sort of

the long-term benefits. This is also a public good, so hopefully other governments will learn from it.

[00:41:30] Another thing that was really important that's really well illustrated by this example in Zambia and one of the things we learned and that J-PAL learned as well is that in order for evidence to be used, it needs to be useful, it needs to be relevant to the potential users, it needs to be accessible to the right people at the right time and you need to have buy-in from the potential users. The way you achieve this is not by, " Oh, we have a great idea, it was evaluated," and then, you go to the potential users and try to convince them to use them. No, the way you achieve that and that's our main learning is by building long-term partnerships between researchers and practitioners, whether it's governments or nonprofits. Those who were on the last panel, you heard about this long-term partnerships between J-PAL and [inaudible 00:42:25]. This really allows you to identify problems together, identify potential solutions, test them and then, bring up new questions based on that and then, iterate on that. That's really through this sort of joint learning that evidence gets adopted, but more than that it's really learning sort of approach.

[00:43:00] What Elizabeth was describing I think is really exciting because it's one way to really learn by doing sort of these rapid experiments and you can't always do that. It depends on what you're measuring and like you say, the data can be a big obstacle, but I think it's really nice approach to institutionalize learning. I'll stop it.

Alissa Fishbane: Elizabeth, do you want to jump in the ... You don't have to convince the US Government-

Elizabeth Fox: [inaudible 00:43:22] yeah.

Alissa Fishbane: You have to scale these up, so you've learned a lot of lessons [inaudible 00:43:26].

[00:43:30] Elizabeth Fox: Well, I think what we're beginning to learn and I don't say we've learned them yet because we're in the middle of this and getting towards a culture of evidence and a culture of real-time tracking is a culture shift. We're getting there. I think a lot of the things that you've seen in these different panels has shown that of being able to do more rapid RCTs and where research is not going to cost you all bunch and it can be rapidly integrated. I think what we're learning though is where's the best place to do this because you don't want to fail. I mean you don't want to go someplace, where you're just going to have to spend most of your money, inventing the systems to collect the data for the research because that makes research very expensive.

[00:44:30] I think as a field or as a group, the lessons learned for scaling up in terms of applying rapid RCTs, using more administrative data rather than, I'm sure you're all familiar with what USAID and other partners financed all along like DHS and bigger surveys is to not start in the hardest places and to not start with the hardest programs. I mean you started in a really hard place with Burkina Faso, but you had a nice natural randomization, but to look at places and I think that's why our program, for example, using data from PEPFAR has been easier because it's very big

[00:45:00] program that collects a lot of data. There's a lot of data routinely collected, so being able to go in on a program like that and say, "Where's the opportunity to quickly test a better way to do something?" Not starting with a better way to do something, but saying, "Where, in what context can this be tested," or to work in a country that's not a Burkina in terms of its data availability, but looking someplace like India in many cases or looking at Vietnam or Philippines on their TB programs.

[00:45:30] Well, you could say there's good registries, there's good routine data on things, what is kind of a threshold as a field that we need in order to do this in a way that's not terribly expensive and doesn't become just a boutique thing that can quickly, once you've got that buy-in from the government, which is so important, go to scale.

[00:46:00] The government and the public health workers are saying they're dealing every day with this data. I think one is looking at what are the kind of things that have to be in place in order to do this in the country. The other, which is connected to it is

looking at places, where the context has a certain stability because if everything's falling apart and you're going to try a nice little innovation, it's fine, but basically you've got too much variability going on. You're not going to be able to scale up because you're testing at least what we're trying to do and what we're trying with our partners in OAS is to test nudges, to test smaller changes. We're not saving

[00:46:30] world. We're testing ways to make things more efficient, to get a little bit more people, 20% more people coming back or 10% more people coming for a vaccine. There has to be kind of a minimum requirement in terms of a health system that is working. I mean, for example, with Ebola in Liberia, we tried absolutely everything that worked in hand-washing. If you go today, you've got every single different kind of hand-washing station there are.

[00:47:00] It's because you just had to. It wasn't, "Let's test this one out." It's like, "What are the minimum requirements necessary to do that?" I think to not over promise because I think we can over promise because the work is so exciting when you see it applied domestically or you see it applied in a country, where data is more accessible. Not over promise, what we can do with this is behavioral nudges

[00:47:30] because the science is so strong and it's really important, but to work with the users and the clients to say, "What do you need to make this work and do you have those conditions?" That's kind of the lessons that we're struggling with now as we integrate this increasingly into our programs.

Shobhini Mukerji: [00:48:00] I'm actually going to jump in here if I may and this is just what Elizabeth is saying is in terms of where do you take this program, what we have found is that if you look at the underlying problem, so we were thinking about immunization, if I take that example, if you look at the underlying problems, then you have to make sure that those underlying issues exist in different contexts-

Elizabeth Fox: Exactly.

Shobhini Mukerji: ... and the different countries, where you want to actually implement that program and where you think that you want to take that program and what we have

[00:48:30] realized, if I take the immunization example is that general problems and general solutions tend to generalize better. If I take the example of immunization, now we are running two, one is an RCT in Pakistan and we are also running a pilot in Sierra Leone. What we find there in both countries, access is not an issue. There is supply. In fact, Sierra Leone, they have tied up with WFP and the incentive is the food. There is supply, there is access. We are looking at different demand side interventions in these countries. I think I'm just trying to say is that you are looking at when you want to generalize the solutions, then there are some underlying factors and mechanisms that you will have to see in how, whether they exist and we saw that these did exist. There was a behavioral issue in these countries [inaudible 00:49:12].

Alissa Fishbane: I think actually that's a really good point because there's often a question of how we replicate and one of the things that we found through a number of global surveys is that what we would call our biases or our tendencies that are often counterintuitive, some of them as humans are really remarkably very similar across regions, but the context in which we live is very different. The question is does the data show that there are similar challenges and barriers, but then what does that look like to take that success like the success of the immunization program in India and then replicated in another country, in this case, you're not going to be handing out lentils-

Shobhini Mukerji: Yeah, exactly.

[00:50:00]
Alissa Fishbane: ... probably. Your case, when you're doing the [inaudible 00:50:00] decision maker maybe very different depending on the country, so you need to contextualize with that. It might not be the mother-in-law. It might be the couple themselves or etc., so I think that's actually a really important point in thinking about scale on a question that I get a lot.

Annie Duflo: There is the country context and also the institutional context of the intervention, so a lot of things we test for example are with nonprofit organizations. It's really important to replicate the adaptation of these ideas within a government context, where people's incentives and the constraints are very different. The targeting [inaudible 00:50:43] at the child's level, which you heard about in the previous panel, it's very different to do it through government than to do it through a nonprofit organization because people's incentives are just very different and the capacity to innovate within the government is much lower. I think this replication across institutional context, even within the same country is really key.

Alissa Fishbane: I could go on, asking questions all day, but I want to make sure we have time for a few questions from the audience.

Shilpa Modi: Hi, I'm Shilpa Modi with the Global Development Lab, here at USAID. I had a question around as organizations are incorporating behavioral science more into their development projects, how well do you think they're also testing, not just the positive outcomes, but also the unintended consequences of their interventions

and how could donors and funders better facilitate this?

Alissa Fishbane: [inaudible 00:51:49].

Shobhini Mukerji: I can give an example here, so we have a study that we've recently concluded, which was supported by DIV in a state in Southern India. We were looking at a mobile technology platform to increase health care worker attendance. We found that they were, I think on average, these are again primary health care clinics in India and we found that huge absenteeism rates. The government decided to replicate a much earlier study that had these very old date and time stamp machines. Now, they had these biometric devices, where you had to swipe your attendance, so we found that one of the ... The short version of the story is it did not work. We did not see any increase in health care worker attendance for the nurses and also [inaudible 00:52:38] midwife nurses, who were using these machines. One of the issues we found, there was a lot of collusion between their supervisors and the health care workers, but one of the unintended consequences, which was actually a positive consequence, I don't have a negative one from there, but the positive consequence was that these very sophisticated devices were also collecting not only the attendance of the health care workers, but health care workers were using that to whatever service they were providing, they were entering child health information into these devices.

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When we say that, "It didn't work," the technology didn't work, but in terms of increasing the intended outcome, which was health care worker attendance, but the positive unintended consequence of this was the government has a very good rich data on child level health statistics. This is what we told the government is that if you're looking at scaling it up, then look at this aspect of it rather than increasing worker attendance. I hope that answers your question. I don't know if this ...

[00:53:30]

Elizabeth Fox: We've seen unintended consequences around the question of incentives to access services, especially when unintended consequences are the result of poor quality of services. When there's an incentive for a woman, for example, to have an institutional delivery and a financial incentive and unintended consequences in terms of one, somebody else collecting the money and two, the woman going to the service and dying because the service is not of good quality. I think a lot of the financial incentives are seen as a no-brainer, but once you think them through, I mean there's cases now, I've seen the opposite, where women are fined for not going to services. You think, "Boy, did you test that?" What what's the unintended consequences of having a fine for a home delivery?

[00:54:00]

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Winston Allen: Yeah, I'm Winston Allen, I'm with the Office of Learning Evaluation and Research at USAID. I was just curious in the work that you all do, the extent to which qualitative methods such as ethnographies incorporated into the research methods and how does that help to balance the quantitative methods you've been talking about?

[00:55:00]

Annie Duflo: We frequently use more qualitative method, especially in the design phase of the studies. The design phase of a study involves first [inaudible 00:55:34] and understanding of what the issue is and then, designing an intervention to address

[00:56:00] the issue. That often requires conducting focus group or one-on-one qualitative interviews. We certainly do a lot of that. Now, the [inaudible 00:55:58] that we learn always involve qualitative survey and qualitative measurements. We sometimes, along those also do qualitative measurements to maybe to measure specific components of the outcomes that we're interested in. As an organization, I think we could probably learn how to do this much better, so I think it's important to incorporate those in the work we do.

[00:56:30] Shobhini Mukerji: Absolutely and I agree with Annie here. This is something that we've started doing a lot of now and especially, when we work with governments, it's not always clear to the government when they come to us with a problem, what the solution is. We do have priors in terms of the evidence that has been collected. The Poverty Action Lab has more than 800 randomized evaluations across the world, but it's also when we want to be able to answer the government, they are thinking in terms of their specific context. What we found, an interesting example I can give from a southern state in India is when the government, they wanted to run these large information campaigns for improving exclusive breastfeeding among women, among the mothers, so we said, "Okay, take a step back." You can design these information campaigns. We can test the effectiveness, but let's understand what are the underlying issues in the communities.

[00:57:00]

[00:57:30] We spent about six months just scoping across the entire state, across several districts, understanding what are the barriers to exclusive breastfeeding and how do we influence mothers. What we found was the mother-in-laws were extremely important to the influence that they have on their daughters-in-law in this [inaudible 00:57:42] breastfeeding. We went back to the government and said, "We've spent six months doing this, now here is what we suggest." We included a lot of the qualitative research that we had. When we found this, we included in the design of the study and it's now in full-fledged [inaudible 00:57:54] in the state. I think there's a huge value to being able to do that and not only in the scoping stages, but there are some evaluations, where we have complemented with the ...

[00:58:00] Because you want to know the underlying, why something works and being able to understand the other part of the story as well is equally important.

Joanna Murray: Yeah, just to add to that point really, we very much advocate using mixed methods and so for the family planning trial, we're working with J-PAL, who are very much focused on the quantitative evaluation. They're using routine health facility data to look at consultations and distribution of contraceptives as well as a baseline and end-line surveys, but then throughout the course of the campaign, we're conducting our own qualitative research. Really, the main purpose of that is to answer the why question and so why the campaign is always not working and to help us then learn and adapt the campaign as we go along. It might be that we discover well some of the messages targeting men or not ... We haven't done enough messages targeting men in particular and so we adapt the weighting of our messaging to focus more on that particular target audience. It certainly serves a purpose in informing the design of the intervention itself throughout the duration.

[00:59:00]

Alissa Fishbane: [00:59:30] I just wanted to add one thing to that which I think is we absolutely 100% agree that this qualitative interviewing is very important to get at the barriers, but I want to also just mention that in addition to these interviews and other ways to do one-on-one, also think about observing the environment and the context that you're in because that gives really important clues like what might be happening. For example, we are working in Uganda on a project, where we thought people were given a micro incentive to show up to the clinic. We thought, "Oh, people aren't showing up," but what was happening was it was working just fine, but there was some confusion of what they had to pay in addition. They were showing up and then they're going away, so the actual challenge was very different than what it first seemed.

I think often observing, you can get clues of what's going on that may be deterring or a barrier in this case.

Mindy: Hi, my name Mindy. I work with Elizabeth in OAS.

Elizabeth Fox: It's her fault.

Alissa Fishbane: [inaudible 01:00:27].

[01:00:30] Mindy: I had to ask this question, which is as we do this work, I feel like a lot of this innovation talk is about disruption and looking at the people up here are from DIV or kind of outside USAID, coming in from OAS to work and like, where is the disruption in USAID contracting or OFM that needs to happen to make room for iterative design and room to say, "We failed at this, this was our target, we didn't meet it, but here's the lesson we did meet," and for implementing partners to be supported in that. That's supposed to be question for Elizabeth.

Elizabeth Fox: I guess that's for me. It's a really good question and we struggle with it. When you write an RFP or an RFA, you say you want deliverables and you say, "Here's how I want it measured." I think increasingly and this is why I talk about a culture shift, I think increasingly we're leaving more space there and both upping the requirements, but then also leaving them more open for the applicant or a proposal to respond and to say, "You need to show real-time tracking of this program, tell us how you're going to do it," for example or "We will hold you responsible for what you tell us you can measure, but you have to be able to measure it X, Y or Z intervals." Writing that into contracts is easier and we're working to see how that can be done. I think we have to work with people, I don't know if he's still here. Yes, he is [inaudible 01:02:17], but working with our Office of Evaluation, working with people, who are looking at how we put in these requirements and contracts and it's a really good question.

[01:02:30] I think it's a question that we could certainly benefit from having a more kind of open discussion with the field and saying, "What might work and what would if ..." If you read a request for proposals [inaudible 01:02:40] this in it, would you just throw it away? What's feasible because partly it's a language issue. We don't know

[01:03:00]

necessarily how to ask for the right things, but it's also a question of such a rapidly evolving field and the kinds of things that you're able to do both quantitative and qualitative, plus the technology and data and being able to get data quicker is changing. Tell us, we should have a little like input meeting that the lab can order, no ask that question. It's a really good question.

Alissa Fishbane:

[01:03:30]

All right, I think with that we have hit time. We're happy to answer your question, I'm sure [inaudible 01:03:23]. I just wanted to thank the panelists for all of their insights and thank you guys for your questions. Hopefully, you've learned at least one interesting thing that you could apply to your work today, so thank you.